

"A comprehensive system of care for children, adolescents and their families"

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Creating a Sanctuary for Trauma-Informed Care

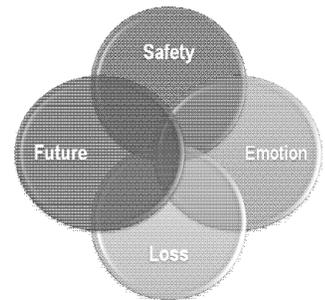
More than 10 years ago, the Centers for Disease Control and Prevention and Kaiser Permanente launched an ongoing study of the effect of "adverse childhood experiences" on later health and behavioral outcomes. Adverse childhood experiences that can affect later outcomes include recurrent physical abuse, recurrent emotional abuse, contact sexual abuse, an alcohol and/or drug abuser in the household, an incarcerated household member, someone with chronic mental illness, a mother who is treated violently, one or no parents, and emotional or physical neglect (www.acestudy.org). When a child experiences one or more of these traumatic events, he or she can respond in ways that are unhealthy, illogical, behaviorally inappropriate and even dangerous to self or others.

Dr. Sandra Bloom, who developed the Sanctuary Model of trauma-informed care, notes that traumatic experiences like the ones at the core of the Adverse Childhood Experiences study affect "the entire person—the way we think, the way we learn, the way we remember things, the way we feel about ourselves, the way we feel about other people, and the way we make sense of the world" (quoted at www.paceschool.org). Children who have experienced trauma need a place to heal or, as the dictionary defines sanctuary, "a place of refuge and protection."

Originally developed in an inpatient setting for adults who experienced trauma as children, the Sanctuary Model of trauma-informed care is now also being implemented in children's treatment programs, including in Pennsylvania. The mission of Sanctuary is "to teach individuals and organizations the necessary skills for creating and sustaining nonviolent lives and nonviolent systems, and to keep believing in the possibilities of peace" (www.sanctuaryweb.com). The model is built on seven core commitments: nonviolence, emotional

intelligence, inquiry and social learning, shared governance, open communication, social responsibility, and growth and change. It is a model that requires systemic change in an organization's culture so that everyone— from senior executive leadership, direct line staff and kitchen and janitorial workers to clients— is in agreement with and committed to the same values.

A second major component of Sanctuary is the S.E.L.F. compass. The acronym itself emphasizes the importance of the individual and is easy for everyone, including young clients, to understand and remember. There are four elements of the S.E.L.F. compass:



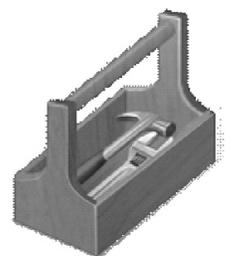
Safety: physical, psychological, social, moral (creating a safe place, a sanctuary, where healing can begin)

Emotions: handling feelings without becoming destructive of self or others (managing the overwhelming feelings that we all experience)

Loss: feeling grief and dealing with personal losses and preparing for change (recognizing that to grow we have to leave something behind)

Future: re-establishing the capacity for choice (regaining hope and creating a life full of possibilities) (Pace School annual report, 2007-2008; downloaded from www.paceschool.org)

A third component of Sanctuary is a "toolkit" which provides a means to develop new habits and change behavior and previously conditioned responses that have been ineffective or inappropriate.



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Making Residential Treatment More Effective

The theme of the December 2008 edition of the newsletter was "Integrated Children's Services Planning." This next edition is one logical extension of that theme. With a vision for "a system that partners with families and delivers the necessary supports and care...that [promote] family stability, child safety, community protection and health development," the integrated children's services planning process assumes a comprehensive system of care and is one of a number of current Department of Public Welfare efforts to improve outcomes for children and adolescents with emotional and behavioral challenges. A significant although certainly not exclusive focus of those efforts has been residential treatment facilities.

The motivation for a focus on residential treatment includes not only the high cost of residential care (\$234 million in 2006) and the high number of Pennsylvania youth who are sent out of state to receive care (sometimes to far-away states), but also the knowledge from research studies that residential treatment is generally ineffective. In addition, analysis of the use of residential facilities for Pennsylvania children and adolescents has suggested that often, if not almost always, there are effective options for treatment other than residential placement. At the same time, there is general agreement that residential facilities are an important component of a comprehensive continuum of care for youth who cannot be adequately cared for any other way or who need intensive care for a discrete period of time (see article by Dr. Gordon Hodas on page 4).

Recognizing the need for residential treatment as one component in the system of care, the department is working hard to improve the quality of care, and several years ago launched the "Alternatives to

Coercive Techniques." The Alternatives to Coercive Techniques project is designed to promote alternatives to the use of seclusion and restraint in child and adolescent programs. Armed with an increasing body of research showing the long-term effects of trauma on children, the department is encouraging the significant changes in organizational culture that are required for provider agencies to implement alternatives to coercive techniques (see www.parecovery.org for more information and resources). The desire to change organizational culture then led to the implementation of the Sanctuary Model in 29 child residential programs including 19 residential treatment facilities (see page 3). This edition of the newsletter includes a special focus on the implementation of the Sanctuary Model across Pennsylvania, especially in residential treatment facilities.

Other collaborative efforts to improve outcomes for youth include the continuum of care workgroup. Involving the Office of Children, Youth and Families, the Office of Mental Health and Substance Abuse Services, the Office of Developmental Program and the Secretary's office, the continuum of care workgroup has the ultimate goal of significantly reducing the number of children placed in residential treatment facilities in Pennsylvania. The workgroup has been considering recommendations offered by a consultant in an April 2008 white paper on "Community Alternatives to Psychiatric Residential Treatment Facilities."

Harriet S. Bicksler, editor

How the Sanctuary Model Came to Pennsylvania

In 2006, Department of Public Welfare Secretary Estelle Richman issued a statement urging child residential treatment providers to move toward reducing or eliminating the use of restraints. A kick-off event was held to roll out the “Alternatives to Coercive Techniques” project, and a workgroup was formed to plan regional forums. Twelve forums were held across the state where discussions included topics such as organizational change, leadership, specific skills for de-escalating conflict and incident debriefing, data collection, and youth and family involvement. The forums were designed to help providers to understand the vision for building a restraint-free system and gain their support for creating that vision.

At each forum, providers were asked for their recommendations, and their evaluations were carefully analyzed. The number one request was for training, specifically on trauma-informed care. In response to that request, two all-day trainings were held with Sandra Bloom, a nationally-known expert on trauma-informed care and the creator of the Sanctuary Model. As a result of the forums and recommendations, Secretary Richman proposed bringing the Sanctuary Model to Pennsylvania.

The Sanctuary Model is about organizational change, and is a three-year process that starts with a diagnostic evaluation and a five-day training for agency leadership. Agency leaders are required to attend five days of intensive training, develop a multidisciplinary core team within their agency, participate in on-site and telephone consultation as well as consortium calls and booster trainings. These steps support the process of change in an organization to a trauma-informed culture. Preliminary data from implementation of the Sanctuary Model in other states show positive results, including a decrease in the use of restraints, less staff turnover, and better outcomes for children and youth.

The Department had limited funding to implement the Sanctuary Model in Pennsylvania, and developed a request for participation with some basic requirements: participating facilities had to have more than 50 beds, the chief executive officer and/or the chief operating officer had to attend the five-day training, and facilities had to agree to collect and submit data that would help evaluate the effectiveness of the program. Applications were sent to all licensed programs (more than 900 total), and 35 applications were received.

Initially, 20 sites were chosen to participate and a state core leadership team was formed to attend the training, support the provider agencies and implement Sanctuary on the state level.

The leadership team is made up of 15 people from the Department of Public Welfare policy office, the Office of Mental Health and Substance Abuse Services, the Office of Developmental Programs, the Office of Children, Youth and Families, and a behavioral health managed care organization. They attend joint site visits with Sanctuary staff and help to support participating providers. By making the same commitment as provider agencies to implement the Sanctuary Model in their own roles and to change the culture within their organizations, the leadership team is “walking the walk.” This full-system approach represents what is called in the Sanctuary Model a “parallel process of recovery from trauma” and requires extensive leadership and support to effect change at the micro and macro levels.

When more funding became available, nine more sites were added, making Pennsylvania the largest state implementing the Sanctuary Model. There are now 29 sites, 19 of which are residential treatment facilities and include treatment facilities as well as detention and youth development centers. See the graphic below for a list of Sanctuary sites in Pennsylvania.

Adapted from a presentation made by Angie Logan, Executive Policy Specialist for the Department of Public Welfare.

Pennsylvania Providers Implementing the Sanctuary Model



- Abraxas Academy, Berks County
- Bethanna, Bucks County • Bethany Children's Home, Berks County
- The Bradley Center, Allegheny County • Carson Valley School, Montgomery County • Children's Home of Reading Youth and Children's Services, Berks County • Children's Service Center of Wyoming Valley, Luzerne County • Devereux Beneto Center, Chester County • Friendship House, Lackawanna County
- Gannondale, Erie County • Glade Run Lutheran Services, Butler County • Harborcreek Youth Services, Erie County
- Holy Family Social Services, Allegheny/Armstrong/Chester/Washington Counties • KidsPeace, Lehigh County
- Mars Home for Youth, Butler County • North Central Secure Treatment Unit, Montour County • Northwestern Academy, Northumberland County • Perseus House, Erie/Crawford Counties • Philhaven, Lebanon County • Presbyterian Children's Village, Delaware County • St. Gabriel's Hall, Montgomery County • Sarah Reed Children's Center, Erie County
- Shawnee Academy, Monroe County • Silver Springs—Martin Luther School, Montgomery County • South Mountain Secure Treatment Unit, Franklin County • SummitQuest Academy, Lancaster County • VisionQuest, Venango County • Wordsworth Residential Treatment Center, Philadelphia
- York County Youth Development Center

Way Stations Not Fix-It Stations

By Gordon R. Hodas, M.D.

Within a comprehensive system of care, mental health residential treatment facilities can effectively serve a small minority of children and adolescents whose severe emotional and behavioral needs cannot be satisfactorily met in the community. When the principles of the Child and Adolescent Service System Program* are applied carefully, the residential treatment facility becomes a temporary “way station” for a child needing extra help, rather than a fix-it station.

Central to Child and Adolescent Service System Program principles is the recognition that a child must be understood in his or her natural context – the family, the community and the child-serving systems – not just individually. Interventions that work with context are most likely to be effective and to render placements less likely. These principles, by being strengths-based and treatment-focused, allow for hopeful and realistic approaches. The essence of strengths-based treatment is a presumption of competence and positive intentions on the part of participants, together with a commitment to collaborate as a team in building on assets, addressing needs and providing individualized responses. Strengths-based treatment enables the child and family to participate actively, be listened to, and be understood. In strengths-based treatment, problems and needs are acknowledged but are seen as temporary barriers to development, subject to change through mutual respect and creative problem-solving by a treatment team that includes the family as a full partner.

In preparing a child who has been placed for a time in a residential treatment facility for a successful return to the community, the residential treatment facility needs to embrace a critical premise: the facility is more a **way station** for the child than a **fix-it station**. These terms implicitly convey the facility’s often-hidden assumptions about the child, the family, the larger system and the mission of the facility. These hidden assumptions substantially affect clinical practice and outcome.

The **way-station** perspective recognizes that placement represents just one phase of the child’s life cycle, not his or her entire life history. The child has both a past and a future without placement, and will eventually return to the community. The child’s fundamental context, therefore, remains the community, even while in placement. The residential treatment facility serves primarily as a catalyst to

promote new possibilities – for the child, family and community. Relationships within the family and community are recognized and supported during the placement period. The child is encouraged to address problematic behaviors and is challenged to develop emotionally, but with an appreciation that the process of change is continuous and need not be completed entirely while in the residential facility. Treatment is flexible, strengths-based and individualized.

When the residential treatment facility functions more as a **fix-it station**, the child must be “fixed” emotionally rather than assisted in coping and moving on. The central treatment question – what will it take for the child to leave the facility and live successfully in the family or other community setting? – becomes obscured. Unnecessary extensions of placement may occur, rendering successful discharge less likely, as the fix-it station focuses on perfecting the child, who may be seen as having deep problems and as being largely incapable of making significant decisions. Discharge criteria may involve unrealistic expectations of behavioral consistency. Effective community functioning may not be recognized as an essential indicator of readiness for discharge. The fix-it station’s preoccupation with the child’s deficits may override recognition of strengths and support for positive action.

Accompanying the fix-it station’s overly ambitious agenda for emotional transformation of the child may be an overly narrow view of the child’s family and community context. Rather than working with the family, the fix-it station approach may marginalize or blame the family, privately if not directly, and take a rescuing stance toward the child. Opportunities for meaningful family participation may be minimal, and the facility’s interest in the child within the residential community may exclude opportunities to integrate the child into the real world and to use community resources.

On the other hand, the way-station residential treatment facility is committed to helping the child address and master in age-appropriate ways those critical dimensions of community living that constitute both opportunities for growth and at times life-endangering threats. Real world issues are addressed according to a child’s developmental level within a strengths-based framework, making use of didactic, experiential and group discussion formats. In promoting real world competence, staff provide information themselves and also call upon families and community

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* There are six Child and Adolescent Service System Principles: child-centered, family-focused, community-based, multi-system, culturally competent, and least restrictive/least intrusive.

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leaders. An important goal is encouraging the child to think through issues and arrive at personally meaningful conclusions. The way-station perspective is characterized by a flexible, individualized approach and recognizes a child's possible readiness for discharge to a less restrictive, community-based level of care even though significant mental health issues may remain, so long as ongoing treatment has incorporated and accessed appropriate community resources and services for the child.

Mental health residential treatment serves as an important temporary resource for children and adolescents who are unable to function safely, at one point in their lives, in less restrictive settings. The residential treatment center has a critical responsibility to reverse demoralization, mobilize the

child and work with the family, natural supports and community agencies. Effective residential treatment is a dynamic process with active participation by the child and family, grounded in a presumption of competence and collaboration, with recognition of the child as a complex evolving individual who must be prepared for the next stage from the time of admission. In pursuing a way-station perspective, the residential facility helps the child prepare for the major challenge of the future – learning to live successfully in the community in the real world.

Gordon R. Hodas, M.D. has served as a child psychiatric consultant to the Office of Mental Health and Substance Abuse Services since 1992. This article is condensed from "The Role of Mental Health Residential Treatment Facilities within a Comprehensive System of Care." For a copy of the full article, contact the editor.

Children Need to Heal: The Sanctuary Model at the Children's Home of Reading

Jeremy has been at the Children's Home of Reading for almost a year and will soon complete his treatment program. When the Children's Home of Reading first started implementing the seven core commitments of the Sanctuary Model, Jeremy, who is 14, wasn't sure he liked the changes, but then they became a normal part of the routine. Even the community meetings, held every day and sometimes two or three times a day, help him focus on how he is feeling, what his goals are for the day, and who can help him if he has any issues. While at the Children's Home of Reading, he has learned how to manage his emotions and cope with the losses he experienced from years of moving around from one foster placement to another. These skills will help him not to slip back into the sexual acting-out behaviors that brought him to the Children's Home of Reading in the first place.

The Children's Home of Reading's traditional residential treatment program serves boys who have been diagnosed with behavioral or psychiatric disorders, while a specialized residential treatment facility serves boys who have acted out sexually, 90-95 percent of whom were adjudicated to the program by the courts. According to Ron Spitz, residential clinical director, the agency had already been incorporating the principles of trauma-informed care that form the backbone of the Sanctuary Model. Several years ago, Dr. Sandra Bloom, the founder and executive director of Sanctuary, trained the staff in Sanctuary's organizational model of change. So when the Department of Public Welfare decided to begin to implement the Sanctuary Model in child programs throughout the commonwealth, they applied to be part of the project. Senior staff from the Children's Home of Reading, including the chief executive

officer, attended the required five-day Sanctuary training in January 2008, and came back committed to implementing the Sanctuary Model throughout the facility.

Spitz and Jason Raines, another member of the Sanctuary steering committee, gave a number of examples of how the Children's Home of Reading has changed its organizational culture in keeping with the seven core commitments of Sanctuary (see article on page 1):

- All staff, not just those who work directly with residents, participated in eight modules of training on the Sanctuary Model. Because staff are given a voice in decision-making as well as more tools to help residents, they have embraced the model.
- Each person on staff – including from such departments as food services and finance – must carry a safety plan with them. When they are angry or upset, this safety plan, which can include a reminder to take a five-minute break or breathe deeply and count to ten, helps them calm down and think more deliberately about how they will respond.
- Living environments have become more home-like. There are posters on the walls, and staff and clients have designed and painted murals on the walls. Units have been renamed after people who have practiced social change and nonviolence, such as Martin Luther King Jr., Mahatma Gandhi and Frederick Douglass.
- A food committee provides feedback from the clients on what kind of food they like, and food services staff make changes to the menu in keeping with this feedback, a demonstration of increased democracy.

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Transforming Organizational Culture

Landa C. Harrison is the coordinator of the Pennsylvania Sanctuary Consortium, a part of the Sanctuary Institute at the Andrus Center for Learning and Innovation in Yonkers, New York. As the former director of clinical services at Pace School in Pittsburgh, which began implementing the Sanctuary Model in 2005, Harrison understands Sanctuary and the huge organizational culture change it requires.

In her role with the Pennsylvania Sanctuary Consortium, Harrison serves as the main contact and the primary consultant for the State Core Team and several of the Pennsylvania Sanctuary implementation sites. She meets with the state core team on a monthly basis, to review their own progress in using Sanctuary as well as to check-in with the sites on their implementation progress. She provides coordination around implementation and technical assistance, especially on trauma-informed care. When an implementation site is struggling in some way – a critical incident, an increase in staff call offs, increases in child acting out behaviors – or when a “collective disturbance” is bubbling up somewhere, Harrison, along with several other consultant faculty members, help agencies examine and learn from what has happened by applying trauma theory at the organizational level.

Sanctuary is considered a promising practice and additional research is currently underway to provide the support necessary to make Sanctuary an evidence-based program. Data collection to date shows that dramatic changes do occur when Sanctuary is implemented with consultation and support in an organization interested in making changes. Harrison emphasizes the significance of the parallel process that is an element in changing organizational culture. Just as individual agencies need to follow the seven core commitments of Sanctuary, so too does the state core team in order to avoid perpetuating re-traumatization. Governing and oversight bodies can mitigate against chronic stress for provider agencies in the same way that the staff in

provider agencies can mitigate against chronic stress in the clients they serve.

Harrison reflects on her previous work and experience at Pace School as being solid preparation for the work she is now doing. When Pace decided to implement the Sanctuary Model in 2005, senior executive leadership attended the five-day training and brought home a staff training manual of eight modules which they used to train a core group of staff members. At the time, the agency had experienced some significant losses: three staff members had recently been diagnosed with cancer and subsequently died between 2005 and 2007, and the agency had moved to a new building a few years earlier. The new building’s layout was different in that there were many more doors. With increased access to leaving, Pace saw a significant increase in the number of children who ran away from school. As they began talking about the environment, asking the question “what is happening,” rather than engaging in the blaming conversations they had previously, they were able to change the emotional climate of the building and saw decreases in elopement behavior of the children. The Sanctuary Model offered Pace staff and students a common language to use as they worked together at changing the organizational culture and the milieu to a more trauma-informed environment.

Though it took a long time until everyone “got it,” eventually the entire building – staff and children alike – became a large community. The Sanctuary Model made a difference in how staff looked at treatment. For example, when a student was refusing to go to class, staff would ask, “I wonder what happened,” rather than focus on the school-skipping behavior. And rather than lament that tools had been taken away from them when Sanctuary’s commitment to nonviolence meant eliminating the use of restraints, staff began to see concrete improvements: the elopement rate decreased, and there were fewer staff turnovers.

Another concrete outcome of implementing Sanctuary at Pace was the development of family groups based on the S.E.L.F. compass (safety, emotions, loss, future). Parent feedback indicated that this was the first time an organization really understood why they as parents didn’t want to put their children on medication. The emphasis on emotion management (the E in S.E.L.F.) helped them develop a safety plan that would keep them from hurting their children in response to the difficult behaviors they faced.

In May 2008, Pace School became the first agency in the United States to be certified by the Sanctuary Institute, and is still one of only two certified agencies. In addition to Pace School, 29 other provider agencies in Pennsylvania are joining the Sanctuary network through a project sponsored by the department. Of her work with these sites, Harrison says, “I’ve seen organizations do things they’ve never done before.” She points to simple yet significant things several agencies are doing that demonstrate how implementing Sanctuary is changing the way they do business. For example, Wordsworth awards a tee shirt to people who are caught practicing the seven commitments. Reportedly, the tee shirts have become hot commodities as others try to earn one too. Holy Family displays posters of children’s artwork and has woven the seven commitments into their mission statement. Northwestern Academy has developed a ropes course where staff and residents can practice their team-building and relational skills with each other. These agencies and others are well on their way to the kind of cultural change that will provide places of healing from the past and nurture hope for the future for many children and adolescents

Based on phone interview by the editor with Landa C. Harrison, LPC. For more information go to www.andruschildren.org.

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- Community meetings are held every day. During these meetings, leaders ask three questions: How are you feeling? What is your goal for today? Who can you ask for help? The meetings and questions help each staff member and resident remember they are part of a community where everyone supports each other.
- Psychoeducational groups have been created based on the core commitments of Sanctuary. Groups are more interactive, and focus on teaching Sanctuary's S.E.L.F. compass (Safety, Emotions, Loss, Future) in language that the residents can understand and apply to their own lives.

Perhaps the most significant changes relate to the clinical treatment model used at the Children's Home of Reading. Treatment focuses on the concept of healing from trauma. The primary question is now "What happened to you?" rather than "What's wrong with you?" Treatment planning includes more emphasis on trauma than behavior, realizing a child's behavior probably came from somewhere, as in Jeremy's case of being moved around from one foster placement to another, which created the instability and stress that led to his acting-out behavior. Using Maslow's hierarchy of needs, where safety is the most basic need after physical needs for food, clothing and shelter, treatment focuses on meeting that

need. Spitz and Raines acknowledge that reframing all treatment planning in terms of trauma and an understanding of how behavior results from something else is a significant cultural shift for the organization. However, they add, it is firmly in keeping with one of their fundamental beliefs: children need to heal.

Jeremy admits it was hard at first to think about what happened to him, and recognize how his past losses affected his behavior. But, he says, "I needed to take the time to look at what happened and now I have learned to be responsible and to have hope that things will be different when I leave."

This article was based on a phone interview by the editor with Jeremy, a resident at the Children's Home of Reading, and Ron Spitz and Jason Raines, staff members.

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The Sanctuary Toolkit includes these five elements:

1. **Safety plans:** everyone has a list of his or her own of five actions that will help them calm down or feel better when something stressful happens
2. **Community meetings:** these are held every day to emphasize that everyone in the community is responsible for and needs each other.
3. **Team meetings:** individuals who work together on the same team check in with each other using a three-question format: What went well today? What did not go well today? What can we do differently or the same tomorrow?
4. **Red Flag meetings:** when crises happen – and they will – anyone can call a meeting to ask for help to solve the problem.
5. **Psychoeducation:** people who have experienced trauma need to have information about how those experiences can influence their current emotions and behaviors, and learn skills to cope with them.



Among the aims of the Sanctuary Model are to increase a sense of community for all staff and clients at an agency and to promote recovery, healing and growth. A required comprehensive training program with ongoing technical assistance ensures that agencies implementing Sanctuary are able to change their entire organizational culture to achieve these aims in a nonviolent and democratic environment.

To learn more about the Sanctuary Institute and training in the Model go to the Andrus Children's Center website at www.andruschildrens.org. Additional information about the Sanctuary Model is available at www.sanctuaryweb.com.