Chapter 17

Building resilient workers and organisations

The Sanctuary® Model of organisational change

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Introduction

If we are to design, implement, and sustain workplaces that diminish and ultimately eliminate bullying we must have a clear, coherent, theoretically based and testable method for doing so. As has been illustrated in this book and well-described in the existing literature, bullying in the workplace is the result of complex and interactive individual, dyadic, group, organisational and societal factors (Hoel & Cooper, 2001; Tehrani, 2001; Einarsen *et al*., 2011). The ideas described in this chapter have their genesis in the bullying that occurs between children and adults. We often learn about universal applications of theory by building systems that are responsive to those who have the most severe impairments. So it is in this case. We have learned about building workplace cultures of respect through learning about building those cultures for people who have been bullied the most, some of whom have become bullies themselves. Beginning in the 1980s my colleagues and I began what has become a long journey of over 30 years discovering how to be most helpful to traumatised and injured children and adults. Our approach has evolved into a model of organisational development that is now known as the Sanctuary Model (Bloom, 1997, 2010; Bloom & Farragher, 2010). In the following pages we will briefly describe what we have learned.

Background

In 1980 we began working within a general hospital based mental health setting in a suburban community. Early on we noticed that many of these adults had been bullied repeatedly throughout their lives in personal relationships, at school, at work, and even in treatment settings. This very fundamental abuse of power in relationships that were supposed to be

nurturing and loving had severe, usually negative, developmental impacts. As children and now as adults, they had no safe refuge from the rigours of existence – no *sanctuary*. They had repeatedly experienced 'sanctuary trauma' defined as expecting a protective environment and finding only more trauma (Silver, 1986). From 1991 to 2001 we developed our Sanctuary programmes and specialised in treating adults who had been maltreated as children. The field of traumatic stress studies was just getting off the ground and we found gratifyingly effective methods to help our injured patients not just to improve but actually to recover from often life-long problems.

In 1998 the landmark Adverse Childhood Experiences Study (ACEs Study) was first released indicating that a high proportion of the subjects of the study – middle-class, middle-aged, Caucasian adults – had been exposed to significant adversity in childhood and those adversities were having negative impacts on their health, mental health, social adaption, and employment capacity across the lifespan (Felitti & Anda, 2010). We were not surprised by the outcome. These findings confirmed what we had been seeing in our clinical practices.

By this time we had begun to create training programmes for other organisations and we did informal ACEs surveys of exposure to childhood adversity of the training participants – all health, mental health, social service and administrative personnel. We found high levels of exposure to physical abuse, sexual abuse and other kinds of childhood adversity among the very people who were supposed to be helping children and adults most injured by these same kinds of exposure.

But while our work was proceeding in an exciting direction with much better results in care, the face of our industry was radically changing. Healthcare and mental healthcare delivery in the United States had become a profitable business and as a result business models and practices were applied to the profit-making and non-profit healthcare and social service industries. Little recognition was given to the bullying conduct and moral distress that subsequently arose when cost-saving measures and other business practices were applied to sectors dominated by the ethical demands of caregiving and 'doing no harm'. The result of these changes has been the widespread demoralisation of entire economic segments with systems 'in shambles . . . incapable of efficiently delivering and financing effective treatments' (President's New Freedom Commission on Mental Health, 2002).

We began to recognise that the combined effects of exposure to childhood adversity, individual stress and chronic organisational stress were having a widespread impact on our caregiving institutions and everyone

within them, producing collective disturbances everywhere we looked. We began thinking about these complex interactions as 'parallel processes'.

Parallel processes

Parallel process at an organisational level has been described as that which happens 'when two or more systems – whether these consist of individuals, groups, or organisations – have significant relationships with one another, they tend to develop similar affects, cognition, and behaviours, which are defined as parallel processes'. As we experienced and these investigators recognised: 'Parallel processes can be set in motion in many ways, and once initiated leave no one immune from their influence' (Smith *et al.*, 1989: 13). As a result of these interactive processes, the symptoms of our clients were often mirrored in our own behaviour and in the attitudes and behaviour of every level of organisation within which we were all embedded. As we began consulting with other health, mental health and social service programmes, we began to recognise that the stressful experiences we had experienced, as well as the consequent demoralisation and interpersonal dysfunction, was widespread and could not be attributed solely to individual causes. We have now trained over 200 organisations, some small group homes or shelters, others that are large, multi-service agencies, in our model of organisational change – the Sanctuary Model. We saw that as a result of widespread changes in service delivery, human service workplace environments in the United States had become fertile ground for bullying behaviour. We also began reviewing the business literature in other industrial settings only to discover that the multiple effects of economic shifts, deindustrialisation, and globalisation appeared to be having similar negative impacts in other economic sectors. The picture that began to emerge we called 'systems under siege'.

Systems under siege

The practice-based evidence we have garnered through formal research and informal observation supports the conclusion that chronic workplace stress results in organisations that are chronically hyperaroused so that they are unable to determine what is and what is not a true crisis and over time become unable to mobilise an effective crisis response when one exists. We view this as a loss of the capacity to manage emotions institutionally, which makes new organisational learning difficult and

sometimes impossible. Under such circumstances, the most emotionally charged information becomes 'undiscussable' and organisations develop 'alexithymia' – the inability to give words to the most pressing internal and external conflicts. In this way, caregiving organisations can develop 'learning disabilities', usually accompanied by 'organisational amnesia' for problem solutions that have been tried and either succeeded or failed in the past. Under these circumstances, formal and informal leaders are likely to become more bullying, authoritarian and punitive, while workers respond with counter-aggression and passive-aggressive behaviour and the social norms within the entire institution become progressively more aggressive, unjust and less democratic. When bullying and authoritarian behaviour are substituted for true leadership, conflicts do not get resolved, learning does not occur, innovation decreases, and creative problem solving comes to a halt. Despite this apparent deterioration, the likelihood is that chronically stressed organisations will be unable to perceive what is happening and instead simply continue to repeat the past, thereby engaging in re-enactment with each other and with their clients.

When this sequence is unfolding, staff members at every level of the bureaucratic hierarchy become ever more crisis-oriented, punitive, disempowered, and demoralised, often living in the present moment, haunted by the past, and unable to plan for the future. Complex interactions among traumatised clients, stressed staff, pressured organisations, and a social and economic climate that is often hostile to recovery efforts recreate the very experiences that have proven so toxic to clients in the first place. The resulting chronic organisational stress both mirrors and magnifies the trauma-related problems from which our clients seek relief. Just as the lives of people exposed to chronic trauma and abuse can become organised around traumatic experience, in this way our caregiving systems also become organised around the recurrent stress of trying to do more under ever-increasing pressure. The result are patterns of attitude and behaviour that we have described at length; parallel processes that at an organisational level self-replicate in uncanny ways creating more of the very problems we are supposed to help (Bloom & Farragher, 2010; Bloom & Farragher, in press).

Parallel process of recovery

Because of our experience working with thousands of very injured clients over the course of two decades, we know that healing is possible. Similarly, our experience of the last decade has demonstrated to us that

healing is possible for chronically stressed and traumatised systems as well.

The first attempt to apply what we had learned in our original programme to traumatised children and adolescents was done under the auspices of a research grant from the National Institute of Mental Health. We found positive changes in the staff as well as the children in that initial study (Rivard *et al.*, 2003; Rivard, 2004; Rivard *et al.*, 2004; Rivard *et al.*, 2005). As part of developing a specific training and certification programme we are continuing to study the organisational impact of implementing whole-system change.

We now know that organisations can change just as individuals can, but such change requires a shift in our basic mental models for understanding the way organisations work, particularly in viewing organisations as living systems rather than machines. The organisational motivation behind such a shift often arises from the need to recognise the advances in our scientific understanding about the impact of trauma, adversity and disrupted attachment that challenges existing ideas about what constitutes illness. But organisational change also requires what amounts to a 'rediscovery' of unconscious dynamics, particularly the power of compulsive re-enactment and a recommitment to the power and possibility of creative change.

Shifting mental models

The process of 'creating sanctuary' begins with getting everyone on the same page – surfacing, sharing, arguing about, and finally agreeing on the basic values, beliefs, guiding principles and philosophical principles that are to guide decisions, decision-making processes, conflict resolution and interpersonal behaviour. Trauma-informed change as we define it requires a change in the basic mental models upon which thought and action are based and without such change, treatment is bound to fall unnecessarily short of full recovery or fail entirely. This change in mental models must occur on the part of the clients, their families, the staff and the leaders of the organisation.

Mental models exist at the level of very basic assumptions, far below conscious awareness and everyday function and yet they guide and determine what we can and cannot think about and act upon (Senge *et al.*, 1994). In any new experience, most people are drawn to take in and remember only the information that reinforces their existing mental models. Mental models thus limit people's ability to change.

There has long been a tension in the mental health field generally, and the psychiatric field in particular, between those who favour doing

whatever it takes to stabilise a patient – drugs, restraint and punishment – and those who see strategic and creative possibilities within the individual chaos of the disturbed psyche. Defining what it is we are actually doing and illuminating the basis of the assumptions we make is critical to achieving meaningful goals. If the goal is 'stabilisation' or 'controlling behaviour' then bullying behaviour on the part of those in control becomes virtually inevitable. There is no way to control another person's thoughts, feelings, and behaviour without some form of coercion. The Sanctuary Model is a method to help shift the mental models of enough people within an organisation that true change in attitude and subsequently in behaviour can occur because people choose to change.

Living organisations

The first mental model shift that we promote in the Sanctuary Model is in helping organisational participants to realise that their organisations are not machines, but instead are living collective entities that emerge out of the combined individual identities of everyone within the organisation. As such, living systems are complexly interrelated and interdependent and therefore change in one part of the system is likely to affect every part of the system. Because they are alive, organisations cannot be successfully 'engineered' but they can evolve, change and grow. The dimensions of that growth, how long it takes, as well as the form it takes, will be determined by the intentions, will and behaviour of all of the living entities that comprise the whole. Therefore, training and education must involve everyone in the system – from the board of directors to the people that work in the kitchen.

Trauma-informed and attachment-based

Science has helped humanity to shift our understanding away from superstition and simple causal explanations of events and probe far more deeply into the complex nature of reality. If we are to solve the multiple crises facing human service delivery systems – and all of humanity for that matter – we need a different way of understanding human nature and human dysfunction, one that incorporates 150 years of accumulated scientific knowledge and clinical wisdom. That requires yet another shift in mental models through developing a working knowledge about the psychobiology of trauma and adversity, what it does to individuals, particularly when trauma is repetitive, occurs in early development, and is a result of interpersonal violence.

In order to understand the profound impact of trauma and adversity, we need to understand the way in which trauma disturbs the human operating system by disrupting attachment relationships – what the grandfather of attachment research, Dr John Bowlby termed the internal working model. What we know now is that trauma and adversity create toxic stress (McEwen, 2002; McEwen & Gianaros, 2010). When toxic stress exposure begins in childhood it does to the human operating system what a computer virus does to the computer operating system. It wreaks havoc with the attachment system and does so unpredictably, contagiously, virulently and intergenerationally. Trauma disrupts attachment.

Organisations have operating systems as well. The operating system for the organisation is embedded within the organisational culture. Organisational culture arises spontaneously whenever groups of people come together for any length of time and focus on tasks long enough to create common traditions, rites and history. It is binding in that it determines how people enter the organisation, survive within it, and learn to solve problems. There are close and interactive relationships between individual identity and organisational identity. Just as attachment is the basis of the individual operating system, social relationships are the basis of organisational functioning as well. We believe that in a parallel way, traumatic experience and adversity can profoundly disrupt the operating systems of organisations. The scientific basis for the Sanctuary Model is a thorough understanding of the ways in which chronic stress, adversity, toxic stress and traumatic stress impact individuals, families, groups, organisations and whole cultures.

Injury instead of illness

A very fundamental shift occurs when people begin truly to reckon with the impact of adversity, trauma and toxic stress on the developmental trajectory of the young. For us this represents a mental model shift from thinking about the subjects of our work as ‘sick’ or ‘bad’ to thinking of them instead as people who have suffered a wide range of injuries and subsequent disabilities. In common parlance, when we hear that someone is ‘sick’ we usually think of a cause that lies within the individual – a weakness, a deficit, a genetic problem. Whatever it is, unless it is an infectious disease, sickness is largely decontextualised and located solely in the person – although there is a social acceptance that they are largely not responsible for their illness. In contrast, an injury model connects the injured person to their environment – injuries always occur within an interpersonal, social and political context. Injury implies

recovery and rehabilitation, even with a possible long-lasting handicap. Injury requires the active participation of the injured party – they must do what they can to help themselves heal and not do anything that will make their injuries worse. They are personally and socially accountable for the healing of their injuries, although the social context within which the injuries occur may make it impossible to fairly locate 'blame'.

In an injury model we should pay a great deal of attention to injury prevention and universal precautions that prevent injury. Injury can be physical, psychological, social and moral, and all these forms of injury are recognised as being interactive and complex. Injuries can result from too much of something or too little – as in neglect, deprivation and developmental insult. An injury model implies a process of recovery and rehabilitation that is mutual and may require a long-term commitment to that recovery. And such a commitment requires an actively collaborative relationship between the helper(s) and the injured party. It leads interactive exploration away from that sickness/badness dichotomy expressed as 'What's wrong with you?!?' to a very different question, 'What happened to you?' (Bloom, 1994).

Conscious and unconscious

Due in large part to the biological reductionism of the past few decades, we find that many people working in healthcare, mental healthcare and other caregiving institutions fail to comprehend the reality of unconscious motivation. But living beings have both conscious and unconscious processes. For a living organism to be consciously aware all the time of everything that is going on would require brain power not available to individuals. Similarly, every organisational culture has both conscious and unconscious components and both elements get transmitted to new organisational members. Their ability to translate these elements – to read and respond to the 'visible and the invisible group' – then determines whether or not they are able to survive in the organisation (Agazarian & Peters, 1981).

Over time, and in the course of individual and organisational development, much activity that may at one point have been conscious, deliberate and strategic takes on a life of its own, outside of conscious awareness. The longer an organisation has been in operation, the more likely it is that much of what occurs in the organisational culture is happening at the level of unconscious norms and basic assumptions, built on mental models that are completely out of view. Any challenges to these basic assumptions – which provide our individual and shared

organisational minds with stability and security – are likely to give rise to anxiety and to 'social defence mechanisms' (Menzies, 1975).

The collective result of this natural inclination to contain anxiety becomes a problem when institutional events occur and produce uncertainty, particularly those events that are associated with insanity, injury, death or the fear of death. Under these conditions, containing anxiety may become more important than rationally responding to the situation. But this motivation is likely to be denied and rationalised. As a result, organisations may engage in behaviour that serves to immediately contain anxiety but that is ultimately destructive to organisational purpose. Especially important is the tendency of organisations under threat to become increasingly totalitarian, authoritarian, punitive and aggressive, and thereby diminish their capacity for innovation and creativity (Menzies, 1975; Lawrence, 1995; Pyszczynski *et al.*, 2003; Pyszczynski, 2004).

Creating and sustaining non-bullying, therapeutic cultures

The Sanctuary Model is a method for reorganising whole organisational cultures. Becoming a 'trauma-informed' culture requires a shift in the very foundations of the way we think, what we feel, how we communicate, and how we practice. The Sanctuary Model represents a trauma-informed method for creating or changing an organisational culture in order to more effectively provide a cohesive context within which healing from psychological and socially derived forms of traumatic experience can be addressed.

The philosophy of a therapeutic community is central to the Sanctuary Model (Bloom, 1997; Haigh, 1999; Norton & Bloom, 2004). The basic tenets expressed by the therapeutic community movement represent what all human beings need to function effectively. Given the widespread exposure to trauma and adversity that exists in the general population, we make the case that all workplace environments should be inherently therapeutic, meaning, 'restoring to health' and 'promoting healing'. The Sanctuary Model challenges organisations to re-examine their basic assumptions concerning the extent to which workplace environments promote safety and non-violence across physical, psychological, social and moral domains. As such, the intervention is aimed both at strengthening the therapeutic community environment and at empowering people to influence their own lives and communities in positive ways. Workplace communities can adopt the therapeutic community's

core values by recognising that every workplace is a community and that being social creatures we are extremely susceptible to the influence of the group for good and for ill; that adult human beings are responsible for their own lives; that we tend to function more effectively in democratic rather than authoritarian settings; and that people can help each other to grow and to learn (Kennard, 1998; Kennard & Lees, 2001).

Some of the critical questions we address in the Sanctuary Model are these:

- How do we create treatment cultures that promote and support positive change in adults, families and ourselves?
- How do we maximise each other's strengths and minimise each other's weaknesses?
- How do we create workplace cultures that buffer us from the impact of repetitive stress so that we can be effective in helping our clients to recover?

These tasks are too large to approach from an individual position. We have to make greater efforts to shape our organisational cultures to achieve more. Organisational culture matters because cultural elements determine strategy, goals and modes of operating, and because the organisational culture plays such an important role in determining whether or not bullying is encouraged as a social norm (Schein, 1999). Organisational factors are clearly important in the emergence, maintenance, prevention and response to bullying behaviour (Brodsky, 1976; Tehrani, 2001; Vaughan, 2011). Bullying will only occur if the offender believes he has the overt or more usually covert support from superiors for his or her behaviour. Organisational tolerance for or lack of sanctions against bullying serves to give implicit permission for the bullying to continue. Unhealthy environments lend themselves to the emergence of what have been described as 'toxic leaders' (Lipman-Blumen, 2004). Toxic leaders are subtly or overtly abusive, violating the basic standards of human respect, courtesy and the rights of the people who report to them. They tend to be power hungry and appear to feed off the use and abuse of the power they have.

In the Sanctuary Model, we recognise that in order to create and sustain a healthy, non-bullying normative culture, the desired culture must be explicit, consciously and deliberately planned to promote the objectives of the organisation. It must be continually monitored both directly and indirectly, while any evidence of a weakening of the culture must produce an immediate, co-ordinated response by the entire organisation. There must be a mechanism to regularly familiarise all members

with the social norms and it will probably be necessary to manipulate member pressures to ensure that high status in the organisation is closely associated with conformity to positive prosocial norms.

The astonishing power of re-enactment

One of the most important challenges to any therapeutic environment is the successful management of traumatic re-enactment. Trauma demands repetition. Clients come into treatment exhausted after a lifetime based on repeating an overwhelming and humiliating past. Trauma produces a fragmentation that results in the accentuation of a non-verbal and a verbal split in memory, affect, perception and identity. The language of the non-verbal self is behaviour and in the presentation of their symptoms our clients tell the story of their most terrible experiences. The role of the social environment is to engage enough with the story to understand the script, but then to change the automatic roles that are being cued for by the client so that the story changes instead of being repeated. Traumatic re-enactment can be seen in the shifting roles that clients and staff assume on the 'rescuer–victim–persecutor' triangle (Karpman, 1968).

In the Sanctuary Model, the group-as-a-whole is conceptualised as having a life different from, but related to, the dynamics of the individuals within the group. In other words, groups are seen as living systems and the individuals in the group are subsystems of which the group is comprised. The group-as-a-whole concept implies that individual behaviour in groups is largely a result of group forces that channel individual action. From this perspective, when a person speaks, he or she does so not only for themselves but also voices the unconscious sentiment of the group.

An organisation that cannot change, that cannot work through adversity, trauma and losses so as to move on will, like an individual, develop patterns of re-enactment, repeating past ineffective strategies without recognising that these strategies may no longer be effective. Re-enactment patterns are most likely to occur when events in the past have resulted in behaviour that arouses shame or guilt in the organisation's representatives. Shame and guilt for past misdeeds are especially difficult for individuals and organisations to work through. If a group-as-a-whole can be a repository of hopes and fears, then it can also become a repository of secrets, of what is fragmented, denied, cast off and suppressed (Ettin, 1993). Such a dynamic system paves the way for individual re-enactment behaviour. So too does it pave the way for group re-enactment. The way an organisation talks to itself is via communication between various 'voices' of the organisation. If these voices are silenced

or ignored, communication breaks down and is more likely to be acted out through impulse-ridden and destructive behaviour (Bloom, 2005). This can easily lead to organisational patterns that become overtly abusive and bullying. With every repetition there is further deterioration in functioning. Knowledge about this failing is available but it tends to be felt before it is cognitively appreciated. If the capacity to put words to feelings is lacking, a great deal of deterioration may occur before the repetitive and destructive patterns are recognised. Healthier and potentially healing individuals enter the organisation but are rapidly extruded as they fail to adjust to the re-enactment role that is being demanded of them. Less autonomous individuals may also enter the organisation and are drawn into the re-enactment pattern. In this way, one autocratic and abusive leader leaves or is thrown out only to be succeeded by another, while those who have been involved in the hiring process remain bewildered by this outcome (Bloom, 2005).

The counteractive power of the creative

Because of the powerful, largely unconscious aspects of compulsive individual and organisational re-enactment, we need the unlimited power of human creativity to counteract the pull toward repeating the past. Any environment that hopes to facilitate the healing of trauma survivors must be able to recognise and respond creatively to repetitive patterns. The capacity for innovation cannot solely reside within the most creative individuals simply because when they individually leave or grow tired they take their innovative skills within them. The Sanctuary Model is designed to promote the processes that encourage what has been called 'group genius'. The most effective improvisational genius groups are self-managing and have an ability to restructure and regroup in response to unexpected events without being directed by a leader and are particularly effective in rapidly changing environments (Sawyer, 2007).

The Sanctuary Model: an operating system for organisations

'Creating Sanctuary' refers to the shared experience of creating and maintaining physical, psychological, social and moral safety within a social environment – any social environment – and thus reducing systemic violence. The Sanctuary Model emphasises the creation of a 'living-learning environment' that is physically, psychologically, socially and morally safe for both clients and staff (Jones, 1968).

Establishing and maintaining a therapeutic community in the Sanctuary Model requires an active process of breaking down institutional, societal, professional and communication barriers that isolate administrators, staff and clients. Simultaneously, the rebuilding process involves consciously learning new ways to relate as interdependent community members, creating and modelling healthy and supportive relationships between individuals, and developing an atmosphere of hope and non-violence.

In order to train other organisations in a specific model we have had to clearly define what was originally simply good interpersonal practice. The value system of the Sanctuary Model is embodied in the seven Sanctuary Commitments. These commitments are tied directly to trauma-informed treatment goals.

The Sanctuary Commitments

The seven Sanctuary Commitments represent the guiding principles for implementation of the Sanctuary Model – the basic structural elements of the Sanctuary 'operating system' – and each supports trauma-related goals for clients and for staff. For organisational change to be effective, the Sanctuary Commitments must become internal commitments for each organisational member and the organisation as a whole. None of these commitments can stand alone. If an organisation fails to be equally committed to them all, it is not likely that they will get traction with any of them. Likewise, there is and always will be a tension between the real and the ideal. The Sanctuary Commitments in their totality describe an ideal environment to promote health and human welfare while minimising the abusive use of power. A picture may best describe how these values fit together (see Figure 17.1).

As an organisation begins to hold itself accountable to these commitments, mental models of individual members and the organisation-as-a-whole begin to shift. Awareness of the importance of grappling with trauma, adversity and disrupted attachment represents the beginning of this shift. But quickly organisational representatives begin to grasp the reality of both conscious and unconscious group dynamics. As this occurs, they deepen their understanding and ability to respond to the chronic stress and the way it has affected and often injured individual and group effectiveness. Truly comprehending the ways in which repetitive but ineffective strategies form the core of present reality eventually compels programme managers and staff to engage in creative problem solving as the only way of getting out of the binds of re-enactment

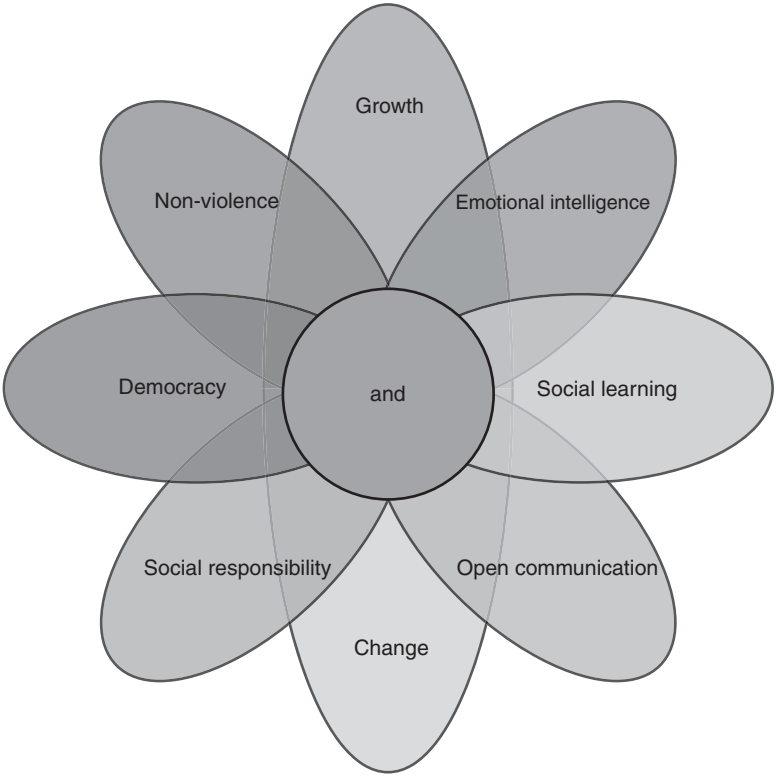

Figure 17.1 The seven Sanctuary Commitments.

behaviour. When this happens, significant treatment gains are made and staff job satisfaction improves.

S.E.L.F. and the Sanctuary toolkit

The four key domains of healing from just about anything include:

- *S = Safety* (attaining safety in self, relationships and environment)
- *E = Emotional management* (identifying levels of various emotions and modulating emotion in response to memories, persons, events)
- *L = Loss* (feeling grief and dealing with personal losses and recognising that all change involves loss)

- *F = Future* (trying out new roles, ways of relating and behaving to ensure personal safety and help others).

This accessible language demystifies what sometimes is seen as confusing and even insulting clinical or psychological terminology that can confound non-clinical personnel while still focusing on the complex aspects of problematic interpersonal adjustment that pose the greatest problems for any working environment.

S.E.L.F. provides a non-linear, cognitive behavioural therapeutic approach for facilitating movement – regardless of whether we are talking about individual clients, families, staff problems or whole organisational dilemmas. S.E.L.F. is useful because it can simultaneously be employed in a parallel process manner to deal with problems that arise within the workplace setting between staff and clients, among members of staff, and between staff and administration. Applied to such issues as staff splitting, poor morale, rule infraction, administrative withdrawal and helplessness, and misguided leadership, S.E.L.F. can also assist a stressed organisation to conceptualise its own present dilemma and move into a better future through a course of complex decision making and conflict management.

The Sanctuary toolkit comprises a range of practical skills that enable individuals and organisations to more effectively deal with difficult situations, build community, develop a deeper understanding of the effects of adversity and trauma, and build a common language. The present toolkit includes staff training in community meetings, safety plans, red flag reviews, S.E.L.F. planning, Sanctuary team meetings, and S.E.L.F. psycho-educational groups. Along with the hundred-plus organisations that are co-evolving this model with us, we have also developed an implementation manual, a direct care staff training manual, an indirect care staff training manual, and several S.E.L.F. psycho-educational manuals as well as a Sanctuary certification process. For more information about our publications, training programme, the Sanctuary Institute, the Sanctuary network and Sanctuary certification, please visit www.sanctuaryweb.com and www.andruschildren.org.

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