Testimony of Sandra L. Bloom, M.D.

Prepared for Attorney General's National Task Force on Children Exposed to Violence

DEFENDING CHILDHOOD
PROTECT HEAL THRIVE

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Sandra L. Bloom, M.D.

Associate Professor, Health Management and Policy
Co-Director, Center for Nonviolence and Social Justice
Drexel University School of Public Health,
Philadelphia, PA
Distinguished Fellow, Andrus Children's Center, Yonkers, NY
Slb79@drexel.edu

Sandra L. Bloom, M.D. is a Board-Certified psychiatrist, and founder of the Sanctuary Model, an evidence-supported, developmentally-grounded, trauma-informed organizational change method focused on caregiving organizations of all kinds. To date over 200 programs nationally and internationally are formally adopting the Sanctuary Model. Dr. Bloom is the founder of the Sanctuary Institute, Distinguished Fellow at the Andrus Children's Center and a Past-President of the International Society for Traumatic Stress Studies and in1998 received the Sarah Haley Award for Clinical Excellence from the ISTSS. From 1980-2001, Dr. Bloom served as Founder and Executive Director of the Sanctuary®, inpatient psychiatric programs for the treatment of trauma-related disorders in adults. Her first book, _Creating Sanctuary: Toward the Evolution of Sane Societies_ tells the story of the creation of one of the nation's first inpatient programs for the treatment of adults who were abused as children. In 2006, Dr. Bloom became a recipient of the Temple University School of Medicine Alumni Achievement Award for her work. She is the Past-President of the Philadelphia chapter of Physicians for Social Responsibility (PSR) and during her tenure Dr. Bloom co-authored a second book, _Bearing Witness: Violence and Collective Responsibility,_ the first book to focus on the intersection between traumatic experience and public health. In 2010 Dr. Bloom co-authored, _Destroying Sanctuary: The Crisis in Human Service Delivery,_ published by Oxford University Press that focuses on the impact of organizational stress in human service organizations. The third volume of this series, _Restoring Sanctuary: Transform Your Organization and Change the World_ is currently in press with Oxford University Press. She is currently Co-director of the Center for Nonviolence and Social Justice and Associate Professor of Health Management and Policy at the School of Public Health at Drexel University.

Written Testimony of Sandra L. Bloom, M.D.

I am Sandra Bloom, Founder of the Sanctuary Model and Co-Director of the Center for Nonviolence and Social Justice at Drexel University's School of Public Health in Philadelphia. I am honored to be invited by the Attorney General and this Task Force to provide testimony about my work in helping children to heal from the adverse conditions that affect so many young people today. I first came to understand what trauma and adversity do to children's brains, minds, and souls through my experience treating several thousand adult survivors of childhood abuse. The most important lesson I learned from them, one I hope this Task Force is able to constantly emphasize, is that most of the damage being done to children in the United States today – and most of the physical, mental, and social dysfunction they will experience as adolescents and adults – is PREVENTABLE.

However, by the time children are in need of our services in the mental health, health, special education, child welfare, and juvenile justice sectors, their suffering has not been prevented but instead, toxic stress has already affected their bodies, brains and development. Our job then becomes reducing the continuing spread of toxic stress while providing them with the tools we know now are necessary for healing and recovery. As I understand it, my role today is to describe The Sanctuary Model, an evidence-supported, developmentally-grounded, trauma-informed methodology for helping all members of staff and whole organizations to

become healthier while achieving better outcomes for the children in their care. The present training program and implementation process, initiated in 2005 has been a joint project of the author and Andrus Children's Center in Yonkers, New York. The Sanctuary Model is currently being used as a systematic organizational change process for over two hundred human service delivery systems around the country and internationally, many of them serving children and adolescents.

CHALLENGING CHILDREN

As many previous witnesses at these hearings have pointed out, the challenges most of the children who enter our services are up against are complex and originated in exposure to childhood adversity. In brief, 1) they have difficulty with maintaining safety in interpersonal relationships largely due to disrupted attachment experiences and the erosion of trust that accompanies such experiences; 2) they have significant challenges in adequately managing distressful emotions in ways that are not self-destructive including exercising the capacities for self-discipline, self-control, and willpower; 3) cognitive problems beset them, particularly when stress occurs and the development of essential cortical functions has not gone as smoothly as it should; 4) as a result, open and direct communication at home and at work pose significant challenges and they frequently communicate through behavior, not directly, openly, or in words; 5) they feel helpless and powerless in the face of a world that they perceive has been unjust and cruel and as a result may be repeatedly bullied or become bullies themselves; 6) living under adverse conditions, these children frequently do not develop a clear sense of social responsibility even into adulthood and moral development may have been affected by disrupted attachment experiences and inadequate role models; 7) they are likely to have experienced significant loss while lacking the capacity to grieve secondary to the emotional management problems, are likely to repeat the experiences that are a part of their past, and often lack any hope that the future will be any better than the past, while their emotional and cognitive challenges interfere with the capacity to plan ahead and tolerate delayed gratification.

CHALLENGED STAFF

All of this means that in the context of the treatment/intervention setting, much is demanded of managers, therapists, caregivers and educators. We must teach, role model and support the development of: 1) safety skills and significant improvements in the capacity for interpersonal trust; 2) emotional management skills, including self-control, self-discipline, and the exercise of willpower; 3) cognitive skills including identifying triggers and problematic patterns while still being able to think in the presence of strong emotion; 4) communication skills that include rehearsals in what to say and how to say it; 5) participatory and leadership skills; 6) judgment skills, including socially acceptable and fair behavioral schemas; 7) skills to manage grief and plan for the future. This work is complicated, complex, interactive and demands much of those who work to change the minds and brains of children suffering from the problems associated with trauma, adversity, and exposure to toxic stress.

What characteristics best describe people who are able to do this complex work? They need to be secure, reasonably healthy adults, who have good emotional management skills

themselves. They must be intellectually and emotionally intelligent and the latter is probably even more important than the former. They need to be able to actively teach new skills and routines while serving as a role models for what they are teaching. There are constant demands on them for patience and for empathy so they must be able to endure intense emotional labor. To balance the demands of home and work, managers and supervisors, children and their families, they must be self-disciplined, self-controlled, and never abuse their own personal power.

WORKFORCE CRISIS

Given this description it becomes easier to understand why we are facing a workforce crisis. As a national report has stated, *"a growing proportion of the U.S. workforce will have been raised in disadvantaged environments that are associated with relatively high proportions of individuals with diminished cognitive and social skills"*(p.10155) [1]. Given the rates of exposure to childhood adversity in the general population, staff members at all levels of social service organizations are likely to have their own past histories of experiences that are not entirely dissimilar to the people they are supposed to help and may have unresolved interpersonal challenges that are also not dissimilar. This is an important part of the workforce crisis that confronts us [2].

But there are additional factors playing a significant role in this crisis. Extraordinary demands are placed upon social service workers in the face of low salaries and inadequate funding for the organizations within which they work. Job complexity and ambiguity is high while the payoff is low, particularly for those in any type of institutional setting where the least educated, trained, and supervised staff spend the most time with profoundly injured children. There is often a lack of cultural diversity and cultural sensitivity in the staff, whose composition may be ethnically and racially very different from the children in care.

And staff members are not safe. Forty-eight percent of all nonfatal injuries from occupational assaults and violent acts occur in health care and social services [3]. In fact, after law enforcement, persons employed in the mental health sector have the highest rates of all occupations of being victimized while at work or on duty [4]. Actual rates of violence expose the problems with physical safety. But there are other safety issues as well that can be thought of as threats to psychological, social and moral safety.

Research in other industries has recorded the top workplace stressors and although insufficiently studied, anyone working in the health, education, social services, or mental health sectors can easily identify with these: too much to do in too little time; unnecessary meaningless paperwork; random interruptions, such as telephone calls, walk-in visits, text messages, emails; demands from supervisors; pervasive uncertainty as a result of organizational problems; unsatisfactorily explained and unannounced change; decreased funding; mistrust, unfairness and vicious office politics; unclear policies and lack of organizational direction; career and job ambiguity resulting in feelings of helplessness and lack of control; lack of feedback, good or bad; absence of appreciation for work done; lack of communication up and down the chain of command [5].

Looking at this list, it is clear that the main causes of workplace stress cannot be laid at the feet of the children and their families. In fact, as this list demonstrates, *"the main sources of*

stress for workers are the ways in which organizations operate and the nature of the relationships that people experience within the work setting (p.70)" [6]*.* This is not an individual problem but a social one, partly due to controllable but severe dysfunctions within those organizations, and largely related to inadequate and unscientific paradigms for intervening in the lives of traumatized people, families, and communities.

ORGANIZATIONAL CULTURE, PARALLEL PROCESSES AND MANAGEMENT

Just as a computer has an operating system that is a master program that controls a computer's basic functions and allows other programs to run on a computer IF they are compatible with that operating system, organizational culture represents the operating system for an organization. Every organization has an organizational culture that represents long-held organizational patterns, routines, and habits that although remembered and taught to every new employee, are largely unconscious and automatic, as most habits are. The nature of the organizational culture largely determines whether or not the organization is able to fulfill its mission and reach its stated goals. Organizational culture may or may not be aligned with the actual values and mission that the organization claims to follow [7]. Alignment of values is usually seen as management driven, if it is referred to at all, and mental health and social service organizations are here at a distinct disadvantage.

Within social services and mental health organizations, there is no universal requirement for anything that resembles management training. CEO's and CFO's may have had appropriate management preparation in their background but usually only if the organization is large and if they came up through the ranks of some other business sector. They are also more likely to have MBA's or some administrative degree that at least academically qualify them for the job of managing other people. But the key middle managers who actually set in motion the routines that guide daily interactions with staff, clients, and families usually are promoted from within the organization or at least from within the social service, education, and social service professions. The training they typically get is whatever experience they have had being managed by other people in similar circumstances beginning, of course, with their own parents.

Contrast this with an organization like Starbucks where even a newly hired high school drop-out working as a barista in his first year will spend at least fifty hours in Starbucks classrooms, and dozens more at home with Starbucks' workbooks and talking to the Starbucks mentors assigned to him. Or the Container Store where employees receive more than 185 hours of training in their first year alone. They are taught to recognize what to do when confronted with an angry coworker or an overwhelmed customer, and rehearse routines for calming shoppers or defusing a confrontation [8].

Not so for staff in our caregiving institutions who must engage in the emotional labor of spending eight to twelve hours a day trying to help some of the most wounded, suffering and sometimes dangerous children and adults on the planet to heal and recover from the adversity that life has dealt out to them. This startling contrast sums up the problem that is more of a social, political, and economic problem, than a professional problem. Starbucks is selling coffee and the company is enormously profitable and they realize that their continuing profitability has as much to do with the good service of their employees as it does to the quality of their brew. We, on the other hand, are trying to change not just minds, but brains and our society

has not yet awakened to the fact that not changing those brains is costing all of us uncounted billions of dollars every year. The Centers for Disease Control estimates that child abuse and neglect alone costs $124 billion a year [9].

Compound the lack of adequate education, preparation and training with breaches in basic safety; diminished funding; an unstable reimbursement system; social devaluation of caregiving work; and an inadequate theoretical framework for delivering services and we end up with hauntingly parallel processes where symptomatic behavior is replicated at every level – clients, staff, management, organization [10].

As our understanding of trauma survivors has grown, we recognize that exposure to severe and overwhelming trauma, particularly when it begins in childhood, disrupts the individual's "operating system" resulting in profound "software" problems as described above, and a personality that has become "trauma-organized" [6]. A similar process affects organizations that are chronically stressed and frequently traumatized by tragic events that occur within the institution. When this happens, organizational cultures become "toxic" for everyone.

REBOOTING THE ORGANIZATIONAL OPERATING SYSTEM: THE SANCTUARY MODEL

The fundamental rationale for the Sanctuary Model is to create parallel processes of recovery by radically altering the operating system for organizations as a whole and everyone who has contact with that organization. That means intervening at the level of organizational culture in order to change the habits and routines of everyone in the organization and the organization-as-a whole.

The Sanctuary Model is structured around a philosophy of belief and practice that creates a process enabling organizations to dramatically shift their approach to traumatized children, adolescents and families. To do so they must identify the habits and routines that are no longer compatible with developmentally grounded, trauma-informed care, while learning new and more useful habits. This kind of organizational change requires radical alterations 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. 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 [11]. This change in mental models must occur on the part of the clients, their families, the staff, and the leaders of the organization.

KEY FEATURES OF THE SANCTUARY MODEL:

The Sanctuary Model is built upon what we call the Four Pillars of Sanctuary: Trauma Theory, the Sanctuary Commitments, S.E.L.F. and the Sanctuary Toolkit. Trauma Theory provides the scientific underpinning for the Sanctuary Model. The Sanctuary Commitments provide the anchoring values and are tied directly to developmentally-grounded, trauma-informed treatment goals as well as the overall health of the organizational culture. S.E.L.F. is a simple and easy-to-use conceptual framework that provides a "compass" that allows everyone to navigate the challenges of complex interventions, while the Sanctuary Toolkit offers practical, grounded tasks that support implementation. "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 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 attitudes, decisions, problem-solving, conflict resolution and behavior [12].

Trauma Theory

The study of trauma gives us a lens into the workings of people under extreme conditions but we are learning much about the entire stress continuum and the extent to which stress, particularly repetitive and toxic stressful conditions, can impact normal development. Along with the expanding field of interpersonal neuroscience this knowledge is leading to the recognition that most of our behavior is determined by previous experiences that may have occurred even before we were born. We are learning how limited our freedom really is at a neurological base. As it turns out, what we call "free will" is not nearly as free as we would like to believe it is [13]. At the same time, we are learning how much our social milieu can influence the brain, now known to be more malleable and "plastic" than was once assumed and how important belief, faith, meaning and purpose are to changing the brain [8] .

In the Sanctuary Model, everyone in an organization needs to have a clear understanding about how the impact of toxic stress and trauma has affected the children we work with and often the staff as well. It is also vital that everyone recognizes that stress causes us to revert to old habits that we may have overcome in the past. Learning about the psychobiology of stress, toxic stress, and trauma is liberating for people. It gives us explanatory reasons for some of the puzzling behaviors we engage in and the feelings that can come to dominate us.

To help programs accomplish universal training without having to invent those trainings on their own, we developed one training manual and accompanying training materials for all of the staff who have direct contact with children and families and another for all of the indirect care staff such as board members, regulators, administrative assistants, finance officers, maintenance and food service staff, and all the other people who are necessary to keep an organization functioning.

Our expanding understanding about the impact of disrupted attachment, toxic stress, adversity, and trauma represents the possibility of being able to base helping and caregiving work on outcomes, a concept that has only been rarely expected from social service and mental health organizations. Embedded in the notion of services that truly understand the complex biopsychosocial impact of traumatic experience is the underlying premise that all people can change, even if it is a little bit, and that if change is not occurring maybe it is because the service provided is not adequately matching their needs and that means *we* need to do something different.

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 commitment supports trauma recovery goals for children, families, staff and the

organization as a whole. The *Sanctuary Commitments* structure the organizational norms that determine the organizational culture while helping the organization as a whole to promote and sustain growth and change.

The Sanctuary Commitments are designed to create a parallel process of recovery: 1) *Commitment to Nonviolence* – to build safety skills, trust, resilience in the face of stress; 2) *Commitment to Emotional Intelligence* –to teach emotional management skills, build respect for emotional labor, minimize the paralyzing effects of fear, 3) *Commitment to Social Learning* – to build cognitive skills, improve learning and decisions, expand awareness of problematic cognitive-behavior patterns and how to change them; restore memory, and develop the skills necessary to create and sustain a learning organization; 4) *Commitment to Open Communication* – to overcome barriers to healthy communication, discuss the "undiscussables", overcome alexithymia, increase transparency, develop conflict management skills, reinforce healthy boundaries and enable skills for resolving collective disturbances; 5) *Commitment to Democracy* – to develop civic skills of self-control, self-discipline, the exercise of healthy dissent; to learn to exercise healthy authority and leadership; to develop participatory skills that overcome learned helplessness; to develop skills for wrestling with complexity, and to honor the "voices" of self and others; 6) *Commitment to Social Responsibility* –to harness the energy of reciprocity and a yearning for justice by rebuilding restorative social connection skills, establishing healthy and fair attachment relationships, and transforming vengeance into social justice; 7) *Commitment to Growth and Change* –to promote the ability to work through loss in the recognition that all change involves loss; to cease repeating irrelevant or destructive past patterns of thought, feeling and behavior; and to envision, be guided by, skillfully plan, and prepare for a different and better future.

S.E.L.F.: A Compass for the Recovery Process

In the Sanctuary Model we use S.E.L.F. as a habit-changing compass for many different tasks. When faced with the complex problems that are typical of the children and families that we serve, it is easy as a helper to lose your way, to focus on what is the most frightening or the easiest to understand and manage rather than what may be the true underlying stumbling block to progress. Similarly, our clients are most likely to pay attention to whatever problems are causing the most pain for them in the immediate present, even though from a helper's point of view, what they are doing or not doing is likely to cause them even greater suffering in the long term.

S.E.L.F. is an acronym that represents the four key interdependent aspects of recovery from bad experiences. S.E.L.F. provides a nonlinear, cognitive-behavioral therapeutic approach for facilitating movement through the Sanctuary Commitments– regardless of whether we are talking about individual clients, families, staff problems, or whole organizational dilemmas. S.E.L.F. is a compass that allows us to explore all four key domains of healing: *Safety, Emotions, Loss* and *Future*. Using S.E.L.F., the clients, their families, and staff are able to embrace a shared, non-technical and non-pejorative language that allows them all to see the larger recovery process in perspective. The accessible language demystifies what sometimes is seen as confusing and even insulting clinical jargon that can confound children, families and staff, while still focusing on the aspects of pathological adjustment that pose the greatest problems for any treatment environment

The Sanctuary Toolkit

The Sanctuary Toolkit comprises a range of practical, routine skills that enable individuals and organizations to develop new habits and more effectively deal with difficult situations, build community, develop a deeper understanding of the effects of adversity and trauma, and build a common language and knowledge base. Community Meetings and universal Safety Plans promote a focus on social responsibility, democracy and nonviolence on a routine, daily basis.

Many of our tools are organized around S.E.L.F. so that we teach S.E.L.F. Treatment Planning, S.E.L.F. Psychoeducational Groups, S.E.L.F. Team Meetings, S.E.L.F. Organizational Assessment, and use S.E.L.F. to structure Red Flag Reviews. It helps us stay on track, keeps our focus, and provides a shared language and meaning system for anyone, regardless of their training, experience, or education. It also helps us see the parallels between what the clients have experienced and what is going on with the staff and the organization and intervene when we notice that a "collective disturbance" is unfolding. In doing so we are able to see the interactive and interdependent nature of our shared lives.

The Sanctuary Toolkit continues to expand as we gain more knowledge about the practical needs of many different kinds of caregiving environments. We teach about the dynamics of reenactment using what we call a Reenactment Triangle. We have developed Sanctuary-based interview, orientation, supervision, conflict management, communication, self-care, and leadership modules as programs recognize existing gaps.

IMPLEMENTING THE SANCTUARY MODEL

The *Sanctuary Institute* is a five-day intensive training experience[a]. Teams of five to eight people, from various levels of the organization, come together to learn from our faculty, who are colleagues from other organizations implementing Sanctuary. Together teams begin to create a shared vision of the kind of organization they want to create. These teams will eventually become the *Sanctuary Steering Committee* for their organization. The training experience usually involves several organizations and generally these organizations are very different in terms of size, scope, region and mission. This diversity helps to provide a rich learning experience for the participants.

Participants look at the change process itself and are asked to anticipate the inevitable resistance to change that is a fact of life in every organization. They look at management styles, the way decisions are made and conflicts resolved. In the process of these discussions, they learn about what it means to engage in more democratic processes on the part of leaders, staff, and clients, especially in terms of the simultaneous increase in rights *and* responsibilities. They evaluate the existing policies and procedures that apply to staff, clients and families and ask whether or not they are effective in achieving their shared goals. They are asked to learn about and become thoroughly familiar with the psychobiology of trauma and disrupted attachment and the multiple ways that PTSD, complex PTSD and other trauma-related disorders present in the children, adults and families they work with. They are challenged to begin thinking about the implications of that knowledge for treatment. They also learn how high levels of stress in the organization can impact relationships, emotions, and decision making at every level of the organization. They develop an understanding of the conceptual tool for organizing treatment

that we refer to as "S.E.L.F.".They learn about vicarious trauma, traumatic reenactment and the importance of understanding themselves and providing support for each other. They are introduced to the various components of the *Sanctuary Toolkit*.

The *Sanctuary Steering Committee* is instructed to go back to their organization and create a *Sanctuary Core Team* – a larger, multidisciplinary team that expands its reach into the entire organization. It is this Core Team that will be the activators of the entire system. The Core Team should have representatives from every level of the organization to insure that every "voice" is heard. It is vital that all key organizational leaders become actively involved in the process of change and participate in this Core Team. The Core Team is armed with a *Sanctuary Direct Care Staff Training Manual*, a *Sanctuary Indirect Staff Training Manual*, a *Sanctuary Implementation Manual*, several psychoeducational curricula and on-going consultation and technical assistance from Sanctuary faculty members to guide them through the process of *Sanctuary Implementation* that extends over three years and leads to *Sanctuary Certification.* Participation in the Sanctuary Institute enrolls programs as part of the *Sanctuary Network*, a community of organizations dedicated to the development of developmentally-grounded, trauma-informed services. We are all committed to the belief that we can do better for our clients and our colleagues as well as our society if we can accept that the people we serve are not sick or bad, but injured and that the services we provide must provide hope, promote growth and inspire change.

Sanctuary Certification

Sanctuary® is a registered trademark and the right to use the Sanctuary name is contingent on engagement in our certified training program and an agreement to participate in an on-going, peer-review certification process. The Sanctuary Certification process is designed to promote, sustain and strengthen an organization's commitment to the maintenance of a healthier culture for all stakeholders. Programs usually seek Sanctuary Certification in the 2-3 year period after participation in the Sanctuary Institute. Research is underway in the hope of moving the Sanctuary Model from an "evidence-supported" to an "evidence-based" approach. In this way we hope to establish a method for guaranteeing an acceptable level of fidelity to the original model upon which the research is based.

OUTCOMES

The impact of creating a developmentally-grounded, trauma-informed culture using the Sanctuary Model should be observable and measurable. The outcomes we expect to see are applicable to all community members and include: less violence including physical, verbal, emotional forms of violence, including but not limited to reduction in coercive forms of so-called "therapeutic" interventions; system-wide understanding of the complex, biopsychosocial and developmental impact of trauma and abuse and what that means for the service environment; less victim-blaming; less punitive and judgmental responses; clearer more consistent boundaries, higher expectations, linked rights and responsibilities; earlier identification of and confrontation with abusive use of power in all of its forms; better ability to articulate goals and create strategies for change; understanding and awareness of reenactment behavior, resistance to change and how to achieve a different outcome; more democratic

environment at all levels; more diversified leadership and embedding of leadership skills in all staff; better outcomes for children, staff, and organization.

There has been one controlled, randomized trial of implementing the Sanctuary Model in children's residential settings thus far. To summarize the results, from baseline to six months there were five significant differences in the staff: Support: how much children help and support each other; how supportive staff is toward the children; Spontaneity: how much the program encourages the open expression of feelings by children and staff; Autonomy: how self-sufficient and independent staff perceive that the children are in making their own decisions; Personal Problem Orientation: the extent to which children seek to understand their feelings and personal problems; Safety: the extent to which staff feel they: can challenge their peers and supervisors, can express opinions in staff meetings, will not be blamed for problems, and have clear guidelines for dealing with children who are aggressive. There was also an unexpected (unexpected because of the short timeframe) but significant difference in the child outcomes and two other positive trends: Decreased verbal aggression (significant trend), Increased internal locus of control (significant trend), and Decreased incendiary communication and increased tension management (significant difference)[14].

In another study comparing residential programs for children using the Sanctuary Model and programs that were not, programs using the Sanctuary Model showed a significant, positive change in organizational culture, supporting the use of the Sanctuary Model in positively impacting the culture of the workplace [15].

In an internal, self-funded study, the Sanctuary Institute looked at the first seven child-serving facilities that participated in the Sanctuary Institute and their subsequent reductions in restraints and holds. Three programs exhibited over an 80% decrease in the number of restraints, two had over a 40% drop in restraints, one exhibited a 13% decrease and one had a 6% drop in restraints. A three year study of organizations using the Sanctuary Model showed reductions in physical restraints on average of 52.3% after the first year of implementation [16]. At Andrus, within the first six years of implementation in the residential and school there was a 90% decrease in critical incidents with a 54% increase in the average number of students served [17].

As part of the Pennsylvania Department of Public Welfare's (DPW) efforts to reduce and eliminate restraints in children's treatment settings, DPW entered into a partnership with Andrus Children's Center to bring the Sanctuary Model to Pennsylvania in 2007. The University of Pittsburgh worked with Pennsylvania Department of Public Welfare, the Sanctuary Institute, and thirty participating provider residential sites to conduct an open evaluation of the implementation of the Sanctuary Model. Annual surveys were conducted from 2008-2010. The evaluation of the implementation of the Sanctuary Model in residential facilities found that greater implementation of the Sanctuary Model was associated with a number of positive outcomes: lower staff stress and higher staff morale, and also with staff feeling more competent and proficient at their jobs and more invested in the individuals they serve. The implementation of the Sanctuary Model was also significantly associated with improved organizational culture and climate. There was also a substantial decrease in the reported use of restraints by many sites over the course of the Sanctuary implementation [18]. Additionally, an analysis of service utilization from 2007-9 of children discharged from residential treatment facilities (RTF) implementing the Sanctuary Model versus other RTFs, was conducted by

Community Cares Behavioral Health (CCBH) and demonstrated that although both groups (Sanctuary implementing and non-Sanctuary implementing) had a similar average (mean) length of stay in 2007, by 2009 RTF providers implementing Sanctuary had: a substantially shorter length of stay and a somewhat greater decrease in median length of stay; a substantial increase in the percentage of youth discharged who received outpatient services in the three months following discharge; a lower increase in the percentage of children readmitted to RTFs in the 90 days following discharge [19]. As the authors of the report wrote, "*the implementation of the Sanctuary Model in residential facilities in Pennsylvania appears to have had a positive impact, with the greatest benefits being seen by residents and staff of those sites who were most successful in implementing the full Sanctuary Model. These positive outcomes occurred at a time of uncertainty and programmatic and staffing change in many facilities, which speaks to the dedication of all involved in the implementation of Sanctuary. At the same time, the variation observed in implementation does suggest an opportunity to consider strategies to support future implementation efforts, as well as the need for providing continued support to sites that have implemented Sanctuary to ensure sustained positive outcomes*" (p.7) [18].

CONCLUSION: THE SANCTUARY PROCESS

We now have a significant body of experience in watching the Sanctuary process occur in many different kinds of organizations. What we see is that adopting a trauma-sensitive organizational paradigm changes the way organizational members think and act in a way that trying to influence individual behavior alone cannot. We attribute this to the power of group influence. Changes in thinking changes habits and therefore changes habitual routines. The S.E.L.F. framework changes how people use language, the Sanctuary Commitments delineate how to best sustain interpersonal relationships, and the Sanctuary Toolkit improves the way we all actually practice. These changes create a sense of possibility and hope in our organizations, which in turn inspires hope in those who come to us for help. Changing behavior then changes the entire organization as demonstrated in reduced turnover, improved morale, improved communication, and decreased incidents of violence. Changing the organizational behavior then changes client outcomes resulting in the development of safety skills, improved emotional management, a greater readiness to participate in trauma-specific treatment approaches, improved social skills and relationships, more satisfactory academic or job performance, and enhanced decision-making and judgment. Changes in client outcomes create a better future for all of us.

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[a] The Sanctuary Institute is a part of Andrus in Yonkers, NY. www.andruschildren.org. For more information contact Sarah Yanosy, Director, 914-965-2700 x1117 or syanosy@jdam.org or visit the Sanctuary Institute website at www.thesanctuaryinstitute.org