Assessing Feasibility of a Learning Collaborative Using Sanctuary Model as a Framework

Bergey, Maureen G.

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Assessing Feasibility of a Learning Collaborative Using Sanctuary Model as a Framework

by
Maureen G. Bergey and Stefanie Rhodes
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ABSTRACT

Assessing Feasibility of a Learning Collaborative Using Sanctuary Model as a Framework
Maureen G. Bergey, MSW, MPH Candidate and Stefanie Rhodes, MPH Candidate
Sandra Bloom, MD

The prevalence of trauma and its associated impacts on individuals, families, organizations, and communities are increasingly recognized by the public, policy makers, and funders. Traumatic experiences also influence the risk of chronic disease and poor health outcomes throughout the lifespan, placing strain on the healthcare system. These economic, physical, and psychological burdens are increasing the stress on human service organizations. In light of the chronic stress faced by human service organizations providers are operating in silos, which impedes progress in developing trauma-informed networks of care. Trauma-informed care acknowledges trauma symptoms and experiences, while incorporating understanding of the impacts of trauma at all levels of an organization, from services to policies. The Sanctuary Model® is one trauma-informed model, which uses a whole systems approach designed to reduce stress within human service organizations. This project investigates the feasibility of using the Sanctuary Model® as the framework for a learning collaborative to implement a trauma-informed network of care in an urban area among several parts of the human service system. Learning collaboratives bring together professionals across settings to advance and disseminate best practices, while fostering continuity of care. Sixteen semi-structured interviews were conducted with key-informants in human service organizations, and analyzed for common themes. The primary themes emerging from the data included: collaboration, indications for trauma-informed care, necessities of collaboration for trauma-informed networks, envisioning the future, and foundations for implementing learning collaboratives using the Sanctuary Model®. These themes will inform cross-systems decision making and framing of future collaborations.

Introduction

Trauma impacts communities at many levels and is increasingly being recognized as a public health crisis. The public awareness of this trauma and its effects are gaining the attention of policy makers and funders, as systems work towards prevention and intervention efforts. The overall purpose of this project is to further inform the development of a trauma-informed system of care. One goal is to determine whether a learning collaborative using the Sanctuary Model as the framework is feasible or appropriate in this setting.

The urgent need for trauma-informed systems is demonstrated by the prevalence of trauma and its associated impacts on individuals, families, organizations, and communities. Trauma is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as "physical, sexual and institutional abuse, neglect, intergenerational trauma and disasters that induce powerlessness, fear, recurrent hopelessness, and a constant state of alert" (SAMHSA, n.d.). Psychological trauma results from a loss or an imbalance of power. According to Herman, "Psychological trauma is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force" (1997, p.33). People are not only exposed to trauma in the form of physical and sexual abuse, but also in the form of community violence and domestic violence. Violence is prevalent in the City of Philadelphia. According to the Federal Bureau of Investigation, there were 306 homicides, 945 rapes and 8,921 assaults in Philadelphia in 2010 (FBI, 2010).

The emergence of trauma theory and new research validate and provide context for the experiences of many trauma survivors (Bloom, 2004). Trauma is physically, psychologically, and economically burdensome. Exposure to violence and potentially traumatic events before the age of 18 is extremely taxing to individuals, the social service system, and the community. The

financial costs associated with childhood trauma are also staggering. According to the Centers for Disease Control (CDC) study, The Economic Burden of Childhood Maltreatment in the United States and Implications for Prevention, "the total lifetime cost associated with just one year of confirmed cases of child maltreatment is $124 billion." (Centers for Disease Control and Prevention [CDC], 2010). Care that addresses trauma and its associated impacts is needed to promote health at all levels and to manage economic costs.

Trauma-informed care acknowledges the impact trauma histories have on current behavior. The Sanctuary Model is a nuanced approach to trauma-informed care because it addresses the impact of trauma at every level of an organization. The foundation of the Sanctuary Model is the belief that "healing from trauma, stress and adversity requires creating an environment that promotes healing" (Sanctuary Institute, 2011). This healing environment is known as a trauma-informed culture. The Sanctuary Model has been tailored for use in a variety of human services settings, including residential treatment facilities, state hospitals, and outpatient treatment, making it an ideal fit for advancing trauma-informed care across human service systems (Bloom, 2011).

Both the Philadelphia Office of Supportive Housing (OSH) and the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) chose to invest in bringing the Sanctuary Model to their organizations. Each agency has completed the five-day Sanctuary Training and booster trainings. These organizations serve overlapping populations that would not only benefit from a safe trauma-informed environment, but continuity of care across systems. For this very reason, this project seeks to determine the feasibility of a learning collaborative between OSH and DBHIDS using the Sanctuary Model as the framework (Bloom, 2011).

Specific Aims

The hypothesis of this project was that it would be feasible to use the Sanctuary Model as a learning collaborative framework to advance a trauma-informed network of care among human service agencies in Philadelphia. Collaboration could foster continuity of care across human service agencies, and encourage a social network approach which will contribute to systems change. Specific project aims include:

- Describe indications for a trauma-informed provider network in the city of Philadelphia
- Determine the benefits and challenges of learning collaboratives
- Assess the feasibility of using Sanctuary as a learning collaborative framework to advance a trauma-informed care network among human service providers in Philadelphia
- Explore policy implications for developing a trauma-informed network connected by a learning collaborative in Philadelphia

Background

Adverse Childhood Experiences Study (ACEs)

The Adverse Childhood Experiences Study (ACEs) is a cornerstone research development linking traumatic experiences in childhood to future health outcomes. Collaborative research between the Centers for Disease Control (CDC) and Kaiser Permanente Health System studied the adverse childhood experiences (exposure to abuse, neglect, or other traumatic stressors) of over 17,000 adults in the Kaiser Health system from 1995 to 1997. As the number of ACEs increased, so did the occurrence of a range of negative health outcomes. Approximately two thirds of subjects reported at least one ACE (CDC, 2010). Increasing ACE scores increased the likelihood of a number of conditions including, but not limited to smoking,

hepatitis, heart disease, obesity, injection drug use, and depression (Bloom & Farragher, 2010). A nationwide U.S. Department of Justice survey showed that over 60 percent of children in our society were directly exposed to violence in the past year (Bloom, 2011).

Exposure to violence and trauma affect the entire workforce, but its effects have particular meaning for the social services system, which attracts workers that are more likely to have their own experiences with adversity (Bloom, 2011). In fact, a survey conducted at the Andrus Children's Center showed that more than 80 percent of the residential staff had experienced some form of childhood adversity (Bloom, 2011). These experiences impact how human service workers interact with one another, their clients, and the system.

Trauma-Informed Care

Many human service organizations are experiencing chronic stress brought about by the work they do, and the environment and culture that is inherent in so many human service organizations. This stress comes from a variety of sources, including the nature of the work, under-resourced agencies, inefficient systems, and ineffective management. One result of this stress is that these organizations operate in silos, impeding progress in developing trauma-informed networks of care. Silos and stagnation in the human service system create further stress and disorientation. This lack of integration slows systems change and can also lead to unsafe organizational conditions. Clients with trauma histories are receiving services in a broken system that despite the best of intentions can be damaging to both clients and providers. Developing trauma-informed systems can be an opportunity for healing for both those providing and receiving services (Bloom & Farragher, 2010).

SAMHSA defines trauma-informed care as "an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role

that trauma has played in their lives" (SAMHSA, n.d.). Developing trauma-informed networks of care has become a growing priority, as we gain understanding of the impacts and prevalence of trauma in our society. In 2005, SAMHSA created the National Center for Trauma-Informed Care (NCTIC), which provides technical assistance and training to programs and systems that receive public funding, raising awareness about the need for trauma-informed care.

Trauma-informed systems embrace change across all levels of the organization, including education in trauma theory and adapting programs to reduce vulnerabilities and triggers for trauma survivors (SAMSHA, n.d.). The NCTIC identifies 12 components of care that must be infused with trauma-informed principles in order for a mental health service system to be considered trauma-informed (see Figure 1).

Trauma-informed systems are comprised of trauma-informed organizations and trauma-specific services. Trauma-specific services are the actual techniques and methods used to treat specific trauma symptoms (Jennings, 2008). These trauma-specific services are one component of trauma-informed organizations and systems. The National Child Traumatic Stress Network (NCTSN) invests in training the workforce in trauma-specific interventions (SAMHSA, 2012). In addition to specific interventions, organizational culture and policies are also important.

Trauma-Informed Mental Health Service System Requirements

1. Designated trauma function and focus in state mental health department
2. State trauma policy or position paper
3. Workforce recruitment, hiring, and retention
4. Workforce orientation, job standards, competencies, and trainings related to
5. Involvement of a consumer/person in recovery/trauma survivor and trauma-informed rights
6. Sustainable financing criteria and mechanisms to support ongoing development of trauma-informed services, and implementation of evidence-based and promising practices
7. Clinical practice guidelines for working with children and adults with trauma histories
8. Access to trauma-informed treatment that avoids retraumatization supported by policies, procedures, rules, regulations, and standards
9. Needs assessment, monitoring and evaluation, and research to investigate prevalence of trauma, assess client satisfaction, service utilization and needs
10. Universal trauma-screening and assessment
11. Trauma-informed services, and service systems
12. Trauma-specific services, including evidence-based and promising practices

Figure 1: Adapted from *12 Criteria for Building a Trauma-Informed Mental Health Service System,* Models for Developing Trauma-Informed Behavioral Health Services & Trauma-Specific Services, pg. 4.

Children who have been impacted by trauma frequently interact with the child welfare and juvenile justice systems. These systems are fragmented and stressed, and children receiving services within them often encounter additional stress, fear, and emotionally overwhelming experiences through this "system-generated trauma" (Ryan, Bashant, & Brooks, 2006). SAMHSA is acknowledging the importance of systems of care, creating the Children's Mental Health Initiative (CMHI), which funds government programs to incorporate principles and values of systems of care, creating networks of community-based services. SAMHSA reports that one third of children in child welfare and almost 40 percent of those involved in the juvenile

justice system demonstrated improvement in emotional and behavioral symptoms and strengths in the first year after receiving services in a system of care (SAMHSA, 2012, pg.2).

Select literature has indicated settings where trauma-informed models have been implemented, both with children and adults (Bloom et al., 2003). Reviews of implementation in inpatient psychiatric settings (Bloom, 1997), state hospitals (Bills & Bloom, 1998; Murphy & Bennington-Davis, 2005), schools (Bloom, 1995; Stanwood & Doolittle, 2004), substance abuse treatment facilities (Wellbank, 2007), and residential treatment facilities (Hummer, Dollard, Robst, & Armstrong, 2010; Rivard, 2004; Rivard et al, 2004; Rivard, Bloom, McCorkle, Abramovitz, 2005) provide examples of implementation experiences and associated outcomes of shifting the paradigm to trauma-informed care. These examples provide a solid foundation for advancing a model of trauma-informed care not only within, but across specific service settings. Additional literature is needed to communicate the impacts and potential for further advancing trauma-informed care in more settings. This research project aims to inform development of trauma-informed care across human service systems, as opposed to simply within systems that provide similar services to a specific population, such as residential treatment facilities.

The NCTSN partners with systems of care, creating standards for best practices in services for children and families exposed to trauma. These established systems of care include the child welfare system, the education system, healthcare, first responders, and juvenile justice systems (Ko et al., 2008). Specific recommendations have been made for developing these trauma-informed systems. Trauma screening and assessment is needed at every level of the child welfare system, along with providers trained in evidence-based practices. The education system must balance their mission of education with the fact that schools are a key access point for mental health services, and that trauma carries implications for education outcomes if not

addressed. First responders are in a unique position to decrease exposure to ongoing trauma, to provide structure, and to promptly facilitate appropriate referrals. Health care systems also have the opportunity to intervene at first point of contact with trauma survivors, and have a vested interest considering the links between trauma and health outcomes. Trauma-informed care can also be approached from a quality improvement perspective in health care. Finally, the juvenile justice system is a stakeholder, as understanding behaviors through a trauma-informed lens makes room for alternate interpretations of these behaviors (Ko et al, 2008).

Many models exist for developing trauma-informed organizations and systems. Models frequently include training manuals, printed materials, and curriculum to assist in implementation of the model. Some models also incorporate consultation and technical assistance. For purposes of comparison, models chosen to be reviewed here include this consultation piece, to create a closer comparison to the Sanctuary Model, which will be described in the following section.

- *Creating Cultures of Trauma-Informed Care*- Developed by Community Connections, this model focuses on an organizational culture change based on core values that include trustworthiness, choice, collaboration, and empowerment. Agencies form a workgroup that attends a primary training and determines areas of focus most relevant for their setting. The model has been used in provider and state service systems (Jennings, 2008).
- *Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse*- This is a therapeutic framework for workforce development. It seeks to help providers understand their own reactions to their work, decreasing stress and burnout. The model is taught to all levels of staff using a 5-module, 20 hour curriculum produced by the Sidran Institute (Jennings, 2008).

- *Children and Residential Experiences: Creating Conditions for Change (CARE)* – CARE is a model specifically for agencies serving children that aims to bring best practices to residential care settings. The model is based on the following principles: developmentally focused, family involved, relationship based, competence centered, trauma-informed, and ecologically oriented (CARE, n.d).

The Sanctuary Model

The Sanctuary Model is an organizational change model rooted in trauma theory. The Sanctuary Model addresses trauma and the accompanied stress within human service organizations, facilitating positive change among the clients and organizations. The Sanctuary Model differs from other models, which focus solely on client treatment. It seeks to create a healing environment for the entire system: administrators, staff, families, and clients, creating a trauma-informed culture (Sanctuary Institute, 2011).

Two basic beliefs are central to the Sanctuary Model. The first is that, "adversity is an inherent part of human experience, and that these experiences shape the way that people behave" (Sanctuary Institute, 2011). The model maintains that people have the capacity to heal from adverse experiences (Sanctuary Institute, 2011). Second, those implementing the model must acknowledge that past experiences influence present behavior and apply this knowledge to the treatment of clients. We are asked to reframe our perspective of clients, as the current perspective frequently focuses only on present behavior. The past is not referenced, even though it is past experiences that created the need for these clients to seek out the services of a human service organization. This new frame of thought must take into account the cause of client behavior. The question can no longer be "what's wrong with you?" The client must now be

viewed through the lens of past trauma and the question must now be "What happened to you?" (Bloom, 2011).

The Sanctuary Model has been implemented in a variety of settings from residential treatment facilities, to state hospitals, to shelter systems, along with many other types of providers. Although adaptable to various contexts, basic tenants maintain the integrity of the model. The Sanctuary Model is built on four pillars: trauma theory education, the Seven Sanctuary Commitments, S.E.L.F., and the Sanctuary Toolkit (Sanctuary Toolkit, 2011).

Key to Sanctuary Implementation is a commitment on the part of both staff and clients to the Seven Sanctuary Commitments. The Seven Sanctuary Commitments provide organizations with a value system. They are:

Figure 2: The 7 Sanctuary Commitments

- **Nonviolence** - being safe outside (physically), inside (emotionally), with others (social) and to do the right thing (moral).
- **Emotional Intelligence** - managing our feelings so that we don't hurt ourselves or others.
- **Social Learning** - respecting and sharing the ideas of our teams
- **Democracy** - shared decision making
- **Open Communication** - saying what we mean and not being mean when we say it

- **Social Responsibility** - together we accomplish more, everyone makes a contribution to the organizational culture
- **Growth and Change** - Managing loss and creating a vision for a different future for our clients and ourselves (Sanctuary Institute, 2011).

S.E.L.F. is an acronym that stands for:

- ***Safety*** **[**emphasis added] ***: [sic]***attaining safety in self, relationships, and environment
- ***Emotional Management*** [emphasis added]***: [sic]*** identifying levels of various emotions and modulating emotion in response to memories, persons, events
- ***Loss*** [emphasis added] ***: [sic]*** feeling grief and dealing with personal losses; recognizing that all change involves loss
- ***Future*** [emphasis added]***:[sic]*** trying out new roles, ways of relating and behaving as a "survivor" to ensure personal safety, envisioning a different and better future (Bloom & Farragher, 2010, pp. 361-362).

Figure 2: S.E.L.F. Domains of Healing

S.E.L.F. provides organizations with a nonlinear communication framework that creates a shared language across organizations and between clients, communities, and staff (Sanctuary Institute, 2011). S.E.L.F. also encourages providers to focus on these four components rather than simply using terminology specific to their training. This therapeutic, nonlinear approach

and shared language helps to facilitate movement and change, whether with clients or at an organizational level (Sanctuary Institute,2011).

The Sanctuary Toolkit represents the behavior behind the values set forth in the Seven Commitments. The tools are "community meetings, the ProQOL scale, red flag meetings, safety plans, self care plans, team meetings, treatment planning conferences, and the Sanctuary Standards" (Sanctuary Institute, 2011). Organizations implementing the Sanctuary Model use these tools to impact culture and processes, creating new alternatives to the status-quo and shifting the paradigm.

As of 2012, over 200 agencies and organizations have participated in the Sanctuary Model training (Sanctuary Institute, 2011). The diversity and breadth of participants continues to grow, and a large concentration of trained providers and organizations lie in the Greater Philadelphia Area. This geographic concentration combined with the historical roots of the Sanctuary Model in the Philadelphia area create opportunities ripe for expanding the model across systems to create a more trauma-informed city.

Learning Collaboratives

In order to define a learning collaborative, it is necessary to define a collaboration. According to Backer, "a collaboration brings together two or more agencies, groups, or organizations at the local, state, or national level, to achieve some common purpose of systems change (Backer & Norman, 1998, 2000). Collaborations involve the sharing of goals, activities, responsibilities, and resources (Backer, 2003, pp. 3-4). Collaboration between two organizations usually occurs at the urging of funders and many nonprofits participate in collaborations. This is because collaboration allows two organizations who typically compete for resources to identify a

common problem that they both share interest in solving. They can then pool together their resources and do a more effective job of solving said problem (Backer, 2003).

Learning collaboratives will be most successful with clear goals and an understanding of the incentives and barriers to collaboration. Prior to the implementation of a learning collaborative a certain degree of preparation is necessary. Part of this preparation should be identifying and acknowledging common barriers to collaboration and determining whether or not a collaboration is applicable. A major barrier is a lack of research about the effectiveness of collaborations. There is very little, if any information about why a collaboration does or does not work, or whether or not it is appropriate to create them in the first place.

Psychological barriers also serve to prevent collaborations. Organizations, like people, have long memories. When organizations have attempted collaborations in the past and those attempts have failed, they are less likely to engage in future collaborations. Organization members may continue to be reluctant to engage in a collaboration even when they find it beneficial due to 'collaboration fatigue'. Collaboration fatigue occurs as a result of involvement in multiple collaborations (Backer,2003).

The ultimate goal of this project is to create continuity of care across systems through a collaborative process. Another option in the pursuit of collaboration would be a Comprehensive Community Initiative (CCI). A CCI can be defined as "an initiative whose purpose is to coordinate a system of services, rather than offer isolated services" (Perkins, 2002, A-1). At face value a CCI seems to fulfill the purpose of this project, which is working toward a collaboration that could break down silos between human service organizations in Philadelphia leading to continuity of care for clients being served. A CCI may be a viable option or an additional element necessary for fulfilling this goal (Perkins, 2002, A-1).

Organizations are beginning to look at the ways in which they can improve care and address problems at various levels through the use of learning collaboratives. Human service organizations recognize that their target populations have a multitude of needs. For example, "a homeless person may need medical healthcare and behavioral healthcare, along with shelter" (Perkins, 2002, p.A-1). It is far more beneficial to have multiple agencies working together to address all of these needs, rather than each agency attempting to address each one independently.

One way to do this is through the development and implementation of a learning collaborative. Some organizations have developed learning collaborative models to target specific populations and policies. For example, the National Child Traumatic Stress Network (NCTSN) Learning Collaborative (LC) and Learning Community (LCom) focus specifically on adapting evidenced based practices as the standard of care across multiple settings. The goal of the NCTSN Learning Collaborative Model is to "improve a process, practice or system" through collaboration amongst multiple NCTSN member centers". Collaboration among the centers allows them to learn from each other's experiences with adapting evidenced based practices as the standard of care within their organizations (NCTSN, n.d.).

Guidelines for conducting a successful learning collaborative based on the NCTSN Learning Collaborative model were developed by the UCLA-Duke National Center for Child Traumatic Stress, along with other NCTSN member centers (NCTSN, n.d.). These guidelines are designed specifically for the purpose of addressing barriers to adopting evidence based practices in NCTSN member settings. Collaboration guidelines include voluntary participation in collaboration teams, and requiring team members to complete an application that details the expectations of team members and the collaborative (NCTSN, 2008). A specific example of a learning collaborative in practice was used to implement trauma-informed care practices and

curriculum across out-of-home treatment settings for children in Florida. This learning collaborative was based on a yearlong process, where residential treatment facilities interacting with the same population learn and implement trauma-informed practices together (Hummer et al, 2010).

Another learning collaborative model in practice is the NIATx Learning Collaborative Model. The NIATx Learning Collaborative Model is one of 4 components within the NIATx Model. The other three components are: Four Aims, Five Principles and Promising Practices. The purpose of the NIATx model is to improve patient access and retention in behavioral health settings, while reducing costs. The goal of the NIATx Learning Collaborative Model component is to provide members with various forums to share ideas and challenges faced in the implementation process. The NIATx Learning Collaborative Model consists of Learning Sessions, Interest Circles and Coaching. All of these services are designed to fulfill the goal of facilitating learning through collaboration (NIATx, n.d.). A universal learning collaborative model that is used across organizations has yet to be found. The models discussed thus far are specific to their members.

According to the literature gathered: (a) guidelines do exist for developing and leading learning collaboratives (NCTSN, 2008), (b) learning collaboratives are an alternative for organizations that normally work independently, but share a common problem (Backer, 2003), (c) learning collaboratives are encouraged by funders (Backer,2003), and (d) learning collaboratives are an effective way to improve healthcare delivery (NIATx, n.d.).

Problem Statement

The sustainability of trauma-informed practices is a challenge among human service providers. Agencies receive training and support, but due to a variety of factors that can include professional isolation, lack of ongoing technical support, and the sheer stress of the traumatic issues being addressed, these efforts at trauma-informed care go by the way-side. Sometimes there are challenges to actively engaging all levels of a provider organization in the Sanctuary Model or other approaches to trauma-informed care. This raises the question of whether a 'top down' versus 'bottom up' approach to organizational changes is the preferred method. The historical and political context is also a relevant factor in the development of trauma-informed care networks (Bloom & Farragher, 2010).

This context in Philadelphia has carried unique implications for the development of trauma-informed care among human service providers. The city has been on the cutting edge of acknowledging the impacts of trauma on society. In 1971, Women Organized Against Rape (WOAR) was created, which was the first rape crisis center in the United States (WOAR, 2011). In the early 1990's, as research on trauma theory was developing (Bloom, 1999) Philadelphia was home to several pioneers in trauma treatment. The Sanctuary Model, founded by Dr. Sandra Bloom and her colleagues, was created for use with adult trauma survivors in inpatient mental health settings, and has been adapted for numerous other settings. The Children's Crisis Treatment Center, also formed during that time, was the first children's outpatient trauma treatment center in Philadelphia, and the agency continues to treat children from across the city (Bloom, 2010). Several local non-profits (Women Against Abuse, Support Center for Child Advocacy, Women's Law Project, Physicians for Social Responsibility) have a long history of providing women's services, legal services, and advocacy around issues of intimate partner

violence and sexual assault. By the late 1990's, the Pennsylvania State Task Force on Domestic Violence was using trauma theory as a foundation for their work, and RADAR (domestic violence intervention) trainings were being provided to medical schools and a wide range of providers (Pennsylvania Medical Society, 2011). Local non-profits mentioned above were also working with the police department to improve victim services (Bloom, 2011).

Throughout the next decade, Philadelphia strengthened its orientation toward the importance of acknowledging trauma in human service delivery. In 2003, the Office of Mental Health (OMH), Office of Addictions Services (OAS), and Community Behavioral Health (CBH) were integrated into the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS). These offices had previously been administered under the Philadelphia Department of Public Health. The new organizational structure created a system of integrated behavioral health and intellectual disability services, emphasizing a recovery-oriented approach to behavioral health care. Numerous trainings were offered across the city, as the department began its 'recovery transformation' (DBHIDS, 2012).

Under the leadership of Dr. Arthur Evans, DBHIDS began trauma initiatives, furthering the prominence of trauma-informed care in the city. In 2009, the Department of Human Services (DHS) also invested by providing Sanctuary training to employees, and the DBHIDS and the Office of Supportive Housing (OSH) eventually followed suit in 2011. Throughout the city, increasing awareness of the impacts of trauma occurred across the human services and legal field. The media provided consistent coverage of trauma as a relevant issue that piqued the public interest (Bloom, 2011).

This combination of awareness, renowned experts in the field being based in Philadelphia, and the fact that several public service agencies chose to make trauma-informed

care a priority, have created an environment primed for further development of cross-systems networks. In addition, advocates, small non-profits, and local foundations have worked together to advance the issue (Bloom, 2011). All of these factors contribute to the relevance of a project that seeks to further develop trauma-informed care across human service systems in Philadelphia, and would position the city on the cutting edge of the trauma-informed care movement.

The OSH and DBHIDS are human service organizations that serve overlapping populations. Separately, each of these organizations chose to invest in bringing the Sanctuary Model to their agencies, potentially to address issues that were inhibiting their ability to provide the appropriate services to the traumatized populations they serve. Currently, the DBHIDS and the OSH have completed the five day Sanctuary training and the booster training. These organizations appear to both be seeking to better address trauma within their organizations in order to provide a trauma-informed environment for clients. Working together to create trauma-informed care across organizations would serve as a paradigm shift; a shift from independent networks of providers to an interactive social network that provides continuity of care for the population being served. A social network approach is self-shaping and reflexive. Its structure emerges from within the network, and can be a significant source of social capital (Bloom, 2011). If DBHIDS and OSH choose to pursue collaboration together, this will further reduce stress for traumatized populations, making the Sanctuary Model more effective.

This project is a precursor to a future goal which is shared trauma-informed values across all sectors of human services (housing, education, physical health, behavioral health, child welfare, justice). The history, non-profit structure, and numerous stakeholders create an opportunity for Philadelphia to be a model of a trauma-informed care network for other cities.

Before attempting to implement further collaboration; however it must be determined whether or not a learning collaborative between organizations is even feasible.

Research Design & Methods

Overview

This qualitative research project gathered data from individuals in the Philadelphia area who are involved in efforts to advance trauma-informed care. These study participants, or key-informants, work in a variety of human service provider agencies, in leadership positions across the city. Results from 16 semi-structured interviews were analyzed for themes and combined with a comprehensive literature review. The findings inform recommendations about the feasibility of learning collaboratives using the Sanctuary Model as a framework, for advancing trauma-informed networks of care in Philadelphia.

Subjects

Key-informants were voluntary participants recruited from a variety of organizations including provider agencies and city government offices. Study participants were recruited individually based on the researchers' selection, using snowball sampling. Recruitment letters were sent to each prospective key-informant, explaining the project using a standardized overview. Upon expression of interest in participating, a list of potential interview questions was provided to ease potential participants' concern about interview content. This concern was discovered during the recruitment process, after several participants agreed to the interviews under the condition that they could preview questions. The research team decided to move forward with releasing a list of questions, particularly due to the political nature of positions held by several of the key-informants. This will be discussed further in the limitations section.

Inclusion criteria were based on the role of the key-informant in their agency, their involvement in or knowledge of Sanctuary Model implementation, and their willingness to participate. All of those recruited who agreed to participate were included in the study. Key-informants self-excluded if they did not respond to recruitment efforts or declined to participate. Of the 18 key-informants recruited, 16 chose to participate in the project. One of the two excluded initially agreed, but never followed through and the other did not respond to recruitment efforts.

Data Collection

Semi-structured interviews with key-informants were used to gather qualitative data (*see Appendix A).* Interviews addressed topics including: Sanctuary Model implementation, systems change, learning collaboratives, and trauma-informed networks of care. The goal of the data collection was to elicit feedback from key stakeholders about the barriers and potential opportunities for building cross-system collaborations to advance trauma-informed networks of care. This feedback will shape the feasibility assessment and provide groundwork for a possible collaborative in the future between DBHIDS and OSH, or across other systems in Philadelphia.

Key-informants were asked several demographic questions at the end of each interview: years worked in the field, position in the organization, and the sponsoring organization of their Sanctuary Model training (if applicable). Among participants, experience in the field ranged from 10 to 40 years. Positions held within the organization were primarily middle management and administrative.

Each semi-structured interview was administered by two MPH student researchers: one conducting the interview, the other taking notes. Interview notes consisted of observations of the interviews, body language, tone, and overall impressions. The interviews took place at the key-

informant's place of employment. Each interview was digitally recorded and later transcribed by the students. Interview duration ranged from 30-70 minutes in length. Parameters for transcriptions were discussed by the student researchers to improve consistency in transcription style. The transcripts were then analyzed, using qualitative coding to look for themes across the data.

Institutional Review Board Considerations

In light of the leadership positions of many of the key-informants, researchers perceived hesitation from key-informants to participate. Researchers believe this phenomenon demonstrates the trauma present in the systems and organizations that plague the human service systems (Bloom & Farragher, 2010). Subject confidentiality was protected by omitting personal identifiers and assigning numbers to each subject. These numbers corresponded to transcripts and serve as a reference. Caution was taken in presenting the findings to ensure that identity of each subject remained protected. A letter of determination, project proposal, and interview questions were submitted to the Drexel University Institutional Review Board (IRB), which determined the project was exempt from full IRB review. The determination letter from the IRB was filed with the Principal Investigator and student researchers.

Each key-informant was verbally consented prior to beginning the interview. As part of the consent, they were notified that data would be de-identified, and that their responses would be analyzed for themes. Key-informants were told to skip any question they were not comfortable answering. They were also notified that their responses would not be subject to public release, and that summary results would be made available to them, should they be interested.

Data Analysis

All 16 key-informant interviews were recorded and transcribed. The transcribed interviews were then coded using Nvivo. The first two transcripts were coded by both researchers simultaneously for the purpose of agreeing upon codes. The remaining transcripts were divided equally between researchers and coded separately. Any new codes that emerged were discussed and agreed upon by the researchers. Upon completion of coding, codes were divided into themes.

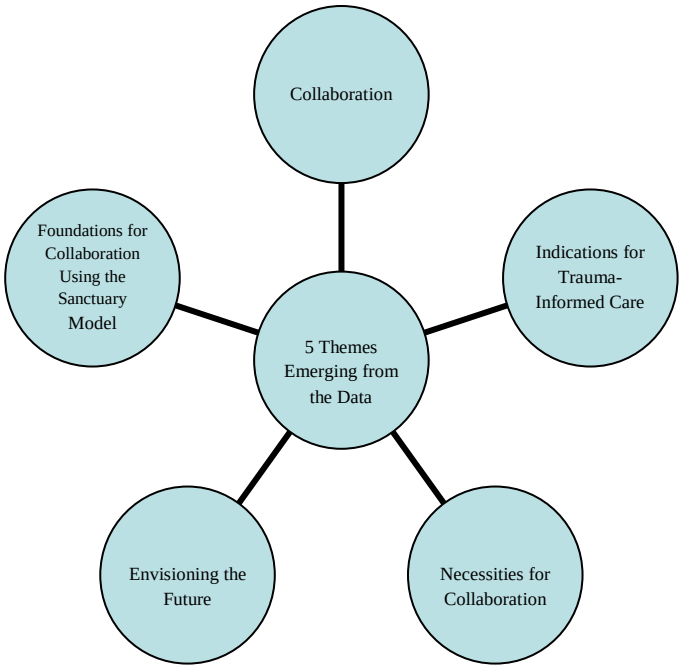

Figure 3: Five Primary Themes Emerging from Data Analysis

Results

Through the data analysis, five primary themes emerged: (1) Collaboration (2) Indications for Trauma-Informed Care (3) Necessities for Collaboration (4) Envisioning the Future (5) Foundations for Implementing Collaborations using the Sanctuary Model. These themes developed based on common grouping of codes. Each of the five themes will be discussed in more detail, broken down by subtopics.

Theme 1: Collaboration

Key-informants were asked about collaboration. Topics known as codes emerged from discussions about collaboration. The codes that emerged within the theme of collaboration were

Collaboration Strengths, Collaboration Barriers, Overcoming Barriers and Ways of Collaborating.

The Collaboration Strengths code formed from the question asking key-informants to discuss inherent strengths within their system that would facilitate collaboration. They identified a wide variety of strengths including: *shared values, transparency, provider and community participation and flexibility*. The two most common strengths mentioned were *openness*, which was mentioned by three out of 16 key-informants and a *departmental structure that encourages collaboration*, which was mentioned by two out of sixteen key-informants. One key-informant stated,

> *"So just from a departmental structure everything that we do is related to somebody else, or something else within the broader system"*

Key-informants also mentioned that they have developed strengths that would facilitate collaboration as a result of implementation of the Sanctuary Model.

> *"Because of the Sanctuary Model, I think there are a lot of strengths in our ability to collaborate because of this notion of open communication and opportunities for growth and change…"*

Key-informants were also asked to identify perceived barriers to collaboration. *Availability of funding* was identified by thirteen out of sixteen key-informants as a Barrier to Collaboration. *Unions* were identified by four out of sixteen key-informants as a Barrier to Collaboration, and also as a barrier to positive change within organizations. Unions have a

history of objecting to changes, including implementation of the Sanctuary Model®, within human services systems in Philadelphia.

> *"I mean unions in this agency in particular have been a barrier to doing the right thing by kids."*

The third most common barrier to collaboration was *distrust of outside agencies*, which was identified by three out of sixteen key-informants. *Safety* was another barrier to collaboration within agencies. Key-informants identified ways in which a lack of safety prevented open and honest communication from ever occurring. This barrier was identified by two out of sixteen key-informants and the power of this fear, this lack of safety is exemplified by the following statement,

> "*How many people go into participate and never open their mouth because they don't feel safe. Either they don't feel smart enough to ask or say, but they don't feel safe. It's a toss-up; each of these is controlling…you hear it every day, 'if I speak up, I'll get in trouble'"*

The final codes that emerged within the theme of collaboration were *Overcoming Barriers* and *Ways of Collaborating.* Key-informants identified a variety of strategies for overcoming barriers and they included the following: (a) open communication about change makes it less threatening (b) feeling safe enough to disagree (c) sharing a common goal and (d) effective leaders and co-facilitators. Key-informants also identified a variety of ways of collaborating including: (a) community involvement (b) NIATx as a model used for

collaborative learning, (c) building relationships across organizations and agencies as opposed to relying on resource guides, and (d) Collaborating with the goal of improving services.

Theme 2: Indicators for Trauma-Informed Care

Indications for Trauma-Informed Care was a theme that emerged from discussions of factors signaling a need for trauma-informed care within their organizations. The four factors, identified as Indications for Trauma-Informed Care were: *overlapping populations, devaluation, parallel process* and *indications for trauma-informed policies.*

The theme of *overlapping populations* refers to populations that are served by multiple systems of care. Key-informants indicated that there was a lack of recognition that the same individuals and families were being served by multiple systems and that these systems were dependent on each other to provide appropriate care to these individuals and families.

> *"We're all serving the same population. This is a finite group of people. But, each of us- each of the systems approaches the work that they do as if the people that they're working with have never touched on any of the other systems"*

Devaluation was another factor identified as an indicator for trauma-informed care. Devaluation communicates the way some workers and agencies feel undervalued within organizations and as organizations. Key-informants mentioned reimbursement of services as a contributor to devaluation. Some services are not reimbursable, giving the perception that these services are of less value. In addition key-informants mentioned that systems undervalue each other's work and contributions.

Parallel process also emerged as an indicator for trauma-informed care. Parallel process is defined as the ways in which staff and systems are affected by and reflective of the trauma experienced by the clients who come to them seeking services (Bloom, 2011). Key-informants acknowledged the stress experienced by staff in human services system. This stress can result from interactions with clients, colleagues, and organizations or systems that have their own histories of trauma. Key-informants acknowledged that there was a need for systems leaders to recognize the stress experienced by staff because of its impact on clients being served.

> *"there is a very real threshold factor for how well you can continue to do that work when you're dealing with that level of daily demand, stress, tension, need"*

The final indicator for trauma-informed care was *Indications for Trauma-Informed Policies*. Indicators for trauma-informed policies are negative outcomes that could be fixed by a change in systems policies or the adoption of policies that would address the impacts of trauma. A common indicator for trauma-informed policies, indicated by three out of sixteen key-informants was the need to improve staff care. Key-informants acknowledged that staff did not always understand the behavior of clients and how to address that behavior. This could possibly indicate the need for education about the effects of trauma. Key-informants also expressed a desire for an evidence-based standard of care both within and across agencies. Trauma-informed providers were also discussed. Key-informants mentioned that there was difficulty referring clients to trauma-informed providers when it was deemed necessary because there was no system in place for identifying and locating trauma-informed providers. One key-informant introduced systems nomads as an indicator for trauma-informed policies. Systems nomads were defined as,

"women who are in the public systems whether they were in the homeless system or the criminal justice system or child welfare or domestic violence or had substance abuse problems or mental health problems- they had one thing in common, which was they had been abused. They had been traumatized. So they went from one system to the next and we called them systems nomads…whatever the presenting problem was, was focused on. So if they were homeless it was their homelessness. If they had parenting issues or child welfare issues, their parenting was addressed and so forth and so on…so recognizing that this, that a system has to be informed about the trauma and the underlying issues associated with the trauma have to be addressed so that healing can occur and they're not going to be bouncing from one system to the next"

Theme 3: Necessities for Collaboration

This theme includes topics and components that key-informants found necessary for collaboration. These necessities were based around three subtopics: leadership, values, and communication.

Leadership. This includes specific individuals and elements of leadership that are important for collaboration. Respondents noted that leadership towards systems change should come from the 'top down', and that modeling the desired behaviors and changes in the organizations impacts the success of those organizational changes. It was noted that leaders must have a physical presence, behave and communicate consistently, and frame change in a way that creates time and space for the process. Relationships among leaders were also important, as perceptions about these relationships appeared to influence perceptions about the change process. More than one key-informant indicated that leaders should be active listeners.

'you first have to be able to hear what's said as opposed to hear what you wanted to hear or what you think what's said and then you need to be able to hear without judging'

Challenges to leadership were also reported. It was identified that invested leaders are powerful, but leadership is often under-resourced and additional professional development for leaders is needed. Leaders should maintain their values and recognize themselves as leaders even in times of adversity, but some felt they needed to prove their leadership abilities. Competing priorities and changes in administration create challenges; however the deputy mayor structure of city government was identified as a strength.

> *"If you don't have leadership on board you're sunk before you sail."*

Key-informants identified a wide variety of leaders. The most frequently identified was the city government leaders at the commissioner level. Based on responses, these commissioners of human service organizations are expected to guide collaborative efforts for trauma-informed networks, and that the ways in which these leaders behave and interact with one another impacts perceptions of the process.

In addition to the responses profiled in the graph (Figure 5), other potential leaders included: the Sanctuary Institute, first responders, the courts/judicial system, the state, and the Children's Crisis Treatment Center.

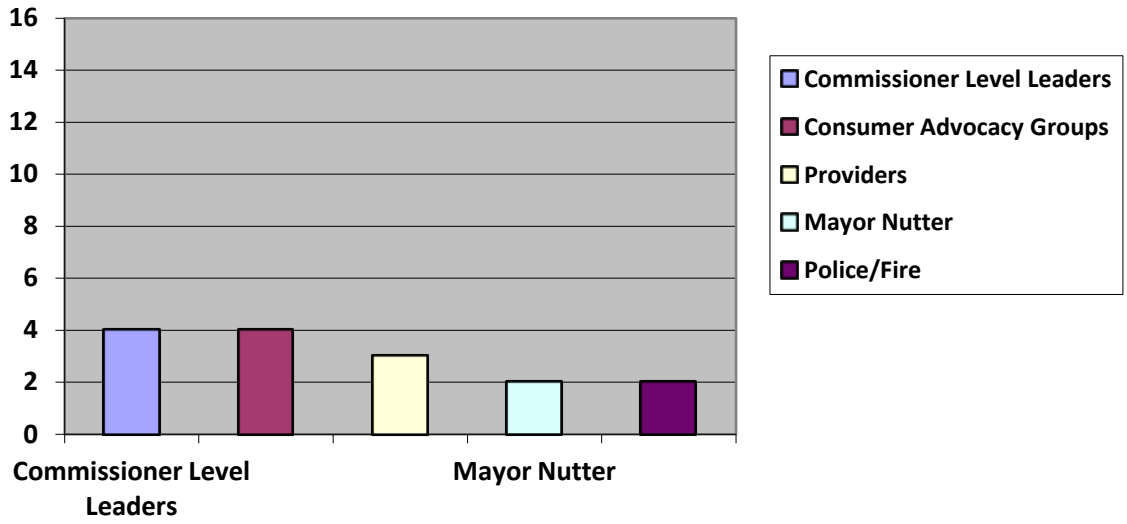

Figure 4: Leaders Most Frequently Mentioned by Key-Informants as Important for Guiding Collaboration

Values. For collaboration to be successful, key-informants noted the importance of establishing and clarifying common values with other organizations and systems. The most common response was the need to find common values across agencies in order to build collaboration; that established relationships can act as the building blocks of collaboration. Key-informants mentioned that organizational mandates can act as a barrier to finding common values, and that the need for organizational self-preservation sometimes takes priority. There was however, mention that the Sanctuary Model provides a set of values for addressing trauma with clients and organizations. Specific values identified by key-informants can be found in Figure 6.

- Transparency
- Dignity
- Consistency
- Service
- Interdisciplinary Work
- Professional Development

Figure 5: Common Values Identified as Important for Collaboration

Communication. The final necessity of collaboration is Communication. Key-informants mentioned most frequently that a common language is needed to facilitate collaboration, and that it would be necessary for cross-systems collaboration to occur. It was recommended that communication be intentional and direct, and that it come from leadership from 'the top down'. Three key-informants reported that a goal of using the Sanctuary Model was to improve communication. The Sanctuary Model was seen to be a source of a common language that could help open lines of communication and build consensus.

> *"And the idea is that we as collaborators are in communication. So it's not a referral system. I'm up to my eyeballs in referral systems and you know resource guides…,'Oh, you're gonna put together another resource guide-that's our solution!'…No! It's not your solution. We don't need another frickin' resource guide- Google it! What we need is people who talk to each other … [raised voice] 'cause it doesn't matter if you know the phone number, what they do-if there's no one there who's in relationship with you, it's not gonna do any good."*

Theme 4: Envisioning the Future

The fourth theme emerging from the data is called *Envisioning the Future*. This theme addresses how key-informants might view the future of trauma-informed care, and what must be acknowledged in order to move forward. The four topics within this theme are: (a) Imagining Trauma-Informed Networks of Care, (b) Paradigm Shift, (c) Organizational Histories, and (d) Organizational Loss.

One interview question encouraged key-informants to look into the future by asking, "If you could imagine a trauma-informed network of care in the City of Philadelphia, what might it look like?" (*Appendix A*). The most common components of this envisioned trauma-informed network included a cross-systems data-base (for example an integrated case management approach), and that a client's trauma history would only have to be shared once by the client.

Paradigm shifts are another component of envisioning trauma-informed networks. A paradigm shift was described by key-informants as a cultural change, a common language, and continuity of care. It would involve a variety of systems working together in a trauma-informed network, understanding that these systems serve overlapping populations.

Imagined Elements of a Trauma-Informed Network of Care

- Knowing who to call
- Education for the community
- Standards of care
- Evidence-based practices
- Continuum of care
- Easier referrals
- Sharing resources, perspectives, & expertise
- ACEs Score would follow clients across systems
- Commitment to Sanctuary Model
- Trauma-informed providers
- Sanctuary Model implementation in systems would parallel implementation in organizations
- I can't envision a trauma-informed network

Figure 6: Components of a Trauma-Informed Network Imagined by Key-Informants

One key-informant described that a shift from framing trauma as disease to injury was needed, and another that 'the once impossible becomes treatable'. Another described indications for a culture change:

"…so I guess I go back to childhood. If we can't fix it for children it's gonna be hard to fix it for adults because it'll never-it'll never catch up."

Respondents noted that use of the Sanctuary Model was a paradigm shift in itself, and that S.E.L.F. becomes ‘a way of thought’. Others expressed that the model can provide a roadmap to get back on track when we lose sight of context, specifically when it came to understanding behaviors.

> *“I don’t think it [Sanctuary Model] can necessarily change human nature, but it can influence what your first reaction is”*

Finally, organizational histories and losses must be acknowledged in order to move into the future. The importance of understanding organizational trauma histories was identified, along with the recognition that long histories can create a cynicism and reluctance to change. Organizational losses are the losses incurred by an organization in the process of implementing the Sanctuary Model or other significant organizational change. Key-informants identified such losses to include staff turnover, funding or structural losses, loss of comfort, and loss of convenience.

Theme 5: Foundations for Implementing Collaborations Using the Sanctuary Model

The fifth theme identified during the data analysis is called *Foundations for Implementing Collaborations Using the Sanctuary Model*. This theme addresses four topics, which serve as building blocks to using the Sanctuary Model as a learning collaborative framework: Defining Trauma-Informed Care, Implementation Challenges, Trauma-Informed Providers, and the Sanctuary Model as a Framework for Collaboration.

One interview question asked key-informants to define trauma-informed care. A response that was mentioned twice was that trauma-informed care is ‘a lens’ that shifts

perspectives. It was also identified as something that facilitates healing, and prevents trauma. Trauma-informed care is when adequate human service capacity exists, combining philosophy and interventions to better understand experiences and stressful circumstances. It means taking an active approach to intervening, understanding our own experiences and their impacts on us, and 'helping people on their journey and giving them a voice in the process'.

> *"Giving people some tools to be able to not be afraid of necessarily stepping into things that are uncomfortable, that may not feel safe…to begin to help build a safer, stronger environment"*

> *"to facilitate a healing process so that kids and families involved in the system ultimately can be successful productive people in society"*

Implementation challenges are something that must be acknowledged and processed if a learning collaborative is to be feasible. Key-informants reported that organizational change is particularly difficult for veteran staff members, and that gathering a critical mass of support is needed.

> *"Some people been here for 40 years, working in this agency. Four decades. So and in their last year they wanna change and learn new things, and have new connections going off in their brain. Working harder, right? They're on auto-pilot, some of them- just auto-pilot."*

Specific implementation challenges included: union structures, staff's own trauma-histories and lack of safety, and staff turnover. Leaders shared that organizations struggle to measure outcomes, maintain accountability, and understand the differences between trauma-specific services, and trauma-informed systems. Resistance to change was a challenge, as were concerns about communicating the model to staff amidst competing priorities. Some key-informants were concerned about what 'wasn't being said', as they attempted to motivate their agencies to move forward with the aggressive implementation timeline. There were also challenges with buy-in from clinicians:

> *"the folks that I have felt most challenged by are the folks with the greatest amount of knowledge about trauma theory. And you know, I think I know what that's about. It's about ownership. It's about identity. It's about- it's about, I've been doing this stuff for decades. Don't you be coming here and telling me how to be trauma informed"*

Trauma-informed providers are another component of implementing collaborations using the Sanctuary Model. Providers are a core piece of a trauma-informed system, and should understand trauma at both the client and organizational level. Several challenges were identified related to developing trauma-informed networks of providers: staff turnover, after significant investments in training, measuring competency of providers (who is really trauma-informed?), and tracking providers throughout the system when they move agencies. A peer-managed network of trauma-informed providers could be one approach; providers themselves determining competency and monitoring their network. Ongoing professional development and education are needed to bolster provider networks.

The final topic was *Sanctuary Model as a Framework for Collaboration*. One of the interview questions asked respondents whether they believed that the Sanctuary Model could be used as the framework for a learning collaborative. It was acknowledged that trauma-informed care must begin at the organizational level, and that a common model must always be the precursor to collaboration. Of the 16 key-informants, 10 responded that yes, they believed the Sanctuary Model could function as the learning collaborative framework. The six remaining responses were mixed: some did not believe the Sanctuary Model was the appropriate model, while others acknowledged the Sanctuary Model is not the only way, or were unsure which model for implementing trauma-informed systems would be appropriate.

> *"The issue for me was not whether or not we should be doing something around trauma. The issue was what should we be doing around trauma? And I think what's interesting about Sandy's model is that the target of the intervention was the organization itself… Sandy's model-and Sandy's on to something in understanding that even if you develop really good clinical strategies organizationally those strategies could be hindered because sort of the organizational context."*

Discussion

Intersection of themes

The five themes that emerged each have unique implications for shaping trauma-informed networks of care, and intersect with one another. *Indications for Trauma-Informed Care* is the starting point, as it describes the reasons why trauma-informed care is needed. These indicators motivate *Collaboration,* as stakeholders begin working together to address these

problems. Collaboration creates opportunities and challenges, but eventually leads towards *Envisioning the Future* together. Collaborating, and envisioning a future together creates another step towards a more trauma-informed city. These three themes build on a common theme: *Foundations for Collaboration Using the Sanctuary Model.* This theme defined trauma-informed care and providers, and addressed implementation challenges. The fifth theme, *Necessities for Collaboration* included leadership, communication, and values. These three elements are required at all stages of the process in order for collaboration to be successful.

SWOT Analysis

Earlier, it was mentioned that Nvivo was used to code the data collected and discover emergent themes. Later in the analysis phase of this study, it was decided that SWOT analysis was another tool that could be used to weigh the feasibility of a learning collaborative using the Sanctuary Model as a Framework. SWOT stands for: Strengths, Weaknesses, Opportunities and Threats. SWOT is a strategic analysis tool used to identify external developments and internal capabilities. The goal of SWOT analysis is to engineer a confrontation between these factors for the purpose of identifying options or possibly a new strategic course (van Wijngaarden, Scholten, & van Wijk, 2012). SWOT analysis was used to identify these factors within Philadelphia's human services system in regards to collaboration and creating a trauma-informed system of care. SWOT also added structure to the analysis of the data collected from the key-informant interviews. The following Strengths, Weaknesses, Opportunities and Threats were identified within Philadelphia's Human Services Systems:

Strengths:

- History of trauma-informed care movement in Philadelphia
- Many leaders and organizations are already familiar with Sanctuary Model

- Crisis as catalyst for change: violence and trauma in the city and its ability to act as a motivator to attempt new, innovative solutions
- Key leaders in the city acknowledge trauma-informed care as a priority
- General awareness of trauma and it's impacts throughout the city

Weaknesses:

- Large size of agencies attempting to implement Sanctuary Model
- Union structures inhibit organization changes
- Trauma histories of organizations and individuals
- Fear of failure: implementation of learning collaboratives and/or the Sanctuary Model are a significant investment of time and resources
- Resistance to change

Opportunities

- Promoting healing
- Preventing further trauma
- Cutting edge in Trauma-Informed Care
- Increasing efficiency
- Setting new benchmarks
- Creating increased accountability across systems

Threats

- The lack of funding or funding structure
- Changes in political leadership or structure
- Choosing an appropriate trauma-informed care model
- Different phases of Sanctuary Model implementation across systems may threaten implementation success

Limitations

This study has several limitations. Study subjects were selected through a subjective process, and should not be assumed to be representative of the organization or all employees there within. Their opinions are subjective as well, and may not fully describe the barriers to developing trauma-informed networks or the advantages of learning collaboratives. The information derived from these interviews represents one component of voices from the organizations, and cannot be assumed to apply to all staff.

Recommendations developed from this research may not be transferable to other cities, based on the unique history and cultural context of Philadelphia. The hierarchical nature of the organizations that employ the key-informants may have influenced the key-informants' responses. While precautions were taken to ensure the privacy of key-informants, an overwhelming majority of the key-informant interviews were conducted in their place of work. This circumstance combined with the order of the interviews may have influenced the key-informants' sense of safety and their level of disclosure. Additionally, key-informants were provided with a list of potential questions prior to being interviewed, providing them with the opportunity to rehearse answers, possibly influencing the key-informants' responses to questions.

Conclusion and Recommendations

Based on the majority of responses from key-informants, using the Sanctuary Model as the framework for a learning collaborative appears to be feasible. The success of such a collaboration may fluctuate with time depending on leadership, politics, funding, and a number of other dynamic variables. An important piece of success would be communicating to all involved stakeholders that a learning collaborative brings accountability. It would be the community of collaborators themselves who must decide these parameters for accountability, as well as outcome measures to determine the collaboration's success.

Implementing a learning collaborative using the Sanctuary Model has several anticipated implications for the human service systems in the City of Philadelphia. Increased safety within organizations would be expected, as a new culture of trauma-informed care develops. Best practices could be adopted and disseminated more quickly, improving care and efficiency. Using the Sanctuary Model as the framework would be a unique model, forging deep cultural changes that would aim to bring systems-level changes that are sustainable over time, and

increased accountability to one another throughout the system. This would be yet another opportunity for Philadelphia to position itself on the cutting edge of the trauma-informed care movement, setting standards for exceptional care, far beyond city limits.

Next steps would include encouraging key city leadership to discuss investment in cross-systems collaboration, and move towards choosing a framework best-suited to the current situation. It would also be beneficial for work to begin adapting the Sanctuary Model as needed to provide adequate support for a learning collaborative, should that next step be taken.

Although concrete answers are unrealistic, this project allowed researchers to check the temperature within human service organizations in the City of Philadelphia, gauging their perspectives about using the Sanctuary Model as a framework for cross-systems collaboration. It is only through collaboration in some form that movement forward towards a trauma-informed city can be achieved. It is also through collaboration that individuals, organizations, and systems can move towards innovative practice, high quality care, and healing.

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Appendix A

Interview Overview: Assessing Feasibility of a Learning Collaborative using the Sanctuary Model

Maureen Bergey and Stefanie Rhodes

We are students in Public Health at Drexel University, and this interview is part of a master's thesis project. We are working under the direction of Dr. Sandra Bloom, and she is supervising our work, and has assisted in developing the interview questions. Dr. Bloom is the founder of the Sanctuary Model, and is Associate Professor of Health Management and Policy at the Drexel School of Public Health.

We are interviewing key-informants holding various roles in human service organizations. The interview is focused around several key topics: the feasibility of developing learning collaboratives between various parts of the human service delivery system, experiences implementing the Sanctuary Model, and impressions about developing trauma-informed care networks. Our objective is to inform the development of trauma-informed systems in Philadelphia, and we need your help- your input as a stakeholder in human service systems is valuable. We will begin by providing a brief background on several of these topics.

As you may or may not be aware, the Sanctuary Model is a trauma-informed whole system approach designed to reduce stress within human service organizations while helping our clients heal from the traumatic events that have led them to seek out our services. Use of the Sanctuary Model shifts interactions with our clients from 'what is wrong with you', to 'what happened to you', acknowledging the role of trauma in the lives of our clients and within our systems.

Learning collaboratives are opportunities for organizations or systems that traditionally compete for resources, to come together and identify a common problem they each have an interest in solving. One goal of this interview is to determine whether or not it would be beneficial for agencies to collaborate or work separately.

Trauma-informed care acknowledges the role trauma has played in the lives of individuals and systems, by recognizing the impact of symptoms and trauma histories. Trauma-informed systems embrace the awareness of the impacts of trauma, and the need for change across all levels of service, through trauma theory education and adapting programs to reduce the vulnerabilities and triggers for trauma survivors.

All of your responses during this interview will remain confidential. They will not be individually identifiable, recorded for public use, or subject to public release.

Collaboration Questions

- What are the strengths in your system that could encourage collaboration?
- What do you think are the major barriers to collaboration?
- Has your organization had initiatives with other organizations in the past?
    - If so, what was the goal of this collaboration? Was there a specific problem you wanted to solve?
    - Did you achieve this goal?
        - If you did achieve your goal, what factors do you believe contributed most to goal achievement? (In the context of a learning collaborative)
        - If you did not achieve the goal, what do you believe were barriers to goal achievement?
- Is collaboration threatening? If so, to whom and why?
- Do you find your agency having to compete with other organizations for resources?
- Do you think it would be easier to have collaboration between organizations and/or agencies if they shared the same value system?

Sanctuary Questions

- When and how did you learn of the Sanctuary Model?
- Based on the progress you've made thus far, what future goals do you hope to achieve through the implementation of the Sanctuary Model?
- What is your understanding of why DBH endorsed this project?
- Are you familiar with the term trauma-informed care? What does it mean to you?
    - If so, why do you think it is important for your organization to implement the Sanctuary Model?
- Have you noticed any changes since your initial Sanctuary training?
- Do you currently have contact with clients at your agency?
    - If yes, how has your exposure to the Sanctuary Model impacted the way you work with clients?
- What challenges have become apparent now that were not apparent prior to the initial training of the Sanctuary Model?
    - Do you believe these challenges can be overcome? If so, how?

SELF Questions/Trauma-Informed Care

- If you imagined that Philadelphia has a trauma-informed network of care, what would this look like?
    - How might it impact your clients?
- What might your organization have to change in order to be more trauma-informed or to implement the Sanctuary Model?
- What losses might your organization experience if they were to become part of a trauma-informed network of providers?

- How has this change process of implementing Sanctuary Model felt safe/unsafe in your organization? (Is there anything that scares you about this implementation process?)
- Do you believe that a collaboration with another agency using the Sanctuary Model as the framework would further improve care in your organization? Why or Why not?
- What fears might be associated with becoming part of a trauma-informed network of providers or learning collaborative?
- Who are the key advocates who we need to network together?

Appendix B

Theme 1: Collaboration		
Code	**Definition**	**Major points**
Collaboration Strengths	Factors that facilitate or encourage collaboration	• Openness 3* • Departmental Structure that encourages collaboration 2* *"So just from a departmental structure everything that we do is related to somebody else, or something else within the broader system"*
Collaboration Barriers	Factors that act as a Barrier to collaboration	• Legal Barriers 2* • Unions 4* • Availability of funding 13* • Lack of safety, preventing open communication • Regulatory Barriers • Power differentials 2* • Leadership 2* • Distrust of outside agencies 3* • Structural differences/hierarchical system 2*
Overcoming Barriers	Example of how barriers to collaboration have been overcome	• Open communication about change makes it less threatening • Feeling safe enough to disagree • Sharing a common goal • Effective leaders and co-facilitators
Ways of Collaborating	Ways in which organizations have collaborated or facilitated collaboration with other organizations, agencies and/or systems	• Community Involvement • Educating and training different systems in mental health and understanding behavioral health • NIATX (example) • Building relationships • Collaborating for the purpose of improving services

Theme 2: Indications for Trauma-Informed Care		
Code	**Definition**	**Major Points**
Overlapping populations	Populations that intersect across systems. Certain populations are usually being served by multiple systems of care	• Recognition same families are being served by each of the systems *2 *"We're all serving the same population. This is a finite group of people. But, each of us-each of the systems approaches the work that they do as if the people that they're working with have never touched on any of the other systems"* • Recognition that systems are dependent on one another to serve clients 1. Ex. Homeless services needs DBH, etc. 2. This encourages collaboration
Devaluation	Organization and systems staff feeling undervalued	• Organizational stress that results when some services aren't reimbursable and therefore impacting the perceived value of the services • Systems devaluing one another
Parallel Process	Systems level behavior reflecting that of the clients being served and vice versa	• Time and resources spent on emotional management with staff • Leaders recognizing impacts on staff and ability to be productive *"there is a very real threshold factor for how well you can continue to do that work when you're dealing with that level of daily demand, stress, tension, need"*

		• Personal staff experiences impacting how they serve clients • System interactions impact clients' interactions with the system
Indications for TI-Policies	Actions, behaviors and policies that demonstrate a need for trauma-informed care	• Need to improve staff care *4 • Concerns were expressed by Children's Work Group *3 • Staff struggles to understand client behavior *2 1. Sanctuary Model has helped to frame this • Desire for a standard of care *2 • Trauma-informed providers move from agency to agency, making it difficult to track where to refer clients for TIC- Staff turnover • Consumers don't know where to go for treatment • Lack of evaluation system for determining who is truly a trauma-informed provider • Traumatized staff when organizations change- need safety in workplace • Disrupted attachments and the difficulty this presents for staff • Providers expressed concerns/desire for T-I-C • Improve organizational health • Populations being served are becoming younger and more violent • System "nomads" *"women who are in the public systems whether they were in the homeless system or the criminal justice system or child welfare or domestic violence or had substance abuse problems or mental health problems- they had one thing in common, which was they had been abused. They had been traumatized. So they went from one system to the next and we called them systems nomads…whatever the presenting problem was, was focused on. So*

		if they were homeless it was their homelessness. If they had parenting issues or child welfare issues, their parenting was addressed and so forth and so on…so recognizing that this that a system has to be informed about the trauma and the underlying issues associated with the trauma have to be addressed so that healing can occur and they're not going to be bouncing from one system to the next" • Health impacts of trauma *"[W]'ve become trauma-organized as a society that trauma is so definitional to who we are that we have to be taking a look at tit….as the ACEs study has shown us in such stark terms, it's not just a psychological experience. It has a profound impact on our health, and yea…I also feel like it's important because we don't experience trauma equally across the board. We have to take a look at it because trauma is experienced at drastically different levels that correlate with privilege…"*

Theme 3: Necessities of Collaboration for Trauma-Informed Networks		
Code	**Definition**	**Major Points**
Leadership	Discussion of leaders or leadership in the implementation of the Sanctuary Model	• Consistency 2* • DBH as a leader 2* • Change must be top down 3* • Active listening 2* "you first have to be able to hear what's said as opposed to hear

		what you wanted to hear or what you think what's said and then you need to be able to hear without judging" • A call to action for city leadership 3* • Don Schwarz as a leader 3* • Dr. Evans as a leader 2* • Ambrose as a leader • Potential Advocates 1. Sanctuary Institute: Joe and Sandy 2. Consumer advocacy groups 4* 3. Commissioner level leaders 4* 4. Dr. Schwarz 3* 5. Providers 2* 6. Mayor Nutter 2* 7. Numerous others (available in full list) • Sanctuary Champions 1. Joe Foderaro 2. PCV 3. Able to recognize hope in midst of trauma 4. Agencies that dedicate a staff person to Sanctuary Model
Values	The values held by organizations and agencies	Indication to find common values to build collaboration 4* 1. Children's Work Group 2. The need for self-preservation can sometimes take priority 3. Mandates sometimes are a barrier • Need to define/clarify values 2* • Building blocks of collaboration are established relationships • Dignity • Consistency

		• Serving others *"I'm here to serve"* • Sanctuary Model sets values 1. Professional values align well with Sanctuary Model *"And that Sanctuary…by being through the commitments, it's like really a value-heavy model, I think it provides that in a way that just getting together and talking about trauma in agencies doesn't do."* • Interdisciplinary work is valued • Valuing trauma-informed care: value for clients and agency • Transparency • Valuing professional development
Communication	The ways in which organizations agencies and providers communicate and how it facilitates and/or hinders collaboration and/or Sanctuary Implementation	• Common Language 2* 1. Desire for cross-systems common language 2* 2. Leadership communicating from top down, the need for common language 2* i. Need direct communication 3. Sanctuary Model provides a common language 4. Common language is key for cross-systems collaboration *"And the idea is that we as collaborators are in communication. So it's not a referral system. I'm up to my eyeballs in referral systems and you know resource guides…,'Oh, you're gonna put together another resource guide-that's our solution!'…No! It's not your solution. We don't need another frickin' resource guide- Google it! What we need is people who talk to each other …[raised voice] 'cause it doesn't matter if you know the phone number, what they do-if there's no one there who's in relationship with you, it's not gonna do any good."* • Use of Sanctuary Model with goal of improving

		communication **3*** • Intentional communication 2* *"to hear my staff and the providers talk about how they're using some of the principles, how they have begun to recognize certain things, how they understand what their own limitations are-you know, what their safety are…they're using those things and they're talkin' about 'em and they're talkin' to each other about 'em…It is really huge to have everyone speaking the same language"* 1. Community meetings can open lines of communication • Using communication to build consensus • Top-down communicating • Can never have too much communication during organizational change

Theme 4: Envisioning the Future		
Code	**Definition**	**Major Points**
Imagining Trauma-Informed Networks	What would a trauma-informed Network look like?	• A cross-systems database 2. A single case management approach (preventing re-traumatization) 2* • Only having to share trauma history once 2*

Paradigm Shift	Examples of change in culture, perceptions and overall outlook	• Common language • Continuity of Care • Cultural Change: comparing US culture/laws with children being property of their parents vs. Scandinavian countries where children are property of state *"That changes the state's responsibility in terms of abuse, and it changes when the state intervenes and what the state can do…so I guess I go back to childhood. If we can't fix it for children it's gonna be hard to fix it for adults because it'll never-it'll never catch up."* • Including variety of systems in trauma-informed network 1. Police • More natural community supports rather than looking to outside agencies • What's wrong with you to 'what happened to you'- what that means in action 2. Acknowledging the time commitment this takes • Putting behaviors in context for staff • Sanctuary has created a roadmap- tools for getting back on track when they lose sight of context
Organizational Histories	Trauma histories of organizations and how it may affect the culture change within that organization today	• Importance of investigating an organization's trauma history • Long histories create cynicism and a reluctance to change
Organizational Loss	Losses that an organization may have to incur in order to implement the Sanctuary	• Staff turnover • Funding and structure • Loss of comfort

	Model and/or collaborate across systems	• Loss of convenience

Theme 5: Foundations for Implementing Collaborations Using Sanctuary as the Framework		
Code	**Definition**	**Major Points**
Defining Trauma-Informed Care	Key Informant Definitions of Trauma-Informed Care	• Preventing trauma • It's a lens 2* 1. Shifting our perspective *"the people providing care understand the roles and impacts of trauma in people's lives and are able to use that knowledge and awareness in interacting with people in ways that…help…interpret… what they're hearing and seeing and help their clients understand their-sometimes their own internal feeling. It's a lens."* • Facilitates healing 2* *"to facilitate a healing process so that kids and families involved in the system ultimately can be successful productive people in society"* • When adequate human service capacity exists • Perception that providers don't really do/understand trauma informed care, even when they claim to be trauma-informed • Means different things to different people *"So what's trauma to me, is not trauma to somebody else."* • Safety *"Giving people some tools to be able to not be afraid of necessarily*

		stepping into things that are uncomfortable, that may not feel safe…to begin to help build a safer, stronger environment" • Combination of a philosophy and interventions • Understanding experiences and stressful circumstances • Taking an active approach to intervening • T-I-C is a public health issue • Understanding of our own experience and its impact on us
Implementation Challenges	Common challenges associated with Sanctuary Model Implementation	• Staff turnover 3* • Lack of safety 3* • Organizational change is challenging for veteran staff "*Some people been here for 40 years, working in this agency. Four decades. So and in their last year they wanna change and learn new things, auto-pilot, some of them- just auto-pilot."* • Sanctuary Myths 1. How valid is a Sanctuary certification? Is there ongoing follow-through? 2. Expectation that Sanctuary Model is the end-all be-all-that it will eliminate all problems 3. That there won't be any more conflict 4. Sanctuary Model is an excuse not have boundaries or accountability 5. Not feeling comfortable doesn't always equal lack of safety "*Feeling safe does not always mean that you're feeling comfortable…that's gonna take some work, and getting to the point where people really realize that they're in triangles: rescuer-victim-perpetrator triangles, and that they probly have been since they were old enough to have a will and a conscience. And um, they don't have to be anymore, but it's going to be really hard to re-*

		script that shit…pmpf…boy…that's really hard for all of us, you know?" • Need for same expectations of systems leaders as they set for their providers • Remembering to use Sanctuary tools • SM implementation timeline too aggressive • Poor communication/difficulty communicating across education levels • Communicating model to clients • Concerns about what *isn't* being said • How to find accountability • Underestimating the amount of work implementation will take • Understanding difference between trauma-informed interventions and trauma-informed systems • Competing priorities • Challenges with buy-in from clinicians *"the folks that I have felt most challenged by are the folks with the greatest amount of knowledge about trauma theory. And you know, I think I know what that's about. It's about ownership. It's about identity. It's about- it's about, I've been doing this stuff for decades. Don't you be coming here and telling me how to be trauma informed"*
Trauma-Informed Providers	Definitions and perceptions of trauma-informed providers	• Addressing staff turnover after significant investment in training • Creating a network of trained providers that everyone knows about 1. A peer-managed group 6. Finding a way to measure competency 7. Providers who understand both trauma-informed

		interventions as well as at organizational level 8. Ongoing professional development
Sanctuary Model as a Framework for Collaboration	discussion of the necessity of model that can be implemented across systems; some believe Sanctuary is necessary while others mention other trauma-informed models	• Trauma-informed care must start at organizational level first • Merges trauma-informed care and trauma-informed organizations *"The issue for me was not whether or not we should be doing something around trauma. The issue was what should we be doing around trauma? And I think what's interesting about Sandy's model is that the target of the intervention was the organization itself… Sandy's model-and Sandy's on to something in understanding that even if you develop really good clinical strategies organizationally those strategies could be hindered because sort of the organizational context."* • Common model is always a precursor to collaboration, but it may not always be Sanctuary Model • Is Sanctuary Model the frame work for collaboration? 1. 10 clear YES responses 2. 6 mixed- Sanctuary may not be the only way, I don't know