The great secret of morals is love; or a going out of our nature, and an identification of ourselves with the beautiful which exists in thought, action, or person, not our own.

—Percy Bysshe Shelley, A Defense of Poetry, 1821

A man, to be greatly good, must imagine intensely and comprehensively; he must put himself in the place of another and of many others; the pains and pleasure of his species must become his own. The great instrument of moral good is the imagination.

—Percy Bysshe Shelley, A Defense of Poetry, 1821

The purpose of this chapter is to describe the Sanctuary Model, a trauma-informed, evidence-supported, relationship-based, high-commitment, high-performance organizational development approach that enables a program, a system, or a community to consciously and deliberately design or redesign their own workplaces so that establishing and maintaining safe moral climates becomes possible (Beer, 2009; Bloom, 2013a; Bloom & Farragher, 2010, 2013). Historical background and evolution of the Sanctuary model is presented along with the articulation of its four current pillars: trauma theory, Sanctuary Commitments, S.E.L.F., and the Sanctuary Toolkit. Outcomes and implementation of the Sanctuary Model are discussed. Information on the Sanctuary Institute and certification program and resulting network are noted.

THE SANCTUARY MODEL: HISTORY AND EVOLUTION

The Sanctuary Model was initially developed in the 1980s in an adult inpatient psychiatric setting when the treatment team realized that the majority of people they were treating had experienced trauma, usually in childhood. Additionally, depending on the treatment setting and the organizational practices, patients were subject to retraumatization. The potential for traumatization was thought to increase if and when staff members and organizational structure took an authoritarian approach in addressing challenging behaviors in the treatment setting. The treatment team, particularly Dr. Bloom, began to publically discuss how many survivors seen in mental health services at the time were not treated with the validation and respect they so greatly deserved. She and her colleagues went on to articulate how the individuals and organizations that provide mental health services could be more welcoming and healing for survivors by understanding the impact of their trauma histories.

A great deal of anecdotal experience on the Sanctuary Model has been documented in numerous books and chapters beginning in the early 1990s (Allen & Bloom, 1994; Bloom, 1994a, 1994b, 1995, 1996, 1997, 1998). By the mid-1990s other practitioners were beginning to use the basic premises of the Sanctuary Model with some remarkable results.
Facing the complex problems of trauma survivors confronting and working through the moral challenges associated with the cause of survivors’ trauma and the resultant damage to self or others from those experiences, as well as the difficulties inherent in recovery, necessitate a willingness to confront evil, transcend trauma, and transform suffering. Treatment then, regardless of the form that treatment takes, must be understood within the context of moral injury and moral repair. Morality is defined as “the vast realm of social actions, intentions, emotions, and judgments aimed at providing benefits (and preventing damage) to people, society, and the world beyond the self” (Damon & Colby, 2015, p. ix).

Several decades of research have demonstrated that the course of childhood, adolescent, and adult development can be radically derailed as a result of exposure to trauma and adversity in a myriad of ways. This derailment often presents as complex physical, psychological, social, and moral challenges (Courtois & Ford, 2013; Ford & Courtois, 2013). These interdependent and interactive challenges require high levels of emotional, social, and moral intelligence on the part of helpers. The demands of emotional and social intelligence are covered elsewhere (Albrecht, 2005; Goleman, 1995). The focus here is on the need for morally intelligent caregivers and caregiver environments.

Moral intelligence has been defined as an individual’s mental capacity to determine how universal human principles should be applied to personal values, goals, and actions. Moral intelligence serves as the central intelligence for all human beings that binds the individual to his or her social group, culture, and moral system, allowing people to define how to use their other forms of intelligence and directing them toward what is worthwhile, thus giving their lives purpose and meaning (Lennick & Kiel, 2005).

The shattering nature of traumatic experience may undermine and sabotage the development of this moral intelligence with profound effects on the individual and the groups of which they are a part. Signs of this moral derailment abound: violence and corruption; insensitivity and empathic failure; silence and secrecy; authoritarianism and autocracy; injustice and narcissism; repetition and stagnation; and children who are hungry, homeless, and hopeless. The result for many is a shattered and pessimistic world view characterized by loss of meaning and purpose; loss of faith in a benign higher power; loss of the capacity for trust; arrested moral development; excessive tolerance for corruption, deceit, and betrayal; racial-, ethnic-, and gender-based hatred; and hopelessness, helplessness, and alienation.

The Sanctuary Model represents a moral system that situates itself in the middle space between the two extreme positions of moral absolutism and moral relativity, and thereby, it constitutes a more modern and scientifically complex view of morality consistent with the notion of moral pluralism, a view proposing that moral beliefs are limited, partial, and incomplete, not that they are wrong (Stevens, 1997). To discover the optimal moral action, then, requires an explorative and dialogical process using and integrating reflection, emotions, cultural awareness, situational factors, and moral imagination, “an ability to imaginatively discern various possibilities for acting in a given situation and to envision the potential help and harm that are likely to result from a given action” (Johnson, 1993, p. 202).

CENTRALITY OF MORAL SYSTEMS, TRAUMA, AND MORAL DISTRESS

Justice, morality, faith, and belief are at the heart of recovery from trauma, and the restoration of a sense of a “just world” is a critical component of healing
Accidents and natural disasters occur quite frequently, but even in these cases, survivors must contend with trying to make sense out of what has happened to them, whether they try to wrestle a restored sense of justice from the legal system or take solace in personal religious beliefs. The term moral injury was first used by Shay (2003) as a descriptor for some of the profound experiences of combat veterans and can be defined as a "betrayal of 'what's right' in a high-stakes situation by someone who holds power" (p. 240), but the experience of moral injury occurs in any situation that the person defines as high-stake.

Those who have been intentionally hurt by other people contend with the abuse of power that inevitably accompanies humans' ability to inflict harm on others, even if that perceived abuse of power is coming from a larger embracing system, as in the case of warfare (Pearlman, 2012). Although it has been clear for many years that moral reasoning can be distorted by psychopathology, the newer findings from the trauma field are illustrating that problems with moral reasoning may sometimes contribute to the development of psychopathology, and that moral injury is a fundamental component of the experience of trauma, particularly when the trauma is a result of interpersonal violence (Doron, Sar-El, Mikulincer, & Kyrions, 2012; Pearlman, 2012).

The resultant moral injury accompanied by the physiological deficits secondary to early experience, particularly chronic hyperarousal, may influence perceptive, social, and cognitive abilities pushing moral preferences away from altruism and mutual self-interest and toward self-protective and self-interested responses (Narvaez, 2014).

Moral injury may also be sustained by caregivers who seek to offer aid to victims of trauma but who are frustrated in their endeavors. This can cause what has been termed moral distress defined as the pain or anguish affecting the mind, body, or relationships in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action; yet, as a result of real or perceived constraints, participates in perceived moral wrongdoing. (Janetos, 1984, p. 5)

Moral distress occurs in situations where a person or group knows what is the right thing to do, but doing the right thing is thwarted by conditions under which the person or group does not have perceived control (Bloom & Farragher, 2013).

To further complicate things, consider what happens when groups of people come together to create the next level of organization (e.g., individual organizations or programs that then network together to become systems). In the Sanctuary Model, it is assumed that all organizations of individual humans have emergent properties that can characterize them as living systems, subject to the stresses, strains, and trauma of living (Bloom & Farragher, 2010, 2013; Pascale, Millemann, & Gioja, 2000). These traumatized systems are viewed as trauma-organized (Bentovim, 1992).

**TRAUMA-ORGANIZED SYSTEMS AND MORAL MISALIGNMENT**

Environments that make people sick—physically, psychologically, socially, and morally—are those systems within which the real problems are denied and therefore conflicts cannot be resolved. The leadership of such systems is likely to be strictly authoritarian, where deference and submission is given to one's place in a rigidly enforced hierarchy or pecking order. In such authoritarian systems, obedience and submission are the paramount goals, and the leaders place vital importance on the need to "break the other's will" rather than work through conflict. But, unresolved conflicts often lead to shameful acts around which a web of secrecy must be woven. Such authoritarian regimes often arise as a reaction to situations where a lack of adequate leadership has led to organizational chaos, frequently secondary to acute or chronic organizational trauma that also cannot be discussed.

People in those situations may find that honesty is a value increasingly difficult to uphold and degradation of truth is accompanied by a simultaneous embracing of self-deceit and deceitful conduct toward others. An atmosphere of deceit,
once established, must be protected; the only way to do that is to guarantee that the members of the system are kept isolated from exposure to outside information that could unveil the deceit. Control over behavior and the flow of information can only be exercised through the coercive use of power and actual threats or acts of violence are simply the extreme example of this coercion. If the system does not respond adequately to milder forms of manipulation and control, then bullying and various kinds of abuse will be used by those in authority. In such a system, boundaries between people, and even internal boundaries within the deceitful self, become confused and susceptible to violation. Tolerance for any kind of difference, which could become a threat to the system, diminishes. The sources of all problems are seen as outside the system, and hostility and blame are directed outward, away from internal problems. One of the ways to protect against the uncovering of a web of deceit is to maintain the pretense of irreproachability leading to an attitude of hypermoralism and self-righteousness, which is inherently and demonstrably hypocritical, but that cannot be discussed or pointed out.

Another way to protect the web of deceit is through secrecy and the enforced maintenance of ignorance. Gradually, all positive experiences and emotions are eroded, leaving only negative relational interactions within the system. To the extent the deceitful edifice is to maintain the pretense of irreproachability leading to an attitude of hypermoralism and self-righteousness, which is inherently and demonstrably hypocritical, but that cannot be discussed or pointed out.

Under such circumstances, moral misalignment is likely to occur between staff and management and between all staff and the overtly stated organizational values and mission. The organization becomes “infected” by “moral viruses,” disabling and inaccurate negative beliefs that are in conflict with universal principles but that are often hidden deep within the organizational operating system (Lennick & Kiel, 2005). In the Sanctuary Model, it is believed that one of the major causes of sanctuary trauma, vicarious trauma, burnout, and the failure of therapists and others to help the people in their charge come about because of systemic infection by these moral viruses, leading to empathic failure and a lack of moral imagination.

If the organizational operating system for mental health and social services is viewed through such a lens, it can be seen that the process of care often begins with diagnostic labeling that can be experienced as dehumanizing. Labeling theory and recognizing labeling as a source of potential harm goes back to the 1960s and is largely ignored today (Scheff, 1975). Dehumanization is often the first step in a process that then justifies harmful behavior because the person has been put outside of the moral universe. In many places, the pressure for

Recurrent stress and trauma can cause the emergence of severe dysfunction in groups of people, not simply in individuals. Trauma-organized systems are more likely to create circumstances where moral disengagement is rationalized and justified. Moral disengagement is the process by which individual moral self-sanctions are selectively uncoupled from what later are recognized as inhumane conduct, usually as a result of social pressures that support such disengagement. A number of strategies to promote disengagement have been described in a variety of different settings but are especially relevant to the social service and mental health environment including moral justification, sanitizing labeling, advantageous comparisons, the diffusion of responsibility, and progressive dehumanization (Bandura, 2002). All have been described throughout the history of mental health treatment and can still be witnessed today in many mental health and criminal justice settings for children, adolescents, and adults (Bloom & Farragher, 2010, 2013).
productivity has made it impossible for the complex group processes that inspire the use of moral imaginative processes to even occur. Each individual comes into the situation with a different schema for understanding what are often incomprehensible behaviors. For true team treatment to occur, there must be some agreed upon understanding of those differences in schemas—not necessarily agreement, but agreement that there are differences.

For example, consider the case of a child who is in residential treatment setting. An art therapist's understanding of what the child's nonverbal behavior is about is likely to be very different from that of the child's psychiatrist, teacher, or other staff member. If together, they are not willing or do not have the time or opportunity to “walk in the other's conceptual shoes” then how are they to even begin deciding what the proper course of action is for that child? The professional point of view that comes to dominate decision making can have a profound impact on outcomes. If the only way one can view a child's oppositional behavior is through a mental model that says that the behavior is intentional, and that the intention must be broken because obedience to lawful authority is mandatory, then punishment becomes a viable option. If, however, the child's behavior is viewed as unwillingness to submit to adults who have been obviously wrong, unjust, or even abusive in the past, then the reaction to the child—and the outcome of those interactions—are likely to be quite different. If the adults dealing with the child have never even considered that there are validly different perspectives, then they have not used their moral imaginations, and this can be detrimental to the child.

Reflections on the way helping systems actually function can raise some important questions. Do therapists and other professionals not have a moral responsibility to repair, or at minimum not repeat, the substantial moral injuries of people who have been harmed by others? What is the moral responsibility to children or adults in the care of therapists? How often do therapists and other professionals even think of these issues rather than stay confined to the description of their roles? Without that freedom, therapists and other professionals can become locked into points of view that are defined by their roles or job descriptions, defeating the inherent strengths of working as a team.

An important component of Sanctuary Model implementation is creating processes within which such morally disengaging conversations and practices can be surfaced, described, discussed, and changed so that the management and staff within the organization become better aligned with organizational values, principles, goals, and behaviors. Such alignment has a vital role to play in outcomes: “A funny thing happens when leaders consistently act in alignment with their principles and values: They typically produce consistently high performance almost any way you can measure it” (Lennick & Kiel, 2005, p. 4).

Moving in parallel from one level of organization to another, it may seem daunting to outline problems characterized by ever greater complexity, even while focusing on individual recovery from traumatic experience. Many people have tried with varying levels of success to bring about positive change within organizations and systems. Even the best of minds can stagger by simply engaging a thought experiment for what it would take to eliminate violent perpetration on a larger scale. The changes inherent in contemplating widespread and causative change will require a change in mental models and a large-scale shift in paradigms that can appear too daunting to contemplate and are, therefore, viewed as nonsensical and categorized as utopian or as dangerously totalitarian as those of the prior century.

But perhaps, getting to the root of the problems may not be as impossible as it seems. In the Sanctuary Model, it is assumed that there is validity to the notion of parallel processes, defined as that which occurs “when two or more systems—whether these consist of individuals, groups, or organizations—have significant relationships with one another, they tend to develop similar thoughts, feelings and behaviors” (Smith, Simmons, & Thames, 1989, p. 13). Although usually understood as a way of understanding what appear to be puzzling layers of conflict within an organization, empirically it is possible to deliberately create parallel processes of recovery from those conflicts, if the correct moral climate is created. If this is true, then creating a paradigm shift at one level of
organization may have relevance to every other level of organization. If so, the notion of "act local, think global" may have enormous implications.

SANCTUARY AS A SAFETY CULTURE: FOUR PILLARS OF SANCTUARY MODEL

Establishing what is required on a day-to-day basis to bring about such a positive moral climate begins with safety. Creating sanctuary refers to the shared experience of creating and maintaining physical, psychological, social, and moral safety within a social environment and reducing systemic violence and countering the destructive parallel processes that have unfolded for many centuries and in many varieties within human cultures (Bloom & Farragher, 2013).

In other organizational settings it has been referred to as the creation of a safety culture defined as the product of individual and group values, attitudes, perceptions, competencies, and the patterns of behaviors that determine the commitments to and the style and proficiency of, an organization's health and safety management...characterized by communications founded on mutual trust, by shared perceptions of the importance of safety and by the confidence in the efficacy of preventative measures. (Cox, Jones, & Collinson, 2006, p. 1124)

The Sanctuary Model is structured around a philosophy of belief and practices that create a structured process enabling organizations to shift their mental models. Trauma-informed, relationship-based system change requires radical alterations in the basic mental models on which thought and action are based; without such change, service delivery 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 organization as well as every level of superordinate systems. 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 on what we can and cannot do (Senge, 1994). This shift in underlying assumptions is the most critical aspect of creating a trauma-informed system (Bloom, 2013a; Bloom & Farragher, 2010, 2013). Without that change in philosophical underpinning, longed-for change may become little more than window dressing. This is precisely why true trauma-informed service delivery requires more than "training"—it requires a process of reeducation, of unlearning "the old" that needs to be discarded, while retaining what remains of value, and learning all that needs to be "new."

The true objective of the Sanctuary Model is to offer practical tools for operationalizing a moral climate at any level of social organization. To do this, there are key aspects of changing culture and creating community. There has to be a shared knowledge base, shared values, shared language, and shared practice. These are the four pillars of sanctuary: (a) trauma theory, (b) Sanctuary Commitments, (c) S.E.L.F., and (d) the Sanctuary Toolkit.

The first pillar, trauma theory, is actually an extensive knowledge base on the impact of trauma and adversity; child development; developmental, social, and spiritual neuroscience; and group dynamics. The Sanctuary Model implementation process is designed to keep the focus on the acquisition of this knowledge by everyone in the organization through the regular use of the Sanctuary Commitments, S.E.L.F., and the Sanctuary Toolkit.

The second pillar, the Sanctuary Commitments, noted in Table 24.1, represents the guiding principles for implementation of the Sanctuary Model—the basic structural elements of the sanctuary moral operating system. The Sanctuary Commitments are designed to be a coherent, anchoring, moral system for decision making and problem solving.

The Sanctuary Commitments represent universal principles typical of all human rights cultures. All seven Sanctuary Commitments are complexly interactive and interdependent. They become the norms that change the habits of thought and behavior that structure the organizational culture and make it easier for organizational leaders to consciously and deliberately apply the principles to whatever they do.

The Sanctuary Commitments require organizational members to remember the multiple ways
Table 24.1
Sanctuary Commitments: Guiding Principles for Model Implementation

<table>
<thead>
<tr>
<th>Principles</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitment to nonviolence</td>
<td>Address all forms of violence—physical, psychological, social, and moral—in principle and practice.</td>
</tr>
<tr>
<td>Commitment to emotional intelligence</td>
<td>Manage own emotions without causing harm to self or others; accurately read and comprehend emotional states in others.</td>
</tr>
<tr>
<td>Commitment to social learning</td>
<td>Willingness to learn (especially from mistakes), grow, adapt, and change in a way that benefits self and society.</td>
</tr>
<tr>
<td>Commitment to open communication</td>
<td>Increasing transparency; developing better conflict management skills; establishing or reinforcing healthy boundaries.</td>
</tr>
<tr>
<td>Commitment to democracy</td>
<td>Willing to work to find fair, nonviolent ways to reconcile conflicts.</td>
</tr>
<tr>
<td>Commitment to social responsibility</td>
<td>Use concern and engagement for the common good.</td>
</tr>
<tr>
<td>Commitment to growth and change</td>
<td>Mourn losses, let go of the past, and move toward a different future.</td>
</tr>
</tbody>
</table>

in which moral principles are demonstrated, even when members may not intend to demonstrate moral principles in what they do or say. The challenge in the Sanctuary Model is to establish and maintain a consistent, fair, coherent moral system, in the face of what are extraordinary moral dilemmas, the kinds of dilemmas that human service delivery professionals encounter every day (Bloom & Farragher, 2010). Even under the most ideal circumstances, there are all sorts of conflicts and tensions that exist within any meaningful moral system. The Sanctuary Commitments structure the organizational norms that determine the organizational culture.

They are designed to lead to a parallel process that provides support for the organization and its staff at the same time as they provide an environment of recovery. But they are not cure-alls: There are inevitable conflicts, unintended consequences, and unforeseeable circumstances which will need to be resolved each day in each program, requiring judgment, flexibility, and moral imagination.

The third pillar is shared language that is used as a nonlinear organizing framework for many aspects of the Sanctuary Model, S.E.L.F. This useful acronym represents the four key domains of recovery: safety, emotions, loss, and future. In the Sanctuary Model, S.E.L.F. is a necessary tool for assessment, planning, and problem solving. S.E.L.F. is the framework for psychoeducation which is an indispensable component of the Sanctuary Model.

Visually, S.E.L.F. is most accurately represented as four points on a compass that are not stages, but phases that can be moved around depending on the situational need. Used as a compass, S.E.L.F. helps to keep the people involved in treatment from getting lost in the chaos of symptoms and to keep them grounded in the fundamental moral question of recovery. What future are they trying to get to and what's the point? How do they get there safely and with moral integrity intact? How do they honor losses while not losing more than is necessary? How do they manage their emotions in the process to prevent further harm?

When faced with the complex problems that are typical of clients served by the service system, it is easy for a service system professional to lose his or her 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. The establishment and maintenance of safety, the first point in S.E.L.F., is medically and psychologically necessary for healthy human growth and development throughout the lifespan. In a group environment safety is necessary for everyone. In the Sanctuary Model, the broad issue of safety is categorized into four discrete but interactive categories. Physical safety refers to anything people need to stay alive and derive a sense of health and well-being in the world. This encompasses everything from avoiding self-destructive behavior to having a sound economic base to considering one's
impact on climatic deterioration. Psychological safety is engaged around individual behavior, the pursuits each individual must follow to be healthy within himself or herself and balance out his or her needs with those of others (e.g., self-discipline, self-control, self-esteem, self-care, self-reflection). Social safety refers to the ability to be a part of a group, to listen and to be heard, to be able to play a role in conflict resolution, to use one's intelligence and creativity to serve a group process without engaging in behavior or activities that destroy the integrity of the self or the group. Moral safety reflects an environment that actively defines and redefines a moral universe of integrity, responsibility, honesty, tolerance, compassion, peace, nonviolence, justice, and an abiding concern for human rights. Being morally safe means having a system of values that are consistent, that guide behavior, and that are founded on a deep respect for each other and all living things. In a morally safe environment there is no “other,” no enemy that is fair game for aggression and violence, no scapegoat on which it is acceptable to project one's own denied feelings or the denied feelings of an entire group (Bloom & Reichert, 1998).

The second point in S.E.L.F. is emotions, most particularly the emphasis on emotional management and the continually evolving development of emotional intelligence. The capacity for emotional management for everyone in the environment focuses on identifying levels of various emotions and developing skills to modulate emotion in response to memories, persons, or events in a way that fosters safety to self and others.

The recognition and response to loss, the third point in S.E.L.F., is often missing, even in therapeutic settings where the enormity of loss may dominate the clinical picture. In S.E.L.F., loss requires organizational members to address feelings of grief in dealing with personal losses that may be tangible or intangible. But all change—even change for the better—requires giving up something and without honoring those losses, change is unlikely to occur. Through S.E.L.F., everyone is trained in how to understand repetition and reenactment as hallmark signs of unresolved loss.

The final point in S.E.L.F. represents future and forces people out of their own, fixed, stable conceptual schemas and pushes them to use moral imagination all of the time without losing the importance of creating concrete safety, valuing emotions, or reckoning with the tradeoffs necessitated by change as embodied in the concept of loss. The use of moral imagination is a vital component of future. Future is about “the vision thing” and encourages people to try out new roles, ways of relating and behaving as a “survivor” to ensure personal safety, envisioning a different and better future. The energy for change actually resides in the future and is always there to be drawn on as a motivating force.

Whenever there is uncertainty or anxiety, the use of S.E.L.F. becomes even more important as a tool that serves the employment of moral imagination. Clients are most likely to pay attention to whatever problems are causing the most pain in the present, even though from a caregiver's point of view, what they are or are not doing will likely cause clients greater suffering in the long term.

S.E.L.F. is not just for the clients but is used to begin to address problems in staff, management, or the organization as a whole. Applied to such issues as change management, staff splitting, poor morale, rule infraction, administrative withdrawal and helplessness, misguided leadership, and collective disturbance, S.E.L.F. can assist a stressed organization to conceptualize its own present dilemma and move into a better future through a course of complex decision making and conflict resolution. To do so, an organization must envision the Future it wants to get to, wrestle with the inevitable barriers to change that are related to loss, develop skills to manage the individual and interpersonal emotions and multiple conflicts surrounding change, while calculating what are the present and potential safety issues in making change or in not making change.

In using S.E.L.F. to deal with any emergent problem or conflict, individual and organizational habits change, creating new, morally informed routines for facilitating change regardless of whether
these involve children, adults, families, staff, or the organization as a whole. S.E.L.F. is easy to teach by using simple, nontechnical, and nonpejorative concepts. As the importance of one or another of the S.E.L.F. domains shift over time, sometimes within minutes, the interpersonal dialogue can shift as well and just as rapidly, thus promoting movement that is the heart of change.

SANCTUARY MODEL TOOLKIT

The Sanctuary Toolkit comprises a range of practical skills that enable individuals and groups to more effectively and consistently use the Sanctuary Commitments in daily practice, build a sense of community, and exercise the capacity for moral imagination by developing new habits. In doing so, organizational members develop a deeper and more comprehensive understanding about the effects of trauma and adversity while gaining the ability to respond to those effects within themselves and in relationship to others in a positive way. The Sanctuary Toolkit “rewires” the organization through structured communication and creation of tasks directed toward safety and, in doing so, opens up new pathways for communal problem solving.

Practically focusing on the Sanctuary Commitments means that basic moral premises are kept in the forefront of organizational functioning. Many of the tools are organized around S.E.L.F. and provide the organizing structure for psychoeducation, supervision, daily interactions, initial assessment and assessments of change, treatment planning, and conflict management. Frequent community meetings and universal safety plans and self-care plans create an ongoing and ever-renewed safety culture. Red flag reviews support and encourage communication, participation, and conflict resolution. The model helps staff, children, and parents to maintain focus while providing a shared language and meaning system for everyone, regardless of their training, experience, or education. It also helps staff members to see the parallels between what children, adults, and their families have experienced and what is going on with the staff and the organization and to intervene when the unfolding of a collective disturbance is noticed. This helps everyone to see the interactive and interdependent nature of their shared lives.

Human beings are not perfect, nor are our systems, but we have seen that with these tools in place for everyone in the environment, a more consistent and honest moral climate emerges and can be sustained (Bloom & Farragher, 2013; Bloom, Yanosy, & Harrison, 2013).

SANCTUARY MODEL IMPLEMENTATION

Sanctuary Model implementation is not a rapid process. Clinical observation suggests that significant change in human beings takes at least 2 years. Any organization is itself a living system that is constantly being affected by external events and then adapting to change. System change is thought to take at least 7 years. The Sanctuary Model includes a highly structured initial method that extends over a 3-year period.

In a living system, every part of the system interacts with—directly or indirectly—every other part. Therefore, for the organizational moral climate to be ethically consistent, everyone needs to be educated and trained in the various components of the Sanctuary Model, and most important, the Sanctuary Commitments, regardless of whether they provide direct or indirect care. The tenets of the model need to be embraced by the controlling group, often the board of directors and senior leadership, conveyed throughout the organization, through middle management, to the direct care and support staff and ultimately to the clients.

The implementation process compels different sorts of conversations between members of various organizational levels. When organizational leaders engage in a different kind of dialogue with other members of their organizational community they find out how divergent people’s views are on what these commitments mean and how to make them real in everyday interactions. Experience has taught that moral leadership is critical to system change; without it, substantial change is unlikely to occur (Bloom & Farragher, 2013).

The Sanctuary Model is designed to make it very clear that there are no “innocent” bystanders. In any morally equivocal situation, the problematic action is likely to be taken by someone who can
be conceived at the moment as the perpetrator, someone else as the victim, and everyone else as bystanders. In the Sanctuary Model, the emphasis on establishing healthy group environments that are values based and anchored by all seven Sanctuary Commitments serves to encourage bystanders to take moral action in the face of a perceived violation of basic principles. Under conditions of chronic stress, group processes that support moral disengagement are more likely to occur. In prior research on the psychology of the bystander, it has become clear that early intervention works best. As bystanders become increasingly passive in the face of abusive and unethical behavior, action becomes increasingly difficult. Just as there can be a deteriorating spiral of perpetration in which each act of violence becomes increasingly easy to accomplish, so too is there a deteriorating cycle of passivity. As perpetrators actively assume control over a system, their power increases unless bystanders put up sufficient resistance to successfully counter it. There is a point, however, where resistance by bystanders becomes extremely difficult because the perpetrator's power has become too concentrated (Staub, 2012). In the Sanctuary Model, prevention and early intervention in any dehumanizing processes are keys to developing and sustaining a health environment. In the process of implementation, participants are guided in an understanding of collective dynamics and the development and resolution of “collective disturbances” and traumatic reenactment (Bloom & Farragher, 2013; Harrison & Yanosy, 2010).

In 2005, the Sanctuary Institute was created to provide training and technical assistance and to serve as the organizing and certifying organization for the Sanctuary Model. The initial training is a 5-day intensive experience for teams of five to eight people, from various levels of the organization, who come together to learn. 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 staff from 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.

During the training, the Sanctuary Steering Committee engages in prolonged, facilitated dialogue that serves to surface the major strengths, vulnerabilities, and conflicts within the organization. By looking at shared assumptions, goals, and existing practice, staff members from various levels of the organization are required to share in an analysis of their own structure and functioning, often asking themselves and each other provocative questions that have never been overtly asked previously.

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 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 with whom they work. 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 learn about vicarious trauma, traumatic reenactment and the importance of understanding themselves and providing support for each other, along with the concept of posttraumatic growth. They are introduced to S.E.L.F. as well as the various components of the Sanctuary Toolkit and the role the toolkit plays in changing organizational habits.

The Sanctuary Steering Committee is instructed to go back to their organization and create a 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 ensure that a voice
from every sector 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 uses implementations and training materials for direct and indirect service professionals as well as several psychoeducational curricula and ongoing consultation and technical assistance from sanctuary faculty members (Bloom et al., 2009; Harrison, McSparren, & Yanosy, 2012; McCorkle, Harrison, Peacock, & Yanosy, 2010; Yanosy, Harrison, & Bloom, 2009, 2011). The process of Sanctuary Model implementation extends over 3 years and aims toward sanctuary certification.

THE SANCTUARY NETWORK
The Sanctuary Network comprises our community of practice, all organizations committed to the development of trauma-informed services. It has grown into a community of organizations helping each other to become more trauma-informed and to improve services and outcomes. Consequently, the Sanctuary Model is constantly evolving, and we remain engaged in the process of cocreation with other members of the Sanctuary Network.

SANCTUARY MODEL OUTCOMES
The Sanctuary Model is considered to be an evidence-supported, best practices approach. In pursuing ongoing research and evaluation, we intend on continuing to develop a method for guaranteeing an acceptable level of fidelity to the original model on which the research was based (Bloom, 2013b; Esaki et al., 2013; Rivard et al., 2003, 2004, 2005). Agencies that meet the Sanctuary Standards can expect to experience improved treatment outcomes, enhanced staff communication, reductions in violence and critical incidents, increased job satisfaction, lower rates of staff turnover, and better leadership as well as a system-wide understanding of the impact of trauma and what that means for the service environment.

To date, one controlled, randomized trial of the implementation of the Sanctuary Model in children's residential settings has been conducted. From baseline to 6 months, there were five significant changes in the staff attitudes and perceptions among those who received the sanctuary model training: 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), and safety (the extent to which staff feel they can challenge their peers and supervisors, can express opinions in staff meetings, are not blamed for problems, and have clear guidelines for dealing with children who are aggressive). Changes in the children were just beginning to unfold as the study ended, including a decrease in children's conflict-escalating communication and increases in their positive management of tension (Rivard, 2004; Rivard et al., 2003, 2004, 2005). In a quasi-experimental study of residential programs for children using the Sanctuary Model, there were similar positive changes in organizational culture, whereas comparable programs not using the Sanctuary Model did not report those improvements (McSparren & Motley, 2010).

The first seven child-serving facilities that participated in the 5-day training that begins the process of Sanctuary Model implementation were evaluated for changes in their rates of restraints and holds. Three programs exhibited over an 80% decrease in the number of restraints, two had over a 40% drop, one exhibited a 13% decrease, and one had a 6% drop. A subsequent 3-year study of child organizations using the Sanctuary Model showed an average of 52% reductions in physical restraints after the first year of implementation. Within the first 6 years of implementation in the Andrus Center residential program and school, there was a 90% decrease in critical incidents with a 54% increase in the average number of students served (Banks & Vargas, 2009a, 2009b).

In one school for emotionally disturbed children that has become certified in the Sanctuary Model, after 2 years of implementation, 64% of the students achieved realistic or ambitious rates of reading improvement. In addition, 99% of the children were promoted to the next grade. There was a 41% reduction in the number of children requiring inpatient
psychiatric hospitalization and a 25% reduction in the number of days children spent in inpatient hospitalization. The same school enjoyed a 56% placement rate in public and private school programs once the students graduated (Banks & Vargas, 2009b).

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 the Sanctuary Institute to bring the Sanctuary Model to Pennsylvania in 2007. The University of Pittsburgh worked with DPW, 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 of the implementation of the Sanctuary Model in residential facilities found that greater implementation was associated with a number of positive outcomes: lower staff stress and higher staff morale, increased feelings of job competence and proficiency, and a greater investment in the individuals served. The 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, Kogan, Magee, & Hindes, 2011).

Additionally, an analysis of service utilization from 2007 to 2009 of children discharged from Sanctuary Model residential treatment facilities (RTF) versus other RTF’s, was conducted by Community Care Behavioral Health (2011). It demonstrated that although both groups had a similar mean length of stay in 2007, by 2009 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 youth who received outpatient services in the 3 months following discharge, and a lower increase in the percentage of children readmitted to RTFs in the 90 days following discharge.

CONCLUSION AND A VISION OF MORAL SAFETY

Experience in treating survivors of childhood trauma as well as bringing about change in the organizations that serve traumatized children, adults, and families has convinced us that starting with a vision of possibility is essential, that surely the biblical notion that “a people without a vision perish” can be seen to be demonstrably true so in the final words in this chapter, let us play with our own imaginations, on an imagined time in a possible future when we all live within a society that is morally safe. Let’s imagine that we live in a culture, in a whole world, where it is clearly recognized that just as people need good food, clean water, and fresh air to live, we similarly require shared ethical principles as the basis for our families, institutions, and society as a whole. A focus on wellbeing means that questions about values—about meaning, morality, and life’s larger purpose—become central. It is recognized that human well-being entirely depends on states of the human brain, so that different ways of thinking and behaving—different cultural practices, ethical codes, modes of government and economic distribution—are translated into significant changes in policies and practices around the world and, therefore, into different degrees of human flourishing.

References


Pearlman, L. A. (2012). Moral dimensions of trauma therapies. In M. Mikulincer & P. R. Shaver (Eds.), The social psychology of morality: Exploring the causes of good and evil (pp. 311–326). http://dx.doi.org/10.1037/13091-017


Staub, E. (2012). *Psychology and morality in genocide and violent conflict: Perpetrators, passive bystanders, and rescuers.* In M. Mikulincer & P. R. Shaver (Eds.), *The social psychology of morality: Exploring the causes of good and evil* (pp. 381-398). [dx.doi.org/10.1037/13091-021


