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# Implementation of The Sanctuary Model in residential out-of-home care: Enablers, barriers, successes and challenges

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ABSTRACT

This study aimed to examine the enablers, barriers, organisational successes and challenges experienced by decision makers (managers and executive staff) when implementing The Sanctuary Model, a trauma-informed, organisation-wide model in residential out-of-home care. Following ethics approval, nine semi-structured interviews were conducted between September 2018 and February 2019. Data were thematically analysed and four enablers for implementing The Sanctuary Model in residential care were identified: (1) shared trauma-informed knowledge and understanding; (2) leadership and champions; (3) structures; and (4) creativity and flexibility. Three barriers of implementation were recognised: (1) infidelity of the model; (2) lack of practice-based and refresher training; and (3) poor resources. The successes experienced during implementation were presented as: (1) the Sanctuary commitments; (2) the SELF framework; and (3) reflective practice. One prominent challenge presented across managers and executive staff was the relevance to staff and young people. Key findings indicate that when implementing The Sanctuary Model, organisations need to commit to organisational and behavioural change by providing resources, hands on support, and ongoing practice-based and refresher training, all of which consistently promote incorporating The Sanctuary Model into practice.

## 1. Introduction

### 1.1. Background

Community service organisations are increasingly recognising the high prevalence of trauma (abuse and neglect) and the associated life-long adverse effects on social, emotional and physical development faced by the young people they work with (Nathanson & Tzioumi, 2007; Putnam, 2006). It is not surprising, therefore, that organisation-wide, trauma-informed models have been developed to respond to the complexities associated with the childhood trauma that community service organisations manage (Anda et al., 2006; Felitti et al., 1998; Leitch, 2017). Organisation-wide, trauma-informed models encompass therapeutic techniques, an overarching approach and a common language and are increasingly being implemented in community service organisations such as in residential out-of-home care (OoHC) (Bailey et al., 2019).

Residential OoHC in Australia refers to the placement of children and young people in a home with approximately 2–4 other young people, which is staffed by carers 24 h per day (Pizzirani, Green, O'Donnell, & Skouteris, 2020). In addition to the development of organisation-wide, trauma-informed models, implementation science has been driving evidence-based and evidence-informed practices, such as The Sanctuary Model, into real-world settings (Hamilton & Finley, 2019; National Cancer Institute, 2020; Nilsen, 2015). Despite the growing interest in these models, there remain significant gaps in identifying and understanding the enablers and barriers of translating and implementing research into practice (Aarons & Palinkas, 2007; Bendall et al., 2018).

### 1.2. The Sanctuary Model

The Sanctuary Model is an evidence-informed model that focuses on

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safety and recognises that trauma has an impact on not only those who have experienced it, but also on the staff who work with them (Esaki et al., 2013). The Sanctuary Model is an organisation-wide, trauma-informed approach developed to provide a structure and common language for people to communicate about trauma and its impacts (Esaki et al., 2013). The Sanctuary Model supports staff and carers to create an organisational culture that prioritises safety and wellbeing at every level within the organisation (Bloom, 2013). The Sanctuary Model was designed across four key pillars: Trauma Theory, the Safety, Emotion, Loss and Future (S.E.L.F) Framework, the Sanctuary Tool Kit and the Seven Sanctuary Commitments (Fig. 1).

### 1.3. Building the evidence for trauma-informed approaches in out-of-home care

Whilst The Sanctuary Model is evidence-informed, there has been a paucity of research conducted to understand how and why components of trauma-informed care models, such as the Sanctuary Model, may lead to positive outcomes for the most vulnerable children and young people, adults and families. A recent systematic review examining the current empirical evidence for organisation-wide, trauma-informed models implemented across the OoHC sector identified three models (Attachment Regulation and Competency (ARC) framework, Children and Residential Experiences (CARE) programme and The Sanctuary Model), however only limited evidence was found on the effectiveness of these models (Bailey et al., 2019). To address this, we are evaluating the implementation of The Sanctuary Model, in a large community service organisation in Australia, to build an evidence base and contribute to the limited research in this area.

The current study contributes to this larger body of research. This research is guided by the Monash Centre for Health Research and Implementation (MCHRI) Knowledge-to-Action framework (Robinson et al., 2018), which was informed by the Consolidated Framework for Implementation Research (Damschroder et al., 2009) and a previously developed Knowledge to Action Framework (Field, Booth, Ilott, & Gerrish, 2014). The MCHRI framework aims to develop co-designed and stakeholder driven, iterative approaches in translating new knowledge and evidence into practice and focuses on methodological rigour (Fig. 2) (Robinson et al., 2018). Stakeholder engagement and partnership is embedded in every stage of the process, including in the formative research, evidence synthesis, efficacy research, implementation research, dissemination, translation, and scale up (Robinson et al., 2018).

Phase one of this research involved formative research in which the attitudes of residential care workers towards trauma-informed care were assessed (Galvin, O'Donnell, Mousa, Halfpenny, & Skouteris, 2020) and key stakeholders (executive staff and residential care staff) had the opportunity to share their understanding and experiences of The Sanctuary Model. In phase two, a systematic review was performed which examined the effectiveness of interventions and practice models for improving health and psychosocial outcomes of young people in residential care (Galvin, O'Donnell, Skouteris, Halfpenny, & Mousa, 2019), and a review of existing guidelines and policies, on structures, processes and supporting infrastructure was conducted, to guide the development of an organisational map. The organisational map outlined the governance, operational structure, programs and interventions embedded to support the implementation of The Sanctuary Model in residential OoHC. To understand the priorities and needs of implementing The Sanctuary Model, stakeholders have been engaged throughout the research to be able to lead the translation of evidence into practice and to inform phases three (efficacy research) and four (implementation research), which are currently underway. Phase 3 and 4 of this research will involve adapting the Sanctuary Model guidelines, practices and resources (data obtained from Phase 2) and co-designing an 'implementation blueprint' and resource toolkit. Adaptations to the model will not interrupt the overall philosophy driving the model but that will ensure the model is more relevant, meaningful and applicable in the Australian OoHC context.

### 1.4. Translation of research into practice in out-of-home care

Research shows that new knowledge and evidence cannot be easily translated in a simple, linear way into practice, and the implementation of programs aimed at improving client outcomes, particularly in child welfare services, can be a complex process (Aarons & Palinkas, 2007; Greenhalgh & Wieringa, 2011). In particular, residential OoHC is often fraught with unanticipated events and crises, which can result in poor translation into practice (Aarons & Palinkas, 2007). Evidence suggests that challenges associated with translating trauma-informed care knowledge into practice include the lack of a clear definition of trauma-informed care, a paucity of research on what implementation of trauma-informed models looks like, as well as individual staff practices, siloed funding and limited information on facilitating organisational change in a complex community service organisation (Ashmore, 2014).

To better translate research into practice, and embed and sustain practice in real-world settings, it is important to identify, understand and manage the enablers or drivers that facilitate and the barriers that hinder implementation, the outcomes of the implementation (challenges and successes in obtaining outcomes), and how implementation drivers vary across the organisation (Grimshaw et al., 2020; Herrmann, Carey, Zucca, Boyd, & Roberts, 2019; Mc Goldrick, Crawford, Brown, Groom, & Crowther, 2016; National Cancer Institute, 2020; Nilsen, 2015). Competency, organisational and leadership drivers, particularly the roles of decision makers within an organisation, have been argued to form the building blocks needed for successful and sustainable practice and organisational change, provided they are used collectively (Bertram, Blase, & Fixsen, 2015; Metz & Bartley, 2012). Given the importance of decision makers in the implementation process (Aarons et al., 2015; Palinkas & Aarons, 2009; Straus, Tetroe, & Graham, 2009), the views of managers and executive staff in relation to perceived enablers, barriers, successes and challenges of implementation provide key insights to foster the translation of research into practice.

| | Pillar | Description of Pillar | Components of Each Pillar | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| The Sanctuary Model | Trauma Theory | Overview of information about how traumatic experiences affect the brain and therefore influence thoughts, feelings, and behaviour | | | | | | | | | | |
| | Sanctuary Commitments | Philosophical underpinnings and values of the Sanctuary Model | Non-Violence | Emotional Intelligence | Social Learning | Democracy | Open Communication | Social Responsibility | Growth and Change | | | |
| | S.E.L.F. Framework | Trauma-informed way to formulate plans for client services or treatment as well as for interpersonal and organizational problem solving | Safety | Emotion | Loss | Future | | | | | | |
| | Sanctuary Tool Kit | A set of practical and simple interventions that reinforce the language and philosophy of The Sanctuary Model | Core Team | Supervision | Training | Community Meetings | Team Meetings | Self-Care Planning | Red Flag Reviews | Safety Plans | S.E.L.F Service Planning | Sanctuary Psychoeducation |

**Fig. 1.** The four pillars of The Sanctuary Model.

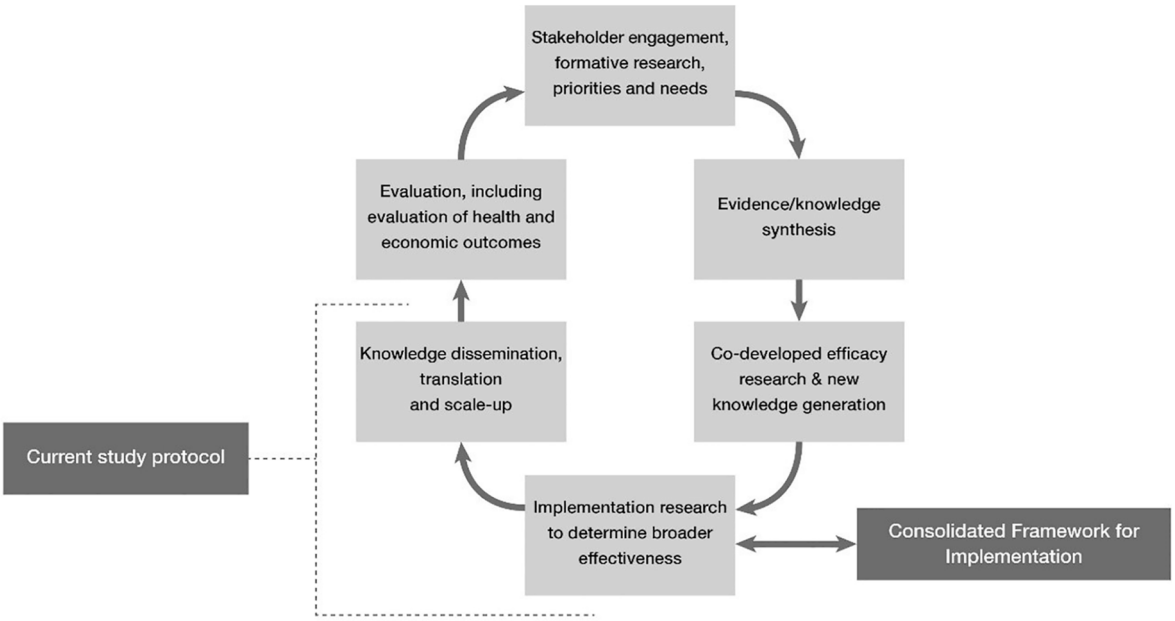


**Fig. 2.** Monash Centre for Health Research and Implementation (MCHRI) framework for knowledge to impact. From: Robinson, T., Skouteris, H., Melder, A., Bailey, C., Morris, H., Garad, R., & Teede, H. (2018). Application of Monash Centre for Health Research and Implementation Framework to the Development of Polycystic Ovary Syndrome Guideline: A Case Study on Implementation.

### *1.5. The current study*

The overall aim of this study was to identify the enablers, barriers, organisational successes and challenges experienced by decision makers when implementing a trauma-informed, organisation-wide model in residential OoHC. The findings of this study will inform enhancements, adaptations and implementation strategies that will be co-designed with key stakeholders for sustainability and continuous quality improvement of The Sanctuary Model.

## 2. Methods

### *2.1. Study design and setting*

This qualitative study involved semi-structured interviews and purposive sampling was used to recruit potential study participants from a pool of senior staff members responsible for strategy and leadership within the residential OoHC program at MacKillop Family Services. MacKillop Family Services is a community service organisation providing services in Victoria, Western Australia, Australian Capital Territory and New South Wales, Australia. MacKillop Family Services provide programs in OoHC (foster, kinship and residential care), family support, alternative education, disability, youth support and heritage and information services. MacKillop Family Services began implementing The Sanctuary Model across its services in 2012 through a collaborative three-year process, provided by the Sanctuary Institute and is supported by a steering committee, core team and local Sanctuary practice teams (LSPTs). All staff at MacKillop Family Services must complete a three-day, Sanctuary training program, at the time of induction.

### *2.2. Ethics*

The study was approved by the Monash University Human Research Ethics Committee (Project ID: 17520) and MacKillop Family Services ethics committee. All participants were provided with an explanatory statement and an opportunity to ask questions, after which they provided informed written or verbal consent prior to taking part in the study.

### *2.3. Participants*

Participants were recruited from MacKillop Family Services for the purpose of this study. MacKillop Family Services have eleven executive staff members across their residential OoHC services, in which eight participated and one HR Manager participated on behalf of one executive staff member.

### *2.4. Procedure*

Nine semi-structured interviews were conducted, each lasting up to one hour. Interviews were conducted either in person or over the phone between September 2018 and February 2019. An interview guide was formulated based on open-ended and non-leading questions, including questions to determine participants' perceptions of the core elements/non-negotiables of implementing The Sanctuary Model, the barriers and enablers experienced during implementation, the ways by which The Sanctuary Model influences their practice and the challenges they are facing and/or have overcome, (see Supplementary File 1 for the Interview Guide). Some questions were asked of all participants, while other questions which came up during one interview, were then included as questions in subsequent interviews. The interviewer also encouraged exploration of responses using a combination of interview techniques (e.g., probing questions, seeking clarification and confirming answers if required). Participants were able to speak freely on the subject which guided the questions asked of them.

### *2.5. Data collection and analysis*

At the beginning of the interview, participants were asked about their level of industry experience and length of time working at MacKillop Family Services. Field notes were taken during and/or immediately after the interviews and were later compared against each transcription. Data saturation was met after nine interviews.

A thematic approach to analysis was taken to explore the common themes between participants in relation to their perceived barriers, enablers, organisational successes and challenges of implementing The Sanctuary Model across MacKillop Family Services. The overarching themes of barriers, enablers, successes and challenges were deductively

predetermined before common themes were identified and codes were defined. Two researchers independently coded and recoded transcripts using NVivo (QSR International Pty Ltd, 2020). Discrepancies were resolved by discussion and the most common and recurrent codes informed the overarching themes. The remaining relevant codes were clustered together as sub-themes. The Consolidated criteria for reporting qualitative research (COREQ) checklist was used to guide the construction of this article (Tong, Sainsbury, & Craig, 2007).

## 3. Results

### 3.1. Participant demographics

Nine upper management and executive staff participated in this study. All participants have over 15 years industry experience and have worked at MacKillop Family Services between 1 and 20 + years. Participant characteristics are presented in Table 1.

### 3.2. Enablers of implementing the Sanctuary Model in residential out-of-home care

Regarding enablers to implementing The Sanctuary Model, the most common themes that emerged from the interviews included: (1) shared trauma-informed knowledge and understanding; (2) leadership and champions; (3) structures; and (4) creativity and flexibility.

#### 3.2.1. Shared trauma-informed knowledge and understanding

When reflecting on what has helped them to implement The Sanctuary Model, participants generally felt that having a "*common understanding of the impact of trauma across the whole organisation*" was imperative to implementation and practice. They acknowledged that understanding trauma was very relevant to their work as "*all the work we do is about being trauma-informed*". Some participants admitted that they approached the Sanctuary training with cynicism, however, they were pleasantly surprised and agreed that having a common language and understanding of trauma and its impacts on behaviour, changed the organisational culture, their own perspectives of young people in care, how they approach a crisis and help the young people understand their own trauma and why they behave the way they do.

> *"We have had staff in the past, that blame these kids and think 'why are they here, get them out of the house, they've damaged that car again'. No one in our team now, would even mention that, they are saying 'oh that poor child, what has happened to him for him to be doing all of this', and that's a real shift in the way that people really think about what happens and those conversations that they have, Sanctuary explains that to them and it all contributes to that general picture"* (P04).

> *"It was unbelievable to see the transition that goes from almost total confusion, feeling as though nobody loves you, you're basically a throwaway item, and then working in a way through to recognising that you have value"* (P08).

**Table 1**
Participant demographics table.

| Participant characteristics | Number of participants |
|---|---|
| **Role** | |
| CEO | 1 |
| Deputy CEO and director of the sanctuary institute | 1 |
| Group director policy and performance | 1 |
| Group director corporate services | 1 |
| State director NSW | 1 |
| Director of clinical services | 1 |
| Director of community engagement | 1 |
| Director of children, youth and family services | 1 |
| HR manager health and wellbeing | 1 |
| **Gender** | |
| Male | 4 |
| Female | 5 |
| **Industry experience** | |
| 10 + years | 6 |
| 20 + years | 1 |
| 30 + years | 2 |
| **Years at MacKillop family services** | |
| 0–5 years | 3 |
| 5–10 years | 3 |
| 10–20 years | 3 |

#### 3.2.2. Leadership and champions

Participants articulated that "*there is a commitment from MacKillop to embed Sanctuary across the organisation*", and that unless you have champions and strong leadership modelling it, you won't be able to *"bring about change, and really embed the practice that's being asked like Sanctuary*". Participants expressed the need for everyone to "*be the leaders in this*", however also acknowledged that "*there will be people who will have much more expertise*" and "*in-depth knowledge of Sanctuary*". Two participants conferred that for implementation to be successful, leadership and/or champions were non-negotiable. All participants felt that, because they are in leadership roles, they must be seen practising the tools and commitments. Although some participants' reasons for practicing The Sanctuary model varied when the model was first introduced, participants expressed that they can now see the value-add of the model. For example, one participated stated that "*I'm not doing it because I've been asked to do it, I actually believe it, and I've seen it change the way we work*", while another stated "*I started using the tools because I felt I had to, and I continue to use them because I feel they are valuable for the team*".

> *"All coordinators and managers and house supervisors should be champions of everything that we prioritise at MacKillop…We know where it has been most successful is when you have your leaders practising it and expecting it. Not, just practising it, but talking about it, setting the expectation"* (P02).

#### 3.2.3. Structures

The connection between the organisation and the structures designed to implement and embed The Sanctuary Model (steering committee, core team and LSPTs) was generally felt as a catalyst of implementing The Sanctuary Model across the organisation. Participants felt as though the connection between the core team and LSPTs helped "*establish the implementation process*", and "*embed it* [The Sanctuary Model] *across the organisation*" because "*the core team challenge the LSPTs continuously*". The steering committee, core team and LSPTs were described by participants as the "*continuous quality management*", practice management, and drivers of the implementation and embedding of The Sanctuary Model. These structures are believed to be the "*conduit*" between implementing and embedding The Sanctuary Model and the organisation. However, it was noted by participants that it is *"really critical"* to have "*frontline roles on core team*", as it "*can just pay off in spades"*.

> *"The local implementation team, we are meeting each fortnight and talking about a whole range of things that are implementation including Sanctuary, so we are checking in regularly about how they are using Sanctuary, what's that looks like, what worked, what hasn't and what they need to do differently, what the gaps are, what the barriers are, and all of those sorts of things. We look at through an implementation science lens"* (P05).

#### 3.2.4. Creativity and flexibility

The flexibility of the model and the creativity of staff when practicing The Sanctuary Model were identified by participants as key facilitators when implementing and embedding The Sanctuary Model. Participants believed that The Sanctuary Model was a good fit for the organisation due to its "*flexibility*" and "*adaptability*" when implementing the model. For example, when discussing the implementation of the Sanctuary

Community Meetings, one participant stated: "of course you don't have to say how are you feeling, you can say how are you tracking, because it's about the meaning of it". Participants also expressed that the creativity from staff when incorporating The Sanctuary Model into practice, encourages other staff to implement the model and for young people to engage.

> *"She organised a zombie apocalypse via evacuation. The whole team got dressed up as zombies and the kids got dressed up as well and then they had this day of activities all focused around zombies, but with a very serious theme of giving the kids the skills that they needed, to know what to do in an emergency. She used Sanctuary all through that process to get to that really positive outcome and they had such a fantastic time and sometimes kids are really resistant to doing that sort of thing but because she made it really fun and incorporated Sanctuary into it, it went off like a dream"* (P05).

### *3.3. Barriers of implementing the Sanctuary Model in residential out-of-home care*

The most common themes pertaining to barriers that emerged from the interviews included: (1) infidelity of the model; (2) lack of practice-based and refresher training; and (3) poor resources.

#### *3.3.1. Model fidelity*

The biggest barrier of implementing The Sanctuary Model was identified by the participants as model fidelity. When reflecting on their own practice, their team's practice and the barriers faced when implementing the model, participants identified that the Sanctuary Tools, such as the community meetings, red flag meetings and psychoeducation were not being used consistently and were misunderstood. It also became evident that some participants were often confused about certain Sanctuary Tools. For example, one participant was discussing their use of safety plans, but kept referring to these plans as the self-care plan, while another participant was referring to the Safety, Emotion, Loss and Future (S.E.L.F) Framework, but kept referring to the components of Emotion as "*Experience*" and Loss as "*Learning*".

Community meetings were identified as a tool that, if used well, *"are a great way of relating to each other and having closer working relationships"*. Despite this belief, participants admitted community meetings are not practiced with fidelity. It was noted that some teams were only having community meetings "*once or twice a week*" and that some people are "*sceptical*", "*lie about how they are feeling*" and "*make up a word each day*". The red flag meetings were generally recognised as a tool of "*last resort"* and only implemented "*when there was a crisis and staff were at an impasse*". Some participants felt as though using red flags was discouraged, with one participant describing the tool as a "*weapon to use when something's not right*". Participants also expressed that people were not using them due to "*confusion about when to use red flags,* [and] *how they are used*".

> *"I feel at times there is an exception, internally, that red flags are a crisis meeting, and that calling a red flag is an indication that there is a problem. It's sort of like they are a mechanism of absolute last resort, there is something wrong if we're having a red flag. I disagree with that. I think that, that perception is felt within my team, it is felt that there is, I'm not saying that there is an express directive to not have red flags, but I think there is an implicit, people perceive, that red flags are frowned upon; and I think that is a problem for us as an organisation"* (P03).

#### *3.3.2. Lack of practice-based and refresher training*

Participants recognised the lack of practice-based and refresher training as a barrier to successful implementation of The Sanctuary Model. Participants expressed their appreciation of the theoretical basis of the Sanctuary training, stating that many frontline staff have some sort of base knowledge in trauma, yet "*we have no training in some of the skills that you might learn in a social work degree*". However, some participants expressed that the Sanctuary training was very "*theoretical*", "*content heavy*" and "*not interactive enough*", and when reflecting on the Sanctuary Model, participants generally expressed the need for more practice-based learning, where they can see the model in practice with young people and can "*think about the more practical, pragmatic ways of using it*" within the residential care homes. There was general agreement among participants that staff should be receiving refreshers in The Sanctuary Model through supervision and team meetings, however, refreshers were not currently offered in a "*regular*", "*organised*" and "*planned way*". Participants conceded that although they remember how "*great*" the Sanctuary training was, they do not remember or think about the training and it does not impact on their daily practice, hence, refreshers would be *"well-received"* and "*valuable*".

> *"In terms of formal training and formal refreshers there hasn't been any, and I think that would be incredibly valuable because there are probably instances at least every week, if not every day, where it would be useful to think can I S.E.L.F this, or use the language of safety plans or self-care; and I don't, because it's just not front-of-mind enough. I have no doubt that a refresher would be valuable"* (P03).

#### *3.3.3. Poor resources*

When participants reflected on the barriers that they have faced during implementation and embedding of The Sanctuary Model, a common theme that emerged was the lack of resources, resources being outdated and resources being hard to access. Participants felt that resources, particularly around psychoeducation, are "*outdated*" and "*too American*". The format and accessibility of resources were considered poor, and participants often described the Sanctuary in Action intranet page as "*messy*", "*all over the shop*", and "*in the wrong format*". Participants also recognised that resources in the residential homes and across the organisation are limited and expressed that better resources are required to better engage the young people in care.

> *"I think that whole area is under-resourced, Sanctuary, the Sanctuary team, the Sanctuary Institute, the clinical staff, and, in every area, I would say is under-resourced…I'm not sure that we have invested in the resources required to be able to really fully embed it"* (P06).

### *3.4. Organisational successes of implementing the Sanctuary Model in residential out-of-home care*

According to the study participants, The Sanctuary Model has been most successfully implemented throughout MacKillop Family Services by means of: (1) the Sanctuary Commitments; (2) the S.E.L.F Framework; and (3) reflective practice.

#### *3.4.1. Sanctuary commitments*

When participants reflected on the successes of implementing and embedding The Sanctuary Model, the Sanctuary Commitments were identified as the "*heart of the organisation*". Participants felt as though they "*live by the commitments*" and that the commitments are "*very real in terms of the work that we do*". It was expressed that staff in residential care and the organisation as a whole act with non-violence, but that open communication was the most successfully implemented commitment.

Open communication was identified as a key component of having difficult conversations with young people about trauma and its impact on the young person, their family and the staff. Participants conveyed that people draw on The Sanctuary Model to speak with respect and openly communicate with each other. They also acknowledged that The Sanctuary Model provided the whole organisation with a shared language, which in turn, facilitated open communication.

*"There will be explicit conversations about trauma, about children and young people's trauma history, but also what happened for this carer, what might be happening for this group of people"* (P05).

#### 3.4.2. Safety, emotion, loss and future (S.E.L.F) framework

The S.E.L.F framework was identified as being "*used pretty widely across the organisation, particularly in residential care*" to analyse difficult situations. Participants felt that the S.E.L.F framework is "*incredibly valuable*" and "*helps us be able to go in and create that safe place to have very open discussions about how people were feeling*". Participants articulated that the S.E.L.F framework is implemented well as "*the nature of our work is that we are quite often involved in challenging communications*" and the S.E.L.F Framework provides a safe space to "*address losses and look towards the future*", particularly when faced with a crisis.

*"I think they do draw on Sanctuary in that respect and certainly when there have been problems like a child death we have used S.E.L.F, and groups of people have used S.E.L.F to talk about how the team are feeling"* (P09).

#### 3.4.3. Reflective practice

Reflective practice was identified as a tool that has been used successfully across the organisation, particularly in residential care. Participants identified that reflective practice has enabled staff to reflect on their day-to-day performance, identify where they need to focus more and share ideas in relation to The Sanctuary Model. They noted that although reflective practice is not a Sanctuary tool, it has helped staff, particularly in residential care, to reflect on challenges faced and to draw on the skills and knowledge of staff within the team to think about the different ways that Sanctuary can be used to approach a challenging situation.

*"Reflecting on their own practice, reflecting on how they have intervened, and what worked, what didn't work. It's taking that step back and thinking about, and sharing ideas, because everybody brings in a different perspective…it's really drawing on the skill and knowledge that is held within the team, and helping the team or the person, with the challenge. To think more creatively or think about different ways of approaching the situation"* (P06).

### 3.5. Organisational challenges of implementing The Sanctuary Model in residential out-of-home care

One prominent challenge identified by participants when implementing The Sanctuary Model was the relevance of the model to the staff and young people. Participants articulated that both staff and young people can be "*very cynical*" and do not understand initially, how The Sanctuary Model can be "*helpful*". Participants expressed that The Sanctuary Model is often seen as "*clinical*" by front-line staff and "*not relevant*" for back-of-house staff, with some participants admitting that they questioned the suitability of The Sanctuary Model for back-of-house staff. Although support of The Sanctuary Model was expressed, some participants admitted to questioning the relevance and suitability of the model to their role and believed that they "*are doing enough, as the model is designed for practitioners and frontline staff*". Participants also expressed that they believe frontline staff view The Sanctuary Model as a supervision management framework, rather than a trauma framework to use with young people in residential care.

*"Sanctuary I think a lot of people don't think about the tools and Sanctuary for using it with kids. I think, they think of it more of a staff to staff supervision management type framework that is helpful to understand how teams operate, but aren't thinking enough about the trauma informed work that they are doing with clients, and what some of the tools are accessible and relevant to working with clients"* (P01).

## 4. Discussion

The aim of this study was to understand the enablers, barriers, organisational successes and challenges experienced by decision-makers, when implementing a trauma-informed, organisation-wide model in residential OoHC. By engaging executive and upper management staff, we gained insights into the perceived enablers, barriers, successes and challenges faced both in residential care and back-of-house services. Not surprisingly, the focal enablers and organisational successes of implementation experienced by staff included leadership, organisational and competency drivers, which, when used collectively, form the building blocks needed for successful and sustainable practice and organisational change.

Leadership drivers distinguish the adaptive and technical challenges of implementation (Bertram et al., 2015). Having effective and engaged leadership and champions that are seen supporting, practicing and encouraging the use of The Sanctuary Model were recognized as core drivers of implementation. This was not unexpected as, according to Metz and Bartley (2012), leadership is a key driver of successful implementation and organisations should ensure that there is leadership buy-in from all levels of the organisation. When implementing an organisation-wide model, staff should be champions or leaders of the model, particularly those who make decisions in relation to the implementation of the model, those who develop protocols, policies and procedures and administrators (Metz et al., 2015). Champions or leaders should be able to provide technical and adaptive leadership where they encourage and support staff to address challenges and overcome disagreement or uncertainty. Participants discussed their implementation of Sanctuary Tools and Commitments when overcoming challenges or disagreements, with particular discussions around using the S.E.L.F. framework for responding to the uncertainty/complex challenge or situation, for example, a young person ageing out of care in the near future.

Organisational drivers create environments where administrative, funding, policy and procedures ensure effective and continuous quality improvement (Metz & Bartley, 2012). The shared knowledge and understanding of trauma-informed care, and the structures developed to support implementation were identified as organisational drivers that shaped a safe, continuous quality and practice management environment. In particular, there was general consensus that the shared knowledge and understanding of trauma (trauma theory) across the organisation, had positive impacts on practice by providing a greater understanding of the trauma a young person may be enduring. The Sanctuary Steering Committees, Core Team and Local Sanctuary Practice Teams were also viewed as driving organisational practice and were perceived as the conduit between implementing the Sanctuary Model and embedding the model, whilst still providing continuous quality and practice management.

Competency drivers are the procedures related to the development, improvement and sustainability of staff's ability to implement a program, which incorporate recruitment, training, coaching and performance assessment (Bertram et al., 2015). Apart from identifying what tools and commitments of The Sanctuary Model have been implemented well, participants noted that reflective practice has also been a successful strategy for boosting and challenging staff's ability to implement The Sanctuary Model. Reflective practice constantly challenges staff to reflect on and deliver regular and systemic practice and participants inferred that reflective practice was or should be included within The Sanctuary Model. Reflective practice was identified as a competency driver due to its nature of encouraging staff to think critically about their and their team's ability to implement The Sanctuary Model, providing themselves with continuous learning.

The current findings suggest that whilst staff appreciate The Sanctuary Model training and the shared knowledge and understanding of trauma and its impact on young people, families and staff, they also feel that there is a need for more tailored, practice-based training and refreshers. A major barrier identified was the lack of up-to-date and

accessible resources and infidelity of the model. Our findings suggest that model infidelity is a result of misunderstanding and confusion around The Sanctuary Model and its purpose. In some cases, where participants identified tools, they described these incorrectly or were confusing the tool for a different tool. These findings suggest that there is a need for systemic, structured practice-based training for frontline residential care staff and practitioners, demonstrating how to practically use The Sanctuary Model in the homes with young people and their families.

The most significant challenge uncovered related to staff questioning the relevance of The Sanctuary Model and viewing the model as a staff-to-staff supervision management framework rather than a model that can be implemented with young people in residential care. Participants acknowledged that prior to undertaking training in The Sanctuary Model and during the first phase of implementation, many staff members, particularly back-of-house staff, questioned the relevance of the model, and clinical staff expressed concern about residential care workers being able to do "*therapy*". Although some participants admitted that they first approached the model with cynicism, all participants stated that they support the model. Unfortunately, it was evident that despite the general support for the model, participants were still questioning its relevance to their role, stating that they are doing enough and that the model is designed for practitioners and frontline staff. This is concerning as research shows that organisational change is not sustained when only the system is adapted (i.e., an organisation-wide model is implemented), but rather requires behaviour change of staff at every level of the organisation (Weiner, 2009). If staff at all levels do not engage and change their behaviours, the organisational structures and systems will not sustain the model or support frontline staff and practitioners to work differently with young people in care and their families (Metz & Bartley, 2012; Weiner, 2009). Some limitations of this study should be acknowledged. The study was conducted in a single community service organisation, MacKillop Family services, which limits the generalizability of our results to other settings or contexts. Given the self-report nature of the data collection, it is also possible that participants in this study responded in ways which they perceived to be more favourable (social desirability bias). For example, participants may have overstated the extent in which they were implementing tools of The Sanctuary Model. Despite these limitations, this study does offer insight into the perceived barriers and enablers and the organisational successes and challenges in implementing The Sanctuary Model within a residential OoHC setting. The qualitative study design facilitated detailed and insightful exploration of executive and upper management experiences of implementing an organisation-wide, trauma-informed model in Australia. Open questioning, the continuation of interviews until data saturation and inductive methods of data analysis were used to maximise genuine participant-driven themes. However, the current study could have been strengthened by recruiting residential care (front-line) staff and young people, as their perceptions would provide an interesting comparison with these findings. Further research on the implementation of The Sanctuary Model in other community service organisations in Australia and from other staff perspectives would be valuable.

Current empirical evidence for the effectiveness of organisation-wide, trauma-informed models implemented across the OoHC is limited, however this paper begins to bridge this gap. Key findings revealed in this study indicate that leadership, organisation and competency drivers are of great importance to successful implementation. Organisations implementing trauma-informed models should focus on how best to support their staff in practice. Results indicate that organisations can support effective implementation through providing pragmatic practice-based training and up-to-date and relevant resources that are accessible. In order to overcome misunderstandings, it is recommended that organisations provide implementation guides for resources and tools that provide not only implementation instructions but also outline the purpose of the resources, and key messages/learning outcomes that should be achieved by implementing the resource/tool. Finally, organisations should strive for continuous quality and practice management. Given the continuous push for trauma-informed care approaches and models globally, more evidence is required, to show that these types of models are effective and lead to improved organisational, staff and client outcomes.

## 5. Conclusions

The core elements of enabling and sustaining The Sanctuary Model in residential care was identified by staff as having strong leadership and champions, a shared knowledge and understanding of trauma, creativity and flexibility and the supporting structures. Results showed that a lack of resources and absence of practice-based and refresher training were major barriers to implementing the model. The development and implementation of resources and training activities may expand understanding of the relevance of the model and increase up-take of The Sanctuary Model within residential care and across the organisation. To sustain and embed The Sanctuary Model in residential care, organisations need to do more than embrace a trauma-informed approach. Organisations need to demonstrate competence, leadership and systemic support, and commit to organisational and behavioural change by providing resources, hands on support, and ongoing practice-based and refresher training, to consistently promote and sustain The Sanctuary Model in practice.

## Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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## Appendix A. Supplementary material

Supplementary data to this article can be found online at https://doi.org/10.1016/j.childyouth.2020.105901.

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