11

The Sanctuary Model

Rebooting the Organizational Operating System in Group Care Settings

OUTLINING THE CHALLENGES

Trauma-Organized Children

The children who arrive for placement in a residential program or group home are there because each one has problems that are exceedingly complex, that cannot be managed in a less restrictive level of care, and that pose significant difficulties for the adults in their lives. When one hears the histories of the multiple adversities to which these children have been exposed, it may be relatively easy to explain how they could come to have such problems. More challenging, however, may be trying to explain how they have survived the terrors of their lives.

The simultaneous realities of complex and interactive developmental problems that affect children's bodies, minds, and spirits alongside the resilience of individual children and of childhood itself have implications for environments that set out to help heal those bodies, minds, and spirits. In brief, children who are admitted to group care environments (1) have difficulty with maintaining safety in interpersonal relationships, largely due to disrupted attachment experiences and the erosion of trust that accompanies such experiences; (2) 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) are beset by cognitive problems, particularly when stress occurs and the development of essential cortical functions has not gone as smoothly as it should; (4) frequently communicate through behavior, not directly, openly, or in words; (5) 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) frequently lack a clear sense of social responsibility, while moral development may have been affected by disrupted attachment experi-

ences and inadequate role models; and (7) are likely to have experienced significant loss while lacking the emotional capacity to grieve, 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. In this way, children's lives become "trauma-organized" as their attempts to cope with unmanageable conditions lead to maladaptive coping skills and the development of problematic habits.

If we are to address the complex needs of these children, our goals must be aimed at resolving the difficulties that exposure to toxic stress creates. To accomplish this in a group 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; and (7) skills to manage grief and plan for the future.

Trauma-Organized Staff

Promoting healing in children who suffer from these kinds of interactive and complex challenges is not so much a technical problem as an adaptive one, meaning that every child is different and the moment-to-moment opportunities presented in the constant interactions between child and adult staff members offer chances for a ceaseless array of corrective emotional, cognitive, behavioral, and spiritual experiences (Bloom & Farragher, 2013). 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. They must be able to actively teach new skills and routines while serving as 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 and self-controlled and must never abuse their own personal power.

Herein lie the greatest difficulties in making use of the advantages offered by residential treatment environments: the outcomes are largely dependent on the nature and quality of the relationships between children and staff, but we are faced with a workforce crisis. As a national report states, "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" (Knudsen et al., 2006, p. 10155). An expanding body of evidence indicates that the rates of exposure to childhood adversity in the general population are so high that, inevitably, a large proportion of staff members in any social service organization are likely to have their own past histories of experiences that are not entirely dissimilar to those of the children they are supposed to help, and they may have unresolved interpersonal challenges that are also not dissimilar (Esaki & Larkin, in press; Felitti & Anda, 2010).

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 are high while the payoff is low, particularly for those in any type of institutional setting where the least educated, supported, 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 that of the children in care.

And then there is the violence. Staff members are not safe, and this is particularly true for residential settings where the children being cared for are—by definition—the children who cannot be safely contained in less restrictive settings. Forty-eight percent of all nonfatal injuries from occupational assaults and violent acts occur in health care and social services (Occupational Safety and Health Administration, 2004). In fact, after law enforcement, the mental health sector has the highest rate of all occupations of persons employed in the sector being victimized while at work or on duty (Bureau of Justice, 2001). Much of this lack of safety has been attributed to the insufficient adoption of best practices that reduce the need for restraint and seclusion, which increase the likelihood of injury to both children and staff (LeBel, Huckshorn, & Caldwell, 2010).

Trauma-Organized Organizations

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 the area is 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, and 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; and lack of communication up and down the chain of command (Collie, 2004).

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" (Bloom & Farragher, 2010, p. 70). 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. These multiple interactive tensions produce parallel processes, a complex group dynamic that is evident when symptomatic behavior is replicated at every level—children, families, staff, management, and organization (Alderfer & Smith, 1982).

TRAUMA-INFORMED ENVIRONMENTS: THE SANCTUARY MODEL

There are distinct advantages in treating a child within the context of a 24-hours-a-day milieu. It becomes possible to organize an entire system around the child's healing. But to effectively create that kind of helping system, certain requirements must be met: (1) an organizational mission and value system that support a culture of healing and transformation; (2) getting—and retaining—the right people for the job; (3) a universally shared, developmentally grounded, trauma-informed knowledge base that guides intervention and becomes incorporated into the organizational culture; (4) language shared by staff, children, and families; (5) thorough assessment and case formulation; (6) ongoing processes for understanding and managing individual and group dynamics; (7) individualized, trauma-informed treatment plans and processes and, where appropriate, trauma-specific

treatment interventions; (8) a method for ensuring that all of the above are created, incorporated, and integrated into organizational function; and (9) a method for ensuring that it all works—that children resolve their previous wounds and get onto sounder, healthier developmental trajectories with the help and support of adults who themselves are constantly learning, adapting, and creatively expanding their own horizons.

The Sanctuary Model is an evidence-supported, developmentally grounded, trauma-informed approach to creating and sustaining an organizational culture that embraces these requirements as fundamental for any milieu setting. The Sanctuary Model is built upon what we call the Four Pillars of Sanctuary: Trauma Theory, the Sanctuary Commitments, SELF, 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. SELF is a simple and easy-to-use conceptual framework that provides a "compass" allowing 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 (Bloom, 2013). 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 (Bloom & Farragher, 2013).

Mission and Values That Support Healing

Existing institutions will have a mission, one that may have been formulated long ago. Many residential programs were originally nineteenth- or early twentieth-century orphanages, and thus the organizational mission may derive directly from a previous era, formulated decades ago by people who were then leading the organization.

Given the knowledge we now have about the way the brain works, normal child development, and the impact of toxic stress exposure, trauma, and allostatic load, most child-serving organizations need to revisit their mission. Given what we have learned in the past three decades, we now know that helping very traumatized children to heal can require significant change in organizations whose original mission was caring for and educating orphans. The work of healing complexly traumatized children is so demanding that residential programs and group homes must be mission-driven, and that mission must be constantly foremost in the minds of every staff member. Arriving at that point requires more than a statement of purpose on a boardroom wall: it requires a shared process that involves everyone in the organization, from executive leadership, through the line staff, and on to maintenance, finance, and housekeeping—that's what it means to meaningfully and consciously develop an organizational mission.

A comprehensive, developmentally grounded, and trauma-informed mission has to be anchored in a value system that can be understood, embraced, and applied by every child and adult in the system, regardless of age, experience, educational background, ethnicity, or socioeconomic class. In complex group processes that have occurred across more than three decades, seven key values have emerged, universal principles that we believe are consistent with human rights cultures around the world. We call these the seven Sanctuary Commitments. These 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 that helps to resolve the problems common to the children who enter group care environments.

1. *Commitment to Nonviolence*—to build safety skills, trust, and resilience in the face of stress
2. *Commitment to Emotional Intelligence*—to embed emotional management skills, build respect for emotional labor, and minimize the paralyzing effects of fear
3. *Commitment to Social Learning*—to build cognitive skills, improve learning and decisions, and expand awareness of problematic cognitive behavioral patterns and how to change them; to 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, and 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.

The Sanctuary Commitments together create an ethical system and a set of checks and balances that serve as the basic skeletal system of a trauma-informed organization.

Getting the Right People for the Job

The Sanctuary Model is an organizational method for helping all staff members "get on the same page" about how we define problems, how we work together, and how we create nonviolent, therapeutic communities. Experience has demonstrated that over time, programs that implement the Sanctuary Model alter their processes for interviewing, selecting, orienting, training, and supervising staff. Primary outcomes of the implementation of the Sanctuary Model are reductions in critical incidents, reductions in child and staff injuries, improved staff morale, and reduced staff turnover, all of which contribute to the quality of care the children receive.

Universal Training

The expanding knowledge base gained across the past three decades, usually referred to as "Trauma Theory," provides the beginning of a framework for radically changing service delivery to troubled children and their families. The study of trauma gives us a lens on 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.

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. Also vital is 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.

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 only 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 a little bit, and that if change is not occurring, maybe this is because the service provided is not adequately matching their needs, which means *we* need to do something different instead of attributing treatment failure or lack of compliance as resistance to change or simple oppositional behavior.

Trauma theory offers an integrative, scientifically based, and developmentally grounded framework for all human systems. The psychobiology of trauma points us toward knowledge that heals the Cartesian split between mind, body, and spirit and, in doing so, "puts Humpty Dumpty back together again." The simultaneous burgeoning of knowledge about the importance of early childhood attachment and the impact of toxic stress exposure offers a developmental continuity between childhood and adulthood. Through the concept of allostatic load, we can now connect the psychobiology of trauma and disrupted attachment to many of the negative social determinants of health, such as racism, gender-based discrimination, and poverty. Never before have we had an integrative framework that allows extensive and specialized bodies of knowledge to be connected to each other within a human rights context as a public health challenge (Bloom & Farragher, 2013). 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 (Gazzaniga, 2011). 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 (Duhigg, 2012).

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 manual 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.

Shared Language: SELF, a Compass for the Recovery Process

In the Sanctuary Model we use SELF as a habit-changing compass for many different tasks. When faced with the complex problems that are typical of the children and families 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 on what may be the true underlying stumbling block to progress. Similarly, children in care 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.

SELF is an acronym that represents the four key interdependent aspects of recovery from bad experiences. SELF provides a nonlinear, cognitive behavioral therapeutic approach for facilitating movement through the Sanctuary Commitments—regardless of whether we are talking about children, their families, staff problems, or whole organizational dilemmas. SELF is a compass that allows us to explore all four key domains of healing: *Safety*, *Emotions*, *Loss*, and *Future*. Using SELF, children, their families, and staff are able to embrace a shared, nontechnical and nonpejorative 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.

Assessment and Case Formulation

Any child who is admitted for placement in a residential program or group home is likely to have had multiple prior assessments, some focused on intellectual development, others on psychological development, although none may have included a complete developmental history. Some of those records may accompany the child, but in other cases vital information about the child's history may have been "lost along the way," particularly in cases where the child has had many previous placements. It is important that the admission team at the residential or group home obtain as many records as possible to help establish a coherent narrative of the child's experience. At the same time, it is important to recognize the possibility of profound disagreement among the records, as various adults used different "lenses" to view the child.

Diagnostic formulations are seen as a necessary element in our human service delivery systems but frequently do not offer any insight into the child's actual lived experience; nor is there usually much emphasis on the strengths the child has used to cope with his or her less-than-ideal circumstances. The trauma history of the child frequently "gets lost" too, forgotten in the demands of day-to-day challenges presented by the child's behavior. It is essential to keep the emphasis on what happened to the child, rather than what is wrong with the child, if residential staff are to achieve the desired outcomes.

All this being the case, it is important that when a child enters a new treatment setting, the staff members take it upon themselves to reassess the child and remain open to major shifts in perspectives about the child. Without such openness, the child can easily become the victim of self-fulfilling prophecies on the part of the staff, in which a child labeled with a diagnosis such as "oppositional disorder" is expected to be, therefore, oppositional. The staff then sets those expectations in interaction with the child, and the child performs oppositionally in accord with those expectations. Although currently largely ignored, research has shown that labeling people tends to create the behavior we expect to see based on the labels (Scheff, 1975).

Managing Group Dynamics: The Sanctuary Toolkit

Information about group dynamics and parallel process should be incorporated into orientation and ongoing training. Working in 24-hours-per-day settings requires specialized knowledge about the complex processes that arise in groups. People who work in group settings should have a high level of competence in understanding and utilizing group processes. These are communities, and the benefits of community should be maximized.

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 SELF, so we teach SELF Treatment Planning, SELF Psychoeducational Groups, SELF Team Meetings, and SELF Organizational Assessment, and use SELF to structure Red Flag Reviews. It helps us stay on track, keeps our focus, and provides a shared language and meaning system for everyone, regardless of their training, experience, or education. It also helps us to see the parallels between what the clients have experienced and what is going on with the staff and the organization and to 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.

Individualized, Trauma-Informed Treatment Plan and Processes

To be effective, residential treatment requires the coordination and delivery of a comprehensive array of therapeutic services, including educational and rehabilitative services that are trauma-informed. Intervention strategies must be designed to address delays in cognitive, social, and emotional development, and education must be tailored to a child's grade level, learning style, and individual capabilities (Abt Associates, 2008). As described earlier, to achieve good outcomes the staff members must be able to address children's complex and interactive problems despite the stressors coming from within themselves and simultaneously from their external environment.

The key to making this possible is fully utilizing the treatment context. Every activity and interaction has to become treatment, and that can happen only if administrators make it possible for staff members to do the challenging job

of integrating many different styles, objectives, and approaches. Under the pressure of higher productivity demands and diminished resources, the failure to do this integrative work is the most glaring loss in all milieu settings. As documented more than 20 years ago, in residential settings for children, it was common to find more than 17 therapeutic approaches cobbled together without necessarily any coherence and lacking a rational linking of diagnosis, etiology, and prognosis (Wells, 1991). That situation has not changed, and if anything, under the pressures of decreased funding and increased stress, it has become far more problematic. For the purposes of reimbursement, staffing, research, and planning, treatment should be defined not as the hour spent with a clinician but as the combined efforts of clinicians guiding and supervising treatment planning and implementation that embraces the whole team, including psychiatry, direct care staff, educational staff, and indirect care staff. At the heart of these integrative efforts should be an emphasis on pattern recognition and changing traumatic reenactment scripts that inevitably unfold in the treatment setting. Providing children with the corrective experiences they require if they are to heal necessitates a wide range of responsive programming that must include trauma-specific forms of treatment and the naturally transformative expressive arts but that often begins with basic psychoeducation.

In the Sanctuary Model, treatment is structured through the use of SELF Treatment Planning, SELF Psychoeducation, and specific formats for team meetings. Similarly, the more consistent the use of the Sanctuary Commitments, the more these commitments serve as anchors for problem solving and decision making and provide internal coherence for the program. This is especially true for the Commitment to Democracy. The greater the involvement of the clients in creating more democratic environments, the more likely they are to have experiences throughout any typical day that are directly counter to many of the habits they have developed. The constant repetition of alternative ways of living and working with each other lays the groundwork for changing habits in a normal, educational and social context rather than focusing on pathology and punishment for infractions. To participate, be esteemed by others, and get recognition in a democratic environment, we have to develop skills that are in direct opposition to the skillset a person has often had to acquire to survive the rigors of a violent upbringing (Bloom & Farragher, 2013).

Integration into Organizational Function: Sanctuary Implementation

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 the computer *if* they are compatible with that operating system, so an 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 (Schein, 1999). Alignment of values is usually seen as management driven, if it is referred to at all, and here mental health and social service organizations are at a distinct disadvantage.

The fundamental rationale for the Sanctuary Model is to create parallel processes of recovery by radically altering the operating system for the organization as a whole and for 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 on 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 (Senge et al., 2000). This change in mental models must occur on the part of the clients, their families, the staff, and the leaders of the organization. We have developed a methodology to help organizations accomplish this kind of deep systemic change.

The Sanctuary Institute is a five-day intensive training experience.* 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 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 manage-

---

*The Sanctuary Institute is a part of Andrus in Yonkers, NY (www.andruschildren.org). For more information, contact Sarah Yanosy, Director, at 914-965-2700, ext. 1117, or syanosy@jdam.org, or visit the Sanctuary Institute website at www.thesanctuaryinstitute.org.

ment styles and 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 in which posttraumatic stress disorder (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 SELF as a conceptual tool for organizing treatment. 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 its organization and create a Sanctuary Core Team—a larger, multidisciplinary team that expands its reach into the entire organization. It is the members of this Core Team who will be the activators of the entire system. The Core Team should have representatives from every level of the organization to ensure 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. To assist the Core Team in structuring its activities, the team is given a Sanctuary Direct Care Staff Training Manual, a Sanctuary Indirect Staff Training Manual, a Sanctuary Implementation Manual, and several psychoeducational curricula. This team will also be able to access ongoing consultation and technical assistance from Sanctuary faculty members to guide it through the process of Sanctuary Implementation that extends over three years and leads to Sanctuary Certification. Programs that have participated in the Sanctuary Institute are enrolled in 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 furnish 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 ongoing, 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 two- to three-year period after participation in the Sanctuary Institute. Research is underway with 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 on which the research is based.*

ENSURING THAT IT WORKS: EVALUATING 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 (1) less violence, including physical, verbal, and emotional forms of violence, and including but not limited to reduction in coercive forms of so-called therapeutic interventions; (2) a system-wide understanding of the complex biopsychosocial and developmental impact of trauma and abuse and what that means for the service environment; (3) less victim-blaming; (4) fewer punitive and judgmental responses; (5) clearer, more consistent boundaries, higher expectations, and linked rights and responsibilities; (6) earlier identification of and confrontation with the abusive use of power in all of its forms; (7) a better ability to articulate goals and create strategies for change; (8) an understanding and awareness of reenactment behavior, accompanied by the skills necessary to rescript reenactment, overcome resistance to change, and achieve better outcomes; (9) a more democratic environment at all levels; (10) a more diversified leadership and the embedding of leadership skills in all staff; and (11) better outcomes for children, staff, and organization.

There has been one randomized controlled 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 attitudes and behavior:

1. *Support*—how much children help and support each other; how supportive the staff is toward the children
2. *Spontaneity*—how much the program encourages the open expression of feelings by children and staff
3. *Autonomy*—how self-sufficient and independent the staff perceives the children to be in making their own decisions
4. *Personal problem orientation*—the extent to which children seek to understand their feelings and personal problems

---

*Articles about the previous Sanctuary Model research can be downloaded from www.sanctuaryweb.com. Information is also available from the Sanctuary Institute (Community Care Behavioral Health, 2011).

5. *Safety*—the extent to which staff members 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 three 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) (Rivard et al., 2004).

In another study, comparing residential programs for children that were using the Sanctuary Model and programs that were not, programs using the Sanctuary Model showed a significant, positive change in organizational culture, supporting the role of the Sanctuary Model in positively affecting the culture of the workplace (McSparren & Motley, 2010).

Organizations working with troubled children have long relied on physical restraints and/or holds to prevent a child from hurting himself or others. When we looked at the first seven child-serving facilities that participated in the Sanctuary Institute and their subsequent reductions in restraints and holds, three exhibited a more than 80% decrease in the number of restraints, two had a more than 40% decrease, one had 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 of, on average, 52.3% after the first year of implementation (Banks & Vargas, 2009a). At Andrus, within the first six years of implementation in the residential unit and school, there was a 90% decrease in critical incidents with a 54% increase in the average number of students served (Banks & Vargas, 2009b).

As part of the Pennsylvania Department of Public Welfare's efforts to reduce and eliminate restraints in children's treatment settings, the department entered into a partnership with the Sanctuary Institute to bring the Sanctuary Model to Pennsylvania in 2007. The University of Pittsburgh worked with the Pennsylvania Department of Public Welfare, the Sanctuary Institute, and 30 participating provider residential sites to conduct an open evaluation of the implementation of the model. Annual surveys were conducted from 2008 to 2010. The evaluation found that greater implementation was associated with a number of positive outcomes among staff: lower stress and higher morale, increased feelings of job competence and proficiency, and a greater investment in the individuals they serve. Implementation of the Sanctuary Model was also significantly associated with improved organizational culture and climate and a substantial decrease in the reported use of restraints by many sites (Stein et al., 2011). Additionally, an analysis of service utilization from 2007 to 2009 by children since discharged from Sanctuary Model residential treatment facilities (RTFs) versus other RTFs was conducted by Community Care Behavioral Health, a managed care company. It demonstrated that although both groups had a similar average (mean) length of stay in 2007, by 2009 the Sanctuary Model RTF providers had a substantially shorter length of stay and a somewhat greater decrease in median length of stay; a substantial increase in the percentage of discharged youths who received outpatient services in the three months following discharge; and a lower increase in the percentage of children readmitted to RTFs in the 90 days following discharge (Community Care Behavioral Health, 2011).

CONCLUSIONS

We now have a significant body of experience in watching the Sanctuary process unfold in many different kinds of organizations—more than 250 as of 2012. What we see is that adopting a trauma-sensitive organizational paradigm changes the way organizational members think and act by effecting group norms in a way that trying to influence individual behavior alone cannot accomplish. Changes in thinking change habits, and therefore change habitual routines. The SELF 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. These children are the future, and we hope that by changing client outcomes we can contribute to creating a better future for all of us.

References

Abt Associates. (2008). *Characteristics of residential treatment for children and youth with serious emotional disturbances.* Washington, DC: National Association for Children's Behavioral Health and National Association of Psychiatric Health Systems.

Alderfer, C. P., & Smith, K. K. (1982). Studying intergroup relations embedded in organizations. *Administrative Science Quarterly, 27*(1), 35.

Banks, J., & Vargas, L. A. (2009a, February). *Contributors to restraints and holds in organizations* (Andrus Center for Learning and Innovation, research brief). www.sanctuaryweb.com/PDFs_new/Banks%20and%20Vargas%20Contributors%20to%20Restraints%20and%20Holds.pdf

Banks, J., & Vargas, L. A. (2009b, March). *Sanctuary at Andrus Children's Center* (Andrus Center for Learning and Innovation,

research brief). www.sanctuaryweb.com/PDFs_new/Banks%20and%20Vargas%20Sanctuary%20at%20Andrus.pdf

Bloom, S. L. (2013). *Creating sanctuary: Toward the evolution of sane societies* (2nd ed.) New York, NY: Routledge.

Bloom, S. L., & Farragher, B. (2010). *Destroying sanctuary: The crisis in human service delivery systems*. New York, NY: Oxford University Press.

Bloom, S. L., & Farragher, B. (2013). *Restoring sanctuary: A new operating system for trauma-informed systems of care*. New York, NY: Oxford University Press.

Bureau of Justice. (2001). *Violence in the workplace, 1993–99* (Bureau of Justice Statistics special report). Washington, DC: Bureau of Statistics, U.S. Department of Justice. www.ojp.usdoj.gov/bjs/pub/pdf/vw99.pdf

Collie, D. (2004, July 7). *Workplace stress: Expensive stuff*. www.emaxhealth.com/38/473.html

Community Care Behavioral Health. (2011). *Assessing the implementation of a residential facility organizational change model: Pennsylvania's implementation of the Sanctuary Model*. www.ccbh.com/pdfs/articles/Sanctuary_Model_3Pager_20110715.pdf

Duhigg, C. (2012). *The power of habit: Why we do what we do in life and business*. New York, NY: Random House.

Esaki, N., & Larkin, H. (in press). Prevalence of adverse childhood experiences among child service providers. *Families in Society*.

Felitti, V. J., & Anda, R. F. (2010). The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders, and sexual behavior: Implications for healthcare. In R. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic* (pp. 77–87). New York, NY: Cambridge University Press.

Gazzaniga, M. (2011). *Who's in charge? Free will and the science of the brain*. New York, NY: HarperCollins.

Knudsen, E. I., Heckman, J. J., Cameron, J. L., & Shonkoff, J. P. (2006). Economic, neurobiological, and behavioral perspectives on building America's future workforce. *Proceedings of the National Academy of Sciences of the United States of America, 103*(27), 10155–10162.

LeBel, J., Huckshorn, K. A., & Caldwell, B. (2010). Restraint use in residential programs: Why are best practices ignored? *Child Welfare, 89*(2), 169–187.

McSparren, W., & Motley, D. (2010). How to improve the process of change. *Non-profit World, 28*(6), 14–15.

Occupational Safety and Health Administration. (2004). *Guidelines for preventing workplace violence for health care & social service workers*. Washington, DC: U.S. Department of Labor. www.osha.gov/Publications/osha3148.pdf

Rivard, J. C., McCorkle, D., Duncan, M. E., Pasquale, L. E., Bloom, S. L., & Abramovitz, R. (2004). Implementing a trauma recovery framework for youths in residential treatment. *Child and Adolescent Social Work Journal, 21*(5), 529–550.

Scheff, T. J. (1975). On reason and sanity: Some political implications of psychiatry thought. In T. J. Scheff (Ed.), *Labeling madness* (pp. 12–20). Englewood Cliffs, NJ: Prentice-Hall.

Schein, E. H. (1999). *The corporate culture: A survival guide—Sense and nonsense about culture change*. San Francisco, CA: Jossey-Bass.

Senge, P., Cambron-McCabe, N., Lucas, T., Smith, B., Dutton, J., & Kleiner, A. (2000). *Schools that learn: A fifth discipline fieldbook for educators, parents, and everyone who cares about education*. New York, NY: Doubleday.

Stein, B. D., Kogan, J. N., Magee, E., & Hindes, K. (2011, September 29). *Sanctuary Survey final state report*. Unpublished data, obtained from the authors.

Wells, K. (1991). Placement of emotionally disturbed children in residential treatment: A review of placement criteria. *American Journal of Orthopsychiatry, 61*(3), 345.