The Sanctuary Model of Organizational Change for Children's Residential Treatment

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ABSTRACT

This paper describes The Sanctuary Model ® of organizational change as applied to children's residential treatment, a trauma-informed method for creating or changing an organizational culture in order to more effectively provide a cohesive context within which healing from psychological and social traumatic experience can be addressed. The theoretical underpinnings of the model are addressed, with an emphasis on the parallel process nature of chronic stress as seen in the behavior of children and of staff, as well as the organization as a whole. A description of the process involved in creating a healthier therapeutic community is described.

The Sanctuary Model

The Sanctuary Model ® represents a trauma-informed method for creating or changing an organizational culture in order to more effectively provide a cohesive context within which healing from psychological and social traumatic experience can be addressed. It is a whole system approach designed to facilitate the development of structures, processes, and behaviors on the part of staff, children and the community-as-a-whole that can counteract the biological, affective, cognitive, social, and existential wounds suffered by the children in care.

The Sanctuary Model was originally developed in a short-term, acute inpatient psychiatric setting for adults who were traumatized as children (Bloom 1994; Bloom 1997; Bloom 2000). The Model has since been adapted by residential treatment settings for children (Rivard 2000; Rivard, Bloom et al. 2003; Rivard 2004; Rivard, McCorkle et al. 2004), domestic violence shelters (Madsen, Blitz et al. 2003), group homes, outpatient settings, substance abuse programs, parenting support programs and has been used in other settings as a method of organizational change (Bills and Bloom 1998; Bills and Bloom 2000; Courtois and Bloom 2000; Wright and Woo 2000; Bloom, Bennington-Davis et al. 2003; Wright, Woo et al. 2003). There have been positive research findings associated with the application of the model to the residential care of children (Rivard 2000; Rivard, Bloom et al. 2003; Rivard 2004; Rivard, McCorkle et al. 2004).

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The Problem

Currently, in most residential treatment settings for children in the United States there is a lack of a clear, consistent, comprehensive and coherent model for delivering care that takes into account the impact of exposure to violence, maltreatment, and other forms of traumatic experience on children in care (Small, Kennedy et al. 1991; Wells 1991; Abramovitz and Bloom 2003). This is particularly important since research has shown that the majority of children treated in these settings have had significant exposure to violence (Small, Kennedy et al. 1991; Wells and Whittington 1993; Guterman and Cameron 1999). Treatment still focuses on one-to-one interventions that are limited in scope and there is commonly a lack of coordination and shared system of meaning between the therapist, the child care staff, and the educational staff.

Although the notion of residential treatment may lead people to believe that therapy is going on twenty-four hours a day, in reality, formal therapeutic interventions do not constitute a significant part of the child's day. Most of the time is occupied in attending to the activities of daily living and in an educational environment that as much as possible resembles the expectations of a normal school. Frequently, the focus of attention becomes exclusively the child's behavior – or misbehavior and the true complexity of the child's dynamics and injuries are lost in the struggle to simply control behavior in the cottages where they reside and in the school. The therapist may have a brief opportunity to address more complicated issues with the child, but most of the child's day is spent with childcare workers who frequently have little professional training and who do not necessarily understand the role they could and should play in the child's process of recovery other than behavior management or with educational staff who must focus on trying to help the child pass state educational standards.

From the staff's point of view the work is difficult, frustrating, and stressful. The interventions desired by the therapist are often in direct conflict with the interventions deemed appropriate by the child care staff and both may interfere with the educational goals of the teaching staff. To complicate this further, organizations are usually under a variety of pressures deriving from economic, performance, and safety concerns, some of which spring directly from social and political forces that exist in the larger environment. Explicit therapeutic community standards for residential child treatment, such as those that exist in the United Kingdom, do not exist or are not consistently applied (Gatiss 2001; Gatiss and Pooley 2001).

As a result, complex, parallel process interactions occur between traumatized clients, stressed staff, pressured organizations, and hostile economic, political and social forces in the wider environment (Bloom 2004; Bloom 2004). In this way, residential treatment programs can inadvertently recapitulate the very experiences that have proven to be so toxic for the children in their care. Not only does this have a detrimental effect on the children, but it also frustrates and demoralizes staff and administrators, a situation that can lead to worker burnout with all its attendant problems. Ultimately, the inefficient or inadequate delivery of service and the toll this takes on workers, wastes money and resources. This vicious cycle also lends itself to a world view that the children receiving the services are the cause of the problem and that their situations are hopeless and they cannot really be helped.

The explicit assumption of the Sanctuary Model is that traumatized children cannot heal within traumatizing – or traumatized – organizations, and that instead such organizations can make children's problems worse. The field of traumatic stress studies has exploded in the last twenty years but only recently have serious efforts been made to widen the scope of study to include the treatment of traumatized children (NCTSN 2004). It is our contention that the children in residential care are most seriously in need of specific trauma resolution techniques but that these cannot be safely and efficiently delivered as long as the institutions themselves are dysfunctional. The goal of the Sanctuary Model is to facilitate the development of an organizational culture that can contain, manage, and help transform the terrible life experiences that have molded – and often deformed - the children in residential care.

Frozen In Time – Trauma Organized Systems

The impact of traumatic experience is so profound because it tends to freeze children in time, trapping them in a seemingly endless feedback loop of destructive repetition that is conveyed from one generation to the next via disruptions in attachment relationships. At the time of the traumatic event (s) it is normal for human beings to buffer their central nervous systems from the immediate impact of overwhelming stress by placing a mental "cast" around the injured part, much like we immobilize a broken leg in a cast to give it a chance to begin healing. However, like a physical injury, a part of oneself that remains overprotected for too long cannot heal and instead becomes frozen and atrophied, effects that are eventually crippling. When this has occurred, the child, though now experiencing the crippling effects of lack of movement, will resist all efforts to move the frozen part because the pain of movement has become overwhelming. The fundamental problem associated with traumatic experience is that victims keep repeating the same destructive intrapsychic and interpersonal behaviors without even recognizing the patterns of repetition and without developing the skills for managing the extremely distressing emotions associated with change. We call this phenomenon "traumatic reenactment". But the hallmark characteristic of living systems is that of constant change and a living system that cannot learn, grow, and change is in the process of dying – the ultimate frozen state.

Traumatic events – and chronic stress – can produce a similar impact on organizations. Without intending to do so, without recognizing that it has happened, entire systems can become "trauma-organized" – inadvertently organized around interactively repeating the patterns of repetition that are keeping the individuals they are serving – and their staff members – from learning, growing, and changing (Bentovim 1992). And like individual trauma survivors, systems find it very difficult to see their own patterns. They resist the pain it takes to grow and change, to thaw their frozen parts and reclaim movement.

Parallel Processes

If we look more closely at the ways in which traumatized children and adults become organized around the unresolved effects of traumatic experience, it is possible to

draw useful analogies between these effects and the ways in which organizations – including families - also become trauma-organized.

Children who are exposed to violence and other forms of traumatic experience, including neglect – particularly if these stressors are recurrent and/or chronic – may respond with a complex variety of problems. They are unable to keep themselves safe in the world and often put other people at risk for harm as well. They are chronically tense and hyperaroused with hair-trigger tempers and a compromised ability to manage distressing emotions. This emotional arousal interferes with the development of good decision-making, problem solving skills and conflict resolution skills and as a result, the ability to communicate constructively with others does not develop properly. This results in grave cognitive, emotional and interpersonal difficulties. As a consequence, self-correcting skills that involve self-control and self-discipline fail to develop properly. Breaches of trust that are a result of failed interpersonal relationships lead to problems with trusting or constructively collaborating with authority figures. These failures lead to a progressive lack of integration among the various cognitive, emotional, and interpersonal functions required of human beings in complex societies. This lack of integration produces basic deficits that result in demoralization, loss of faith, helplessness, hopelessness, the loss of meaning and purpose and the spiraling degradation of repetition and avoidance. Lacking the necessary skills to deal with overwhelming emotions, victims frequently resort to substances, behaviors, and destructive relationships that will help them avoid the shame of failure, the anger of unjust treatment, and the grief of recurrent loss.

Parallel difficulties may be found in organizations that attempt to serve these individuals. In the United States today, social service systems are experiencing significant stress. In many helping organizations, neither the staff nor the administrators feel particularly safe with their clients or even with each other. Atmospheres of recurrent or constant crisis severely constrain the ability of staff to constructively confront problems, engage in complex problem-solving, and involve all levels of staff in decision making processes. Communication networks tend to break down under stress and as this occurs, service delivery becomes increasingly fragmented. When communication networks break down so too do the feedback loops that are necessary for consistent and timely error correction.

As decision-making becomes increasingly non-participatory and problem solving more reactive, an increasing number of short-sighted policy decisions are made that appear to compound existing problems. Unresolved interpersonal conflicts increase and are not resolved. As the situation feels increasingly out of control, organizational leaders become more controlling, instituting ever more punitive measures in an attempt to forestall chaos. Staff respond to the perceived punitive measures instituted by leaders through acting-out and passive-aggressive behaviors. As the organization becomes more hierarchical there is a progressive and simultaneous isolation of leaders and a "dumbing down" of staff. Over time, leaders and staff lose sight of the essential purpose of their work together and derive less and less satisfaction and meaning from the work. Standards of care deteriorate and quality assurance standards are lowered in an attempt to deny or hide this deterioration. When this spiral is occurring, staff feel increasingly angry, demoralized, "burned out", helpless and hopeless about the people they are working to

serve. Ultimately, if this deadly sequence is not arrested, the organization begins to look and act in uncannily similar ways to the traumatized clients it is supposed to be helping.

Healing From Trauma

Strategies that focus on organizational culture change can draw upon the knowledge gained from helping individual survivors of traumatic experiences to heal and grow. Danger and losses that attend the loss of safety are usually the wakeup calls that urge individual survivors and organizations to recognize that it is time for change. But once we start facing problems, they are generally bigger – more complex - than they appear at first glance and it is difficult to know where to start. When faced with complexity it is important to have some kind of cohesive framework that helps structure the formulation of an action plan for change. In a therapeutic situation, it is essential that the client and the helper get on the same page so that their goals and strategies for achieving those goals are aligned. Similarly, in an organizational setting it is critical that staff members, administrators, and when relevant, board members agree on basic assumptions and beliefs about their shared mission, desired outcomes, and methods for achieving their goals.

For individuals and for systems this requires a rigorous process of self-examination and the development of a core system of meaning that will guide behavior, decision-making, problem-solving, and conflict resolution. Such a process involves the willingness to temporarily reflect on the past, create a culture of inquiry to examine the present, and commitment of sufficient time to engage in honest dialogue. Productive discourse, however, depends on good communication and recovering individuals need to learn how to listen and how to talk. Likewise, chronic systemic problems lead to communication breakdowns and the loss of feedback loops within organizations. As a result, an organization must learn how to reconnect and integrate with the various parts of itself.

This can only occur by practicing democracy in action, not just in theory. Thus far in human evolution, democracy is the best method we have created to approach the problem of complexity. There is little about modern life that is not complex and this is particularly true in addressing the problems related to trauma and its impact on human individual and social existence. To heal, individuals must learn skills to modulate emotional arousal so that emotion does not interfere with the cognitive processes necessary to insure good decision making and problem-solving. It is through participation in work groups, teams, and meetings that routine emotional management occurs within organizational settings. Crisis-driven organizations sacrifice communication networks, feedback loops, participatory decision making and complex problem-solving under the pressures of chronic stress and in doing so, lose healthy democratic processes and shift to an increasingly hierarchical, top-down control structure that discourages creativity, innovation and risk-taking resulting in an inability to manage complexity. The cure for this situation is more democracy. This requires leadership buy-in and immersion in the change process, an increase in transparency, and deliberate restructuring to insure greater participation and involvement.

Democratic participation requires a level of civil discourse that is missing within many organization settings largely due to a lack of conflict resolution mechanisms within

the organization. To be healthy, organizations must have the goals of conflict resolution and conflict transformation as organizational goals. This means learning to walk the talk, embedding conflict resolution strategies at every level, not turning them over to a separate department or individual who is the formal instrument of conflict resolution. An environment that encourages participatory democratic processes, complex problem-solving, and routine conflict resolution is an environment that encourages social learning. In an environment of social learning, every problem and conflict is seen as an opportunity for growth and learning on everyone's part (Jones 1968). In this way, error correction becomes a challenging group educational process instead of a method for punishing wayward individuals. This requires a growth in understanding of the power of the group process.

"Is it working?" is the question that an organization needs to repeatedly ask itself. Healing from trauma and chronic stress requires change and movement since the hallmark characteristic of stress is repetition and resistance to change. Like individuals, organizations often keep repeating the same strategies that never work, or that do not work any longer and then attribute failure to the children that are being served instead of the methods that are being used to help them change. Change can be frightening and dangerous or change can be exciting and even fun. This depends a great deal on the values and vision that the members of an organization are willing to share together and share with the children. The hopelessness, helplessness, and loss of faith that accompany trauma and chronic stress are signs of stagnation that can only be overcome through creating a different vision of possibility toward which every change can be measured.

An organization that heals from its own past history of chronic stress and trauma and rejects the notion of inevitable crisis is an organization that is able to contain the emotional turmoil so characteristic of working with traumatized individuals without becoming "trauma-organized" itself. This is what we mean by a "trauma-informed system".

The Sanctuary Model: A Plan and a Process

What has emerged from experience with various therapeutic and social service settings is a plan, process, and method for creating trauma-sensitive, democratic, nonviolent cultures that are far better equipped to engage in the innovative treatment planning and implementation that is necessary to adequately respond to the extremely complex and deeply embedded injuries that children, adults, and families have sustained. The therapeutic community approach aims at a total culture intervention and the Sanctuary Model builds upon the work of others in describing a healing culture (Manning 1989; Kennard 1998; Campling and Haigh 1999; Haigh 1999; Kennard and Lees 2001). The aims of the Sanctuary Model are to guide an organization in the development of a culture with seven dominant characteristics all of which serve goals directly related to trauma resolution:

- Culture of Nonviolence – helping to build safety skills and a commitment to higher goals
- Culture of Emotional Intelligence – helping to teach affect management skills
- Culture of Inquiry & Social Learning – helping to build cognitive skills

- Culture of Shared Governance – helping to create civic skills of self-control, self-discipline, and administration of healthy authority
- Culture of Open Communication – helping to overcoming barriers to healthy communication, reduce acting-out, enhance self-protective and self-correcting skills, teach healthy boundaries
- Culture of Social Responsibility – helping to rebuild social connection skills, establish healthy attachment relationships
- Culture of Growth and Change – helping to restore hope, meaning, purpose and empower positive change

The S.E.L.F. framework is a trauma-informed tool that helps to orient staff and clients around the tasks necessary to heal. S.E.L.F. is an acronym that represents the four interactive key aspects of recovery from bad experiences. S.E.L.F. provides a nonlinear, cognitive behavioral therapeutic approach for facilitating client movement through the four critical aspects of recovery: *Safety* (attaining safety in self, relationships, and environment); *Emotional management* (identifying levels of affect and modulating affect in response to memories, persons, events); *Loss* (feeling grief and dealing with personal losses), and *Future* (trying out new roles, ways of relating and behaving as a "survivor" to ensure personal safety and help others) . Using S.E.L.F., the clients and staff are able to embrace a shared, non-technical and non-pejorative language that allows them all to see the larger recovery process in perspective. The accessible language demystifies what sometimes is seen as confusing and even insulting clinical or psychological terminology that often confounds clients and line-staff, while still focusing on the aspects of pathological adjustment that pose the greatest problems for any treatment environment (Foderaro and Ryan 2000; Foderaro 2001; Bills 2003) [2].

The impact of creating such a trauma-informed culture should be observable and measurable. The outcomes we should expect to see include:

- Less violence including physical, verbal, emotional forms of violence
- Systemic understanding of complex biopsychosocial and developmental impact of trauma and abuse with implications for response
- Less victim-blaming; less punitive and judgmental responses
- Clearer more consistent boundaries, higher expectations, linked rights and responsibilities
- Earlier identification of and confrontation with perpetrator behavior
- Better ability to articulate goals, create strategies for change, justify need for holistic approach
- Understanding of reenactment behavior and resistance to change
- More democratic environment at all levels
- Better outcomes for children, staff, and organization

[2] When applied to adults, the acronym used is S.A.G.E. representing similar concepts: Safety, Affect Management, Grieving and Emancipation. The references included here were written about adults in treatment before the different words were adopted by the children's programs.

Through the implementation steps of the Sanctuary Model, staff members engage in prolonged dialogue that serves to surface the major strengths, vulnerabilities, and conflicts within the organization. By looking at shared assumptions, goals, and existing practice, staff members from various levels of the organization are required to share in an analysis of their own structure and functioning, often asking themselves and each other provocative questions that have never been overtly surfaced before. The emphasis on the development of more democratic, participatory processes is critical because these are the processes most likely to lend themselves to the solution of very complex problems while improving staff morale, providing checks and balances to abuses of power, and opening up the community to new sources of information.

As these discussions proceed, participating staff begin to make small but significant changes. Taking risks, trying new methods of engagement and conflict resolution, they feed these innovations and their results back into the process discussions. They are asked to begin community meetings, or if they are already holding community meetings, to hold them more frequently and take them more seriously as a significant method for changing the culture. In the Sanctuary Model, wherever possible, two community meetings a day provide punctuation and structure for the beginning and the end of the therapeutic day. These meetings are structured, simple and designed to steadily and repetitively reinforce the social norms of the community. The staff are encouraged to engage in regular safety planning, collaborating with clients in the development of these plans and simultaneously utilizing the safety planning process as a way of beginning to teach clients the S.E.L.F. constructs while they are at the same time, learning the constructs with the clients. Embedding these fundamental tasks of recovery as a common language is an essential part of the Sanctuary Model and is supported by the implementation of psychoeducational groups for clients that follow a S.E.L.F. format. As this occurs, the clients begin using S.E.L.F. language and their developing skill in managing emotional states becomes noticeable. As this process unfolds, the staff members become much more interested in the history of what these clients have actually experienced and how that history has determined present behavior. Through case discussions and an increase in collaborative efforts among various treatment team members, innovative approaches are tried and discoveries made that further reinforce the process of continuing change.

Leadership Commitment

Implementing the Sanctuary Model begins with the development of a core team that represent participation from every level of the organization to insure that every "voice" is heard. It is vital that all key organizational leaders become actively involved in the process of change and participate in this core team. Experience has taught that courageous leadership is always the key to system change and without it, substantial change is unlikely to occur. This change process is frightening for people in leadership positions and they rightfully perceive significant risk in opening themselves up to criticism, in leveling hierarchies and sharing legitimate power. The gains are substantial, but a leader only finds that out after learning how to tolerate the anxiety and uncertainty that inevitably accompanies real change. Since few of us have much real-life experience

with operating within democratic systems, learning how to be an effective democratic leader necessitates a sharp and often steep learning curve.

The core team can be comprised of 25-40 people and that may constitute the entire staff of smaller organizations. However, in larger organizations the core team will by necessity be a representative body. This requires a team composition that is diverse along every dimension that comprises the organization: age, race, gender, ethnicity, religion, profession, class, education, status, etc.

The responsibility of the core team will be to actively represent and communicate with their constituency and to become trainers for the entire organization. The core team will work out team guidelines and expectations of involvement for individual team members as well as a meeting schedule. The core team will also need to decide on safety rules for the constructive operation of the team itself. Ultimately the core team will be responsible for the development and implementation of a curriculum aimed at including the entire organization in the change process. The ultimate goal is to maximize the sharing of information that is so vital to healthy therapeutic community function (Kennard 1998).

S.E.L.F. System Evaluation - Review of The Past And The Present

The further utility of the S.E.L.F. framework is that it can simultaneously be employed in a parallel process manner to deal with problems that arise within the treatment setting between staff and clients, among members of staff, and between staff and administration. Applied to such issues of staff splitting, poor morale, rule infraction, administrative withdrawal and helplessness, and misguided leadership, S.E.L.F. can also assist a stressed organization to conceptualize its own present dilemma and move into a better future through a course of complex decision making and conflict resolution.

The first task of the core team is to engage in a S.E.L.F. System Evaluation. This first involves a review of organizational history, using the past to help us understand the present. The focus then shifts to the fundamental question of “Are we safe?”. Similar to the application in individuals, organizational safety is understood as occupying four domains, all of which must be in place for an organization to be truly safe: physical, psychological, social, and moral safety. “How do we manage emotions as a group?” is the second dimension of S.E.L.F. – Emotional management - and necessitates a review of the change process inherent in every organization. Team members are asked to anticipate the inevitable resistance to change that is a fact of life in every organization. They look at management styles, the way decisions are made and conflicts resolved. “How do we deal with loss?” touches on how the organization deals with the losses that are inherent in every organizational setting – staff leave, leaders depart, funding changes necessitate the loss of whole parts of a program, clients fail and sometimes they die. The inability to deal with the Loss part of S.E.L.F. at an organization level may lead to a system whose growth is arrested, similar to the impact of unresolved grief in the lives of individuals. A focus on Future affords the core team the opportunity to begin creating a new vision of what the organization can be and do if it can move again. In this part of the evaluation, team members together begin to forge a different model of how they want to work together to achieve organizational goals.

Creating Shared Assumptions, Beliefs and Values

In the third implementation step, the core team must identify the most important organizational values and honestly surface and identify areas where the organization is not actually living those values. The discussions about shared assumptions are likely to begin with an assumed consensus that is actually false – profound conflicts are likely to have been bubbling under the service for quite some time but have never been clearly articulated. The core team must surface these conflicts, evaluate the impact on the functioning of the program, and decide on the values they are willing to share – and act on – together. Then the core team will have to develop a statement on how they would like the staff and administrators to view their clients, each other, and the organization as a whole. Through this shared group experience, the core team members experience open and transparent decision making and the personal feedback that is so valuable in a functioning therapeutic community(Kennard 1998).

Becoming More Democratic

Didactic presentations and discussion will help the core team members learn about what it means to engage in more democratic processes on the part of leaders, staff, and clients, particularly in terms of the simultaneous increase in rights and responsibilities. They must learn about the basic principles that go into creating and sustaining a therapeutic trauma-informed community. They evaluate the existing policies and procedures that apply to staff and clients and ask whether or not they are effective in achieving the goals that they strive for. The team begins to draft a program constitution and develops a comprehensive plan for the steps they will take to close the gaps between the organization they want to be - based on their constitution - and the organization as it exists in the present. This constitutional process will focus on inclusiveness, participation, rights and responsibilities, decision-making, conflict resolution, rules and norms, consequences for deviant behavior, responses to stress and to violence, responses to vicarious traumatization and self-care, and continuance and maintenance of normative standards.

Teamwork and Collaboration

The next focus of implementation is on teamwork, collaboration and systems integration. The core team develops a vision statement for how they believe the work groups or teams should function together to produce a more integrated system. They then develop a plan for the steps they will take to improve teamwork and collaboration in order to make that vision a reality. The team also begins the process of developing a statement of expectations for staff around their responsibility to confront each other in a constructive manner and initiate a plan to increase the conflict resolution resources within the organization.

Understanding Trauma and Its Impact

Studying and understanding concrete information about the impact of trauma on individuals, families and systems is vital for creating a trauma-informed system. Supplementing didactic and experiential training, core team members are expected to read and report on key articles about the psychobiology of traumatic stress, child maltreatment, family violence, community violence. Discussion focuses on the ways in which the knowledge about traumatic stress needs to be integrated into the existing policies and procedures of the organization including the impact of exposure to vicarious trauma and its impact on organizational function.

Using S.E.L.F.

In the next phase of implementation, the core team develops a plan for consistent review and response to incident reports that identify safety breaches. They will identify what client behavior and what staff behavior can lead to the loss of safety. In most cases, staff have already had training in restraint reduction and de-escalation techniques that are complementary to the Sanctuary principles. Sanctuary emphasizes the creation of a nonviolent environment with normative standards so clear that violence is far less likely to emerge. The core team will develop an intervention plan to use with each other in high affect and escalating situations. They will develop a policy for the thorough debriefing after any incidents of violence or loss and develop a plan to train staff in the area of grief work. They will review and revise grievance procedures as well as performance reviews to reflect the emphasis on safety and emotional management. The core team will outline how the organization should address issues relating to Future, both for themselves and in their clients. This involves an ongoing dialogue with each other and with the children about what it takes to build a better future, to change the trajectory of one's life from what it has been to what it can be, an opening up of other possibilities. They will develop an outline for constructing treatment plans and case reviews using S.E.L.F.

Assessment and Formulation

At this point the core team will decide what they need to assess in the population they are serving in order to provide more trauma-informed services. They will design a written description of the assessment process that ensures that all team members contribute to the process and receive the information generated from the process. Since it is evident that the traumatic history frequently is "lost" over time, the core team will also develop a plan to ensure that the trauma history is reviewed and discussed at all relevant team meetings.

Community Meetings

The core team develops a format for regular community meetings and will decide on a regular, twice daily schedule for those meetings that can be integrated into both residential and school settings. Community meetings serve many purposes including the

dissemination of information, an open and public process of decision making, a forum for personal feedback, and a vehicle for community members to expert pressure on those who are not conforming to community norms (Kennard 1998). In addition to formulating a plan for community meetings, the core team must also develop training and supervisory plans to ensure that the community meetings are conducted as planned. The members of the core team then initiate community meetings according to the plan they have devised. It is critical that community meetings are just that – meetings of the community – and therefore staff attendance must become a high priority. The greater the staff involvement, the more effective community meetings will be in managing even the stormiest of emotional management challenges in the residences or the school.

Safety Plans

In Sanctuary, every person – child and staff – must develop safety plans for themselves. These plans should be simple and straightforward and provide options for immediate steps that can be taken as soon as the individual finds himself and a stressful, challenging, or dangerous situation. Having the staff draft and use their own safety plans helps them become more capable in helping the children design and use their safety plans. The core team then drafts a process for review and revisions of the safety plans. Safety plans are recorded on cards for the children and for the staff to carry with them as a useful cognitive-behavioral self-management tool.

Curriculum Development

Sanctuary will not be effective unless everyone in the community is on the same page. Using a training-of-the-trainers model, the core team begins to develop a training curriculum and delivery plan to ensure that all staff are trained in the area of traumatic stress studies. Consistent with therapeutic community practice, this training should include all members of staff, even those not directly involved in treatment. The training plan will include a plan for embedding the curriculum material into the orientation program for new staff. The curriculum will cover the psychobiology of trauma, S.E.L.F., safety planning, building community and other key areas.

Psychoeducation

Based on this knowledge, the core team will begin to develop an appropriate psychoeducational curriculum about trauma for the clients and will begin delivering that curriculum. The psychoeducational curriculum for clients must be consistent with that delivered to the staff and include information about the basic psychobiology of trauma and the concepts covered under S.E.L.F. Psychoeducation is a key aspect of recovery, empowerment, and the development of better self-control. The Sanctuary treatment environment is richly educational utilizing all available methodologies to help the children understand the impact of negative experiences on their development and enlisting them in the process of positive change. Psychoeducational groups stimulate learning and the development of consistent community norms and a shared language. This kind of education is necessary to ready children to safely engage in the direct trauma

resolution work that many of them need. It is best if the psychoeducational groups are flexible and that the subject matter is varied based on the immediate needs of the community on the day of the group. As a result, the group leaders must be reasonably good educators who have a sufficient grasp of the material to adapt S.E.L.F. concepts to the needs of the moment.

Staff Training and Supervision

The core team will develop a plan for clinical staff training in the area of trauma-specific interventions as they are relevant within the organization. As the staff become more clinically sophisticated, it will be possible to introduce trauma-specific treatment approaches that are likely to bring about better outcomes for the children. This may mean specialized training for professional staff or it may mean developing a plan to link with those resources in the community. The core team will also work on developing supervision guidelines to assist staff with the adverse effects of working with traumatized people and they will also identify procedures and practices to incorporate into the organization to protect staff from the adverse effects of vicarious traumatization.

Client Participation

One of the challenges for the core team is to develop a plan for increasing the children's participation in the service delivery plan. Residential treatment staff are often reluctant to encourage active participation on the part of the children because they fear losing control. But self-governance is a critical aspect of recovery and the children must have multiple opportunities for learning and rehearsing new behaviors within a contained environment. Included in this discussion should be a plan for increasing the involvement of other family members as well as better preparations for a child's discharge back into the community.

Evaluation

Finally, the core team must decide on indicators they want to use to evaluate their Sanctuary program in an on-going way – their Sanctuary Program Evaluation Plan. The indicators should be observable and measurable and consistent with standards established by Sanctuary leaders. There should be a regular process of evaluation and review that involves all core team members. It is vital that there be a thorough method for reviewing problems and failures and establishing remedial courses of action. But likewise there must be methods for reviewing and capturing successes.

Review and Certification

Sanctuary is a registered trademark and the right to use the Sanctuary name is contingent on engagement in a certified training program and an agreement to participate in an on-going, peer-review certification process. In this way we hope to establish a method for guaranteeing an acceptable level of fidelity to the original model upon which

the research was based (Rivard, Bloom et al. 2003; Rivard 2004; Rivard 2004; Rivard, McCorkle et al. 2004). In 2005, a Sanctuary Leadership Development Institute is opening at the Andrus Children's Center in Yonkers, New York to train residential center leadership teams in how to incorporate Sanctuary principles into their own programs [3].

Conclusion

This paper has described the basic theoretical framework and implementation steps necessary to introduce The Sanctuary Model ® to children's residential treatment settings. Since most of the children who enter residential care have been exposed to overwhelming experiences related to trauma and disrupted attachment it is imperative that trauma-informed methods of care become integrated into standard practice. The long-term negative consequences of failing to deal with the impact of psychological trauma are now well established (Felitti, Anda et al. 1998; Anda, Croft et al. 1999; Dietz, Spitz et al. 1999; Hillis, Anda et al. 2000; Anda, Felitti et al. 2001; Dube, Anda et al. 2001; Dube, Anda et al. 2001; Hillis, Anda et al. 2001). Children's continuing physical, psychological, social, and moral development offers a window of opportunity for the prevention of a multitude of adult problems and it is urgent that we maximize that opportunity to bring about substantial change, emotional growth and healing – before it is too late.

References

Abramovitz, R. and S. L. Bloom (2003). "Creating Sanctuary in a residential treatment setting for troubled children and adolescents." Psychiatric Quarterly **74**(2): 119-135.

Anda, R. F., J. B. Croft, et al. (1999). "Adverse childhood experiences and smoking during adolescence and adulthood." Jama **282**(17): 1652-8.

Anda, R. F., V. J. Felitti, et al. (2001). "Abused boys, battered mothers, and male involvement in teen pregnancy." Pediatrics **107**(2): E19.

Bentovim, A. (1992). Trauma Organized Systems. London, Karnac Books.

Bills, L. J. (2003). "Using trauma theory and S.A.G.E. in outpatient psychiatric practice." Psychiatric Quarterly **74**(2): 191-203.

Bills, L. J. and S. L. Bloom (1998). From Chaos to Sanctuary: Trauma-Based Treatment for Women in a State Hospital Systems. Women's Health Services: A Public Health Perspective. B. L. Levin, A. K. Blanch and A. Jennings. Thousand Oaks, CA, Sage Publications.

Bills, L. J. and S. L. Bloom (2000). "Trying out Sanctuary the hard way." Therapeutic Communities: The International Journal for Therapeutic and Supportive Organizations **21**(2 (Special issue)): 119-134.

Bloom, S. L. (1994). The Sanctuary Model: Developing Generic Inpatient Programs for the Treatment of Psychological Trauma. Handbook of Post-Traumatic

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Therapy, A Practical Guide to Intervention, Treatment, and Research. M. B. Williams and J. F. Sommer, Greenwood Publishing**:** 474-49.

Bloom, S. L. (1997). Creating Sanctuary: Toward the Evolution of Sane Societies. New York, Routledge.

Bloom, S. L. (2000). "Creating Sanctuary: Healing from systematic abuses of power." Therapeutic Communities: The International Journal for Therapeutic and Supportive Organizations **21**(2): 67-91.

Bloom, S. L. (2004). "Neither Liberty Nor Safety: The Impact Of Fear On Individuals, Institutions, And Societies, Part I." Psychotherapy and Politics International **2**(2): 78-98.

Bloom, S. L. (2004). "Neither Liberty Nor Safety: The Impact Of Fear On Individuals, Institutions, And Societies, Part I I." Psychotherapy and Politics International **2**(3): 212-228.

Bloom, S. L., M. Bennington-Davis, et al. (2003). "Multiple opportunities for creating sanctuary." Psychiatric Quarterly **74**(2): 173-190.

Campling, P. and R. Haigh, Eds. (1999). Therapeutic Communities: Past, Present and Future. London, Jessica Kingsley.

Courtois, C. and S. L. Bloom (2000). Inpatient Guidelines for the Treatment of Post-traumatic Stress Disorder. In Effective Treatments for PTSD: Pracice Guidelines from the International Society for Traumatic Stress Studies. E. B. Foa, T. M. Keane and M. J. Friedman. New York, Guilford.

Dietz, P. M., A. M. Spitz, et al. (1999). "Unintended pregnancy among adult women exposed to abuse or household dysfunction during their childhood." Jama **282**(14): 1359-64.

Dube, S. R., R. F. Anda, et al. (2001). "Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: findings from the Adverse Childhood Experiences Study." Jama **286**(24): 3089-96.

Dube, S. R., R. F. Anda, et al. (2001). "Growing up with parental alcohol abuse: exposure to childhood abuse, neglect, and household dysfunction." Child Abuse Negl **25**(12): 1627-40.

Felitti, V. J., R. F. Anda, et al. (1998). "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study." Am J Prev Med **14**(4): 245-58.

Foderaro, J. (2001). Creating a nonviolent environment: Keeping Sanctuary safe. In Violence: A Public Health Menace and a Public Health Approach. S. Bloom. London, Karnac Books**:** 57-82.

Foderaro, J. and R. Ryan (2000). "SAGE: Mapping the course of recovery." herapeutic Communities: The International Journal for Therapeutic and Supportive Organizations **21**(2, Special Issue): 93-104.

Gatiss, S. J. (2001). "Standards and criteria for therapeutic community childcare, health and education." Therapeutic Communities **22**(3): 197-214.

Gatiss, S. J. and J. Pooley (2001). "Standards of practice for working with children and young people in a therapeutic community setting." Therapeutic Communities **22**(3): 191-196.

Guterman, N. B. and M. Cameron (1999). The Odyssey Project individual agency report., Columbia School of Social Work and Jewish Board of Family and Children's Services of New York.

Haigh, R. (1999). The quintessence of a therapeutic environment: Five universal qualities. Therapeutic Communities: Past, Present and Future. P. Campling and R. Haigh. London:, Jessica Kingsley Publishers**:** 246-257.

Hillis, S. D., R. F. Anda, et al. (2001). "Adverse childhood experiences and sexual risk behaviors in women: a retrospective cohort study." Fam Plann Perspect **33**(5): 206-11.

Hillis, S. D., R. F. Anda, et al. (2000). "Adverse childhood experiences and sexually transmitted diseases in men and women: a retrospective study." Pediatrics **106**(1): E11.

Jones, M. (1968). Beyond the Therapeutic Community: Social Learning and Social Psychiatry. New Haven, CT, Yale University Press.

Kennard, D. (1998). An Introduction to Therapeutic Communities. London, Jessica Kingsley Publishers.

Kennard, D. and J. Lees (2001). "A checklist of standards for democratic therapeutic communities." Therapeutic Communities **22**(2): 143-151.

Madsen, L., L. V. Blitz, et al. (2003). "Sanctuary in a domestic violence shelter: A team approach to healing." Psychiatric Quarterly **74**(2): 155-171.

Manning, N. (1989). The Therapeutic Community Movement: Charisma and Routinization. London, Routledge.

NCTSN (2004). National Child Traumatic Stress Network. www.nctsnet.org.

Rivard, J. C. (2000). Trauma Focused Intervention Targeting Risk For Violence, National Institutes of Health. **2000**.

Rivard, J. C. (2004). "Initial Findings of an Evaluation of a Trauma Recovery Framework in Residential Treatment." Residential Group Care Quarterly **5**(1): 3-5.

Rivard, J. C. (2004). "Initial Findings of an Evaluation of a Trauma Recovery Framework in Residential Treatment." Residential Group Care Quarterly: Child Welfare League of America **5**(1): 3-5.

Rivard, J. C., S. L. Bloom, et al. (2003). "Assessing the Implementation and Effects of a Trauma-Focused Intervention for Youths in Residential Treatment." Psychiatric Quarterly **74**(2): 137-154.

Rivard, J. C., D. McCorkle, et al. (2004). " Implementing a Trauma Recovery Framework for Youths in Residential Treatment." Child and Adolescent Social Work Journal **21**(5): 529-550.

Small, R., K. Kennedy, et al. (1991). "Critical Issues for Practice in Residential Treatment: The View from Within." American Journal of Orthopsychiatry **61**(3): 327-337.

Small, R., K. Kennedy, et al. (1991). " Critical issues for practice in residential treatment:The view from within." American Journal of Orthopsychiatry **61**(3): 327-337.

Wells, K. (1991). " Long-term residential treatment for Children: Introduction,." Amer. J. Orthopsychiatry **61**(3): 324.

Wells, K. and D. Whittington (1993). "Characteristics of youths referred to residential treatment: Implications for program design." Children & Youth Services Review. Special Residential treatment as long-term treatment **15**(3): 195-217.

Wright, D., W. L. Woo, et al. (2003). "An investigation of trauma-centered inpatient treatment for adult survivors of abuse." Child Abuse & Neglect **27**: 393-405.

Wright, D. C. and W. L. Woo (2000). "Treating Post-Traumatic Stress Disorder in a Therapeutic Community: The Experience of a Canadian Psychiatric Hospital." Therapeutic Communities: The International Journal for Therapeutic and Supportive Organizations **21**(2): 105-118.