

Creating Sanctuary Symposium
Treating Trauma in Children, Adults,
Organizations and Society
Thursday, October 5, 2006



The second day of the symposium included a keynote address from Bessel van der Kolk, entitled “Frontiers of Trauma Treatment” followed by a keynote address by Sandra Bloom, entitled “Sanctuary: Creating a Trauma-Informed Society.” The day also included panel discussions on the use of the Sanctuary Model in residential care settings, school settings, drug and alcohol treatment settings, and acute care settings. The event ended with a discussion of the policy implications for trauma-informed care.



Summary of Breakout Sessions 10/5/06

Sanctuary in the Schools Panel

Panelists: Alexandria Connally, MA, teacher Andrus Children's Center

Joe Ciffone, Dean of Students Andrus Children's Center

Karen Shepherd, Director of Education at Pace School

Representatives from the Andrus Children's Center and the Pace School presented their work with the Sanctuary Model. The panel discussion included some examples of ways in which teachers and other school staff have been able to respond differently to children's behaviors and manage their work environments to create a trauma-sensitive culture for staff and children. Some examples of how both agencies are doing this include:

- Creating a class constitution and goals
- Selecting a class quote
- Granting a certain number of "no questions asked time-out passes" to help students manage their emotions.
- Training teachers in trauma theory and ACES study
- Integrating TCI's four questions with discussions of emotion management for staff
- Sharing information with parents about Sanctuary and including them as part of the team

Domestic Violence Shelters and Homeless Shelters Panel

Panelists: Lisa Blitz, Director Genesis Domestic Violence Shelter

Susan Brotherton, Director The Salvation Army Red Shield Residence

Sandy Sheller, The Salvation Army Red Shield Residence

Ruthanne Ryan, The Original Sanctuary at Friends Hospital, consultant to shelter

Highlights from the discussion were:

- Origins of Sanctuary – based on a program for Vietnam vets called “Without Sanctuary
- Establishing safety for the first time, not necessarily re-establishing safety
- Having to call the police multiple times per month due to incidents of violence, but since implementing Sanctuary, they’ve had only one call in a month
- Dealing with loss and committing to social responsibility: community members honoring the janitor who died on the site by saying that they wanted to do his work
- Organizing all areas of the shelter around the SELF model
- Doing work on class, race and oppression in the “L” part of SELF
- The last part of SELF being about emancipation

Acute Care Panel

*Panelists: Maggie Bennington-Davis, Director Evolutions in Healthcare Salem OR
Lyndra Bills, Medical Director Lancaster General Hospital*

Joe Foderaro, Sanctuary Consultant

Tim Murphy, Director Evolutions in Healthcare Salem OR

Panelists gave examples of the use of the Sanctuary Model in inpatient care settings. They spoke about having an understanding that virtually everyone in acute care and public health systems has been exposed to trauma. Some of the highlights from this presentation included:

- Staff becoming very creative in order to de-escalate violence on a unit - one group of nurses sang “God Bless America” in order to change the script for a patient who typically presented with behaviors that lead to forced medication.
- Validating experiences and emotions, creating a communal sense of responsibility and helping patients imagine a better future resulting in the lowest elopement rate in the hospital for an unlocked unit
- Asking clients how they can get off a psychiatric unit rather than running away from it as a way of encouraging self-efficacy
- Hoping to have controlled chaos rather than rigid structure
- Comparing the use of restraint for “asylum” patients 800 years ago to the eerily similar practices we use today and use of Sanctuary to move the field beyond an 800 year old process
- Staff changes because people are not willing to change – how losses are managed and modeled for patients



Residential Care Panel

*Panelists: Jeff Anderson, Dir. of Sanctuary Implementation, Hawthorne Cedar Knolls
Clint Bryant, Team Leader, Hawthorne Cedar Knolls*

Irving Jennings, Executive and Medical Director, Family and Children's Aid

Peg Mahoney, Clinical Operations Director, Uta Hallie/Cooper Village

Lina Pasquale, Director of Trauma Programs, Family and Children's Aid

The panelists gave a history of each agency's discovery and adoption of the Sanctuary Model and talked about the implementation process at each site. Some panelists had been using the model for many years, others for much less than that. Highlights from the panel's discussion included:

- The recognition of trauma as an imperative part of addressing needs of clients
- Cultivating democratic processes and principals for the staff and the children
- Changing language: from weakness to struggles
- Positive outcomes: improved behavior, lower numbers of restraint, decrease in staff call-outs
- The difficulty of being democratic when you are in a leadership position, including involvement of the children
- Adapting training to the needs and levels of understanding of the staff
- Behavioral management systems that complement Sanctuary – questions about whether level systems are worth using
- Discussion of trauma measures used – UCLA PTSD, CBCL, Culture Free Self Esteem Scale
- The use of the model with developmentally challenged youth – although some is cognitive based material, the model is still adaptable
- Dealing with physical violence toward staff – using safety plans
- Dealing with staff who are not interested in using Sanctuary – taking a system-wide approach to treatment

Drug and Alcohol Treatment Panel

Panelist: Janie Hogue, Director Vinita Alcohol and Drug Treatment Center



Ms. Hogue discussed her experience of using the Sanctuary model in her agency in Oklahoma. Highlights of her discussion included:

- Explaining use of the model as the “framework of the house” and use of treatment modalities as the “furniture” in the house.
- Looking at changing focus from “graduation” from treatment to creating a “future art piece” as a way to encourage a focus on future and the sense of continuity of treatment
- Increase in length of stay due to work around managing underlying issues of safety, emotion management and loss rather than just managing symptoms

- Examining rigidity of rules and the decrease in aggressive incidents since allowing clients to have input in developing rules for the community
- Understanding reenactment and how the past influences the present and future
- Using Sanctuary to bridge gaps in approaches for staff and other agencies

Policy Panel

*Panelists: Katie Henson, Oklahoma Dept. of Mental Health and Substance Abuse
Bill McLaughlin, Deputy Commissioner for Quality Assurance, New York State Office for Children & Family Services*

New York and Oklahoma were represented in this panel, and it was noted that these two states have an intimate understanding of trauma and its effects because of their experience of terrorist attacks. OCFS in New York State has funded seven agencies, five voluntary and two juvenile justice residential treatment centers, to implement Sanctuary. OMDSAS in Oklahoma is providing support in OK for training to five agencies in the state. Highlights from that discussion were:

- A recognition that there is often a disconnect between the philosophy espoused by an organization and what really goes on at the ground level
- Sanctuary's involvement of all levels of staff and clients which helps bridge those disconnects
- The need for the field focus on creating conditions of long term success
- Ways of sharing success stories – COFCA as a way to document success
- Education – sharing of best practices will also encourage government agencies to support the model
- Trauma research as a way to engage people

*The conference was attended by over 300 participants.
Thank you to all those who took part!*