

Applying an Anti-Racist
Framework to a Residential
Treatment Center:

Sanctuary®, a Model for
Change

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Abstract

This paper addresses the impact of systemic racism and white privilege in a residential treatment center for children who are referred by the child welfare and juvenile justice systems. The chosen treatment approach, the Sanctuary® Model, addresses all forms of oppression through the core concepts of therapeutic community, safety, and trauma theory.

Keywords: racism, residential treatment, White privilege, Sanctuary® Model, milieu treatment; therapeutic community

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Nationwide, children of color are disproportionately represented in the child welfare and juvenile justice systems (Gibbs & Huang, 2003). They are more likely to be over-represented in child maltreatment reports than White youth, based on general population estimates. African American children represent 28 % of substantiated allegations of abuse or neglect, and they represent 41 % of the child welfare population, despite being only 15 % of the general U.S. population (Petit & Curtis, 1997). African American youth are more likely to be detained by police authorities than White youth. Youth of color are more likely to encounter the juvenile justice system because of living in neighborhoods with higher crime rates and harsher police practices. White youth who commit crimes are more likely to receive probation than youth of color, who disproportionately receive out-of-home placements (Snyder & Sickmund, 1999), while White youth are given more opportunity to stay with their families. The National Mental Health Association (2004a) reports that African-American youth between the ages of 10 and 17 make up 32 % of delinquency referrals to juvenile court, 46 % of juveniles committed to secure institutions, and 52 % of juveniles transferred to adult criminal court.

Children in the juvenile justice system have higher rates of mental disorder than in the general population (National Mental Health Association, 2004b). Despite the high rates of mental disorder, children do not receive adequate mental health screening upon entrance to the juvenile justice system. Since youth of color are more likely than White youth to become involved in the juvenile justice system, they are also more likely to have their needs under-identified. Their access to adequate mental health screening is lacking, despite the prevalence of mental disorders.

Among the reasons why youth of color are more often involved in the juvenile justice system than White youth are racial profiling and racial bias in the system (Gibbs & Huang, 2003). White youth who commit crimes are more likely to be referred to mental health systems for treatment, than to juvenile justice placements.

The population in residential treatment centers (RTC) for youth mirrors the adult prison system, in that nationwide, African Americans make up almost half the prison population, yet only 12 % of the general population (NAACP Prison Project Page, 2004).

Invisibility Syndrome: Seeking to Be Seen

Children of color are often expected to live amicably in a racist system, in which their voices are not heard, and their playful behavior is viewed as threatening or deviant. A.J. Franklin (2004) describes the conflict that African American families experience when balancing keeping their children safe and allowing them to be kids, “Our safety is connected to how and when we make ourselves visible, particularly outside of the community. It is such a powerful concern that when African American boys want to engage in normal, innocent risk-taking

behavior – boys will do – they get caught in a protective net of community vigilance” (2004, p. 80). His example refers to children who are still in their communities, and not in the juvenile justice or child welfare systems. Parents attempt to protect their African-American children from the unfair standards and expectations placed upon them by a racist society. Within a residential treatment setting, the children are either temporarily or permanently parentless. They have experienced such pervasive trauma that their ability to take guidance from caring adults is compromised. Without a thoughtful parent in the picture, a child may behave recklessly, without concern for consequences. This often translates into behavior that is seen as deviant: stealing, fighting, disrespecting adults, truancy, self-harm, and drug and alcohol abuse. All children, particularly adolescents, are looking to find a solid sense of self. They seek attention and validation in ways that may unfairly create more personal problems.

Children Living with Constant Racism

A.J. Franklin (2004) discusses the signs and symptoms that African American boys and men display as a result of persistent micro-aggressions or racial slights. He lists the following: frustration, increased awareness of perceived slights, chronic indignation, pervasive discontent and disgruntlement, anger, immobilization or increasing inability to get things done, questioning one’s worthiness, disillusionment and confusion, feeling trapped, conflicted racial identity, internalized rage, depression, substance abuse, and loss of hope. These signs and symptoms describe many of the children in residential treatment. Not surprisingly, these symptoms are also some common post-traumatic reactions. There is a link between racism and chronic stress, and the shared reactions they create.

Racism and Post Traumatic Reactions

“The chronic, institutional stresses of poverty and racism are examples of social forces that can be termed traumatogenic in that they breed interpersonal traumatic acts” (Bloom & Reichart 1997, p. 37). When people are under constant stress from multiple directions, interpersonal violence is an increasing threat. Additionally, a person living in an environment of constant violence and stress is less likely to develop interpersonal trust (Bloom & Reichart, 1997), thereby reducing the development of healthy attachments. Many children in residential treatment have difficulty forming healthy attachments with adults because of the stressful environments in which they were raised. This limits their ability to relate to others empathically and makes anti-social behavior more likely, leading to negative consequences. When a child has been traumatized in the past, her current functioning is impacted. Some common adolescent expressions of post-traumatic reactions are drug and alcohol abuse, self harm, and aggressive and violent behavior. Children with these behaviors are easily considered as “bad” or “delinquent” by society.

Traumatic reminders may trigger reactions that seem confusing to those who do not know the child’s trauma history. Existence of ongoing stress, such as institutional racism, can

exacerbate a person's post-traumatic reactions. Therefore, it is essential to work from a lens based in trauma theory, which acknowledges forms of oppression, such as racism and poverty. The lens must also include methods by which oppression is not perpetuated. Effective intervention must acknowledge impact of trauma and recognize racism and poverty as potential sources of traumatic injury. Furthermore, residential treatment must not itself be a source of trauma, including the trauma of racism and oppression.

Racism and White Privilege within Children's Residential Treatment

Racism is race prejudice plus power. It is not about individual acts of meanness or prejudice, but refers to a systemic power arrangement, which permeates every institution in American society (Chisom & Washington, 1997). Pinderhughes (1989) explains that the problem of racism is not caused by a single entity, but by the complex interlocking of policies and institutions that reinforce one another. She states, "Belief in superiority of Whites and the inferiority of people-of-color based on racial differences is legitimized by societal arrangements that exclude the latter from resources and power and then blame them for their failures, which are due to lack of access" (p. 89). This excerpt pointedly describes the situation of children and families held hostage by the child welfare and juvenile justice system. Although many White individuals within American society would not describe themselves as racist, they allow for the perpetuation of the "social arrangements" which hold captive millions of people of color in the adult and child judicial and welfare systems. But where is the justice and where is the welfare?

Abramovitz and Bloom (2003) describe the historical trends of treatment of youth in residential treatment settings. Post World War II, many treatment settings applied psychoanalytically informed individual therapy, group therapy, and milieu therapy. The emphasis on psychoanalytic theory placed the blame of bad behavior on the child, rather than considering the external stressors, such as systemic racism and poverty. The emergence of social psychiatry of the 1960s and the creation of the PTSD diagnosis in the 1980s were efforts to consider external factors that may contribute to delinquent behavior. It is important for residential treatment programs to be aware of cultural and race bias embedded in psychological theories, which may be applied in individual psychotherapy, created by Whites in a White-dominant culture. In a milieu treatment setting, all modalities – individual, group, case management, advocacy, skills training, etc., are considered equally important in the healing.

Anti-Racist Framework

Working within an anti-racist framework requires that all people, staff and residents, must have the opportunity to develop a healthy and well integrated racial identity. Developing such an identity is extremely challenging for children of color in residential treatment when racism has so profoundly impacted their lives, and continues to through their living in an environment in which people of color are lower paid with less access to training and education.

Applying an Anti-Racist Framework

In residential treatment, people of color may be more likely to hold lower paying front line jobs that do not require advanced formal education, as will be described below.

No RTC is exempt from the dynamics of institutional racism and unearned White privilege. One way of addressing the “systemic process of racism” (Pinderhughes, 1989, p. 90) is by looking at one institution, in which racism and White privilege exist by virtue of being a part of the larger interlocking institutions described above. In order to work toward an anti-racist system, it is necessary to define the areas in which racism and White privilege are present. Unless an organization is intentionally anti-racist, everything it does will disproportionately benefit White people and disseminate racism.

In “Why are all the Black Kids Sitting Together in the Cafeteria” Tatum (1997) eloquently describes what it means to a passive participant in racism,

I sometimes visualize the ongoing cycle of racism as a moving walkway at the airport. Active racist behavior is equivalent to walking fast on the conveyor belt. The person engaged in active racist behavior has identified with the ideology of White supremacy and is moving with it. Passive racist behavior is equivalent to standing still on the walkway. No overt effort is being made, but the conveyor belt moves the bystanders along to the same destination as those who are actively walking. Some of the bystanders may feel the motion of the conveyor belt, see the active racist ahead of them, and choose to turn around, unwilling to go to the same destination as the White supremacists. But unless they are walking actively in the opposite direction at a speed faster than the conveyor belt- unless they are actively antiracist- they will find themselves carried along with the others (p 11-12).

Walking, or running in the opposite direction is necessary to work from an anti-racist perspective. To some extent, all White people are beneficiaries of unearned White privilege, and all people of color are affected by racism. Some people may wonder why it is necessary to change the status quo, if they are benefiting from the situation of White privilege. In reality, the entire society suffers from the oppression of people of color due to “the loss of human potential, lowered productivity, and a rising tide of fear and violence in our society” (Tatum, 1997, p 200).

The following sections will provide a view of one RTC from an anti-racist lens, highlighting the relationship between power, privilege, and race in that system. The analysis is in no way a critique of individuals, but rather a snapshot of a large system informed by the greater society, in which racism and white privilege are dominant.

A word about the authors: One author, George, is a Black heterosexual male director of the RTC, who has worked in residential treatment for 25 years. George has experienced the negative effects of interpersonal, institutional and societal racism, and has been the beneficiary of male privilege. The other author, Caroline, is a White lesbian administrator for a trauma-based model of care on the campus, and has been working in social service settings for 6 years. Caroline has been the recipient of unearned White privilege in educational, professional, and

every day situations. She has experienced the negative effects of interpersonal, institutional, and societal homophobia and heterosexism, which have made her more sensitive to social and institutional prejudice. George and Caroline began discussions together about racism and White privilege when given the task of writing this paper. George has been personally mindful of racism and White privilege for many more years than Caroline. Throughout the process of writing this paper, new ideas have been developed while thinking about racism and White privilege on the campus.

The Facility

In New York State, Residential Treatment Centers care for children referred by the child welfare and juvenile justice systems. Similar facilities exist throughout the United States, although they may have different names. This paper will describe one such facility, located in the suburbs north of New York City. The residents, girls and boys, range in age from ten to eighteen, and come mainly from the boroughs of New York City. The children are grouped by age and gender in cottages on a central campus. The initiating event for entering the child welfare or juvenile justice system can range from being the victim of abuse to being the perpetrator of petty or more serious crimes. The children can either be removed from their home of origin by child protective services, or their families can request removal based on difficulty in disciplining or managing the child.

Description of Staff

At the Residential Treatment Center, children receive a variety of forms of treatment: psychotherapy (individual, group and family therapy), milieu, recreational, and drug and alcohol treatment. The RTC is staffed by 161 employees, including milieu counselors, social workers, administrators, maintenance workers, nurses and psychiatrists. The position of milieu counselor requires a high school diploma, although many have some college credits or college degrees. Social workers are required to have a master's degree, and must have or be working toward state licensure. Administrators have a variety of educational backgrounds based on the discipline. Maintenance workers are required to have a high school diploma or GED. Nurses are required to be licensed by the State, and psychiatrists must have a medical degree and be licensed in the State. At this RTC, 93 % of milieu counselors are people of color, 7 % are White. Fifty-six percent of administrative staff members, including assistant unit directors, unit directors, and administrative supervisors are people of color, and 44 % are White. Twenty-two percent of social workers are people of color, and 78 % are White.

Description of Clients

Children who have been involved in the child welfare system may have had numerous unsuccessful foster care placements, for example having behaved in ways that the foster parents could not manage. Some who come to the RTC have been in as many as eleven different foster care placements. As their emotional distress and behavioral difficulties increased, they have been placed in an RTC, which is a more restrictive and highly supervised environment. Some children who have been placed at the RTC through the juvenile justice system have been given a “last chance” to straighten up before being remanded to a detention facility. The children in the RTC are often seen by court judges as “bad kids” because their behavior may include fighting, stealing, truancy, and other difficult to manage conduct. Many have parents who are themselves survivors of the child welfare and juvenile justice systems. Some have parents who are incarcerated, or engaged in their own drug and alcohol treatment. The common denominator for the majority of the children in the program is traumatic exposure, usually of a pervasive and interpersonal nature.

The children in the RTC are predominately from families of color. Ninety-six percent of the children are people of color, and 4 % are White. Many come from impoverished neighborhoods, low or no-income households, in which access to adequate food, health care, shelter, and education is lacking. Most of the children are far below grade level in their education, and many are illiterate.

Professional and Paraprofessional

The milieu counselors provide the essentials: supervision of residents, food, and rules for the living environment. They are the temporary parents of the children in this residential setting. The milieu counselors spend their time “on the unit” and are available to the residents at any time. Milieu counselors are always there: nights, weekends, and holidays. When there is one child left on the unit on Christmas day, a milieu counselor is there providing supervision, food, and care. For our setting, this means that the people who spend the most amount of time with the children are of the same race and sometimes ethnicity.

The social workers and psychiatrists provide therapy, case management services and psychotropic medication, when necessary. They have private offices in the clinic wing, where individual treatment sessions can take place with the child. The physical setting differentiates the type of treatment the child receives in the milieu as compared to in the clinic wing. The clinical treatment has traditionally been referred to as “professional,” while the milieu treatment is called “paraprofessional.” Referring to one discipline as “professional” and another as “paraprofessional” assumes that one position is less legitimate. On the contrary, the position of milieu counselor requires extreme patience, excellent people skills, crisis management knowledge, and flexibility, to name a few. Milieu counselors provide the bulk of treatment—without them, the system could not function. They are very much “professional.”

Applying an Anti-Racist Framework

The clinic wing is often locked and only accessible by those who have a key, which does not include all of the milieu staff. The residents' case records are located in the clinic wing, and based on the previously mentioned fact regarding the locked door, are primarily accessible to clinical staff only, creating an inequity in accessibility to important treatment information. This is what Tatum (1997) refers to as "passive racism." The lack of access is not directly communicated as a racial issue, but because it primarily limits people of color, it is a racial issue.

Behavior Management and Treatment

The clinicians are thought to be responsible for the *treatment* of the residents, while the milieu staff handles the *management* of the children. When a resident is "in crisis" the team of milieu counselors and clinicians works to calm her down. When she becomes a physical danger to herself or others, a therapeutic restraint is used as the last resort. If there is a crisis on the unit and the clinician is present, she has the option of retreating to the clinic wing. The milieu counselors are required to stay and *manage* the situation. Staff members of all disciplines are trained in the techniques of therapeutic restraints, but the clinicians rarely take part. The restraints are almost exclusively made by milieu staff; the clinician does not have to participate in the activity. Peggy MacIntosh (1989) explains that Whites are regularly given the option of staying comfortable and confident, while people of color are made to take part in violence and hostility. In this situation, people of color are made to physically express dominance over children of color for the goal of safety.

Training and Education

From a baseline there is a higher level of education among White employees, than people of color. This mirrors the image of the general population, with higher level positions being held by Whites, and lower-level positions by people of color. Within our RTC, staff members of all disciplines receive training. Social work staff is required to complete 180 hours of in-service training to enhance their clinical skills. Milieu counselors attend a child care "professionalization" institute, which reinforces that their position is not professional. Milieu counselors have to work overtime to attend training, as it is not built in to the regular work schedule. Throughout the year there are other training opportunities that are only made available to clinical staff, creating a distinction between what is referred to as "professional" and "paraprofessional" staff.

Child Rearing Techniques

Child rearing techniques are an important aspect of milieu treatment because milieu counselors are in the role of parents on the unit. Boyd-Franklin (2003) explains that many African-American families may choose physical discipline over other forms of discipline. She

suggests that therapists might try to understand the “protective posture” of families who choose corporal punishment, meaning that it may be used as a way to protect children from future and possibly harsher punishment for “bad” behavior. Based on racial differences, the child-rearing techniques of the milieu counselors may differ from those of the clinical staff. Despite some of the cultural similarities between the children and the milieu counselors, the clinical approaches may be viewed as superior by the institution. As a result, there may be a cultural distinction between the approaches that milieu counselors and clinicians may have experienced or used in their own families. The authors are not arguing one case over another, but merely acknowledging the potential racial difference in approaching discipline. The National Mental Health Association (2004c) has goals and principles for providing culturally competent practice, which is one form of developing an anti-racist framework. One principle is that major differences in world views may exist in cross-cultural relationships between providers and consumers. The difference in world views also exists between providers and providers. The National Mental Health Association recommends addressing and discussing these differences.

The Message the Kids Receive

Children are keenly aware of the unspoken messages among the adults around them. They see the power dynamics among clinical and milieu staff. They know who are the “professionals” and who are not. They know who are the gatekeepers to their discharge: not the milieu counselors, but the social workers, supervisors, and administrators. Leon Chestang (1972) describes the concept of “social inconsistency” as “the institutional disparity between word and deed. It is the social immorality perpetrated on the oppressed group by the manners, morals, and traditions of the majority group” (p. 42). At the RTC, as in most institutional settings, there is a social inconsistency in word and deed. We support the concepts of cultural competency and anti-racist practice, and yet there are disparities in the application. In our setting, the children become active players in the institutional racism and White privilege that is maintained by the outside and inside systems.

Our Radical Approach: The Sanctuary® Model

*“Without revolutionary theory, there can be no revolutionary movement”
(Lenin 1901)*

Over the past four years, the RTC at JBFCS has been implementing Sanctuary®. The process is supported through the agency’s Center for Trauma Program Innovation (CTPI), whose mission is to enhance trauma-related services throughout the agency and community. This model was adopted in an effort to create a consistent method of working with traumatized children, and to address the impact of chronic stress and trauma on the lives of clients, staff and the system.

Sanctuary® is a trauma-based model that uses therapeutic community to create a safe environment in which people can heal from traumatic experiences. Sanctuary® was co-created by Sandra Bloom and colleagues in a short-term acute inpatient psychiatric setting. The book “Creating Sanctuary®” (Bloom 1998) describes the work over many years. Over the past two decades, Sanctuary® has been modified and implemented in a variety of settings to match the population, including this RTC. Although Sanctuary® is not explicitly an anti-racist model, it inherently addresses the effects of all forms of oppression through core anti-oppression and humanistic concepts. More than a product or a model of care, Sanctuary is a process. The process of creating Sanctuary® includes the collective development of a shared vision. In the shared vision, multiple perspectives are honored through a flattening of the hierarchical structures. Sanctuary® places an emphasis on open communication between and among different disciplines, creating an atmosphere in which the traditionally oppressed or devalued voice is heard and becomes an important part of the decision making process. The Sanctuary® Model rests on a foundation of shared assumptions, by which all staff approach working with the children and with each other. The shared assumptions were co-created by an original Sanctuary® team, and have been slightly adjusted to apply to the clients in the RTC. At the RTC, five main assumptions have been adopted as guidelines for creation of a safe and therapeutic community. All five assumptions implicitly address the impact of racism, and offer a guideline by which to confront it.

Shared Assumptions

#1: Safety and Non-Violence are the Cornerstones of a Sanctuary® Unit.

“The first value to be established, goal to be set, and practice to be formulated is that of safety. Regardless of whether we are referring to an individual victim of violence, a small group, or an entire community, healing cannot advance unless there is an environment of safety for all community members” (Bloom, 1997, p. 228). Creating a safe environment is a tall order in residential treatment. The children, staff, and system need to feel physically, emotionally, socially and morally safe in order for healing to take place. The concepts of safety and non-violence are taught to the staff and residents through the teachings of Rev. Martin Luther King, Jr. and Mahatma Gandhi. Role models who are people of color are essential applications of this assumption. On a systems and personal level, racism and White privilege are inherently unsafe for all parties. Although the White individual or system may prosper due to the unbalanced power structure, it is only committing violence against itself through the oppression of others.

One way that children and staff maintain personal and community safety is through use of Safety Plans. Every staff person and resident has a card on which she has identified five options for staying safe when feeling overwhelmed by feelings or difficult situations. The Safety Plans are designed to be used at anytime, in any situation within the RTC community or while visiting family. Because it is a self-monitoring tool, the Safety Plan places the power of recovery in the hands of the child. While staff offer consultation and support, the child develops her own plan and owns her choices. Self-monitoring is inherently anti-racist because the power is in the hands of the client.

#2 Children in Residential Treatment are not Sick or Bad, but Hurt and Injured

It is easy to attend to only the behavior of children who end up in residential treatment. If a child in this system were only defined by his behavior, it would be difficult to have empathy. The Sanctuary® Model requires and supports understanding the current behavior in relation to the trauma history. Here is a case example:

Michael is refusing to stay in his room at night. He keeps his roommate awake, disturbs the milieu staff and says that he is “not tired.” Michael is frequently agitated in the mornings, and tends to fall asleep in school. After reviewing his trauma history, the staff understands that Michael’s behavior is related to his history. He was removed from his family in the early morning, and his disruptive behavior around sleeping comes from his fear of the danger that morning can bring.

One way that the assumption that children in residential treatment are not sick or bad, but hurt and injured is actualized through the protocol for case conferences. Every conference begins with a review of the child's trauma history, followed by a discussion of the current behavior in relation to the history. In Michael's case, the team will link his current behavior with his trauma history. They understand his needs and can create a treatment plan that focuses on recovery from the trauma of removal. One possible intervention would be for an evening milieu counselor to reassure Michael before bed that in the morning a particular staff person will be there to wake him and be a support. This treatment plan addresses Michael's avoidance and hyperarousal symptoms in relation to his trauma history. It also engages milieu counselors in a critical part of treatment. Rather than managing his behavior, they are the therapists.

Another expression of this assumption is through the Sanctuary® question: "What happened?" Whenever there is a crisis or a child is upset, staff begin by asking "What happened?" rather than, "What is wrong with you?" or "What did you do wrong?" The approach of viewing the child through a trauma lens is not a free pass for bad behavior. The child is still held responsible, but when the staff and child have an understanding of the events that led to a negative occurrence, the path to better decision making is more accessible. With a societal predisposition of viewing youth of color as "bad," this concept of children as "hurt and injured" provides a framework to look at each child individually and to avoid racially-based assumptions.

#3 Leveling of Hierarchy

Leveling of hierarchy means that every individual in a system is equally important. It does not mean that everyone is doing the same job, but that each discipline works together to make the system function properly. The metaphor that is presented to the children is that of a jazz band, in which each player uses her instrument in collaboration with the others to make beautiful music.

When the hierarchy within a system is leveled, the gatekeepers are diversified. Multiple perspectives are essential to the healthy functioning of a system, and therefore the children receiving services may be given more options. When individuals of traditionally lower-level positions have a voice within the system, everyone benefits from the extended and diverse experience base. The leveling of hierarchy requires a process of shared decision making. This assumption is a core concept for applying an anti-racist framework. Here is a case example:

John is a 15-year-old in a Sanctuary® unit at the RTC. He engages with his social worker in individual therapy, but remains somewhat withdrawn in the milieu. When encouraged by his primary milieu counselor to participate in a group unit activity, John becomes angry, is verbally aggressive with the counselor, and goes "out of place" (leaves the supervised area without permission). During a treatment conference, the team consisting of milieu counselors, the unit director, social worker, and social

work supervisor, is discussing John's progress in the program. The social worker is pleased with his progress and feels that John should be allowed to go home for the weekend. The primary milieu counselor disagrees, stating that John's action of going out-of-place automatically dismisses the possibility of a home visit for that weekend. Applying the leveling of hierarchy assumption, the team acknowledges and respects the milieu counselors suggestion. These alternate perspectives are both honored in a team with leveled hierarchy, leading to a decision for John to remain on the unit for the weekend.

This example is very common; differences of opinion in treatment planning are bound to occur, but a level hierarchy allows open, honest communication and a healthy working environment. When shared decision making takes place, people of color have a voice in the traditionally White-dominated system. This concept is also applied to the residents. During daily community meetings, children have the opportunity to discuss community issues, and to make shared decisions about key elements of their daily living. Sometimes the decisions may revolve around seemingly simple topics, such as group trips and snacks, and sometimes more complex topics, such as cottage rules and privileges. The basic process of consensus building is empowering to the group and to each member.

Shared decision making through the leveling of hierarchy is inherently anti-racist because the power is in the hands of the community members. Pinderhughes (1989) refers to this process as "power sharing." She explains that when individuals or groups share power, the power is experienced differently. "Power will be experienced not as a consequence of dominance, but as freedom from it. There is freedom from the entrapment embedded in the dominant position, from the sense of conflict, the fear and the stress, the rigidity, and need for sameness" (p. 142). When power is shared, the wealth of perspectives is an asset. In "Cultural Competence in Serving Children and Adolescents with Mental Health Problems" SAMHSA (1996) suggests allowing the community to determine direction and goals of treatment in culturally competent practice. Although they are not referring to a community, such as a group of children and staff in a residential treatment setting, the recommendation is nevertheless important.

#4: The Team is the Treatment

In a Sanctuary® unit, every person has something to contribute, and every person's opinion counts. In a therapeutic community, the whole community provides the treatment, not just one individual who has a private office or a particular educational degree. Traditionally, the treatment was expected to take place in the therapist's office for forty-five minutes a week. The child would attend therapy, and return to a chaotic and unsafe environment in the milieu. Sanctuary® shifts the concept of where treatment actually takes place: it happens primarily in the milieu. The children, milieu counselors, clinicians, and administrators are all therapeutic agents. When a child has a problem in the milieu, she is encouraged to discuss it with her

primary milieu counselor. When there is a community issue, there will be a group discussion and processing to resolve it. Children and staff have the option of “calling” an impromptu group meeting to address any community issues that are pressing. SAMHSA (1996) recommends that to achieve culturally competent work, the community should determine direction and goals. Sanctuary® does exactly this.

Community Meetings are a central component to the actualization of Sanctuary®. At the RTC, all members of the community, or “cottage”, meet twice a day. One resident functions as the leader for the meeting. The children and staff are asked the following questions by the leader: “How are you feeling?”, “What is your goal for today?” and “Who will you ask for help?” At the end of the day, the morning goal is followed up on, and there is a time to discuss and process community issues. These questions are based in trauma theory and create a therapeutic community. “How are you feeling?” develops the ability to label affect, a common difficulty for people who have been traumatized. “What is your goal?” helps individuals to see how their actions now can impact the near or far future. “Who will you ask for help?” helps to rebuild healthy attachments, or create them for the first time.

All staff members participate in the Community Meeting. Everyone sits in the same circle, and the hierarchy is leveled. Every individual in the meeting is held to the same standard. All staff members are active agents for treatment in Community Meetings, and in the general therapeutic milieu. They are able to encourage children with goals, offer their help, and model affect management. When the children see the collaboration between different disciplines, such as clinical and milieu, they realized the power paradigm can be changed from what is known on the outside.

Using the whole team as the treatment is inherently anti-racist in nature because it honors the multiple perspectives that different individuals may bring to the work. Having the team as the treatment requires that the individual members of a team work collaboratively so that it is not confusing for the child. When this assumption is actualized, and all members are providing treatment, but not in collaboration, it can be very disruptive to the child. However, when individuals do collaborate, healing can occur. This is the same concept as “It takes a village to raise a child.” When a resident knows that the milieu counselors, who are likely of the same race and ethnicity as she is, are respected and honored as essential members of the system, it provides a stronger sense of self in relation to the child’s own race and ethnicity.

#5: Everyone can get better, even if only a little bit

Without hope, a dream cannot be actualized. For many of these children, there is little or no internal or external hope. Sanctuary® provides a hope that all people can recover, if only a little bit, from the experiences of chronic trauma in their lives. This assumption is also based on the concept of resiliency. For example, a child comes from an impoverished neighborhood, experienced chronic physical and emotional abuse, lost a parent to incarceration, survived eleven foster care placements, and is still able to wake up each morning and go to school – *that* is resiliency.

S.E.L.F.-Based Recovery

The Sanctuary® Model is organized around a phase-based recovery framework called S.E.L.F. (Safety, Emotional Management, Loss and Future). The residents are responsible for their own recovery by working through these phases with the treatment team and the community. All staff members are trained in the concepts of S.E.L.F., and these recovery phases are worked into every aspect of treatment. Here are a few examples of how S.E.L.F. is integrated into treatment:

Safety is addressed through creation of Safety Plans. Staff members frequently set daily community meeting goals related to safety, such as “My goal is to keep the community safe this evening.”

Emotional Management is self-monitored through use of Safety Plans. Education around emotional management is ongoing, such as in daily Community Meetings when children answer the question, “How are you feeling?”

Loss is addressed through Loss and Bereavement groups for children who have suffered the death of a primary caregiver. Milieu counselors also discuss issues of loss, such as children leaving home, losing friends, etc. with the children individually and in groups.

Future is a constant topic during daily Community Meeting goal-setting, independent living groups, and the motivational speaker series.

S.E.L.F. also applies to the staff and the system and provides a means to recognize and work against racism. Staff members talk with each other regularly to promote safety among themselves. If the RTC perpetuates racism, children and staff cannot feel safe alone or in relation to one another. If there is not enough safety to address racially-based inequality, a milieu counselor cannot feel that her opinion really matters. Emotional management is sometimes referred to as “managing your stuff” with the residents. The organization also has to “manage its stuff,” meaning that when issues of racism and other forms of oppression arise, they have to be acknowledged and dealt with. Milieu counselors and social workers teach the children to talk about things that bother them, thereby creating an environment in which unsettling feelings can be aired. This process must be applied to the staff as well. Loss is keenly felt in social service and mental health care settings, as funding is frequently cut, and there is regular turn-over of staff. Issues of loss, whether personal or institutional, create a stressful environment. Processing on a micro or macro level is an essential part of recovery. In order to stay hopeful in a stressed system, there has to be a shared vision for the future. The organization, and the people within it, need to discuss with each other what the shared vision is, so that members of the system can support and reinforce each other.

Through its application to the individual and to the organization, S.E.L.F. provides a self-monitoring and therefore anti-racist framework for recovery. The power for change is within each individual and the system, and not determined by an outside force.

A Long Way To Go

The RTC described in this paper is at the beginning stages of a culture change initiated by the Sanctuary® Model and facilitated by a commitment to anti-racist practice. The RTC continues to diversify its staff, as is demonstrated by the administrative position demographics of 56 % people of color and 44 % White individuals. All clinical and milieu staff are required to complete training on issues of race, ethnicity, class and cultural competence. The RTC proudly incorporates a motivational speaker program that honors people of color as role models for the residents. Residents will soon be starting a social justice organizing group, so that they can make change in the systems that have oppressed them.

Culture change is continuous and has no tangible ending or product. Some beginning tangible changes have occurred through the implementation of model, such as Safety Plans, Community Meetings, and psychoeducational modules. Application of Sanctuary® shared assumptions provides an opportunity to self-monitor the ways that racism and other forms of oppression play a role in our system. Many of the treatment teams, consisting of clinical and milieu staff successfully work together in a non-hierarchical and team approach. The benefits are incredible for the team members, and most importantly, for the residents. Sanctuary® provides us with a framework for openly and honestly discussing racism, White privilege and other forms of oppression, but we must be vigilant. We can easily fall into the trap of saying we honor Sanctuary® values, while not *practicing* in a Sanctuary® way. The work is hard, especially as it requires each of us to look at the ways that racism and/or White privilege have played a role in our lives, and continues to impact our work relationships and the treatment of the children inside a larger racist system and society. We must consciously turn around on the conveyor belt that Tatum (1997) describes and head in the opposite direction.

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