The challenges that children in intensive therapeutic treatment are up against are complex and often originated in exposure to multiple forms of adversity. In brief, these children have (1) difficulty with maintaining safety in interpersonal relationships largely due to disrupted attachment experiences and the erosion of trust that accompanies such experiences; (2) significant challenges in adequately managing distressing emotions in ways that are not self-destructive, including exercising the capacities for self-discipline, self-control, and willpower; (3) cognitive problems, particularly when stress occurs and the development of essential cortical functions has not gone smoothly; (4) problems with open and direct communication at home and at school that pose significant challenges because they frequently communicate through behavior, not directly, openly, or in words; (5) feelings of helplessness and powerlessness in the face of a world that they perceive as unjust and cruel, and as a result, may be repeatedly bullied or become bullies themselves; (6) no clear sense of social responsibility even into adulthood, and their moral development may have been affected by disrupted attachment experiences and inadequate role models; (7) likely experienced significant loss while lacking the capacity to grieve secondary to the emotional management problems; (8) a tendency to repeat the experiences that are a part of their past; and (9) often a lack of any hope that the future will be any better than the past, while their emotional and cognitive
challenges interfere with the capacity to plan ahead and tolerate delayed gratification.

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

What characteristics best describe people who are able to do this challenging work? They need to be secure, reasonably healthy adults, who have good emotional management skills themselves. They must be intellectually and emotionally intelligent—and the latter is probably even more important than the former. They need to be able to actively teach new skills and routines while serving as role models for what they are teaching. There are constant demands on them for patience and for empathy, so they must be able to endure intense emotional challenge. As they balance the demands of work and home, managers and supervisors, children/clients and their own families, they must be self-disciplined, self-controlled, and never abuse their own personal power.

Given this description, it becomes easier to understand why, as a society and in particular in its mental health and social service systems, we are facing a workforce crisis. As a national report has stated, “A growing proportion of the U.S. workforce will have been raised in disadvantaged environments that are associated with relatively high proportions of individuals with diminished cognitive and social skills” (Knudsen, Heckman, Cameron, & Shonkoff, 2006, p. 10153). Given the rates of exposure to childhood adversity in the general population, staff members at all levels of social service and other mental health organizations are likely to have their own past histories of experiences that are not entirely dissimilar to the people they are supposed to help, and they may have unresolved interpersonal challenges that are also not dissimilar (Felitti & Anda, 2010). In a recent survey of a residential treatment setting for children, almost three-quarters of staff respondents to the Adverse Childhood Experiences (ACE) questionnaire had an ACE score of at least 1 and 16% had an ACE score of 4 or more (Esaki & Larkin, 2011), making this issue a significant part of the workforce crisis.

Additional factors play an important role in this crisis. Extraordinary
demands are placed upon social service workers who are paid low salaries and whose organizations receive inadequate funding. The job complexity and ambiguity is high whereas the payoff is low, particularly for those in any type of institutional setting where the least educated, trained, and supervised staff spend the most time with profoundly injured children. And these workers are not in environments that are safe. Forty-eight percent of all nonfatal injuries from occupational assaults and violent acts occur in health care and social services (Occupational Safety and Health Administration, 2004). In fact, after law enforcement, persons employed in the mental health sector have the highest rates of all occupations of being victimized while at work or on duty (Bureau of Justice Statistics, 2001). Actual rates of violence expose the problems with physical safety, but there are other safety issues as well that can be thought of as threats to psychological, social, and moral safety.

Thus, although working with traumatized children can be stressful, the main causes of workplace stress cannot be laid at the feet of the children and their families: “The main sources of stress for workers are the ways in which organizations operate and the nature of the relationships that people experience within the work setting” (Bloom & Farragher, 2010, p. 70). This is not an individual problem but a social one, partly due to controllable but severe dysfunctions within those organizations and largely related to inadequate and unscientific paradigms for intervening in the lives of traumatized people, families, and communities.

Managing Organizational Culture

The Sanctuary Model is designed to address these dilemmas by intervening at the level of organizational culture in order to change the habits and routines of everyone in the organization and the organization as a whole. The Sanctuary Model is an evidence-supported, theory-based, developmentally grounded, and trauma-informed methodology for helping all members of staff and whole organizations to become healthier while achieving better outcomes for the populations they serve. The Sanctuary Model is firmly rooted in 18th and 19th century Quaker philosophy and its practical application as “Moral Treatment,” an early attempt to apply principles of relational nonviolence to the treatment of the mentally ill, with dramatically good results (Bloom & Farragher, 2013). Two other important historical movements occurred following the devastation of World War II that have influenced the development of the Sanctuary Model: the democratic therapeutic community movement (Whiteley, 2004) and the human rights movement, particularly in reference to the universal human reactions to overwhelming stress (Bloom, 2000). The Sanctuary Model programs were originally developed from 1980 to 2001 in a short-term, acute inpatient psychiatric setting for adults who were traumatized as children (Bloom,
The Sanctuary Model is currently being used as a systematic organizational change process for over 250 human service delivery systems around the country and internationally, many of them serving children and adolescents.

A computer metaphor is most useful in conveying the significance of this model. An operating system in a computer is the master program that controls the computer's basic functions and allows other programs to run on the computer if they are compatible with the operating system. As our understanding of trauma survivors has grown, we recognize that exposure to severe and overwhelming trauma, particularly when it begins in childhood, disrupts the individuals' normal development of brain and mind— their "operating system"—resulting in profound "software" problems, as described above, and a personality that has become "trauma-organized" (Bloom & Farragher, 2010).

Similarly, organizational culture represents the operating system for an organization. Every organization has a culture that represents long-held organizational patterns, routines, and habits that, although remembered and taught to every new employee, are largely unconscious and automatic, as most habits are. The nature of the organizational culture largely determines whether or not the organization is able to fulfill its mission and reach its stated goals. Organizational culture may or may not be aligned with the actual values and mission that the organization claims to follow (Schein, 1999). Alignment of values is usually seen as management-driven, if it is referred to at all, and mental health and social service organizations are at a distinct disadvantage in this regard.

Within social services and mental health organizations, there is no universal requirement for anything that resembles management training. CEOs and CFOs may have had training in their background if the organization is large and especially if they came up through the ranks of some other business sector. They are also more likely to have MBAs or some administrative degree that at least academically qualifies them for the job of managing other people. But the key middle managers who actually set in motion the routines that guide daily interactions with staff, children, and families usually are promoted from within the organization or at least from within the social service, education, and social work professions. The training these professionals typically receive is whatever they experienced being managed by other people in similar circumstances—beginning, of course, with their own parents.

Contrast this process with an organization such as Starbucks, where even a newly hired high school dropout working as a barista in the first year will spend at least 50 hours in Starbucks' classrooms, and dozens more at home with Starbucks' workbooks and talking to the assigned Starbucks mentor. Or consider the Container Store, where employees receive more than 185 hours of training in their first year alone. They are taught to recognize what to do when confronted with an angry coworker or an
overwhelmed customer, and they rehearse routines for calming shoppers or defusing a confrontation (Duhigg, 2012).

Not so for staff in our caregiving institutions who must engage in the emotional labor of spending 8–12 hours a day trying to help some of the most wounded, suffering, and sometimes dangerous children and adults on the planet to heal and recover from the adversity that life has dealt them. This startling contrast sums up what is a social, political, and economic problem, not a professional one. Starbucks is selling coffee; the company is enormously profitable, and its management realizes that continuing profitability has as much to do with the good service of employees as it does with the quality of their brew. We, on the other hand, are trying to develop and change minds and rewire brains, and our society has not yet awakened to the fact that not changing those brains is costing our society uncounted billions of dollars every year. The Centers for Disease Control and Prevention estimate that child abuse and neglect alone cost us $124 billion a year (Fang, Brown, Florence, & Mercy, 2012).

Compound the lack of adequate education, preparation, and training with breaches in basic safety; diminished funding; an unstable reimbursement system; social devaluation of caregiving work; and an inadequate theoretical framework for delivering services—and we end up with hauntingly parallel processes wherein symptomatic behavior is replicated at every level—client, staff, management, organization (Alderfer & Smith, 1982). The fundamental rationale for the Sanctuary Model is to create parallel processes of recovery by radically altering the operating system for organizations as a whole and for everyone who has contact with that organization. That means intervening at the level of organizational culture in order to change the habits and routines of everyone in the organization as well as the organization as a whole.

**Key Features of the Sanctuary Model**

The Sanctuary Model is structured around a philosophy of belief and practice that shifts organizations' existing ways of operating in approaching the treatment of traumatized children and families. To make such a shift, organizations must identify the habits and routines that are not compatible with developmentally grounded, trauma-informed care, and develop new and more useful habits and strategies. Organizational change of this sort requires radical alterations in the basic mental models upon which interventions have traditionally been based; without such change, treatment is bound to fall short of full recovery or to fail entirely. Mental models exist at the level of very basic assumptions, far below conscious awareness and everyday function, yet they guide and determine what individuals can and cannot think about and act upon (Senge et al., 2000). An explicit change in mental models must occur in the leaders of an organization and the staff
in order to change their implicit models, and then to teach these new mental models to the children and their families.

The term creating Sanctuary refers to the shared experience of creating and maintaining physical, psychological, social, and moral safety within a social environment—any social environment, but especially one directed toward mental health treatment—and thus reducing systemic violence. The process of creating Sanctuary begins with getting everyone on the same page—eliciting, sharing, arguing about, and finally agreeing on the basic values, beliefs, guiding principles and philosophical principles that are to shape attitudes, decisions, problem solving, conflict resolution, and behavior (Bloom & Farragher, 2013). The Sanctuary Model is built upon four pillars that are described below: Trauma Theory, the Sanctuary Commitments, S.E.L.F., and the Sanctuary Toolkit.

Trauma Theory

Although the impact of overwhelmingly horrific experiences—natural or humankind—has been recognized throughout history, the modern scientific study of trauma originated in the disasters, terror, and wars of the 20th century (Bloom, 2000). Trauma Theory has challenged and undercut many “sacred cows” involving centuries of reductionism best characterized for those of us in mental health by either “mindless” or “brainless” psychiatry (Eisenberg, 1986). It has demonstrated, among other things, the interconnected and interdependent nature of human biology, psychology, sociology, and morality.

As the study of psychological trauma has developed, much has been learned about the entire stress continuum and the extent to which stress, particularly repetitive conditions over the course of childhood, can impact normal development (usually, if not always, adversely). Along with the expanding field of interpersonal neuroscience we are learning how limited our freedom really is, since so much of behavior once learned becomes automatic and runs outside of conscious awareness. As it turns out, what we call “free will” is not nearly as free as we would like to believe it is (Gazzaniga, 2011). At the same time, much is being learned about how the social milieu can influence the brain, now known to be more malleable and “plastic” than was once assumed, and how important belief, faith, meaning, and purpose are in changing the brain (Duhigg, 2012).

In the Sanctuary Model, everyone in an organization needs to have a clear understanding about how toxic stress and trauma have affected the children served, and often the staff as well. Furthermore, it is vital that everyone recognizes that unacknowledged and unaddressed stress responses can result in problematic and unhealthy behaviors in both clients and staff. This understanding can be liberating and can lead to major changes in attitudes and behavior. One comprehensive training manual and accompanying training materials on the definitions and impact of traumatic stress...
on human development are provided for all of the clinical staff who have
direct contact with children and families and another for all of the indirect
care staff (i.e., administrative assistants, finance officers, maintenance and
food service staff, and all the other people who are necessary to keep an
organization functioning) (Sanctuary Indirect Care and Direct Care Staff
Training Manual).

The Sanctuary Commitments

The seven Sanctuary Commitments represent the guiding principles for
implementation of the Sanctuary Model, the basic structural elements of
its “operating system.” Each of the commitments supports trauma recovery
goals for children, families, staff, and the organization as a whole. The
commitments are designed to create a parallel process that provides sup-
port for the organization and its staff at the same time as they provide an
environment of recovery. Other than the newer scientific findings regard-
ing stress, trauma, and attachment, these commitments represent universal
principles typical of all human rights cultures. They become the norms that
structure the organizational culture and make it easier for organizational
leaders to consciously and deliberately apply the principles to whatever they
do.

For the organizational climate to be ethically consistent, the Sanctuary
Commitments need to be embraced by the board of directors and senior
leadership, conveyed throughout the organization, through middle man-
agement, to the direct care and support staff and ultimately to the children
and families. Often, when organization leaders hear the seven commit-
ments, they assume that the commitments already guide their organiza-
tional culture. In many cases this is at least partially true since it is likely
that there are many divergent views of these commitments and what they
mean and how to actualize them in everyday interactions.

The change process, however, can be frightening for organizational
leaders, and they rightfully perceive significant risk in opening themselves
up to criticism when they attempt to level hierarchies and share power. The
gains can be substantial, but a leader only finds that out after learning how
to tolerate the anxiety and uncertainty that inevitably accompanies real
change. It should also be noted that change does not occur just because
a leader wants it to. Leaders may be willing to share power with others,
but this does not necessarily mean that those others are always willing to
assume power and the responsibility that comes with it. Although staff and
clients may indicate that they want a greater voice, creating the conditions
in which they have one is not always welcomed. It is easy to stay in or slide
back to a familiar and comfortable nonparticipatory arrangement.

The challenge in the Sanctuary Model is to establish and maintain
a value-based system, even in the face of what are extraordinary ethical
dilemmas, the kinds of dilemmas that human service delivery professionals
encounter every day (Bloom & Farragher, 2010). All sorts of tensions exist within any meaningful value system. The Sanctuary Commitments are trauma-informed objectives that apply to children and their families, staff, and the organization as a whole. They are not cure-alls. Inevitable conflicts, unintended consequences, and unforeseeable circumstances will need to be resolved each day in each program, requiring judgment and flexibility. Organizational processes are needed that provide enough structure to be able to respond flexibly in ways that support the emergence of innovative solutions to complex problems. The seven Sanctuary Commitments are described in fuller detail in Bloom and Farragher (2013) and are summarized in Figure 15.1 (Bloom & Farragher, 2010).

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

S.E.L.F. is an acronym that represents the four key interactive aspects of recovery from bad experiences. S.E.L.F. provides a nonlinear, cognitive-behavioral therapeutic approach for creating new, developmentally grounded, trauma-informed routines for facilitating change, regardless of whether these routines involve individual children, families, staff problems, or the organization as a whole.

S.E.L.F. is a compass that allows the exploration of four key domains of healing:

1. **Safety**: attaining physical, psychological, social, and moral safety in self, relationships, and environment.
2. **Emotional management**: identifying various emotions and their levels of intensity and modulating emotions in response to memories, persons, events.
3. **Loss**: feeling grief and dealing with personal losses while recognizing that all change involves loss.
4. **Futures**: trying out new roles and ways of relating and behaving as a “survivor/thriving” to ensure personal, professional, and organizational safety, to find meaning, to make more viable life choices, and to help others. A focus on the future compels imaginative planning and to think ahead in ways that may have previously been precluded by ongoing posttraumatic symptoms.

While using S.E.L.F., the children, their families, and staff are able to embrace a shared, nontechnical language that is neither blaming nor judgmental. It allows all to put the larger recovery process in perspective, recognizing that safety issues may crop up repeatedly as the child wrestles with painful feelings and memories. Accessible language demystifies what sometimes is experienced as confusing and even insulting clinical or psychological jargon that can confound children, families, and even staff.
GROWTH AND CHANGE
- All change means loss but human intention can change the future

DEMOCRACY
- Complex problems require complex responses

NONVIOLENCE
- Physical, psychological, social, moral safety

EMOTIONAL INTELLIGENCE
- Human behavior makes sense if we have information

SOCIAL LEARNING
- Mistakes happen and we must learn from them

OPEN COMMUNICATION
- Information is the flow of life so communication must be open and direct

SOCIAL RESPONSIBILITY
- Social justice is the key to a peaceful, nonviolent society

**FIGURE 15.1.** The Sanctuary Commitments.

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

As a result, it is easy for staff and children to get stuck on safety issues. When someone is doing something that is obviously dangerous, it is hard not to focus entirely on that danger. But an exclusive focus on physical safety may lead nowhere if underlying issues are not identified and addressed. S.E.L.F. functions as a kind of compass to get participants out of the maze of confusing symptoms. By using these four apparently simple concepts that actually are like the cardinal points of a compass, helpers and children can rapidly organize problems into categories of safety, emotions, loss, and future, which then can lead to a more complex treatment or service plan. It has the added value of conveying an implicit message that it is possible to change what has previously seemed insurmountable by "chunking out" the chaos of people's lives into more manageable bits—without losing sight of the complexity of the challenges.

But S.E.L.F. is not only applied to the children and their families. In parallel, these compass points represent problems that arise within the treatment or service setting between staff and children, among members of staff, and between line and support staff and administrators. Applied to
such issues as change management, staff splitting, poor morale, rule infra-
ction, administrative withdrawal and helplessness, misguided leadership,
and collective disturbance, S.E.L.F. can also 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 actualize, 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 the possible present and potential
safety issues in making change, but also in not making change.

The Sanctuary Toolkit
The Sanctuary Toolkit includes a range of practical, routine skills that
enables individuals and organizations to develop new habits and deal with
difficult situations more effectively, build community, develop a deeper
understanding of the effects of adversity and trauma, and build a common
language and knowledge base. Community meetings and universal safety
plans promote a focus on social responsibility, democracy, and nonviolence
on a routine, daily basis. The Sanctuary Toolkit “rewires” the organization
and, in doing so, opens up new pathways for communal problem solving.

Many of our tools are organized around S.E.L.F.; we teach S.E.L.F.-
based treatment planning, psychoeducation, team meetings, and organi-
zational assessment, and we use S.E.L.F. to structure red flag reviews
(i.e., emergency team meetings called to deal with an urgent concern). 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 the children 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 bidirectional
focus helps everyone to see the interactive and interdependent nature of
their shared lives.

Implementing the Sanctuary Model
The Sanctuary Institute
The Sanctuary Institute is a five-day intensive training experience on the
Sanctuary Model. Teams of five to eight people, from various levels of the
organization, come together to learn from our faculty, who are colleagues
from other organizations implementing Sanctuary. Together teams begin to
create a shared vision of the kind of organization they want to create. These
teams will eventually become the Sanctuary Steering Committee for their
organization. The training experience usually involves 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 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. Many of these questions have not been raised because participants have never felt safe enough to speak their minds or their hearts, even after many years of working together. Although the continual focus is on the fundamental question of “Are we safe?,” participants quickly learn that in the Sanctuary Model, being safe means being willing to take risks by being willing to say what needs to be said and hear what needs to be heard. Safety is vital but being safe does not necessarily mean being comfortable.

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 what it means for leaders, staff, children, and families to engage in more democratic processes in terms of the simultaneous increase in rights and responsibilities. They evaluate the existing policies and procedures that apply to staff, children, 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 posttraumatic stress disorder (PTSD), complex PTSD, and other trauma-related disorders present in the children, adults, and families with which they work. They are challenged to begin thinking about the implications of that knowledge for treatment. They also 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 the various components of the Sanctuary Toolkit and the role the toolkit plays in changing organizational habits.

The Sanctuary Steering Committee members are 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 activate the entire system. The Sanctuary 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 is armed with a Sanctuary Direct Care Staff Training Manual, a Sanctuary Indirect Staff Training Manual, a Sanctuary Implementation Manual, several psychoeducational curricula, and ongoing consultation and technical assistance from Sanctuary faculty members. The process of Sanctuary Implementation extends over 3 years and aims toward Sanctuary Certification. Organizational change takes several years to really get traction and then continues—hopefully—throughout the life of the organization. The objective of the implementation and technical assistance is to nudge an organization closer and closer to the “edge of chaos” where creative, self-organizing change occurs, without destabilizing it to such a point that it becomes dangerously chaotic.

The responsibility of Sanctuary Core Team members is to actively represent and communicate with their constituents and to become trainers and cheerleaders for the entire organization. The Core Team works out team guidelines and expectations of involvement for individual team members as well as a meeting schedule and decides on safety rules for the constructive operation of the team itself. The Core Team is ultimately responsible for the development of an implementation process aimed at including the entire organization in the change process that involves teaching everyone about the Sanctuary Commitments, Attachment Theory, Trauma Theory, S.E.L.F., and the Sanctuary Toolkit. The Core Team facilitates the development of educational programs for direct care staff as well as indirect care staff who work in human resource, finance, facilities management, food service, and administration. It is likely that Core Team members will facilitate changes in admissions, interviewing of new staff, orientation programs, supervisory practices, as well as training and education policies. They oversee a plan for greater client participation in planning and implementation of their own service plan and figure out how they are going to engage a wider network of their stakeholders in the community in the Sanctuary change process. The ultimate goal is to take meaningful steps to change the organization’s culture and engage as many community members as possible in the process.

As discussions are taking place in the Core Team, participating staff begin to make small but significant changes. Members take risks with each other and try new methods of engagement and conflict resolution. They feed these innovations and their results back into the process discussions. The Core Team must always maintain a balance between process and product. It is not enough to talk about how things will change; there must also be actual changes in the way business is conducted. The Core Team members therefore not only plan together how best to share what they are learning with the larger organization but also decide how to integrate the Sanctuary Toolkit into the day-to-day operation of the organization, how to evaluate how well these initiatives are taking hold in the organization, and how to train all agency personnel and children in the Sanctuary principles.

The work of the Core Team is facilitated by a combination of trainings
and consultations provided by faculty at the Sanctuary Institute who move an organization through a series of steps to align the practices, attitudes, and philosophies of an organization toward a trauma-informed perspective. As this happens, more democratic, participatory processes begin to emerge. These processes are critical because they are most likely to lend themselves to the solution of very complex problems while improving staff morale, providing checks and balances to abuses of power, opening up the community to new sources of information, and achieving better outcomes with the children.

From the outset of implementation the Core Team members must decide on indicators they want to use to evaluate their program in an ongoing way—their Sanctuary Program Evaluation Plan. The indicators should be observable and measurable and consistent with standards established by Sanctuary leaders. There should be a regular process of evaluation and review that involves all Core Team members. It is vital to create a thorough method for reviewing problems and failures and establishing remedial courses of action. But likewise there must be methods for reviewing and capturing successes.

The impact of creating a developmentally grounded, trauma-informed culture using the Sanctuary Model should be observable and measurable, often by paying special attention to areas that are already being measured in the organization. The expected outcomes include less physical, verbal, emotional violence, including (but not limited to) reduced/elminated seclusion and restraint; systemwide understanding of complex biopsychosocial and developmental impact of trauma and abuse and what that means for the service environment; less victim blaming; less punitive and judgmental responses; clearer, more consistent boundaries on the part of staff, higher expectations, better linkage between rights and responsibilities; earlier identification of and confrontation with abusive use of power in all of its forms; improved ability to articulate goals and create strategies for change; expanded understanding and awareness of reenactment behavior, resistance to change, and how to achieve a different outcome; more democratic environment at all levels; more diversified leadership and embedding of leadership skills in all staff; and, most important, better outcomes for children, staff, and the organization.

The Sanctuary Network

The Sanctuary Institute is the gateway to the Sanctuary Network, a community of organizations dedicated to the implementation of developmentally grounded, trauma-informed services. All members are committed to the belief that we can do better for our clients and our colleagues as well as our society if we can accept that the people we serve are not sick or bad, but injured, and that the services we provide must provide hope, promote growth, and inspire change.
As of the beginning of 2012, the Sanctuary Institute has trained over 250 organizations worldwide. These include adult inpatient psychiatric and substance abuse facilities, domestic violence shelters, residential programs and group homes for children, schools and educational programs, juvenile justice facilities, and large programs that have a wide variety of inpatient, outpatient, partial, community-based, and residential programs. The Sanctuary Network has grown into a community of organizations helping each other to become more trauma-informed and to improve services and outcomes. The Sanctuary Network sponsors an annual conference that features innovations in practice. The network also disseminates new materials to its members, has a website, and holds regular webinars and other opportunities for members to share and learn. With greater geographic spread, local networks are beginning to form as well.

Sanctuary Certification

Sanctuary® is a registered trademark and the right to use the Sanctuary name in relation to a psychological model or program is contingent on engagement in the certified training program and an agreement to participate in an ongoing, peer-review certification process. The Sanctuary certification process is designed to promote, sustain, and strengthen an organization’s commitment to the maintenance of a healthier, developmentally grounded, trauma-informed culture for all stakeholders. Programs usually seek Sanctuary Certification in the 2- to 3-year period after participation in the Sanctuary Institute. Research is under way in the hope of moving the Sanctuary Model from an “evidence-supported” to an “evidence-based” approach.

Certification is a symbol that an organization provides a higher level of care, a trauma-sensitive environment for children and their families, and a better environment for staff who provide care. This process affirms an organizational commitment to ensure fidelity to the Sanctuary Model and meet the standard of providing a safe, secure, and developmentally appropriate environment in which children and staff will recover and thrive. 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.

When an organization becomes a certified Sanctuary organization, there is an agreement that it will maintain its practice in accordance with the tenets of Sanctuary, utilize the S.E.L.F. framework for Sanctuary practice, maintain Sanctuary training, expand the scope of developmentally grounded and trauma-informed and trauma-specific clinical treatment, and routinely recertify the staff and the organization. Certified Sanctuary organizations also agree to follow and maintain the Sanctuary Certification Standards postcertification between surveys.
Sanctuary Model Outcomes

To date, one controlled, randomized trial of the implementation of the Sanctuary Model in children's residential settings has been conducted. The model was piloted in four residential units that self-selected to participate in the initial phase of the project; then four additional residential treatment units were randomly assigned to implement the Sanctuary Model the following fall. Eight other units that provided the standard residential treatment program served as the control group. Changes in the therapeutic communities and in youth were assessed every 3–6 months. To summarize the results of the randomized control study, from baseline to 6 months, there were changes in staff attitudes and perceptions in five domains of organizational culture 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 the children to be in making their own decisions
- **Personal problem orientation**: the extent to which children seek to understand their feelings and personal problems
- **Safety**: the extent to which staff feel they can challenge their peers and supervisors, can express opinions in staff meetings, 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 et al., 2004). 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 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 (Banks & Vargas, 2009c). Within the first six 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).
Working with schools is part of the Sanctuary Institute focus. 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 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 Pennsylvania’s 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 in the DPW project from 2007 to 2009 of children discharged from Sanctuary Model residential treatment facilities (RTFs), versus other RTFs, was conducted by Community Care Behavioral Health. It demonstrated that although both groups had a similar average (mean) length of stay in 2007, by 2009 Sanctuary Model RTF providers had (1) a substantially shorter length of stay and a somewhat greater decrease in median length of stay; (2) a substantial increase in the percentage of discharged youth who received outpatient services in the 3 months following discharge; and (3) a lower increase in the percentage of children readmitted to RTFs in the 90 days following discharge (Community Care Behavioral Health, 2011). As the authors of the report wrote,

The implementation of the Sanctuary Model in residential facilities in Pennsylvania appears to have had a positive impact, with the greatest benefits being seen by residents and staff of those sites who were most successful in implementing the full Sanctuary Model. The positive outcomes associated with implementing the Sanctuary Model have occurred at a time of uncertainty and programmatic and staffing change in many facilities, which speaks to the dedication of all involved in the implementation of Sanctuary. At the same time, the variation observed in implementation does
suggest an opportunity to consider strategies to support future implementation efforts, as well as the need for providing continued support to sites that have implemented Sanctuary to ensure sustained positive outcomes. (Stein et al., 2011, p. 7).

Conclusion

The Sanctuary Model is a blueprint for clinical and organizational change, which at its core promotes safety and recovery from adversity through the active creation of a trauma-informed community. A recognition that trauma is pervasive in the experience of human beings forms the basis for the Sanctuary Model's focus not only on the people who seek treatment but equally on the people and systems who provide that treatment. This chapter has provided a description of the Sanctuary Model, an evidence-supported, developmentally grounded, trauma-informed intervention for an entire organization.

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Edited by
JULIAN D. FORD
CHRISTINE A. COURTOIS

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