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## BEST PRACTICE PRINCIPLES: GAY AND LESBIAN YOUTH IN CARE

by D. Mark Ragg and Dennis Patrick

For adolescents, developing and integrating their identity can be difficult. For gay and lesbian youth, this task is greatly complicated because they must integrate an identity that diverges from mainstream society.

Gay identity develops through four phases: discovering same sex attraction; experiencing confusion; assuming a gay identity; and committing to this identity (Cooley, 1998). As identity solidifies, youth discover a life direction that diverges from other youth (Swann & Anastas, 2003). Gay and lesbian youth must develop their identity in the face of homophobia and hate (Tharinger & Wells, 2000; Swann & Anastas, 2003).

Gay and lesbian youth need help resolving adolescent identity crises (Cooley, 1998; Tharinger & Wells, 2000). Such support is often unavailable for youth living in out-of-home care. For example:

- Natural sources of support—family, friends and teachers—are often unavailable (Omizo, Omizo, & Okamoto, 1998; Saltzburg, 2004).
- Youth are often subjected to jokes, gay-bashing, politicized religiosity, and moral debates by professionals paid to help them (Mallon, 2001; Tharinger & Wells, 2000).
- Youth frequently lack effective support and are harassed and abused

by caregivers in residential situations (Mallon, 1992, 1997, 1998).

- Worker turnover and multiple placements can erode potentially supportive relationships.
- Agency policies, procedures, and protocols create obstacles and communicate a lack of acceptance to gay and lesbian youth (Maccio & Doueck, 2002).
- Agencies screen out gay and lesbian caregivers who could serve as mentors (Brooks & Goldberg, 2001; Hicks, 2000).
- Youth are often referred to therapy, implying their identity is a problem rather than a developmental issue requiring support and understanding (Cooley, 1998; Elze, 2002; Stone, 1999; Yarbrough, 2003).

Given these realities, many youth elect to remain invisible while in care and feign heterosexual interests and activities to protect themselves. Providing appropriate support is difficult when caregivers often do not know the difference between straight and gay or lesbian youth. Caregivers can easily make heterosexist assumptions if they never know when a gay or lesbian teen might be present.

Guiding principles are needed to better prepare professional caregivers

for supporting gay and lesbian youth living in out-of-home care. This article is a first step. Important practice principles were developed through interviews with 25 gay, lesbian, and bisexual youth living in out-of-home care. The youth identified actions by helpful workers and contrasted them with actions by workers deemed harmful to positive identity development. Identified practice

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principles focus on three dialectical themes:

- vulnerability versus empowerment,
- stigmatization versus validation,
- and acceptance versus rejection.

### Vulnerability versus Empowerment

Youth interviewed identified a sense of vulnerability associated with being gay or lesbian in out-of-home care. Workers have a powerful influence over a young person's coming out process by sharing his identity with others. The young person is vulnerable to caregivers' agendas and rationales for telling others.

Gay or lesbian youth are often ostracized or picked on by other youth as his or her true identity is shared. These youth are particularly vulnerable if their identity is put into their file. Anyone reading the file will know this private aspect of the teen's identity, even before meeting him or her.

Workers identified as harmful tended to see gay and lesbian youth as a threat to others and compromised confidentiality based on this perceived threat. Harmful workers also established different relationships with youth based on perceived sexual orientation.

Frequently, gay youth faced jokes or differential treatment.

Workers must be able to protect youth and manage their feelings of systemic vulnerability. This is especially important when youth are experiencing identity confusion and questioning the sexual elements of their identity. The five best practices associated with empowerment versus vulnerability are:

- **Monitoring heterosexist bias.** The best workers never ridiculed a population with comments or jokes, but conveyed respect for all people. Concurrently, the best workers used inclusive language that avoided heterosexist biases, asking, for example, "Do you have a partner?" or "Are you seeing somebody?" versus, "Do you have a girlfriend?" This communicated openness and allowed youth to share small elements of their identity until they felt comfortable coming out.
- **Tuning into comments.** Gay and lesbian youth often share hints with workers about their identity. Comments might reference a television show with a gay actor or provide vague information indicating

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the youth may not be heterosexual. A young person might tell a worker, for example, “I like *Will and Grace*. I never miss the show.” The best workers picked up on the comments and communicated acceptance of gay content or identity.

***Gay and lesbian youth note social attitudes about homosexuality daily as they struggle with their identity. Youth are very susceptible to integrating negative messages about their sexuality.***

- **Working things through.** Youth indicated that supportive workers intervened with other staff, professionals, and youth who reacted strongly to their sexual identity. Good workers mediated negative attitudes and misconceptions to minimize impact on youth.
- **Respecting youth privacy.** The best workers consistently allowed youth to control their “coming out,” including situations where the worker may have suspected a teen was gay or lesbian, but waited for him or her to disclose this information rather than pressuring the young person to come out. Similarly, workers maintained confidentiality when talking with other professionals.
- **Limiting formal exposure.** The best workers consistently approached sexual information in official documentation. If they did not normally note a young person’s heterosexuality, they would not note his or her homosexuality.

### **Stigmatization versus Validation**

Gay and lesbian youth note social attitudes about homosexuality daily as they struggle with their identity. Youth are very susceptible to integrating negative

messages about their sexuality into their self-esteem. Most gay and lesbian youth noted professional statements and actions that elevated feelings of stigma. In extreme situations, teens experienced self-loathing and self-destructive feelings associated with their sexual identity.

Ongoing validation is necessary to help gay and lesbian youth integrate positive identity. Youth identified five best practices:

- **Individualizing messages.** The best workers helped youth separate themselves from negative messages and stereotypes. Workers emphasized negative messages are not about the teen as an individual, but about other’s discomfort with the teen’s identity.
- **Affirming the young person.** Good workers affirmed youth when they shared developmental struggles, including listening to the teens’ attractions and relationship problems concurrent with struggling to integrate elements of their identity.
- **Reframing differences.** When a young person highlighted his “differences” with workers, the best workers tended to refer to differences as “unique traits.” Good workers identified positive or neutral meanings that could be attached to the unique qualities of the young person. The worker might explain to him, for example, “You are just more sensitive and attuned to other people.”
- **Promoting pride.** Many of the interviewees spoke of workers who affirmed their strengths and positive attributes. Good workers promoted these unique traits as potential sources of pride, and helped the youth connect with other gay and lesbian young people who felt pride in their unique qualities.
- **Normalizing youth.** Youth noted worker responses that stressed a young person’s normal and natural elements. Workers, for example, would include a teen in activities with straight peers. The best workers included gay-related content when selecting movies, television shows, or other entertainment.

### **Acceptance versus Rejection**

Rejection is often traumatic for gay and lesbian youth in care. This is especially true when professional caregivers are the one’s rejecting youth. Conversely, acceptance promotes the internalization of affirming messages.

Almost every interviewee shared a story of open rejection where a person, who had initially been supportive, severed or altered their relationship after learning about the young person’s sexual identity. Such interactions exerted powerful influence on the teen’s developing identity.

Youth often protected themselves by withholding parts of their identity from others, living their lives in partial relationships. Frequently, a young person believed she only received support because people did not know her full identity. Other youth exhibited behavior

***Some caregivers acted as if they accepted a teen but conveyed messages that the young person somehow did not measure up.***

likely to cause rejection so they could control anticipated rejection by others.

Some caregivers acted as if they accepting a teen but conveyed messages that the young person somehow did not measure up. Sometimes staff compared a gay or lesbian teen to a heterosexual teen, pointing out aspects of heterosexual youth that were more highly-valued. The support person then pressured the young person to measure up to the more highly-valued person.

Sometimes a worker assumed expertise on the teen’s experience by dismissing the seriousness of his identity struggle. Almost all of the youth interviewed shared a story of a worker or other professional dismissing his or her sexual identity.

Common messages from workers focused on the teen being young, inexperienced, needy, or reacting to past abuse. In contrast, following are five best practices for workers to be highly supportive and effective:

- **Welcoming.** Workers identified as most helpful tended to always greet gay or lesbian youth with enthusiasm, and the workers made themselves available, especially when a teen struggled with more troublesome aspects of his identity.
- **Maintaining engagement.** The best workers remained engaged with youth, resisting the impulse to react or enact their agendas when a young person disclosed information associated with his or her sexual identity.
- **Remaining open.** Helpful workers avoided advice giving traps, sharing opinions, or judging a teen. Workers allowed youth to describe and explore all aspects of their identity.
- **Supportive engagement.** The best workers helped youth connect with other gay or lesbian youth, finding drop-in centers or gay resources, and ensuring safe transport to meet with other gay and lesbian youth.
- **Responsive exploration.** The best workers maintained a curious position so they could explore situations with youth. The worker asked questions and reflected rather than instructed youth, allowing them to find solutions.

Helpful versus harmful workers are distinguished by their responses to gay and lesbian youth. No worker enters the field to harm youth in their care, but it is easy to inadvertently harm a young person's developing identity through uninformed reactions to his or her sexual identity. This does not mean professional staff must suspend their values and beliefs.

This article focuses on behavioral and interactive responses. The best workers can respond in a manner that affirms and helps gay or lesbian youth build positive identities. When youth referred to helpful workers, they knew little about the workers' values, only their behavior.

This article was written to help

professional caregivers identify best practice principles for helping gay and lesbian youth in out-of-home care. The information is based on the experiences of gay and lesbian youth with workers while in care and provides general guidelines for building skills that can enhance, rather than deter, the identity development of gay and lesbian youth.

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# Integrating Training into Practice

by Dale Curry

In recent years, training and development (T&D) professionals have realized training often does not transfer to ongoing practice. Common examples in our everyday lives illustrate the gap that frequently occurs between what we know and what we do. Many of us are knowledgeable in self-competency areas such as diet, exercise, and stress, but we often fail to use our knowledge in an effective, lasting manner.

Some researchers estimate only 10%–13% of learning from training is used on the job (Baldwin & Ford, 1988; Rackham, 1979). This can be discouraging to T&D professionals, interpreted by funding agents as demonstrating poor business practice, and can potentially increase risk of harm or death to clients due to lack of application or misapplication of crucial learning areas such as physical restraint.

Assessing and improving our ability to promote transfer of learning is obviously important, yet we often overlook well-researched principles of transfer of learning in our day-to-day T&D activities. Responsible T&D professionals can no longer train without planning for the transfer of practice setting training. The National Staff Development and Training Association Code of Ethics for Human Services Training and Development Professionals states that training and development professionals should include transfer of learning activities or interventions in all training and development initiatives (Curry et al., 2004).

## Applications From Traditional Transfer Research

Traditional transfer research and intervention have emphasized instructional strategies involving the use of principles such as identical elements, general principles, stimulus variability, and response availability (Baldwin & Ford, 1988; Goldstein, Lopez, & Greenleaf, 1979).

Following are a few implications of each principle to a training session on behavior management:

### Identical Elements

According to the principle of identical elements, training and transfer settings that are as similar as possible will enhanced transfer. The degree of similarity determines the extent of transfer. Based on this principle, suggestions for behavior management training include:

- Use behavior management case scenarios in training that are as similar as possible to actual situations workers will encounter. Create a feedback loop from the practice setting to the learning setting and back to the practice setting.
- Use instructional strategies that closely approximate how skills will be used on the job. A worker, for example, may rehearse during training how to redirect a typical disruptive behavior to a more appropriate behavior.
- Help learners cognitively store ethical information, with retrieval in mind. Identify situations where behavior problems are likely to occur. Help learners identify cues that will signal to the worker when the newly learned behavior management skill should be used.
- Help learners recognize the “common something.” There must be something in common between the learning and transfer situation for learning to transfer.

### General Principles

Transfer occurs when general rules and principles underlying the subject matter are taught. Based on this principle, suggestions for behavior management training include:

- Train underlying principles of behavior management that transcend context. Help learners recog-

nize these underlying ethical principles. According to Salomon and Perkins (1989), this approach promotes “mindful abstraction.” Help workers recognize, for example, the need to use both authority and relationship skills.

- Train on behavior management principles that apply to many different problems. Examine, for example, the antecedents, specific behaviors and consequences—the ABCs.
- Use parallel processing. Have learners examine, for example, how trainer-trainee, supervisor-supervisee, worker-client, and parent-child relationships are similar in the use of power.
- Teach metacognitive skills (the ability to monitor and guide ones own learning and application). Help training participants learn and apply application principles for behavior management. Help them learn to recognize opportunities to use new skills and how to monitor their performance. Provide suggestions and application aides to remind workers on the job that a case situation may have implications similar to a case discussed and practiced in training. Suggest participants keep an application log to reflect on application of learning.

### Stimulus Variability

This principle suggests that using a variety of relevant stimuli promotes a transfer of behavior management learning.

- Use many case examples for each behavior management principle to strengthen a learner’s understanding of the principles.
- Provide examples of when a principle applies and when it does not.
- Use many situations and individuals. Involve people from the work environment in the training, such as supervisors and coworkers.

## Response Availability and Conditions of Practice

This refers to strategies that promote eliciting the appropriate response at the appropriate time. Suggestions for ethics training include:

- Identify concrete behavior management skills that can be practiced in training and work environments. Demonstrate behavior management skills using real case scenarios, or scenarios similar to real cases. Learners need to demonstrate skills, not just discuss cases.
- Practice key behavior management skills so they become automatic. Some behaviors can be “over-learned” so that a worker routinely employs them with little conscious effort. For example, a worker may routinely use reflective listening when interacting with youth.
- Help learners store information with application in mind. Make cognitive connections between learning and doing situations (similar to the identical elements principle). For example, ask a learner to role play a typical work situation. You may ask them to choose another role player that most reminds them of someone in their work situation.
- Use distributed practice with gradual removal of practice. Integrate the practice into the work environment. This may involve using trainers and coaches in team meetings. Encourage supervisors and others within the work environment to promote behavior management skills practice through discussion and demonstration in team meetings.
- Help participants plan to apply learning. Help them think about overcoming application barriers, as well as strategies to prevent backsliding into old habits.

## Ecological Transfer Intervention

Traditional research on transfer has emphasized the instructional design of training (mostly during the workshop). Recent approaches, however, are more ecologically focused, recognizing the important role of the learner’s work environment. These approaches also emphasize the importance of key persons

before, during, and after the formal training session (Beaudin, 1987; Broad & Newstrom, 1992; Curry, 1996; Curry, 2001; Curry & Caplan, 1996; Curry, Caplan, & Knuppel, 1991; Curry, Caplan, & Knuppel, 1994).

An approach developed and used at the Northeast Ohio Regional Training Center, Summit County Children Services, builds off psychologist Kurt Lewin’s force field theory and advocates for assessment and intervention within a worker’s work space.

## A Practical Model for Promoting Application of Learning On-the-Job

Curry et al. (1991, 1994) describes a basic but comprehensive model that can be used to guide the development of a comprehensive transfer plan. Broad and Newstrom (1992) and Wentz (2002) also advocate a similar approach. Lewin (1951) suggested a simple approach to

change (force field theory), which involves the interaction between two opposing sets of forces.

Change, or transfer, occurs when equilibrium is disrupted. An existing field of forces is changed by increasing transfer driving or decreasing transfer restraining forces. The number and strength of driving and restraining forces will determine if transfer occurs, as well as the extent of transfer. If the strength of the total number of transfer driving forces is greater than the restraining forces, transfer will occur. If the total strength of the restraining forces is greater or equal to the driving forces, transfer will not occur.

Using football as a metaphor, for example, one could imagine several training participants on the 50-yard line of a football field (transfer field). Transfer driving and restraining forces before, during, and after training affect

Figure 1

Person	Before	During	After
Learner	Identify relevant cases to include in ethics discussion.	Think about how you will recognize an ethical dilemma while on the job.	Meet with your supervisor for help identifying your value pattern tendencies (e.g., deontological-teleological).
Trainer	Meet with child and youth care personnel to identify relevant ethical case scenarios for later use in training.	Help learners’ cognitive connections between class discussions and real work situations by helping them identify a case to apply the ethical decisionmaking model.	Email learners, reminding them to work on their ethics action plans. Follow up with a “booster shot” session to discuss ethics learning application.
Supervisor	Emphasize to workers the importance of ethics training for the organization. Communicate the value of training and integration of the <i>Code of Ethics: Standards for Practice of North American Child and Youth Care Professionals</i> .	Attend ethics training with the entire team.	Lead a discussion during a team meeting about how to incorporate the ethics training into daily practice.

Figure 1: Ethics Transfer Matrix

Adapted from: Curry, D., & McCarragher, T. (2004). Training ethics: A moral compass for child welfare practice. *Protecting Children*, 19, 37–52.

the extent of transfer (yardage gained or lost) of each participant. In other words, three periods of play take place on the transfer field (before, during, and after).

Even though participants attend the same training workshop, they may have substantially different experiences on the transfer field. Individual characteristics interact with unique environmental events that result in forward or backward movement on the field. One participant, for example, may meet with his or her supervisor before the training to discuss training relevance and potential applications.

As a result of this meeting, this participant probably has an increased learning and application readiness. The participant will probably move forward on the football or transfer field (transfer yardage gained).

Other participants may have different experiences before attending training. Some will move forward, and others backward. Even before a participant trains, he or she may have greater or lesser transfer potential due to driving and restraining forces that have already occurred. The total strength of these forces before, during, and after training will affect the amount of transfer (position on the field at the end of the game).

In addition to emphasizing key times (before, during, and after formal training), this approach emphasizes that key persons, such as workers, coworkers, supervisors, and trainers, can help or hinder transfer effectiveness. Using a transfer matrix for transfer assessment and intervention can be applied to any training.

Figure 1 (page 6) illustrates how the model could be used with ethics training to promote ethical youth care practice. Many additional before, during, and after transfer strategies can help a child and youth care T&D professional achieve training and transfer objectives.

Total number and strength of transfer factors in each cell promoting transfer (driving forces) and hindering transfer (restraining forces) determines the amount of transfer. The transfer matrix can be used as a template to place over any existing training program to assess factors that affect transfer and develop

an effective plan for transfer intervention and evaluation by increasing transfer driving forces and decreasing transfer restraining forces. This approach involves a paradigm shift from viewing training as an event that occurs during the training to an intervention influenced by key individuals before, during, and after training.

This article has emphasized the importance of planning for the transfer of youth work learning. It also describes implications of well-established transfer principles and a practical model to guide transfer intervention efforts before, during, and after formal training.

Future efforts should consider applying the transfer of learning knowledge base for practical use in other areas such as transfer of learning from the supervisory conference or team meeting to the job. Additionally, principles of transfer of learning can be applied to the children and families we work with.

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# Wizard's Way: A Level I Intervention to Reduce Seclusion and Restraint

by Dennis Alters

*The Wizard's Way is a novel approach that combines anger management and social skills training. It involves children in a unit fantasy that promotes self-control while retaining and promoting a child's interest (AACAP, 2002).*

I created Wizard's Way (WW) in 1990 to address in-patient management difficulties. The program effectively reduces the need for seclusion and restraint. This article expands on its brief description in the Practice Parameters for the Prevention and Management of Aggressive Behavior. (AACAP, 2002).

This carefully designed program entices children and young teens into the therapeutic milieu. A 90% decrease in the use of seclusion and restraint occurred in the first in-patient facility. Psychiatrist Kerry Kluner cited a 50% decrease in the second (Alters, 1998).

WW deescalates and reduces the frequency of potential crisis. Training and programming increases staff skills and sensitivity. An initial feasibility study assesses the facility's behavior management culture and therapeutic and crisis models. Various instruction models are offered, from training the trainer, to models for the full in-house staff. Staff in-servicing accommodates individual learning preferences; ongoing support and program reassessments facilitate the implementation of goals.

Imagine the following scenario: Johnny, age 11, angrily exits a family session. His outstretched hands pause short of grabbing an unsuspecting boy by the neck. Johnny throws an empty chair to the floor instead. Staff arrive shortly after the crash.

Johnny responds by walking over to the eye-catching WW map. He moves

his skateboarder game piece from the rewards path to a penalty zone and announces, "I am in the Volcano of Temper and headed to The Ice Dunes of Danger!"

A staff member serving as his guide calmly tells him, "Let's talk about what happened and maybe you can get back on the path." Johnny explains, "I hate it when my sister calls me a dork and no one does anything." The staff guide replies, "Let's go on a Smugwamp hunt together. You are having a Smugwamp

***WW reaches kids on their level and motivates change in an upbeat fashion. On this journey, patients perceive the clinical staff as mentors and guides, not as adversaries. Clinicians reported a boost in staff morale.***

kind of day." Startled, Johnny asks, "But don't you get a reward for doing that? I was mean. I was going to choke Billy and I threw a chair."

The staff guide gives Johnny the WW workbook to complete the challenge of the Smugwamp. He intently draws his two-headed, purple green, name-calling Smugwamp monster that steals good moods. He lists three triggers that make his Smugwamp appear and three activities that can make it go away and feel better. The situation calms, and the staff process his feelings, including assertive training. Johnny is

acknowledged for not hurting his peer. WW rewards him for implementing the three positive activities.

Current treatment models are not anticipatory, creating reactionary system responses. Risks to the minor and staff during "takedowns" are numerous (AACAP, 2002; Masters, 2002; Wadeson & Carpenter, 1976; Devitt, 2002). Programs create appropriate responses only after a crisis, which rewards crisis.

Level 1 interventions are skill-based techniques to "increase the patient's behavioral self control and encourage self-determination, while preserving the safety of the patient, others, and property" (AACAP, 2002). WW has a deeply intuitive, intrinsic, emotional meaning to the child. Language is used symbolically to address treatment in a multi-modal, multisensory fashion, and accounts for the analogues of children's communication (Trad, 1992).

Preoperational and operationally-based exercises use peek performance, sociometrics, and conflict resolution, with cognitive, behavioral, dynamic, art, psychodrama, conflict resolution, and music therapies. The interventions are a cleverly cloaked, high-powered standard of care made child friendly. More than 300 DSM coded, maturationally sensitive skill-building interventions exist. These range from mild to intense, positive to restrictive, and structural to insightful.

WW is effective with all major and minor psychiatric disorders, except for severe autism and severe mental retardation. This broad scope, in playful format, reduces stigma. To reinforce internal positive change, WW transitions from maturational development to a self-rating system.

The interventions are clear and positive. Children gain a deeper understanding of problems and retention of coping skills. They are readily able to identify and assert needs and feelings. This builds a sense of mastery. Parents and children are less anxious in this milieu. Also, consumer response improved (Alters & Alters, 1998).

WW reaches kids on their level and motivates change in an upbeat fashion. On this journey, patients perceive the clinical staff as mentors and guides, not as adversaries. Clinicians reported a boost in staff morale. Neophyte or non-clinical staff, as well as per diems, can administer the program. Satirz reported easy, cost effective, and turnkey user-friendly implementation (Alters, 1998). There is nearly seamless record keeping for clinical progress, research and quality assurance (Alters, 1998).

WW provides multitiered levels of care for continuity and longer lasting results (Alters, 1998). Applications are available for school, home, outpatient

therapist offices, group and foster homes, residential and partial day programs, and community settings.

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CONNECTING JUVENILE JUSTICE AND CHILD WELFARE

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# Q: *Should Prone Restraints Be Eliminated from Practice?*

**POINT:** Prone restraints are necessary and are only one factor associated with restraint-related deaths or injuries. Additionally, not enough is known about any of the restraint techniques to single out one technique for elimination.

by Martha Holden

In 1999, Cornell University's Residential Child Care Project began a fatality study to help inform our Therapeutic Crisis Intervention (TCI) system—used to prevent and deescalate aggression and violence in children's residential agencies.

Although our TCI system is focused primarily on organizational components such as policy, clinical management, supervision, training, and quality assurance to prevent and deescalate aggression and violence, physical interventions are taught as safety interventions if supported by an organization's policy, accreditation bodies, and regulation. By studying and understanding the frequency, nature of, and circumstances surrounding restraint fatalities, we felt we could provide agencies valuable safety information and prevent tragedy.

What we discovered did not point to any one factor, but to a pattern of child care practice rooted in inadequate supervision and training, insufficient review and monitoring of restraints, and organizational cultures that support physical management as a strategy for program compliance and punishment.

Our research found 45 child or adolescent fatalities between 1993 and 2003 involved physical or mechanical restraints. Other results of the study concluded that most of the fatalities were male (35). The most common immediate cause of death was asphyxia (25 cases), followed by cardiac arrest in 10 cases. Physical restraint was the cause in 38 of the 45 fatalities, 27 of those in a prone position.

Of the 27 prone fatalities, 7 involved multiple staff lying on the child, 6 had staff crossing the child's arms across the child's chest while prone, 4 involved a staff member sitting on the child who was lying on the ground, and 2 were the result of a neck or chokehold. In 20 cases, staff ignored signs of distress such as vomiting, turning blue, and statements of "I can't breathe." These techniques or practices are not prescribed by any recognized crisis management system.

When the rationale for these fatal restraints was examined, information was available in only 23 of the 45 fatalities. In the 23 cases, restraints were initiated because children refused to comply with staff or program requests while in an isolation or

see POINT, page 12

## COUNTERPOINT:

Prone restraints have been associated with numerous deaths or injuries and should be banned from practice.

by David Leadbetter

Security necessity or abuser's charter? Prone restraints do not have the monopoly on risk. Other high-risk and aversive procedures, such as basket, supine, pain compliance holds and hyper flexion (bending over) have largely evaded proscriptive action so far. Prone restraints have emerged, however, as the villain of the piece in current practice and social policy debates.

Apologists for high-risk methods—a constituency that may include training vendors defending their products, user programs, and self-appointed gurus—will frequently resort to the pseudo empirical argument that lack of research prevents definitive conclusions on restraint safety. The smoking gun standard, however, is a distraction given the various factors that impede accurate data on restraint injury:

- under-reporting incidents;
- liability pressures and inaccurate reporting;
- absence of national reporting and data collection mechanisms; and
- failure by medical examiners to employ standard post mortem diagnostic categories.

For a profession tasked with protecting child welfare, current knowledge must be the criteria for action. Limited evidence should not be confused with an absence of evidence.

We are well beyond any credible argument that prone restraints are safe. Their prima facie danger is accepted by almost all responsible authorities and is reflected in government guidance in the United Kingdom and best practice advice in the United States, such as CWLA's *Best Practice Guidelines for Behavior Management*, (2002). Many executive authorities, including regulatory bodies, national governments, and police departments have explicitly banned them.

Of the 142 restraint-related deaths listed by the *Hartford Courant* database (Weiss, 1998), 31% of known methods involve the prone position. A similar pattern of overrepresentation is detected in other data sources (NAMI, 2000) and in U.S. and U.K. fatality case studies. One significant U.S. multiple case study concluded that death was "entirely attributable" to the prone position (Morrison et al., 2002).

see COUNTERPOINT, page 11

Oversimplification and reductionism characterize the current debate. Literally one technique, or system, is safe; another is not. The mechanisms of restraint injury and fatality are complex and likely to involve a conjunction of risk factors inherent in the child, staff, and contextual factors. Accepting the role of prone position as a catalyst for catastrophe, however, is the tipping point required for increased safety.

Many known risk factors for restraint fatalities are disproportionately represented in the child population under care, notably in preexisting medical conditions, poor risk awareness, and prolonged resistance to physical restriction.

Most restraints can be executed safely in practice, but Murphy's Law inevitably prevails. If it can go wrong, it will. Power struggles, heightened and primitive emotions, and pressures that impede a coordinated response, often characterize real restraint events.

Equally, where impaired, staff fitness, competence, motivation, team coordination, emotional control, and environmental hazards significantly heighten risk.

Few services employ exclusively young, athletic males. The staff profile in many cases is of an older, unfit, and often predominantly female workforce (Hunter et al., 2004). Hence, it is absurd to believe restraint training will equip staff to physically manage assaulting behavior from younger, streetwise, fitter clients.

All other sectors that use physical skills accept that motor competence requires constant repetition and over learning, as in martial arts, sports, and the military. Yet the care sector seems to expect safe intervention on the basis of a short training course, frequently taught by instructors whose own training only exceeds that of students by one or two days. The resulting moral, ethical, and liability implications should not be lost.

Potentially dangerous, unsubstantiated, and fallacious beliefs, such as the safety of prone procedures, the therapeutic value of restraint, or the Easter Bunny, must be rejected. (Sorry kids!)

Prone restraints are inherently frag-

ile (Leadbetter et al., 2005) and require considerable skill to perform them safely. Many also allow staff to increase the pain or restriction levels by additional pressure. Restraint training essentially hands staff a weapon that will inevitably be used. In the hands of unsupported, poorly trained, or disempowered staff, fragile techniques carry a high potential for abuse and injury. Hence, the question of restraint safety cannot, and must not, be removed from its practice context.

***Most restraints can be executed safely in practice, but Murphy's Law inevitably prevails. If it can go wrong, it will.***

Many myths characterize the debate over aggression management, often promoted by training vendors or executive authorities offering or seeking quick-fix solutions. Research offers conclusions that question prevailing orthodoxy:

- Training may increase rather than reduce incident and injury rates.
- Breakaway training usually has little impact on staff safety.
- Literally no valid evidence supports the effectiveness of conflict resolution training.
- Injury rates in restraint training may exceed those in operational use.
- Agency milieu factors, not interpersonal skill, are the key determinants of injury and restraint rates.

Advocates often argue that prone restraints are justified on safety and security grounds. This argument ignores the fact that restraint outcomes are multiply determined, and that safety is relative—some level of residual injury is inevitable (CWLA, 2004).

No evidence confirms prone restraints are more secure or safe than alternatives. The reverse seems to be true. Comparative evaluative research is

urgently needed. The security perspective may, nevertheless, have face value. If so, a harm reduction approach that reduces use, promotes a rigorous approach to competence development, and teaches staff about risk factors may be more effective than risk avoidance, which simply bans their use.

In the context of poor or contrary safety evidence and the routine teaching and use of known high-risk techniques, often by national U.K. and U.S. providers, there remains perhaps the biggest scandal. If prone restraints have a place, it can only be as a restricted and selectively taught technique, at the end point of a broad, graded response hierarchy, and subject to rigorous individualized risk assessment, robust confirmation of staff competence, and explicit approval by senior agency management. As the saying goes, "If all you have in your tool box is a hammer, all the world will look like a nail."

Where they remain a significant element of restricted training curricula, tragedies will continue. Based on current safety knowledge, pending valid comparative research and moral courage, our obligation to vulnerable children requires that we reverse the balance of proof. The burden of evidence is now on those advocating their use.

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time-out room; for example, children refused to give up an object like a picture, refused to put their shoes on or to take them off, or refused to leave a classroom or gym. None of these conditions would meet the standard of danger to self or others—the criteria taught in any reputable crisis management training and governed by the vast majority of state and professional regulatory bodies.

These facts lead me to question the effectiveness of banning prone restraints as a way to prevent restraint fatalities. In the cases where information existed, no one appeared to be conducting the restraint according to any standards of practice, regardless of the type of restraint that was used. The misuse and misapplication of the restraints appear to have led to the fatalities, not the technique alone. Since other restraint techniques, such as supine and seated holds, have also resulted in fatalities, it would appear that any restraint technique could be lethal.

The solution to prevent fatalities by banning the most common occurrence is misguided. Most fatalities are male children. If we used the most common occurrence as a guide, we would restrict restraint to female children and, in the process, greatly increase our risk to female children. In fact, one could argue that restraint risk to female children is higher because females make up a significantly smaller percentage of children in care.

Banning staff members from sitting on children when they are being restrained on the floor, or using chokeholds, or ignoring signs of distress, would be more realistic. In our work, we have talked with organizations that are no longer permitted to use a certain type of restraint since it has been banned by a regulatory agency. When asking their regulatory agent what to use instead, the advice has at times been more dangerous than the banned technique.

The knee-jerk reaction to ban a certain technique based on a recent fatality has resulted in confusion, frustration, bad advice, wasted resources, and inconsistent practice. It has also resulted in regulatory agencies deceiving themselves

into thinking they have solved the problem and can move on to other agendas.

Our study found that restraint-related fatalities in residential child caring organizations have multidimensional problems. The continued use of restraints by residential child caring organizations demands vigilance on the part of the facility's leadership, supervisory, clinical, quality assurance, and training staff to ensure safety. The use of any restraint technique on any child should be assessed, prescribed, monitored, and reviewed. Any staff member who may need to be involved in a restraint should be trained, supervised, monitored, and debriefed.

Limitations should be placed on the use of any restraint based on the medical, physical, and emotional condition of the child and the staff members. If we are to protect children and staff members in residential organizations from physical and emotional harm from the very interventions we impose, we must look at the basic and root causes of these injuries and fatalities, not just the position in which the child ended up. There is no quick fix to this problem.

*Martha Holden is a Senior Extension Associate and Director of the Residential Child Care Project at Cornell University, Ithaca, New York.*

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### ***In the next Residential Group Care Quarterly Point/Counterpoint...***

#### ***Question:***

What is the best congregate care setting for gay, lesbian, bisexual, transgender, and questioning (GLBTQ) youth?

#### ***Point:***

Population-specific programs for GLBTQ youth have proven to effectively address the particular needs of these youth.

#### ***Counterpoint:***

GLBTQ youth are better served when integrated into general population programs.

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