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MULTIPLE OPPORTUNITIES FOR CREATING SANCTUARY

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This article describes the experience of five change agents from a diverse group of settings: two residential treatment programs for children and adolescents, a group home for disturbed adolescents, a residential substance abuse program for urban women, and an acute care psychiatric inpatient unit. What all of these innovators share is a willingness to engage in the challenging and complex process of changing their systems to better address the needs of the traumatized

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children, adolescents, and adults who populate their various programs. Using the Sanctuary Model as originally applied to a specialty inpatient psychiatric program for adult survivors of childhood abuse as their guide, the leaders of each of these organizations discuss the process of change that they are directing.

KEY WORDS: sanctuary; residential treatment; children; substance abuse; adolescent group home; inpatient; seclution; leadership.

INTRODUCTION

The Sanctuary® Model is a template for changing social service delivery systems so that they are better equipped to respond to the complex needs of trauma survivors. The Model is informed by four basic pillars of knowledge: the psychobiology of trauma; the active creation of nonviolent environments; principles of social learning; and an understanding of the ways in which complex adaptive systems grow, change, and alter their course (1–3).

For the last two years, the Sanctuary Model has been applied in a number of other settings including residential programs for children and adolescents (4,5); domestic violence shelters, (6) private and public school settings, a group home setting, a residential substance abuse facility for women, and an acute care inpatient unit. In this article, the primary facilitators of the model in five of these settings briefly describe components of their own experience in implementing the concepts of the model. In the first section, Maggie Bennington-Davis writes from a psychiatric medical director's point of view as she and her staff make the changes necessary to significantly reduce seclusion and restraint and make their unit a safer and more healing environment for both patients and staff. In the second section, Brian Farragher addresses the special issues relevant to being a leader within an organization undergoing the change process. David McCorkle presents the point of view of an outside change agent interfacing with an established system in the third section and in the fourth section, Kelly Nice-Martini speaks from the point of view of line staff workers struggling with helping troubled teenagers to make changes in their lives, while being compelled to change themselves. Kathy Wellbank uses a clinical example to illustrate the challenges faced by an administrator as she helps her organization reshape itself in the final section.

CREATING SANCTUARY FOR THE ACUTELY ILL PATIENT

Maggie Bennington-Davis, M.D.

Salem Hospital is located in Salem, Oregon. The Medical Director of the program is Dr. Maggie Bennington-Davis.. The Psychiatric Unit program managers became increasingly concerned about the rising utilization of seclusion and restraint, particularly given an impending threat of decreasing staff. They also recognized the need to address the background of exposure to violence that is such a predominant part of their patients' histories. Over the course of a year and a half, the program managers organized several Sanctuary training experiences for the staff and integrated the material presented with the work of other collaborators. They have refocused their mission, altered their policies and practices, and their training approach.

On January 1, 2001 Salem Hospital's psychiatric unit began a new approach to acute inpatient psychiatric treatment. The vision was to create an environment where people with psychiatric symptoms could find ways to heal in an environment that was, in every conceivable way, conducive to therapeutic progress. Objectives were defined as increased patient satisfaction and significant decrease in the use of seclusion and restraint. A particularly challenging factor was that the hospital as a whole was in the midst of planning a reduction in work force and redesign of remaining resources with a mandate to maintain the same or better quality of service to the same or increased numbers of patients. While this process was hard on staff members' morale, our hope was to contribute to increased employee satisfaction and to develop an innovative program that would attract and retain excellent nurses, doctors, and therapists.

Salem Hospital is a 400-bed community general hospital serving a catchment area of approximately 350,000 people and the capacity of the inpatient psychiatric service is 22 patients (16 general adults and 6 geriatric adults). The unit is usually full. Salem Hospital is one of several regional acute care units that replaced the state hospital system in Oregon nearly a decade ago. The general adult patients who are admitted are acutely ill with psychiatric symptoms. Seventy percent have symptoms consistent with psychotic disorders or bipolar disorder. Most of the remaining have major depression. Approximately 60% are "dually diagnosed" with comorbid substance abuse disorders at the time of admission. 50% are admitted involuntarily; 65% of patients are experiencing their first hospital admission. The average length of stay

is nine days. More than 95% of patients are discharged into the community, though a small number are transferred for longer-term state hospitalization or to step-down units.

In October 2000, at an all-staff retreat, staff members were introduced to the new vision and objectives, and the work of Dr. Sandra Bloom regarding creation of a "therapeutic milieu." Dr. Bloom's articles and copies of her book, "Creating Sanctuary," were made available to staff members (2). Dr. Bloom began work as a consultant in January 2001 to formally begin the cultural shift away from an environment of containment to one of healing and flexibility. In her work the focus is shifted from the individual to the context of the community (the inpatient population and the staff). The community goal is full participation of its members in its daily life. Treatment is no longer confined to a specific hour or group, but becomes a continuous process in the context of an environment that lends itself to healing. Change occurs because of interpersonal interaction, wherein conflicts and crises are analyzed in the group setting. A group atmosphere is developed via education and discussion in community meetings. There is an acute awareness by staff members of the likely history of trauma, including trauma that has been previously experienced in a hospital setting. As a result, the staff have developed a firm resolve to avoid reproducing trauma during the hospitalization. No controls are used other than social control, and the staff establishes the firm expectation that the patient can and will control impulses. Dr. Bloom talked at length with staff members about trauma theory. Staff members were wary and critical of an approach that was developed with cognitively intact, nonpsychotic patients being applied to involuntary, thought-disordered, acutely symptomatic patients. Dr. Bloom returned for a staff-member "check-in" in April 2001, when staff members had the opportunity to discuss early experiences with the model and discuss individual situations. By April, the resistance initially present among staff members had markedly decreased. Many staff members were reporting increased satisfaction with patient-interactions, and pleasure in working therapeutically with even very symptomatic patients. Seclusion and restraint rates were beginning to fall.

A daily community meeting, which involves most staff members and patients, stimulated the development of an environment of social responsibility. Discussion regarding behavior and its impact in the hospital community is a standing agenda item. Patients and staff members exchange perspectives regarding community activities—including seclusions and other dramatic outbursts. Reactions from all community members, including those directly involved in various incidents

are solicited. Seclusions are "debriefed" both in the context of the community as well as among staff members and the affected patient. Even patients with severe psychotic symptoms or cognitive impairment are usually able to engage in discussion about their experiences and regulate their impulses in an environment with particular cues.

Gradually our staff members identified a goal of designing such an environment, and to look to changes in the environment if patients are unable to maintain their own safety. The vocabulary and language we use is regularly reviewed to avoid words and phrases that are not consistent with our mission. Patient labels, such as "a schizophrenic" are replaced with "Bob, who currently has symptoms of auditory hallucinations and paranoia". "Code" phrases that staff members once used to communicate with one another, such as "let's take control now" are replaced with discussions that include patients. Criminal justice system words are eliminated, such as "contraband," "search," "security check." Even in casual conversation with one another, staff members are conscious of vocabulary and help to remind each other of the impact of words.

Patient expectations are influenced even prior to admission. Information is given to the referring physician, nurse, therapist, or crisis worker regarding our anticipation that staff members will be doing everything possible to create therapeutic opportunities, and that patients behave in safe, nonviolent ways while in the hospital. The admission coordinator speaks with the prospective patient on the phone whenever possible, helping the person to know what to expect. The healing, nonviolent environment is emphasized throughout the admission process, with the reading of our vision, our philosophy, and discussion about what circumstances will most likely lead to successful use of nonviolent coping strategies. The admission process ideally occurs in a comfortable, informally appointed room with family members present whenever possible. New patients are often oriented by other patients to the inpatient unit, which is accented with frequent posters and signs referencing healing and nonviolence, and reminding patients of various coping strategies for problematic impulses. Our current approach represents a stark contrast to a year ago when patients were brought into the locked unit via an "ante" room, often escorted by security officers, and were required to change into hospital garb to eliminate any possibility of "contraband."

One year later, we are well on our way to having achieved a major cultural shift. Patients are included in planning and decision-making for their own treatment, and also for the hospital community. Staff members attend regular training seminars to hone therapeutic skills for early interventions and strategies for coping skills. People with hospital

experiences are invited to in-service discussions. Patient satisfaction surveys indicate considerable improvement, and the patients appear to view positively our community and group focus.

Seclusion and restraint numbers have dramatically reduced. Between 2000 and 2002 we have seen an 87% decrease in the use of seclusion. During April, 2002 we had the highest ever average daily census, number of admissions, and number of discharges but we had *no* seclusions. Hours spent in seclusion per seclusion episode are also decreased by more than 50% compared to a year ago. Our unit has 2 seclusion rooms but it has been more than a year since both were used simultaneously. Staff members have spontaneously suggested converting one of the rooms into more usable space. We have the vision now of eradicating the use of seclusion and restraint entirely. These are values that have emerged among staff members who were initially extremely wary of their ability to keep patients and themselves safe without the use of traditional interventions. Staff members have incorporated numerous alternatives to seclusion and restraint. The admission process itself involves education, setting expectations, understanding patients' coping styles and the events most likely to trigger unhealthy impulses. Intensive interactions with patients occur more frequently and by more staff members. Review and expansion of coping skills are built into nearly every hour of the day. Handouts specific to each patient's circumstances, symptoms, and coping needs are distributed. Posters listing communication skills, relaxation techniques, telephone conduct, and stresses provide touchstones that staff members often refer to.

Staff members are taking more interest in their work and pride in doing their jobs well. Staff members find ways to support each other to accomplish tasks. Direct patient interaction is highly valued. Staff members "cover" for one another so a specific staff member can respond to milieu and group events by facilitating discussion with involved patients at the moment the events occur. Most importantly we are giving patients excellent care, avoiding traumatization and retraumatization, maximizing the chances for therapeutic engagement, and creating a workplace that attracts dedicated, caring professionals.

LEADING THE SANCTUARY CHANGE PROCESS

Brian Farragher, M.S.W.

The Julia Dyckman Andrus Memorial Center in Yonkers, New York, serves about 150 children, 73 in a residential program in Yonkers, New York and the rest in a Day Treatment setting. The Director of Campus

Programs is Brian Farragher, a social worker and candidate for a master's degree in business. The campus includes a self-contained school, The Orchard School. The Sanctuary process at Andrus has involved bimonthly retreats with a multidisciplinary team representing the five key subcomponents of the institution: social workers, childcare workers, teachers, teachers' aides, and the administrators of all five key components. Members of the Sanctuary Senior Faculty have led the Sanctuary Facilitation Team through a training process designed to prepare them to become trainers for the rest of the institution. The team has developed and is currently implementing a curriculum for training their entire staff in the Sanctuary Model.

When we began this project, we knew that over 75% of the children we worked with in the Residential Program and another 40% of the children in our Day Program were victims of serious childhood trauma. Andrus has a long history of a very top down, hierarchical management style. The notion of doing something different, managing or leading in a more open and participatory fashion was both exciting and intimidating. As the leader of this initiative, my initial frustration with the process was not that it was tough to give up the reins of power; the hard part for me was that there was so little interest at lower levels of the organization in picking up the slack and taking more responsibility for decisions. Early on I had to resist the impulse to throttle everyone for their passivity. Doing so would not have advanced the group process but would have only served to confirm their belief that as a leader, I was a scary guy.

The initial challenge for me was to work with this core group in such a way that indicated I was willing to be more democratic and willing to embrace a participatory management style consistent with the Sanctuary Model that we were learning about. In order to demonstrate that I was willing to embrace this style of management I had to sit and wait patiently for their participation. Leaders usually become leaders because they are action oriented. Looking back, the early months of this process were excruciating for me while I waited patiently for something to happen. It is clear now that the patient waiting was essential to moving.

What became apparent in this process is that we have a very entrenched culture and that many members of our staff assume an attitude of learned helplessness not dissimilar to the children that we treat. The line staff tend to kick all decisions "upstairs" and then complain about the awful decisions leaders make. Leaders happily make all the important decisions while they grouse about the impotence of the line staff. These are our roles, our patterns, our culture. I used to think that

if leaders changed, followers would quickly get in line. I found that in the Sanctuary process, when leaders change the first response of the followers is skepticism quickly followed by a frenzied effort to get leaders to behave the way they always have. As a leader I had to hang in there and maintain faith that we were going in the right direction even though we appeared stalled.

In addition to patience I learned that leaders need to role model appropriate behavior at all times. If we were going to move this core team to a place where they could believe we were serious about their participation it would be essential that we not control the process. According to Sanctuary Model principles, we had to listen to opposing points of view, avoid stepping on people's thoughts, welcome dissent and do all of this in a respectful and civil fashion. This is where we began to send powerful messages about the kind of organization and treatment program we hope to become. If we hope to develop a program based on respect and compassion, then leadership has to model these values for all community members. We discussed the uses and misuses of power and recognized that although power will always be unequally distributed in organizations like ours, power does not give us the right to misbehave. If we believe we can treat our staff badly because we are more powerful, then what kind of moral authority do we have to ask our staff to treat the children and their families respectfully? Leaders always need to be the best-behaved people in the organization.

It was challenging for me to be patient with the process and let things unfold, while acting as the leader in what was ideally a democratic process. Ultimately, I had to get comfortable with managing what felt like a hopeless paradox. The first three months of the core team meetings I felt like things were stuck, that we weren't really going anywhere. In retrospect we were exactly where we should have been. My impatience was the problem. Four to six weeks later, when we were in the same place, I finally came to the realization that, although I was a core group member, I was also the organizational leader of the process. As the leader I needed to take greater responsibility for steering things in the right direction.

What has been reassuring in this process is that as the core team has evolved and we have engaged in a more democratic process, the decisions about when to move and when to stay put became easier. Now, when I push too quickly for action the team slows me down and helps me reconsider. When I am slow to move someone on the team pressures me to act. This is consistent with the Sanctuary concept that when things are really working, we are maximizing each other's strengths and minimizing each other's weaknesses. As a core team we have made

a shift in the way we interact and hopefully we have learned some lessons that will position us for making what is actually revolutionary change in the way we manage and provide treatment at Andrus.

THE SHARED EXPERIENCE OF IMPLEMENTING A SANCTUARY COMMUNITY IN RESIDENTIAL TREATMENT FOR CHILDREN

David McCorkle, C.S.W.

Hawthorne-Cedar Knolls is comprised of three residential programs for children and adolescents in Westchester County, New York that is owned by the Jewish Board of Family and Children's Services. As part of a NIMH research project, there are nine pilot units comprising about 112 children living in cottages of about 11–17 children each. These children have a wide variety of emotional and behavioral problems and a majority of them have been exposed to severe violence, multiple placements, and a great deal of loss (4). Many of them are involved in the juvenile justice system.

The beginning of building the Sanctuary Model is developing a shared base of common assumptions which are created in a "culture of participation and citizenship" (3). One of the assumptions is that to create healthier social structures, we need shared assumptions, goals, and practices. When applied in practice, this means that every organization or subcomponent of the organization, needs to create its own constitution involving all members of the community (3). This constitution is meant to be the organizing framework for the day-to-day functioning of the program. Into this web, a work group of administrators, milieu counselors, nurses, social workers and psychiatrists must meet to create a shared set of beginning assumptions and implications which starts the flow of a greater harmony in our mission of helping the children served at JBFCS's residential campus.

In this new Sanctuary paradigm community, all members are essential to the health of the whole organization. These beginning discussions reflected JBFCS's core moral purpose, which is to create a nonviolent health-promoting environment for emotionally disturbed children. The creativity of crafting Mission Statements—a clear defining goal for each unit—for the nine pilot units has been an exercise in being part of a group atmosphere. In some units, residents voted for several of their peers to represent them in a staff meeting. They worked in tandem with staff on their mission statement. This statement was then taken back

to the larger community and voted on as part of a democratic process reinforcing group ownership.

Psychoeducation groups led by the staff, teach how trauma effects children and adults. A phase treatment model called S.E.L.F. (adapted from the model's original adult acronym called "S.A.G.E."in order to make the concepts more "child-friendly) is taught (7). S.E.L.F. is an acronym for Safety, Emotions, Loss, and Future. S.E.L.F. is a shared language for the whole community. Safety plans are developed for children, staff and the community as a whole. Situations constantly occur in which the children act out their past bad environments. The staff is accustomed to responding to "bad" behavior with a strict behavioral and often punitive response. A vital part of the Sanctuary Model is that the staff learn how to ask different questions and take different approaches to the "E"—Emotions—the children experience, that still provide clear structure and consequences but are not punitive. A Sanctuary question is not, "What did you do?" but "What happened?". The task of the professional and resident community is to ask "What did you learn from this situation?" and to guide them to find other ways to express their emotions and their losses, while still assuming responsibility for their behavior. The need for working with "L"—losses—is to help children understand how healing from loss is connected to emotions and safety and that this is connected to a better future" (8). The "F" of future is to help the kids know that they have choices and encourages them to repeatedly envision a different future that is not a reenactment of their traumatic pasts.

Community meetings are held daily following a Sanctuary protocol and will soon be expanded to twice daily meetings, co-led by staff and residents. Community meetings are at the heart of the Sanctuary Model reflecting the core assumptions that all development originates in a group (family) context and that a primary job of the community is to provide people with a corrective emotional and social experience in the context of a group. The protocol of the Community Meetings is very simple and relates to the S.E.L.F. model. The purpose of the community group is to keep the entire community (staff and residents) safe. The assumption is that violence is a symptom of a breakdown in social order and is not just an individual but a group problem (2). The regularity of the meetings daily reinforces the notion that we are all part of something bigger and meaningful, and that we each have a role to play in keeping the community safe.

Another component of the Sanctuary Model's ecological approach allows for the exploration of the "bystander effect" on the staff. The impact of hearing the violent case histories, as well as becoming involved

in traumatic reenactment scenarios with the residents, leaves many staff reacting to the toxic effects of "secondary traumatization" (9). The need to maintain safety, boundaries and to prevent further reenactments requires us to do cooperative work. The split between clinical and childcare staff has been a significant part of our institutional history (4). The healing of that split through sharing power, especially healing power, is part of the Sanctuary assumption that everyone in a milieu must see themselves as part of, influenced by and responsible to the group-as-a-whole (2).

Sanctuary has helped us refocus on our moral purpose wherein we have open and honest group discussions about making a difference in the lives of the children we hope to help. We are learning the value of being part of a cooperative group. The connections that we have formed by trying to facilitate a Sanctuary community with shared assumptions and a clear moral purpose have emphasized that it is relationships that make a difference

CRR GROUP HOME

Kelly Nice-Martini, B.A.

The CRR Group Home is a small residential facility for ten troubled adolescent boys and girls in Wilkes-Barre, Pennsylvania and the Director of the program is Kelly Nice-Martini. The staff have been involved in five day and a half long workshops over the last year and a half with the Sanctuary team, and have additionally had regular supervision with a local trauma therapist.

Children enter the Community Residential Rehabilitation group home from a variety of other settings—residential treatment facilities, foster homes, natural homes where the children have been unable to improve. Most of the children are involved with child protective services. The children usually stay in the home for about six months to a year. They are all voluntarily admitted and come already labeled with various diagnoses including ADHD, mood disorders, oppositional defiant disorder, and other personality problems. Whatever diagnosis they carry, violence and aggression are problems for most of the children. They have difficulty expressing themselves in words and are more likely to act-out their internal conflicts. They have serious family difficulties; have often been exposed to child abuse, family violence, and other kinds of overwhelming stresses. They have usually been in many previous placements and are very hesitant to acknowledge the difficulties they have and are reluctant to trust adults.

These children present extraordinary challenges for the staff. For the most part, the staff members receive on-the-job training. They are mostly high school graduates, some have associates degrees, and others are currently attending school. They earn very little and as a result it is difficult to hold on to staff members who are stable, experienced, and qualified. What they learn, they learn on the job, shepherded by their peers but staff members often leave after they have gained valuable experience in order to find better pay.

The model we previously used focused on the behavior the kids were manifesting—particularly the negative behavior. We saw our job as being that of modeling, redirecting, or reshaping this behavior. We did not focus on the thoughts that went along with the behavior, or where the behavior came from—at least not consistently. Behavior modification was what the group home was about: the kids acted badly and our job was to modify that behavior.

We assumed that the children knew how to do things they were supposed to be doing and when they didn't follow our direction, we assumed that they were just being defiant. We never considered that they really did not know how to do the things we were asking them to do because from our perspective—that of having had reasonably good parenting—it never occurred to us that these kids could have the defects that we have discovered they have. Since our job was to somehow alter their defiant behaviors, a great deal of staff time was taken up wrestling for control. Our punitive responses to their behaviors, and then our escalating efforts to get them to control themselves resulted in a repetitive cycle of escalating emotions that would frequently lead to acting out and violence. In retrospect I see that we actually spent very little time struggling to understand why the kids do what they do, or what brought them to any particular crisis point, nor did we consistently strategize the best way to respond as a group to alter that child's repetitive patterns.

We started attending the Sanctuary trainings and almost immediately began applying what we were learning to our practice because the new information we learned about the impact of trauma was so consistent with the behavior we had been seeing in the children. As a result, we became more patient. We tried to figure out the factors that contributed to a child's behavior at any point in time. We began looking at the children in a different way. Instead of seeing them as "bad" kids, we developed a better understanding of what they had been through in their lives and as a result the compassion among the staff increased. The staff demeanor towards the children has become more positive and by connecting what the child does in the present with his or her past experiences, we are taking their behavior less personally. We

also became more consistent in our approach because we had a framework that helped us all "get on the same page." As a staff we are more unified and more able to speak with one voice. We have reduced our control struggles and now attend to simple things like paying attention to our vocal tones, our mannerisms, our attitudes and what we are each conveying to the children and the rest of the staff. At the same time treatment has become more reality based and we are not "tippy-toeing" around very sensitive issues because we now have a better idea of how to address those issues.

We are more able to deescalate situations and have developed signals to use among ourselves when we see one another caught in a power struggle with a child. By utilizing these signals we can come to each other's aid before the situation escalates out of control, or we can signal to another one of our team members that we need assistance in doing that. We are more able to step back and avoid getting caught up in an unnecessarily tense situation. We have become much better at "choosing our battles" and have begun to rely more on the kids to take responsibility for the well-being of the home that is theirs as well as ours. We involve them more in decision making, give them more choices, giving them opportunities to see that what they do affects everyone in their life space. We do our best to model the norms that we want the children to adopt.

The impact of all this has been dramatic. Counter-aggressive acts between residents and staff have significantly decreased. From September, 2000 to December, 2000, forty-one therapeutic holds were utilized. We attended the first Sanctuary training in January, 2001 and from January, 2001 to December, 2001 there were only forty-four therapeutic holds for the whole year. From March, 2001 to March, 2002 none of the residents required hospitalization—a significant change. Oppositional behavior on the part of the children has decreased by at least half. The overall atmosphere is more relaxed, less tense and less loaded with conflict.

The kids are more invested in the house. They are more goal-oriented and aware of the issues they need to face and work on. Acts of violence and aggression have decreased significantly. There are fewer complaints about staff, less splits between staff and children. The kids are starting to show displeasure in each other when the environment is disrupted, when in the past they would have joined in the disruption. We have begun to implement community groups once a week to focus on overall group home issues.

The results of changing our system are tangible, but difficult and challenging to maintain. It is a rigorous discipline for the staff as well

as the clients. The staff must always be aware of the role modeling aspect of their job and this is an uphill battle when the staff is constantly changing. It seems that just as we succeed in achieving a critical mass of experienced staff and things are going smoothly, a key staff member or several key staff—leave again. This is continually problematic, particularly since we now realize how vital it is for us all to be consistently on the same page.

IMPLEMENTING THE SAGE MODEL INTO A WOMAN'S SUBSTANCE ABUSE PROGRAM: REASSESSING OUR DISCHARGE CRITERIA

Kathy Wellbank, L.S.W.

Interim House is a long-term residential program for impoverished women who are substance abusers and victims of violence. The Executive Director of the program is Kathy Wellbank, a social worker. Many of the women in the facility have been previously incarcerated. Over the course of a year, a training team of Sanctuary faculty met with the entire staff in a series of eight trainings in order to introduce the Sanctuary concepts and integrate this framework into the existing substance abuse treatment model, including "translating" the S.A.G.E. concepts into 12-Step language.

Interim House, founded in 1971 and one of the first gender-specific substance abuse programs in the country sought the assistance of Dr. Bloom to implement the Sanctuary Model, due to the increasing number of women in addictions treatment who are recognized as suffering from trauma-related psychiatric diagnoses, such as depression, dissociation and anxiety disorders. Over the last several years, Interim House has become increasingly aware that in order to maximize treatment outcomes, core treatment issues of trauma and psychiatric disorders must be fully integrated into the treatment program. Evidence suggests that without addressing the underlying causes and factors associated with substance abuse, especially histories of violence, female substance abusers will continue to be vulnerable to relapse, recidivism, and future victimization. A previous study found that 81% of the women at Interim House had suffered from abuse (10).

One incident provides an example of how Interim House incorporated the SAGE concepts into our treatment program (7). S.A.G.E. provides an easily understandable framework to organize a treatment response, even for very complex problems. One day all of the clients

were attending an HIV/AIDS education group. A physical fight broke out between two of the clients, a situation that previously would have resulted in the discharge from treatment of all involved parties. Instead of responding automatically, we decided to address this problem from a S.A.G.E. perspective. Over the course of the next few days, many steps were taken to use the experience as a social learning tool for all of us.

We began by assessing the immediate safety of the two involved parties and by working with them to develop a Safety plan that would reduce tension. Our immediate response was a demonstrable example of Affect Management, as various members of the staff worked individually with the two combatants and then with the other clients in the house to restore a sense of calm.

The next step was to ensure the overall sense of safety of the community as a whole. Through special community meetings, the entire community was included in this process while being reassured that the staff wanted to carefully address the crisis in a thoughtful way. These efforts served to restore peace to the environment and the first day closed without further incident.

The next day, the Program Director met with therapists, clinical supervisor and the Assistant Director and informed the staff that our current discharge policy stipulates that "fighting" is grounds for discharge/transfer. We decided to use this incident as a way of re-assessing the existing policy, given the recent trainings we had in trauma and its impact. This led to a complex conversation among the staff addressing issues of safety for the clients and community, our fear of condoning physical aggression, our concerns about the counter-therapeutic effects of discharging the clients involved in the dispute paired with our concerns about appearing inconsistent to the rest of the community. Important questions were raised: Since we view relapse as a part of recovery, couldn't this situation be viewed as a relapse in behavior?; Could the clients and the community utilize this incident as an opportunity for healing and growth?; How could we include the community of clients and staff in this process—making the decision more democratic so everyone felt safe?

The staff agreed that the clients should remain in treatment due to four major factors: Both clients had significant trauma and violent histories and therefore an expectable part of their symptom picture is the resort to violence; both clients had demonstrated motivation to be in treatment before this incident; both clients were extremely remorseful and willing to learn from the experience; and part of the problem was the group facilitator's lack of group experience in resolving conflict.

By engaging in this complex group decision-making and problem solving exercise typical of the Sanctuary approach, we realized that it would be counter-therapeutic to discharge the clients and NOT discharging them would be consistent with our policy on positive drug screens. The program does not discharge clients for one "hot" urine—we allow a positive drug screen to be used as an opportunity for growth. Instead of automatically and simplistically discharging these clients, we would treat this aggressive behavior as a "relapse" and institute individual safety plans for each client. We decided that we would get feedback from the clients and ask them for input into the decision, while retaining our responsibility to make the final decision.

The three program therapists met with all of the clients to get their input, as to what they were feeling about the incident and what they believed would be best for both women involved in the fight: allow them to remain in treatment, or discharge them from the program. These proceedings were difficult but powerful experiences for the two women involved in the fight and led to an increase in self-revelation while providing a powerful social learning experience. It even led to the opening up of Grieving issues, as the incident triggered the women with reminders of their difficult childhood experiences.

The staff then asked the community how it would feel if both clients were permitted to remain in treatment. The community's response reflected the view of the treatment team. They indicated that both women should remain in treatment so they could learn how to manage their feelings and express themselves in more positive ways. The community felt safe and believed that the clients could learn from this experience. No one wanted them discharged.

Two and one-half months have passed since the incident and there have been no further incidents of violence in the community. Both of the women involved in the fight have made difficult changes in treatment and although they both have a long way to go in their recovery, they remain actively engaged in the process.

This example provides one illustration of the ways in which we have been influenced by our growing knowledge of the impact of trauma on our clients and on the way we work together. If this incident had occurred prior to the Sanctuary/SAGE training, the outcome would have resulted in an unsuccessful program outcome. Both clients would have been summarily discharged. The clients, the staff, and the whole community would have missed an important social learning experience. However, due to the staff's elevated awareness of trauma and our willingness to wrestle with greater complexity the outcome was much more positive. Our outcome has ramifications for other residential treatment

programs in reassessing their discharge criteria. Due to the horrific histories of women in many addiction treatment settings, it is critical that aggressive behavior directed at the self and at others be viewed similarly to a positive drug screen—as part of the recovery process indicating a need for increased, not decreased supports for the involved parties while still maintaining the safety and integrity of the community and the program goals.

CONCLUSION

As the authors of this article, and any practicing therapist or psychotherapy client can attest to, change is difficult and changing an entire system compounds the difficulties. And yet change is a hallmark characteristic of all living systems—the most stable equilibrium is *death* (11). The objective of the Sanctuary Model is to help systems move out of the rigid equilibrium that typifies so many hierarchical organizations, thus enabling them to develop the flexibility in leadership, decision making and therapeutic response that complex situations demand, without deteriorating into chaos and violence. This can only be accomplished within an environment that actively promotes nonviolence, a willingness to constantly enhance learning within a social context, and a compassionate regard for survivors of overwhelming experience.

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