NCTSN The National Child Traumatic Stress Network

Sanctuary Model

CULTURE-SPECIFIC INFORMATION

Engagement

For which specific cultural group(s) *(i.e., SES, religion, race, ethnicity, gender, immigrants/refugees, disabled, homeless, LGBTQ, rural/urban areas)* **is this treatment tailored? If none, please respond "not specifically tailored."**

The Sanctuary Model is not specifically tailored to any cultural group, but as it is based on universal principles and commitments (e.g., commitment to nonviolence) it is easily available to culturally specific adaptation. The model has been used with groups of individuals of various SES, religions, races and, ethnicities. It has also been used in settings that are co-ed as well as single sex. It has been used with refugees and homeless populations and in urban, suburban and rural settings. Although it has not yet been used in settings that provide services exclusively to LGBTQ clients, many people who identify as sexual minorities have been included in other populations being served.

Within the Sanctuary Model it is recognized that in addition to recognizing cultures specific to such characteristics as race or ethnicity, there are many ways to conceptualize culture. This model begins with the premise that any treatment setting that provides services to people who have experienced adversity has its own culture. This treatment-setting culture, based on shared experience, must be considered and addressed in addition to the cultures which individual clientele might identify.

Because of this, the Sanctuary Model is not tailored to any one specific cultural group. The aim of the Sanctuary Model is the creation of a trauma-informed culture. The model places emphasis on organizational culture through commitments to nonviolence, emotional intelligence, social learning, shared governance, social responsibility, open communication and growth and change. These commitments shape the process of creating a culture that is trauma-sensitive, but not distinct or marginalized from the wider organizational culture or society at large.

Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible. As of April, 2007, clinicians working in different areas of the United States as well as in Mexico and Ecuador have adapted the model in a number of ways to tailor engagement for the individuals of specific cultural groups whom they serve. This has included tailoring the model for individuals in treatment for substance abuse, mental illness, for children, for individuals in both urban and rural settings, as well as for individuals of specific ethnic groups such as Native Americans, Mexicans and Ecuadorians.

There are a number of ways that clinicians have tailored engagement for these specific cultural groups. For clients being treated for substance abuse, clinicians have tailored the Sanctuary Model to align with the 12 steps and to incorporate the 12 step language to foster familiarity and introduce the concept of trauma. Clinicians working with young children have tailored the Sanctuary model's language to be more child-friendly and to include pop culture references in some of the lessons to engage youth more effectively. For Native American clients, clinicians have introduced the concept of incorporating tribal symbols into client or staff safety plans. In Mexico and Ecuador, staff members have created posters and signs in Spanish to explain the concepts of the Sanctuary Model to engage those walking into their setting.

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Engagement continued	**Are there culture-specific engagement strategies** *(e.g., addressing trust)* **that are included in the intervention?** The Sanctuary model includes the culture-specific engagement strategy of building community while providing trauma-specific treatment. This community includes both service providers and clients and focuses on leveled hierarchy in an organization. This strategy of engaging clients and staff in shared governance allows an experience that engages clients and staff from marginalized populations in a process that is more empowering. With an understanding that the experience of trauma can affect an individual's sense of efficacy, sometimes resulting in feelings of powerlessness or helplessness, the Sanctuary Model addresses issues of power and leadership as a way of creating a trauma-sensitive culture. Since the Sanctuary Model is aimed at engaging staff as well as clients, one of the strategies used is the development of a core team. The core team is the main vehicle for implementation of the model and includes a cross section of staff from all levels in the organization's hierarchy. Agencies are trained to develop a core team that is designed to include both formal and informal leaders as well as people from different races, ethnicities, SES, sexual orientations, genders, ages, positions within the organization, levels of education and experience. The inherent diversity in the core team, as well as the implementation of specific Sanctuary tools that require multiple voices representing different perspectives to plan interventions, are engagement strategies included in the model.
Language Issues	**How does the treatment address children and families of different language groups?** The Sanctuary Model strives to create a shared language among the community members who use it. This shared language has been translated into Spanish, and is easily accessible for translation into other languages. Because much of the material is in written form, it is also accessible to the deaf and hard of hearing. The model has also been translated from a language that was specific to adults to a language that is more accessible to children. This was accomplished by changing the acronym SAGE, which stands for safety, affect management, grief and emancipation, to SELF, which stands for safety, emotion management, loss and future. **If interpreters are used, what is their training in child trauma?** We have not had the experience of using translators, but as has been demonstrated by its translation into Spanish, the Sanctuary Model is accessible for translation into other languages. **Any other special considerations regarding language and interpreters?** None encountered.
Symptom Expression	**Is there research or clinical evidence to suggest that the populations served manifest trauma symptoms in differential ways? If so, are there differences in the ways that symptoms are assessed for the various populations?** There is clinical evidence that lists the many ways that trauma can be expressed in symptoms.

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Symptom Expression continued	Symptoms are assessed differently in children through standardized measures specifically designed for assessing trauma symptoms and collecting information about exposure to trauma. Although the DSM-IV does not include a diagnosis of disorders of extreme stress not otherwise specified, as suggested by the DSM-IV PTSD Committee to include a diagnostic category that would capture the developmental impact of childhood adversity, the Sanctuary Model encourages service providers to understand the expression of trauma symptoms in the context of ongoing development when working with children. The model also encourages practitioners to recognize that trauma histories are associated with a host of other psychiatric problems and diagnoses. In assessing those who are in treatment for addiction, trauma symptoms are explored in the context of substance abuse. The Sanctuary Model has also been used in inpatient and outpatient settings, residential settings and detention settings. Each of these settings has developed ways to understand the symptoms and behaviors presented in their populations through the lens of trauma and reenactment. **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** The Sanctuary Model is open to using multiple treatment interventions and works on the level of creating a trauma-informed culture.
Assessment	**In addition to any differences noted above, are there any differences in assessment measures used across cultural groups? If so, please indicate which measures are used for which cultural groups. Are there normative data available for the populations for which they are being used?** The Sanctuary Model does not mandate any specific assessment measures, so it is open to trauma measures for specific cultural groups. The assessments that are used in the current implementation are focused on assessing the organizational culture as the Sanctuary Model is an organizational intervention. The measures used are an Environmental Assessment, Implementation Survey, Demographic Survey and COPES. **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** The demographic, implementation and environmental measures are being piloted at this time with 18 organizations. The COPES has normative data. **What, if any, culturally specific issues arise when utilizing these assessment measures?** The assessment tools are used to measure organizational culture and staff perceptions of the extent to which the agency demonstrates a commitment to nonviolence, emotional intelligence, social learning, shared governance, open communication, social responsibility and growth and change. Any of these categories may touch on culturally specific issues for staff and should serve as an alert to an organization's leadership that there are issues to address.

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Cultural Adaptations	**Are cultural issues specifically addressed in the writing about the treatment? Please specify.** Yes. Below is a small sample of published works on the Sanctuary Model that specifically discuss cultural issues. McCorkle & Yanosy, accepted for publication, April 2007 McCorkle & Peacock, 2005 Farragher & Yanosy, 2005 Bloom, Bennington-Davis, Farragher, McCorkle, Nice-Martine & Wellbank, 2003 **Do culture-specific adaptations exist? Please specify** *(e.g., components adapted, full intervention adapted)***.** The practitioners of the model have adapted components for use in the East Coast and Midwest of the US, Mexico and Ecuador, rural and urban settings, and with different racial and ethnic groups. **Has differential drop out been examined for this treatment? Is there any evidence to suggest differential drop out across cultural groups? If so, what are the findings?** At this time, only baseline data has been collected.
Intervention Delivery Method/ Transportability & Outreach	**If applicable, how does this treatment address specific cultural risk factors** *(i.e., increased susceptibility to other traumas)***?** The Sanctuary Model incorporates information from the study conducted by Kaiser Permanente and the CDC which found correlations between Adverse Childhood Experiences and a host of medical problems. This research has demonstrated increased risk for co-morbid medical problems for those who have experienced trauma. The work of Kenneth Hardy and John Rich, has shaped the Sanctuary Model to expand the understanding of loss to include the secondary losses experienced by marginalized groups. By creating a trauma-informed culture that focuses on safety, emotion management, loss and future, the Sanctuary Model provides a framework for addressing both general and culture-specific risk factors that increase an individual's susceptibility to trauma. The Sanctuary Model also recognizes the extent to which loss and the experience of trauma can be isolating. The community building aspect of the model provides relief from that isolation for clients as well as protection against vicarious trauma for workers. **Is this a clinic-based treatment or is the treatment transportable** *(e.g., into home, community)***? If the treatment is transportable, how is it adapted into the new setting? Is it still efficacious?** The Sanctuary Model has been adapted for use in outpatient, group homes, community based clinics and in-home settings. One adaptation has been "Sanctuary to Go," which is a tool kit for families to use at home that teaches the interventions that are applicable to a home setting (community meetings, safety plans, red flag meetings, psychoeducation).

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Intervention Delivery Method/ Transportability & Outreach continued

For clinic-based workers, the model has been adapted to focus on the organizational components of the model for the staff delivering treatment which focuses on maintaining the seven Sanctuary commitments. The model has been efficacious in inpatient, residential, outpatient, substance abuse treatment, group homes, homeless and domestic violence shelters and schools.

Are there cultural barriers to accessing this treatment *(i.e., treatment length, family involvement, stigma, etc.)***?**
Apart from the need for language translation, there have been no specific cultural barriers identified. One barrier to treatment which is experienced in many cultures is the stigma of mental illness. This stigma could present a barrier to accessing Sanctuary informed care. However, effective practice of the Sanctuary Model requires treatment facilities to seek out stakeholders and collateral supports of both the individuals in treatment as well as the treatment agency. This serves as a way of mitigating against this stigma.

Are there logistical barriers to accessing this treatment for specific cultural groups *(i.e., transportation issues, cost of treatment, etc.)***?**
The barriers that are endemic to treatment providers as they currently exist are also barriers to treatment in this model. The fact that it is transportable may negate transportation issues. Health insurance coverage is a potential barrier to access.

Are these barriers addressed in the intervention and how?
The Sanctuary Model addresses these barriers with a focus on the normalization of symptoms as a response to trauma through psychoeducation and with a focus on empowerment through including clients in shared governance and teaching them civic responsibility and advocacy skills. The focus on future and building skills to manage emotions is also a way that the model engenders independence in self-reliance in clients and staff.

What is the role of the community in treatment *(e.g., local groups such as faith-based organizations, community groups, youth and/or parent organizations, first responders, schools)***?**
The Sanctuary Model encourages collaboration with a community of practice called the Sanctuary Network. This is a group of organizations who are using the Sanctuary Model and can provide support and feedback to each other. In addition to the community of practice, the model encourages organizations to collaborate with and educate community stakeholders, specifically collateral service providers, by familiarizing them with the Sanctuary language and concepts. In educating collaborating organizations in the model's concepts this enhances the likelihood of a more seamless and effective continuum of care for the traumatized individuals seeking treatment.

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Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** Supervision and training address issues of power and hierarchy as both potential cultural issues and factors that interact with culture-specific issues. Understanding that many staff may have trauma histories themselves and/or may be members of marginalized groups, the model allows for the consideration, discussion and intervention needed to assist potentially vulnerable staff working with clients who have experienced trauma. This capacity of the Sanctuary model enables agencies to decrease the likelihood of further trauma to client (for example, it highlights the necessity of monitoring for client and staff engagement in harmful traumatic reenactments during treatment). **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** In addition to the above, cultural issues are addressed in supervision and training in the context of shared governance, flattened hierarchy, shared responsibility, education on vicarious trauma and staff self-care. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** Potential cultural issues between the clinician and the client are addressed in supervision and training by using the SELF (safety, emotion management, loss and future) framework for case conferences, treatment planning, individual, group or family sessions or supervision. In addition, continual focus and refreshers on the seven commitments aid staff in avoiding or mitigating against potential cultural issues between clinician and client. **Has this guidance been provided in the writings on this treatment?** Yes **Any other special considerations regarding training?** The Sanctuary Model is not an intervention but a full organizational system approach focused on helping injured children recover from the damaging effects of interpersonal trauma. Because it is a full system approach, effective implementation of the Sanctuary Model requires extensive leadership involvement in the process of change as well as staff and client involvement at every level of the process. All disciplines must become actively engaged in creating a Sanctuary environment.
References	McCorkle, D. & Yanosy, S. (accepted for publication, April 2007). When loss gets lost: Using the SELF Model to work with loss in residential care. In S. Bloom, & L. Vargas (Eds.), *Loss, hurt and hope.* McCorkle, D. & Peacock, C. (2005). Trauma and the isms–a herd of elephants in the room: A training vignette. *Therapeutic Communities, 26*(1), 127-133. Farragher, B. & Yanosy, S. (2005). Creating a trauma-sensitive culture in residential treatment. *Therapeutic Communities, 26*(1), 97-113. Bloom, S., Bennington-Davis, M., Farragher, B., McCorkle, D., Nice-Martine, K. & Wellbank, K. (2003). Multiple opportunities for creating sanctuary. *Psychiatric Quarterly, 74*(2), 173-190.