The Sanctuary Model® of Trauma-Informed Organizational Change

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The Sanctuary Model® is a trauma-informed method for creating or changing an organizational culture. The model was originally developed in a short-term, acute, inpatient psychiatric setting for adults who were traumatized as children. Over the years, it has evolved into an evidence-supported template for system change based on the active creation and maintenance of a nonviolent, democratic, therapeutic community in which staff and clients are empowered as key decision-makers to build a socially responsive, emotionally intelligent community that fosters growth and change (Bloom, 1997; Rivard et al., 2003; Rivard et al., 2004a; Rivard et al., 2004b; Rivard et al., 2005). The Sanctuary Model® has proven effective with children and adults across a range of human service organizations, including residential treatment centers, public and private schools, domestic violence shelters, and drug and alcohol treatment centers.

To provide some background on the theoretical foundation of this model, this article will address the strong research-based connections between exposure to various forms of childhood adversity and the later abuse of substances and other problematic behaviors as methods for coping with that adversity, and define what it means to have an organizational culture that is truly "trauma-informed." The article will then describe the Sanctuary Model® and the use of the "S.E.L.F." tool as a framework to help children, adult clients, and staff to develop a trauma-informed organization.

Childhood Adversity and the Problems that Follow: The ACE Study

The Adverse Childhood Experiences (ACE) study provides a documented link between childhood exposure to violence and other traumatic experiences and later psychiatric disorders, physical disorders, and substance abuse. This large-scale study interviewed 17,337 adult health maintenance organization members (54% female; mean age 57 years), who attended a primary care clinic in San Diego, California within a 3-year period (1995-1997) and completed a survey about childhood abuse and household dysfunction, substance use, depression and suicide, and multiple other health-related issues. The ACE study provides a documented link between childhood exposure to violence and later psychiatric disorders, physical disorders, and substance abuse (Felitti et al., 1998). [1]

The researchers asked people to place themselves into eight categories of adverse childhood experiences by answering the following questions. Before the age of eighteen:

- Were you physically or psychologically abused by a parent?
- Did anyone sexually abuse you?
- Were you emotionally or physically neglected?
- Was anyone in your household violent against your mother?
- Was anyone in the household mentally ill or abuse drugs and/or alcohol?
- Was there anyone in the household who was imprisoned?
- Were your parents divorced or separated?

The number of categories (not the number of occurrences) of these adverse childhood experiences was then compared to measures of adult risk behavior, health status, and disease.

The number of categories—not events—that the person admitted to then became their ACE score which essentially represents their "trauma dose" as children. Only one-third of this middle-class, largely Caucasian and well-educated population, had an ACE score of zero. Two-thirds of the population reported an ACE score of one; one in four people were exposed to two categories; and one in 16 to four categories. The authors also noted that ACEs tend

1 More information and a list of publications can be found on the website of the Centers for Disease Control and Prevention at http://www.cdc.gov/nccdphp/ace/

to be grouped together. So, given one ACE, there is an 80% chance of having exposure to another (Felitti et al., 1998).

ACE AND SUBSTANCE USE AND ABUSE

After adjusting for age, sex, race, and education, the risk of alcoholism in adulthood increases as the number of reported adverse experiences increases. Likewise, the ACE score had a strong graded relationship to the risk of drug initiation from early adolescence into adulthood and to problems with drug use, drug addiction, and IV drug abuse. The persistent graded relationship between the ACE score, and initiation of drug use for people born as early as 1900, suggests that the effects of adverse childhood experiences transcend social changes such as increased availability of drugs, social attitudes toward drugs, and recent massive expenditures and public information campaigns to prevent drug use. The authors point out that ACEs seem to account for one-half to two-third of serious problems with drug use (Dube et al., 2003).

It was also clear from the study that children in alcoholic households are more likely to have adverse experiences. Depression among adult children of alcoholics appears to be largely, if not solely, due to the greater likelihood of having had adverse childhood experiences in a home with alcohol abusing parents (Anda et al., 2002). Compared to persons who grew up with no parental alcohol abuse, the likelihood of each category of ACE was approximately 2 to 13 times higher if the mother, father, or both parents had abused alcohol. For example, the likelihood of having a battered mother was increased 13-fold for men who grew up with both parents who abused alcohol. Those who grew up with both an alcohol-abusing mother and father had the highest likelihood of ACEs. The authors of the study concluded that exposure to parental alcohol abuse is highly associated with experiencing adverse childhood experiences (Dube et al., 2001b).

ACE AND SEXUALLY TRANSMITTED DISEASE

Researchers also found a strong graded relationship between ACEs and a self-reported history of sexually transmitted diseases among adults. For both women and men, the prevalence of STDs was five times higher for those who had been exposed to six to seven categories of ACE during childhood than for those who were exposed to no ACEs during childhood (Hillis et al., 2000; Hillis et al., 2001). Each category of adverse childhood experiences was associated with an increased risk of intercourse by age 15; with perceiving oneself as being at risk of AIDS, and with having had 30 or more partners (Hillis et al., 2001).

What is a "Trauma-Informed Culture"?

The results of the ACE study indicate that mental health, substance abuse, and social service providers need to recognize the role that traumatic experiences play in the lives of their clients and the need for trauma-informed staff and interventions. To create a truly trauma-informed treatment culture requires trauma-specific treatment approaches that help psychologically, injured people to heal. In fact, our growing knowledge about the short- and long-term effects of chronic stress and repetitive trauma requires a shift in the way we view all human problematic behavior. We need to stop viewing people as either "sick" or "bad"—philosophical positions that inevitably lead to the problems associated with the mental health system or the criminal justice system—and instead begin viewing all of these problems as the result of injuries—some to the body, some to the mind, some to the ability to relate, some to the sense of right and wrong, and some to the soul.

The ACE study also tells us that it is not just the clients in treatment programs who have been traumatized, but, perhaps, the staff members as well. So being trauma-informed means being sensitive to the reality of traumatic experience—children, their parents, staff, administrators, state officials, police, courts, schools, and everyone else. It means being sensitive to the ways in which trauma has affected individuals, families, and entire groups (i.e. Native Americans, African-Americans, lesbian/gay/bisexual/transgendered individuals), and it it means becoming sensitive to the ways in which trauma impacts organizations and entire systems.

Organizations committed to working with troubled individuals all face enormous stresses. Unfavorable financial, regulatory, social, and political environments can adversely impact organizational functioning and, under these circumstances, it is relatively easy to lose sight of the mission, goals and values that should guide the work. Over time, stressed systems can become reactive, change-resistant, hierarchical, coercive, and punitive. Traumatized organizations may begin to exhibit symptoms of collective trauma similar to those of their clients, creating a "trauma-organized culture."

The Sanctuary Model®: A Trauma-Informed Organizational Approach

Sanctuary Model® is not a specific intervention, but a full system approach focused on creating an organizational culture designed to help injured clients recover from the damaging effects of interpersonal trauma. 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 that simultaneously create a sound treatment environment, while counteracting the impact of chronic and unrelenting stress:

- Culture of Nonviolence – building and modeling safety skills and a commitment to higher goals
- Culture of Emotional Intelligence – teaching and modeling emotional management skills and the integration of thoughts and feelings
- Culture of Social Learning – building and modeling cognitive skills in an environment that promotes conflict resolution and transformation
- Culture of Shared Governance – creating and modeling civic skills of self-control, self-discipline, and administration of healthy authority
- Culture of Open Communication – overcoming barriers to healthy communication, reducing acting-out, enhancing self-protective and self-correcting skills, teaching healthy boundaries
- Culture of Social Responsibility – rebuilding social connection skills, establishing healthy attachment relationships
- Culture of Growth and Change – working through loss; restoring hope, meaning, purpose.

Because it is a full system approach, effective implementation of the Sanctuary Model® requires extensive leadership involvement in the process of change, as well as staff and client involvement at every level of the process (Farragher & Yanosy, 2005). A first step in this model is participation in the Sanctuary Leadership Development Institute (SLDI)[2], where key organizational questions frame an intensive five-day workshop that helps organizational leaders to reclaim a culture of hopefulness and innovation. The Institute is an intensive and transformational process that requires deep commitment and participation from organizational leadership.

Next, through the implementation steps of the Sanctuary Model®, staff members engage in prolonged dialogue that serves to identify 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 discussed before.

As agencies across the country are beginning to use Sanctuary Model®, SLDI is setting up a network to allow them to share their experience and innovations with each other. In this way, agencies can count on long-term support, as well as a process to ensure fidelity to the model, among all of the agencies practicing Sanctuary.

The results of creating a trauma-informed culture should be observable and measurable. The outcomes we expect to see include: less violence of all kinds, better staff morale, lower staff turnover, fewer injuries to staff and client, a truly collaborative treatment environment, the reduction or elimination of coercive forms of intervention, and better client outcomes.

S.E.L.F.: A Trauma-Informed Implementation Tool

S.E.L.F. is the implementation tool that is a fundamental component of the Sanctuary Model®, an acronym that stands for Safety, Emotional management, Loss, and Future. S.E.L.F. is a conceptual tool (originally called S.A.G.E.) (Bills, 2003; Foderaro & Ryan, 2000; Foderaro, 2001) that guides assessment, treatment planning, individual and team discussion, and the psychoeducational group work. S.E.L.F. is not a staged treatment model, but rather a non-linear method for addressing, in simple words, very complex challenges.

The four concepts: Safety, Emotions, Loss, and Future represent the four fundamental domains of disruption that can occur in a person's life. Within these four domains, any problem can be categorized. Naming and categorization are the first steps in making a problem manageable. Victims of overwhelming life experiences have difficulty staying safe, find emotions difficult to manage, have suffered many losses, and have difficulty envisioning a future. As a result, they are frequently in danger, lose emotional control, or are so numb that they cannot access their emotions, have many signs of unresolved loss, and are stuck in time, haunted by the past, and unable to move into a better future.

2 For more information see www.andruschildren.org or www.sanctuaryweb.com; or contact Sarah Yanosy at 914-965-3700.

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Case Study

Incorporating the Sanctuary Model® at Interim House

Interim House is a private, 501(c)(3) nonprofit corporation licensed by the Commonwealth of Pennsylvania's Bureau of Drug and Alcohol Programs. Interim House provides a continuum of comprehensive services to women addicted to drugs and alcohol that includes three levels of care: Residential Treatment, Intensive Outpatient Treatment, and Outpatient Counseling. In 2002, Interim House recognized the need to become a trauma-informed program based upon program research data that indicated over 90% of its clients had suffered significant trauma, abuse and maltreatment as children and/or as adults.

In order to address these needs, Interim House implemented an agency wide year-long training in 2002 on the Sanctuary Model® developed by Dr. Sandra Bloom. Trainings were monthly and included all staff—professional and para-professional. During the course of the trainings and throughout subsequent years, the program has incorporated gradual changes to its structure that reflect the core components of Safety, Affect management, Grieving, and Emancipation (S.A.G.E.) (This tool has been renamed S.E.L.F., see page 14.). Some of these trauma-sensitive treatment components include:

- Incorporating the S.A.G.E. principles into the 12 steps by creating a S.A.G.E. grid to help clients understand that addiction and trauma are intertwined.
- Developing individual safety plans for each client and focusing on significant anniversary deaths involving grief and loss.
- Asking clients to create their own personal safety kits.
- Establishing grieving rituals such as a grief box, ceremonies, letting go of helium balloons to represent "letting go."
- Building in more mastery, such as having more input into the program activities and rules, to help the clients restore their own sense of mastery that will help them overcome dependency and helplessness.
- Implementing a morning check-in that requires each client to state how they feel, goal for the day, plan to stay safe and motivation level based on a scale of 1 to 10.

Interim House has worked to ensure that the Sanctuary Model® is being incorporated into all aspects of the program, not just the clinical component. As a result, we changed our program philosophy to reflect an understanding of addiction and trauma. All staff—clinical and non-clinical—are now trained in trauma theory and understand the impact that trauma has on the brain and on clients' behavior. We have also reviewed our policies and procedures to ensure that we are not creating unintended secondary trauma. Additionally, we now evaluate staff for their effectiveness in utilizing the S.A.G.E. model and include this category on annual performance evaluations. We use the S.A.G.E. model as a way of identifying and resolving staff conflicts, individually and collectively, and also use this model to evaluate program policies to ensure they reflect the principles of S.A.G.E. This was especially significant in a modification to our discharge criteria which tended to punish people for their symptoms.

We are not the same organization we were, evolving with changing needs of the clients and learning from our mistakes. We recognize that role modeling is critical—everyone must lead by example and to paraphrase Gandhi: We all must be the change we want to see.

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Program Director
Interim House

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The S.E.L.F. Psychoeducational Group[3] is designed to provide clients and staff with an easy-to-use and coherent cognitive framework that can create a change momentum. Because it is a model that is circular, not stepped, it provides a logical framework for movement. We think of S.E.L.F. as a compass through the land of recovery that can help guide individual treatment, staff decision, team treatment planning, and an entire institution. It is not constrained by gender, age, race, religion, or ethnicity because the domains of healing that S.E.L.F. represents are human universals, unbound by time, place, or person. In our residential programs, children as young as four are comfortably using the S.E.L.F. language—and using it appropriately.

Conclusion

Ultimately in the Sanctuary Model®, the purpose of our shared assumptions, goals, practice, and vision is to create what Maxwell Jones, a half-century ago, described as a "living-learning environment" within which healing, growth, and creative expression can occur (Jones, 1968). Through this model, a wide range of settings, including residential treatment settings for children or adults, acute care inpatient units, substance abuse programs, domestic violence shelters, homeless shelters, group homes, day hospitals, and intensive outpatient programs, have had an opportunity to create environments that are intrinsically humane, as well as healing and health promoting.

Our clients who have suffered extraordinary violence, at the hands of others, have much to teach us about both individual and social healing, about how to change our institutions to reflect actual human needs rather than the distortion of unresolved trauma. In an era of tightening budgets and bottom-line focus, finding methods to aid recovery from overwhelming experiences that are environmental, and not solely dependent on expensive individual forms of treatment, are even more critical than ever. Sanctuary Model® is in many ways a subversive idea in that it works not to maintain an unhappy status quo, but to create the "heat" that generates change, which is generated largely through the trauma-informed interactions between staff and clients, and clients with each other.

3 S.E.L.F.: A Trauma-Informed Psychoeducational Group Curriculum is available at www.sanctuaryweb.com

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Case Study

Vinita Alcohol and Drug Treatment Center and the Sanctuary Model®

(VADTC) is a state-operated facility located in Vinita, Oklahoma. In July 2005, the Center converted from a co-ed environment to an integrated behavioral health residential treatment program for women. This change to a gender-specific population necessitated a re-evaluation of the Center's functioning, philosophy, and programmatic needs, and to the development of a trauma-informed integrated treatment model including systemic organizational change.

The Center received approval from state leadership to begin the process of working with Dr. Sandra Bloom to implement the Sanctuary Model® as the overarching organizational change and guiding recovery philosophy of VADTC. This process entailed facility and state leadership commitment, leveling of the hierarchy, time intensive staff training, complete re-design of treatment programming, policy change, and continual role modeling of the Sanctuary principles to transform the organizational culture into a collaborative trauma-informed environment with the ultimate goal of supporting the staff and participant's growth and change process.

Although the implementation process is "not for the faint of heart," VADTC leadership has been impressed with the initial outcomes of the change process. While the implementation process at VADTC has been challenging, the initial benefits of: decreased staff resistance to change; increased staff cohesion; reduced critical incidents; increased staff/participant collaboration; improved participant functioning; increased staff understanding of trauma-related effects on the organization and participant population; increased capability of staff and participants to create/maintain a safe recovery environment; improved staff/participant emotional management; improved open communication/conflict resolution; and an observable increased hope for the future has created a synergy for continued progress not previously apparent in the organizational culture.

These results led to discussion on how to embed the model within the state system. The VADTC, along with the Oklahoma Youth Center (another state-sponsored project that has implemented the model), approached state leadership with a three-year pilot project proposal to expand the model to four additional residential treatment facilities throughout the state. State leadership approved the proposal and a selection process was conducted which included a statewide application process, agency self-assessment of readiness to change, and interviews with prospective applicants. Four residential substance abuse facilities applied and were accepted in May of 2006: one adolescent program and three programs serving women with children in residence. Requirements for participation in the three-year pilot project included: data reporting (demographics, the implementation process, environmental assessment, and standardized measures of the recovery environment) to track and trend outcomes; monthly consortium meetings including on-site training with Sanctuary faculty every other month; monthly group phone consultation with Sanctuary faculty; monthly individual agency phone consultation with Sanctuary faculty; and yearly on-site individual consultation and evaluation with Sanctuary faculty.

The six facilities participated in an intensive 5-day Sanctuary Leadership Development Institute in June of 2006 to educate the new agencies regarding the implementation process and to solidify the group support process. Since the training, all six sites have been meeting monthly, supporting each other in implementing the model and providing a "think tank" experience, which is, sharing ideas, resources, policy change examples, and dialogue regarding solutions to challenges.

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