Case Study

Incorporating the Sanctuary Model® at Interim House

Interim House is a private, 501(c)(3) nonprofit corporation licensed by the Commonwealth of Pennsylvania's Bureau of Drug and Alcohol Programs. Interim House provides a continuum of comprehensive services to women addicted to drugs and alcohol that includes three levels of care: Residential Treatment, Intensive Outpatient Treatment, and Outpatient Counseling. In 2002, Interim House recognized the need to become a trauma-informed program based upon program research data that indicated over 90% of its clients had suffered significant trauma, abuse and maltreatment as children and/or as adults.

In order to address these needs, Interim House implemented an agency wide year-long training in 2002 on the Sanctuary Model® developed by Dr. Sandra Bloom. Trainings were monthly and included all staff—professional and para-professional. During the course of the trainings and throughout subsequent years, the program has incorporated gradual changes to its structure that reflect the core components of Safety, Affect management, Grieving, and Emancipation (S.A.G.E.) (This tool has been renamed S.E.L.F., see page 14.). Some of these trauma-sensitive treatment components include:

* Incorporating the S.A.G.E. principles into the 12 steps by creating a S.A.G.E. grid to help clients understand that addiction and trauma are intertwined.
* Developing individual safety plans for each client and focusing on significant anniversary deaths involving grief and loss.
* Asking clients to create their own personal safety kits.
* Establishing grieving rituals such as a grief box, ceremonies, letting go of helium balloons to represent "letting go."
* Building in more mastery, such as having more input into the program activities and rules, to help the clients restore their own sense of mastery that will help them overcome dependency and helplessness.
* Implementing a morning check-in that requires each client to state how they feel, goal for the day, plan to stay safe and motivation level based on a scale of 1 to 10.

Interim House has worked to ensure that the Sanctuary Model® is being incorporated into all aspects of the program, not just the clinical component. As a result, we changed our program philosophy to reflect an understanding of addiction and trauma. All staff—clinical and non-clinical—are now trained in trauma theory and understand the impact that trauma has on the brain and on clients' behavior. We have also reviewed our policies and procedures to ensure that we are not creating unintended secondary trauma. Additionally, we now evaluate staff for their effectiveness in utilizing the S.A.G.E. model and include this category on annual performance evaluations. We use the S.A.G.E. model as a way of identifying and resolving staff conflicts, individually and collectively, and also use this model to evaluate program policies to ensure they reflect the principles of S.A.G.E. This was especially significant in a modification to our discharge criteria which tended to punish people for their symptoms.

We are not the same organization we were, evolving with changing needs of the clients and learning from our mistakes. We recognize that role modeling is critical—everyone must lead by example and to paraphrase Gandhi: We all must be the change we want to see.

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The S.E.L.F. Psychoeducational Group3 is designed to provide clients and staff with an easy-to-use and coherent cognitive framework that can create a change momentum. Because it is a model that is circular, not stepped, it provides a logical framework for movement. We think of S.E.L.F. as a compass through the land of recovery that can help guide individual treatment, staff decision, team treatment planning, and an entire institution. It is not constrained by gender, age, race, religion, or ethnicity because the domains of healing that S.E.L.F. represents are human universals, unbound by time, place, or person. In our residential programs, children as young as four are comfortably using the S.E.L.F. language—and using it appropriately.

Conclusion

Ultimately in the Sanctuary Model®, the purpose of our shared assumptions, goals, practice, and vision is to create what Maxwell Jones, a half-century ago, described as a "living-learning environment" within which healing, growth, and creative expression can occur (Jones, 1968). Through this model, a wide range of settings, including residential treatment settings for children or adults, acute care inpatient units, substance abuse programs, domestic violence shelters, homeless shelters, group homes, day hospitals, and intensive outpatient programs, have had an opportunity to create environments that are intrinsically humane, as well as healing and health promoting.

Our clients who have suffered extraordinary violence, at the hands of others, have much to teach us about both individual and social healing, about how to change our institutions to reflect actual human needs rather than the distortion of unresolved trauma. In an era of tightening budgets and bottom-line focus, finding methods to aid recovery from overwhelming experiences that are environmental, and not solely dependent on expensive individual forms of treatment, are even more critical than ever. Sanctuary Model® is in many ways a subversive idea in that it works not to maintain an unhappy status quo, but to create the "heat" that generates change, which is generated largely through the trauma-informed interactions between staff and clients, and clients with each other.

3 S.E.L.F.: A Trauma-Informed Psychoeducational Group Curriculum is available at www.sanctuaryweb.com

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