A Pocket Guide

BEST PRACTICES in
COMMUNITY MENTAL HEALTH

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The Sanctuary Model: A Best-Practices Approach to Organizational Change
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The Sanctuary Model is an evidence-supported, theory-based, trauma-informed, whole organizational approach that provides a clear and structured methodology for creating trauma-informed systems of care. The model was developed by the Sanctuary Institute, part of Andrus Children’s Center in Yonkers, New York. The goal of implementing the model is to enable organizations to more effectively provide a cohesive context in which healing from psychological and social traumatic experience can be addressed. The Sanctuary Model challenges organizations to reexamine their basic assumptions concerning the extent to which social service environments promote safety and nonviolence across physical, psychological, social, and moral domains for everyone involved—clients, family members, staff, and administrators. The Sanctuary Model requires an active process of breaking down institutional, societal, professional, and communication barriers that isolate administrators, staff, family members, and clients from one another. Simultaneously, the rebuilding process involves consciously learning new ways to relate as interdependent community members, creating and modeling healthy and supportive relationships among individuals, and developing an atmosphere of hope and nonviolence. As such, the intervention aims both to strengthen the therapeutic community environment and to empower people to influence their own lives and communities in positive ways. We begin the chapter with a review of a case of organizational change in a psychiatric hospital that implemented the Sanctuary Model (box 20.1).

Box 20.1. Case Study: Using the Sanctuary Model in a Psychiatric Hospital

The administrators of a psychiatric hospital recognize that most of the adults and young people they treat are survivors of trauma and multiple forms of adversity, but they also realize that there are significant barriers to appropriately addressing those problems. Lengths of stay have been
shortened, funding for services has been radically decreased, training
time has been greatly attenuated, and the staff they hire are often insuf-
iciently trained and supervised for the demands of the job. The result is
that there has been a steady rise in staff turnover, staff and patient
Injuries, workmen’s compensation costs, and the use of coercive interven-
tions. A long-term employee who remembers a time when things were
very different in this organization brings some information about the
Sanctuary model to the attention of the hospital administrators. After
conversations among themselves, with the Sanctuary Institute staff, and
with other program administrators who have already adopted the San-
cuary model, the hospital leadership decides to commit to a three-year,
challenging method of organizational change. A team of key formal and
informal leaders attend a five-day training during which this team—the
Steering Committee—begins to wrestle with the implications of trauma
theory for their patients and for their staff, the ways in which the staff and
the organization itself frequently engage in problematic processes that
parallel the problems of the patients. When the Steering Committee
returns to the organization, they gather a larger core team representing
a wider variety of voices from the organization, including, whenever pos-
sible, some “people with lived experience” of the mental health system,
and they begin working through the Sanctuary model’s implementation
manual and the direct-care and indirect-care staff training manuals,
which guide them through the process of confronting the many-layered
interpersonal and systemic problems that pose barriers to delivering
trauma-informed services. Technical assistance provided by Sanctuary
Institute faculty who have already been through this process supports
key change efforts and helps prevent backsliding. The leadership guide
the entire staff in adopting the components of the Sanctuary Toolkit
including engaging patients in intensive psychoeducational groups
around the ways in which trauma and adversity have affected them.
Community Meetings, Red Flag Reviews, and the organizing framework
of SELF help the administrators, staff, patients, and family members get
on the same page about treatment process and goals and while holding
one another accountable to the value system encapsulated in the San-
cuary commitments that guide interpersonal and community interac-
tions. Violent episodes rapidly decrease within the hospital, thereby
reducing injuries, complaints, staff turnover, critical incidents, and coercive methods. Staff notice that patients are much clearer about the goals of treatment, more motivated toward change, and making more progress in treatment. Clinical staff are now eager to embrace more trauma-specific forms of treatment and are thereby achieving better results. Administrators have to field many fewer complaints that stem from mistreatment of staff or of patients, and so they are able to more successfully address the organizational demands for better methods of adaptive change in a constantly changing environment.

Background

Originally developed from 1985 to 1991 in an acute-care, community-hospital-based psychiatric unit for adults, from 1991 to its closure in 2001, the Sanctuary was an inpatient program designed to treat the complex problems of adults who had been maltreated as children. The first published description of the program came out in 1994, in which I quoted a colleague remarking on the now-often-repeated phrase “It’s not what’s wrong with you; it’s what happened to you” (Bloom, 1994, p. 476). The name itself derived from the first chapter describing the inpatient treatment of trauma survivors, a program for Vietnam veterans, in which I described “sanctuary trauma,” the expectation of finding a welcoming and healing environment and finding instead more trauma (Bloom, 1997). In 1997, I published Creating Sanctuary: Toward the Evolution of Sane Societies, which described the development of what has since become known as a trauma-informed approach (Bloom, 1997).

After the publication of that book, in the late 1990s, the Jewish Board of Family and Children’s Services of New York obtained a grant to study the implementation of the Sanctuary Model in residential treatment programs for children through the National Institute of Mental Health and asked me to collaborate in the development and implementation of that project. The randomized controlled study showed positive findings.

In 2000, together with my colleagues, I began consulting with Andrus Children’s Center in Yonkers, New York, and after the Sanctuary program itself closed in 2001, the locus of development shifted to Andrus. In 2005, we created the Sanctuary
Institute, a reeducation methodology and certification program to train mental health and social service organizations in the Sanctuary Model. As of 2011, more than two hundred programs, including a wide variety of mental health, educational, and social service programs for children and adults, nationally and internationally, have been trained in the Sanctuary Model.

The first ten years of development of the Sanctuary were captured in Creating Sanctuary, in which the notion of “hurt people, hurt people” was explored (Bloom, 1997, p. 237). The wider public health implications of trauma and its effects were similarly developed in Bearing Witness: Violence and Collective Responsibility (Bloom & Reichert, 1998). Most recently, two of the current developers of the Sanctuary Model coauthored a volume describing the impact of organizational stress and the trauma-organized systems that result: Destroying Sanctuary: The Crisis in Human Service Delivery Systems (Bloom & Farragher, 2010). Currently in press, the next volume of the series, Restoring Sanctuary: A New Operating System For Organizations, will describe in more detail the process of implementing the Sanctuary Model (Bloom & Farragger, in press).

**Theoretical Perspective**

The Sanctuary Model is structured around a theoretical philosophy of belief and practice informed by the scientific study of attachment and child development and the impact of adversity, toxic stress, and trauma. Attachment between parent and child results in the human operating system, whereas toxic stress disrupts that operating system. Human beings and human organizations are living systems that adapt to changing conditions in complex ways. From these scientific findings new mental models for how we view human problems are beginning to emerge. The notion of parallel processes helps explain how trauma-organized systems develop and provide a framework for helping systems to recover and, in doing so, to become trauma informed.

**Principles**

In the early years, the practice principles for the Sanctuary Model were grounded in ideas surrounding the eighteenth-century development of moral treatment and the twentieth-century creation of therapeutic communities. Later, the Sanctuary Model evolved as a well-developed philosophical approach grounded in the com-
plex biopsychosocial and existential adaptations that individuals and groups make to cope with overwhelming and repetitive stress. As an organizational approach, the Sanctuary Model views systems as alive and therefore as subject to conscious and unconscious dynamics similar to those of the individuals who work in and are served by those systems.

The phrase “creating sanctuary” refers to the shared experience of creating and maintaining safety in any social environment. In the Sanctuary Model, the notion of safety encompasses physical, psychological, social, and moral safety. The philosophical tenets of the Sanctuary Model are embodied in the Sanctuary Commitments. The seven Sanctuary Commitments are tied directly to trauma-informed treatment goals. The process of creating sanctuary begins with getting everyone on the same page, which means surfacing, sharing, arguing about, and finally agreeing on the basic values, beliefs, guiding principles, and philosophical principles that are to guide decisions, decision-making processes, conflict resolution skills, and behavior.

The Sanctuary Commitments are a core component of the Sanctuary Model. These values structure the organizational norms, determine the organizational culture, and apply to everyone in the organization. The commitments represent the guiding principles for implementation of the Sanctuary Model—the basic structural elements of the Sanctuary “operating system”—and each commitment supports trauma-recovery goals for clients, staff, and the organization as a whole. All seven Sanctuary Commitments (or principles) are complexly interactive and interdependent:

- **Principle of commitment to nonviolence**—Requires a shared definition of safety, the universal development of safety skills, trust, and resilience in the face of stress.

- **Principle of commitment to emotional intelligence**—Fosters emotional management skills, respect for emotional labor, the minimization of the paralyzing effects of fear, and an expanded awareness of problematic cognitive-behavioral patterns and how to change them.

- **Principle of commitment to social learning**—Based on the need to build cognitive skills, to improve learning and decisions, to promote healthy dissent, to restore memory, and ultimately to develop the skills necessary to sustain a learning organization.
• **Principle of commitment to open communication**—Organizations must overcome barriers to healthy communication, discuss the “undiscussables,” and thereby undo organizational alexithymia while increasing transparency, improving conflict management skills, and reinforcing healthy boundaries.

• **Principle of commitment to democracy**—Supports the development of the civic skills of participation, self-control, self-discipline, the healthy exercise of authority, and leadership while overcoming learned helplessness.

• **Principle of commitment to social responsibility**—Aims to harness the energy of reciprocity and a yearning for justice by rebuilding restorative social connection skills, establishing healthy and fair attachment relationships, and transforming vengeance into social justice.

• **Principle of commitment to growth and change**—Represents a recognition that all change involves loss and that if people are to cease repeating irrelevant or destructive past patterns of thought, feeling, and behavior, they must be able to envision, be guided by, skillfully plan, and prepare for a different and better future.

**Steps for Implementing the Sanctuary Model**

The Sanctuary Model offers two approaches to implementing the Sanctuary Commitments: use of the Safety, Emotional Management, Loss, and Future (SELF) Model and the Sanctuary Toolkit.

The SELF acronym represents the four key interdependent aspects of recovery from bad experiences. The SELF Model provides a nonlinear, cognitive-behavioral therapeutic approach for facilitating movement in individuals and organizations, and it is used as a compass to allow for the exploration of four key domains of healing:

1. Safety (attaining safety in self, relationships, and environment)

2. Emotional management (identifying levels of various emotions and modulating emotion in response to memories, persons, and events)

3. Loss (feeling grief and dealing with personal losses and recognizing that all change involves loss)

4. Future (trying out new roles and ways of relating, behaving as a “survivor” to ensure personal safety, and envisioning a different and better future).
The SELF acronym is a simple and effective linguistic tool that enables a wide variety of people to get on the same page about treatment goals, planning, and everyday interactions, without losing the true complexity that is involved in treating very complex problems.

The Sanctuary Toolkit comprises a range of practical skills that enable individuals and organizations to more effectively deal with difficult situations, build community, develop a deeper understanding of the effects of adversity and trauma, and build a common language while remaining consistent in practicing the Sanctuary Commitments. The tool kit guides participants in focusing on six different activities. These activities are listed here along with descriptions of each activity:

1. The safety plan is a list of simple activities that a person can choose when feeling overwhelmed so that the person can avoid engaging in the unsafe, out-of-control, or toxic behavior that he or she is accustomed to resorting to under stress, and instead can engage in an activity that is safe, effective, and self-soothing. In the Sanctuary Model everyone in the organization must develop and use safety plans.

2. Community meetings are deliberate, repetitive transition rituals intended to psychologically move people from some activity that they have been doing into a new group psychological space, thus preparing the way for collective thought and action. In the Sanctuary Model, community meetings are instituted systemwide, from executive meetings to patient interactions.

3. SELF psychoeducational groups help clients shift their understanding of what has happened to them, how they have responded to those events, and the role they must play in their own recovery.

4. Red-flag meetings provide a team with a structured method to respond to any critical incident or concern, to any circumstance that arises that the entire community must respond to as a group so that an existing problem does not escalate to become a bigger problem.

5. SELF team meetings are active, focused meetings in which every member feels comfortable talking and listening, is engaged and contributes, shares insights, and generates new ideas.

6. SELF treatment planning offers a structured, nonhierarchical approach for measuring client progress in treatment while evaluating goals and current
obstacles to improvement, using a language that clients, family members, and all levels of staff can share.

**What's the Evidence?**

The desired outcomes for the Sanctuary Model are complex; to some extent each organization must decide on them, as the model targets such a wide variety of programs. At a minimum the aim is to eliminate interpersonal violence in all of its forms, as well as all coercive forms of treatment. Early research efforts were both qualitative and quantitative, demonstrating that it was possible to use the Sanctuary Model as a method for reducing violence and coercive forms of intervention in adult psychiatric settings (Bennington-Davis & Murphy, 2005; Bills & Bloom, 1998; Wright, Woo, Muller, Fernandes, & Kraftcheck, 2003). The Sanctuary Model as it is applied to residential child care is considered evidence supported, on the basis of a controlled, randomized study that was funded by the National Institute of Mental Health (Rivard et al., 2004). Subsequent research also demonstrated significant differences in organizational culture in organizations using the Sanctuary Model (McSparren & Motley, 2010).

**Assessment and Evaluation**

In terms of assessment and evaluation, we look for outcomes that reflect change in measures that the organization has easy access to and that include decreases in workers’ compensation claims; in staff and patient injuries; in staff turnover; and in the utilization of coercive measures like seclusion, restraint, and coercion around medications. Less easy to measure are substantial changes in staff attitudes toward patients and toward one another, more clinical sophistication, better assessment and case formulation, and significant increases in the application of complex strategies for change. If all is progressing well, we expect to see an increased clinical commitment to employ trauma-specific forms of treatment by well-trained and supervised staff.

**Implementation Issues**

Implementation of the Sanctuary Model begins with attendance at the Sanctuary Institute, a five-day intensive training experience. Sanctuary is a registered trademark and the right to use the Sanctuary name is contingent on engagement in the
certified training program and an agreement to participate in an ongoing, peer-review certification process. It requires a several-year commitment, and research is under way in the hope of moving the Sanctuary Model from an evidence-supported to an evidence-based approach.

Teams of five to eight people, from various levels of the organization, including executive leadership, come together during the Sanctuary Institute’s five-day training to learn from our faculty, who are colleagues from other organizations implementing the Sanctuary Model. These teams become the Sanctuary Steering Committee for their organization. Together they are introduced to the practices of the Sanctuary Model and take home with them the implementation, staff training manuals, and psychoeducational manuals created to assist and structure the implementation process (for steps to implement the Sanctuary Model, see figure 20.1).

**Figure 20.1. Implementing the Sanctuary Model of Organizational Change**

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**Provider Competencies**

Adopting the Sanctuary Model requires a major leadership commitment. Organizational leaders must model the Sanctuary Commitments to nonviolence, emotional intelligence, social learning, open communication, democracy, social
responsibility, and growth and change in the way they interact with one another, with staff members, and with clients. The more frequently the other staff members see leaders using the Sanctuary Commitments, SELF, and the Sanctuary Toolkit in everyday interactions, the more rapidly the organizational culture will change.

The first task of the Sanctuary Steering Committee is to go back to their organization and create a core team—a larger, multidisciplinary team that expands its reach into the entire organization. It is this core team that will be the activators of the entire system. The core team is required to have representatives from every level of the organization, to ensure that every “voice” is heard. It is vital that all key organizational leaders become actively involved in the process of change and participate in the core team. In addition to the curricula and manual created to support the implementation process, ongoing consultation and technical assistance from Sanctuary faculty members guide organizations through the process of Sanctuary implementation that extends over three years and leads to Sanctuary certification.

Once an organization has committed to adopting the Sanctuary Model by attending the Sanctuary Institute’s five-day training, the organization becomes a part of the Sanctuary Network, a learning community of practice that extends nationally and internationally and that involves many different kinds of mental health and social service organizations, all committed to the development of trauma-informed services.

The Sanctuary implementation manuals systematically guide the process of organizational change over three years. After three years, organizations are encouraged to seek Sanctuary certification, a peer-review process informed by a set of standards that represent the evaluation “We are a Sanctuary organization” at this point in time. Recertification occurs every three years.

**Future Directions**

Scientific advances in understanding the complex problems associated with exposure to adversity, toxic stress, and trauma across the life span require a radical reformulation of how all of our mental health and social services respond to people who need our help. As a species we are good at responding to acute emergencies like terrorism and hurricanes, but we are less prepared to address the slow-rolling, disastrous impact of chronic stress and trauma on the lives of individuals, families,
organizations, and entire societies. Exposure to chronic stress is the greatest public health challenge of the twenty-first century. The publishers and authors of this guidebook hope that in providing these summary accounts, we can promote more rapid dissemination of critical knowledge aimed at positive changes in health, mental health, and social well-being for all of us.

Websites

Andrus Children’s Center—http://www.andruschildren.org
Sanctuary—http://sanctuaryweb.com

Glossary

Parallel process: A notion that helps explain how trauma-organized systems develop and provide a framework for helping systems to recover and, in doing so, become trauma informed.

Sanctuary Model: An evidence-supported, theory-based, trauma-informed, whole organizational approach that provides a clear and structured methodology for creating trauma-informed systems of care.

SELF: An acronym for the Safety, Emotional Management, Loss, and Future Model, which represents the four key interdependent aspects of recovery from bad experiences; provides a nonlinear, cognitive-behavioral therapeutic approach for facilitating movement in individuals and organizations.

References


