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In This Issue

Origins of Group Care

by Martha J. Holden, John Gibson and Angela Stanton-Greenwood

Children cared for by extended family and community is a practice that has a long history in many societies. *The Circle of Courage or Caring* (Brendtro, Brokenleg, Van Bockern, 1998) describes the care of children provided by tribes and villages in North America for thousands of years. Prior to the 17th century, Ireland was governed by a system of law known as Brehon Laws (Robins, 1987). During this period, the tribe or clan took responsibility for the care of destitute, orphaned or abandoned children. Robins reports that "fosterage" (p. 3) of children was common practice and that this strengthened the tribe. Community responsibility for raising children is not a recent phenomenon, but has been around in many forms for centuries.

Early Group Care: A Solution to Social Tensions

In ancient Ireland children were cared for in monasteries by monks, but in 1703 the first workhouse was opened and became the "national repository" for unwanted children (Robins, 1987). It then became a public responsibility at the request of the citizens of Dublin who were concerned about vast numbers of vagrant children and beggars on the street. Other workhouses were established throughout the century in order to protect the citizens from encountering begging children on the street. In England, the Elizabethan Law of 1601 was the first law to assign public responsibility for needy children. This law was passed at the demand of the middle classes

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Residential Child Care Project Wins Cornell University Award for Excellence

The Residential Child Care Project has received the 2007 Human Ecology Extension, Outreach, and Public Service Award for outstanding accomplishment in Extension/Outreach from Cornell University. The award brief states: "Individual or team candidates for this award have demonstrated leadership in developing a highly innovative and responsive extension/outreach program which responds to a critical human issue and that significantly addresses stakeholder needs. Extension/outreach encompasses a broad range of non-credit education and training programs. The program will be well-integrated with research and may also be integrated with college teaching. The extension/outreach program will have demonstrated effectiveness through major impacts benefiting a significant population segment. In addition, the program will be characterized by strong collaborations and stakeholder involvement. Collaborations may include such groups as Cornell Cooperative Extension professionals, county and state level agency and department representatives, elected officials, professional organizations and the private sector. The RCCP program exemplifies a long-standing commitment to excellence, to using research to inform practice, and to international leadership in the field of child welfare. This outstanding program has had national and international impact and recognition over many years. In addition, it brings honor to the College of Human Ecology's research, outreach/extension and teaching."✷

Use, Abuse, and Death by PowerPoint

by Nick Pidgeon

Jerry Seinfeld reminds us that most people's greatest fear is public speaking. He also reminds us that most people's second greatest fear is death. So logically he says, most people would rather be in the coffin than make a speech at a funeral. But the Seinfeld series ended long ago before the proliferation of PowerPoint. This remarkable software package now makes public speaking easy.

Or does it? We have probably all had experiences like this.

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who wanted something done to control the dangerous poor classes. The law established workhouses for the orphans and the children of adults who worked under enforced conditions in other workhouses. These children were placed in almshouses (an early form of group care) and indentured to master craftsman (an early form of foster care). In North America during this period, orphanages, apprenticeships, reform schools, almshouses, and informal kinship care were the main components of a loose system of out-of-home care for most of the first two centuries of American history.

The mid-1800s brought the industrial revolution throughout the Western world. With the increased urbanization came big city problems: long working hours, crime, unhealthy living conditions, poverty, and relaxed morals. Countries conceived of prisons and insane asylums to deal with these social problems and sought ways to institutionalize the overpopulation of children on the streets. The question of what to do with the overpopulation of unclaimed children officially was addressed by establishing group care facilities for children and the first orphanages. Orphanages provided an immediate solution to the bothersome problem of parentless children and residential group care became the solution to these social problems.

Orphanages: Philanthropy and the Church

In the United States, the number of orphanages grew throughout the first half of the nineteenth century largely in connection with large epidemics and an outpouring of religious benevolence. The Civil War greatly expanded demand for orphanages and by the late 1800s orphans and children of destitute single parents increasingly found their way to orphanages. This solved the problem of "street kids" but did not solve the problem of overcrowded orphanages. Orphan Trains became an alternative to the warehousing of children in large institutions. Children from New York City were given train tickets and sent to the Mid-West. These trains would stop at different locations and families would choose children to adopt. Most of these families were farmers and the children were taken home to help work on the farm. The two main institutions responsible for this mass "emigration" of children from New York were The Children's Aid Society and The New York Foundling Hospital. The Children's Aid Society and The New York Foundling Hospital continued to "place out" children until 1930 (Legends & Legacies, 1999). There were several reasons the orphan train movement ended. The primary reasons were 1) the beginning of the depression in 1930 made it extremely hard for families to consider "adding another mouth to feed," and 2) there were new laws and new programs being instituted that were designed specifically to help children whose families could not provide for them. These laws made it harder for the trains to continue bringing children into different states and new foster care homes began to replace the large institution/orphanages of the past.

Toward the end of the nineteenth century, both Catholic and Protestant churches were active in the provision of education and residential care in Ireland. The Sisters of Mercy were particularly active in caring for orphans. The Irish Sisters of Charity and the Sisters of Charity of St. Vincent de Paul were also active. By 1864 there were twenty-four Catholic lay bodies or religious orders orphanages. The largest of the Protestant or non-Catholic church providers of orphanages and the boarding out scheme was the Presbyterian Orphan Society. This society operated nationally and in 1883 had 2,800 children in its care or living with "suitable families."

In England two significant proponents of philanthropic social work were Thomas Stephenson who founded the National Children's Homes and Thomas Barnardo who founded the Dr. Barnardo's charity. Thomas Barnardo was a missionary who arrived in England from Ireland in 1866. The cholera epidemic of that year left many children alone and destitute and he opened his first Ragged School in the East End in 1867, followed by a boys home (1870) and home for girls. The mission of Barnardos then was to secure domestic work for the girls and to provide boys with a trade. In 1918, after the First World War, Barnardos began child migration to Australia and Canada. Children were seen as needing a fresh start in a land of opportunity. This migration remained unchallenged until after the Second World War when the evacuation of children to the countryside to save them from the bombing brought charity children and upper middle class families together. The disruption of the war also improved society's understanding of family break up, loss, separation, and the effect on children of being brought up away from home. This understanding meant a change of focus into keeping families together in their communities and the need for specialized care when children were placed away from their families.

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You go to a presentation on a topic that interests you. But in moments boredom sets in. You can't concentrate. The rows and rows of multicoloured bullet points on the screen don't make sense. You can't take in what the speaker is saying. And then the final horror. You notice at the bottom of the screen: "Slide 3 of 76." You leave.

Why does this happen?

In this article I'm going to review some of the recent work on why PowerPoint can be counterproductive and suggest some tips on avoiding the pitfalls.

But before I begin I need to point out that I'm not talking about TCI training here. The good news in the recent research on PowerPoint is that the advice we have always given on how to use our PowerPoint slides still stands. More good news is that we will incorporate the most recent research on making PowerPoint effective into our next generation of TCI slides.

Criticism of PowerPoint is not limited to the person dozing off next to us at a presentation. The Yale emeritus professor of information design, Edward Tufte writes: "PowerPoint allows speakers to pretend that they are giving a real talk and audiences to pretend that they are listening. . . Bullet outlines make us stupid."

The Educational Psychologist John Sweller of the University of New South Wales goes further. On the Sydney Morning Herald website he states, "The use of PowerPoint presentation has been a disaster. It should be ditched."

The Redundancy Effect

The biggest criticism the experts make of PowerPoint concerns what Sweller calls, "the redundancy effect." This means that if someone reads something to us that we can read for ourselves not only is this unnecessary, but it also inhibits learning. The reason, Sweller says, is that we process auditory and visual information differently. When the same information is presented simultaneously in different forms, for example when someone reads aloud a PowerPoint slide we also read to ourselves, our limited working memory capacity is overloaded and we find it hard to absorb the information. His remedy is simple. He advises not to use words at all on slides only pictures and diagrams. This advice is extreme but Sweller's work informs my first tip:

Tip 1: Never read a slide to participants. Show them the slide, maybe even tell them to read it to themselves (and give them time for this) and continue to use the questioning techniques we have always advocated in TCI training.

Making Powerpoint Effective

Richard Mayer of the University of California, Santa Barbara and Roxana Moreno of the University of New Mexico also acknowledge that the redundancy effect (they call it "redundant presentation") can be harmful, but they do not rule out the use of words on slides. Instead their advice is to be careful. Mayer has developed this advice in collaboration with the management consultant and author Cliff Atkinson.My remaining tips on how to use PowerPoint effectively are drawn from Mayer and Atkinson's work. Their ideas will influence the next generation of TCI slides but you might want to consider their work if you are writing PowerPoint slides for other presentations.

Tip 2: Keep it brief. Write only a few words on each slide. Use questioning techniques and discussion to cover information. Don't try to get it all on the screen. Atkinson and Mayer recommend moving as much text off a slide as possible and presenting information in bite size chunks though a series of slides.

Tip 3: Write a headline for each slide rather than a title. Summarise the main idea of each slide in simple conversational language.

"Just as in newspapers," Atkinson and Mayer say, "write your PowerPoint headlines in active voice with a subject and verb."

Tip 4: Use visuals to support the words rather than words alone. On every slide include pictures and diagrams.

"Text alone on a screen is simply not effective," according to Atkinson and Mayer. "People learn better from words and pictures than from words alone."

Tip 5: Don't clutter the slide with irrelevant visual information. Avoid corporate logos and the patterned backgrounds offered by the PowerPoint software.

"Cut everything out of your PowerPoint slides that does not support your main idea," Atkinson and Mayer advise.

Conclusion

PowerPoint is seductive. It makes public speaking simpler. It's easy to use and easy to fall into the trap of writing long bullet pointed lists. If we're not careful the bullet pointed lists become our lecture notes reminding us what to say. And then we can easily fall into the next trap of actually reading these lists to our audience. And the result? The audience switch off and learn nothing.

But if we follow the advice of Sweller, Mayer, Marino and Atkinson we can avoid these traps and use PowerPoint to enhance learning.

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In The Best Interests of the Child

Toward the end of the nineteenth century pioneering individuals presented an early challenge to "penal and punitive" (Balbernie, 1966) approaches to the care of children. As the nineteenth century progressed, public concern about the plight of children in adult goals (jails) found focus on both sides of the Irish Sea (Balbernie, 1966; Robins, 1987). Mary Carpenter, a social reformer from Bristol, England, took note of humane developments in the treatment of delinquent children on the European Continent and argued for "humane and enlightened treatment of delinquent and homeless children." Carpenter also proposed a plan for reformatory schools for juvenile offenders and industrial schools for destitute children. Mary Carpenter was greatly influenced by the Rauhe Haus in Hamburg, operated by M. Wicheren. In the Rauhe Haus, children were "made to feel at home in a well-developed family system of care and develop the faith that they could do something, be something and own something" (Balbernie, 1996, p. 22). The first Reformatory School opened in England around 1854 and, although the British Government was willing, it took longer to establish these schools in Ireland as the churches had to be satisfied that the religious needs of children would be adequately met. It took until 1898 to end completely the practice of sending Irish children to adult goals.

Thomas Stephenson, the founder of the National Children's Homes, a Methodist Minister was so horrified at the child poverty and homelessness in London in 1869 that he, Alfred Mager and Frances Horner co-founded the first residential home in a stable in Church St., London in July 1869. This was a small home and was very much in contrast to the large institutions destitute children were living in, i.e., workhouses. Through donations several small homes were developed and their popularity grew around the country. At Edgworth, near Bolton in England, Stephenson, his boys and his staff were given a house and reclaimed the land together, building their own village and farm. Stephenson was the first to recognize the need for professional training for residential care staff. In 1878 a group of orphans and foundlings began a year-long course in child psychology. By 1892, 140 graduates known as the "Sisterhood" were working full time in residential homes.

Pioneers of Group Care For Children With Special Needs

Group care for children with special needs is a rather recent phenomenon. There has been a growing body of literature related to caring for children with special needs. The following pioneers have contributed greatly to the growing body of knowledge in the residential care field.

By 1925 the first description of residential childcare organized explicitly on psychoanalytic lines appeared (Aichorn, 1925). Richard Balbernie's list of pioneers includes A. Aichorn, S. Neil of "Summerhill," George Layward of Finchden Manor, W. D. Willis (Wills, 1960; Wills, 1970), Otto Shaw of Redhill, and F. G. Lenonnhoff of Shotton Hall. Barbara Dockar-Drysdale (Dockar-Drysdale, 1968) began her work with children during World War II. She pioneered therapeutic work with children who experienced very early emotional deprivation. She set up the Mullberrybush School in Oxford and was a consultant to Balbernie in work that he did to convert a traditional approved school, The Cotswold Community, into a therapeutic school for young teenage boys (Wills, 1971). Janusz Korczak, a pediatrician who became the director of The House of Children in Warsaw, Poland in 1911, wrote twenty books about children (Wolins, 1967). Korczak concluded, "Your authority as a child care worker is based on the strength of your status as a beloved and admired model person. This cannot be acquired by tools and technology" (Brendtro, 1990 p.82). These early pioneers established the importance of building relationships and paying attention to the emotional needs of children.

During World War II, Anna Freud and Dorothy Burlingham provided a safe residential setting for young children who were from central London and in danger from bombings (Cohler & Zimmerman, 2000). Their reports of the children's problems as a result of separation from parents, moving to group care, reuniting with parents, and their exposure to violence has had a big impact on group care and is most relevant for residential care today. Children and young people coming into care today very often come from homes where violence is commonplace, either within the family or in the neighborhood and school. Many have been physically abused and neglected. With these conditions, children come to placement with a myriad of special needs in addition to the complications resulting from separation from their parents.

Bruno Bettleheim (1950) at the University of Chicago Orthogenic School stressed an environmental approach. He felt that it was just not enough to love children but that one must also consider the impact of regular contact with the staff, the benefit of routines and transitions, as well as the activities and the educational advantages in the particular setting. Fritz Redl, (1952) at the Pioneer House in Detroit, outlined a continuum of interventions beginning with the least intrusive, such as environmental control and structure, to ones that require a high degree of intrusion. He also introduced the concept of the Life Space Interview, a

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process that he described as "the clinical exploitation of life's events" designed to promote new coping strategies for the youth (Redl & Wineman, 1952).

Al Trieschman, at the Walker School in Massachusetts, supported the use of a therapeutic milieu building on Aichorn, Bettleheim, and Redl's work and "a general theory of how child growth and development can be supported and nourished by adults who care about and for children. Helping children in residential care does not need to be a special treatment for disturbed children to be phased into their lives by highly trained and dedicated adults"(Trieschman, Whittaker, & Brendtro, 1969, p.vi). Larry Brendtro at Starr Commonwealth wrote, "it has been our theses that the most effective programs for troubled youth entail a holistic synergy which results from skillfully harmonizing many important variables" (Brendtro & Ness, 1983 p.178). He felt that the youth workers who could develop strong bonds with children ultimately are the most successful. Much like the early pioneers, Brendtro stressed relationship building, environmental support, and Life Space Interviews as some of the keys to successful work with emotionally and behaviorally disturbed youth.

Larry Brendtro (1990) identified themes promoted by pioneers that underpin best practice residential care today: relationship and competence.

Relationship. August Aichorn in the early part of the 20th century saw the relationship as the cornerstone of the re-education process. His ethic was that love must be dispensed to aggressive youth since it meets their unmet need. Alan Keith-Lucas who came to the United States from England saw love, acceptance and understanding as the key to promoting positive behaviors. "One doesn't have to behave in order to be loved, but to be loved in order to behave." (Brendtro, 1990, p80). Al Trieschman often spoke of his concern of professionalism overshadowing attachment. While visiting a group care facility, he declared that the social workers should place the children in the file cabinets where they would get more attention. He then added, that the most important milestone for a youth worker was when the worker becomes a glimmer in the child's eye and the child becomes a glimmer in the worker's eye. Gisela Konopka, a major contributor to social group work and working with young people, encouraged workers to "listen to the cry of young people to be a person, not a thing to be treated." She also cautioned against behavior modification programs that deteriorate into mechanistic rituals failing to meet the needs of the young people (Brendtro, 1990; Andrews, 2000).

Competence. The pioneers of group care saw their core responsibility to build competence and relationships by having positive expectations for young people. As early as 1833 M. Wicheren in Germany wanted children "to develop the faith that they could do something, be something and own something" (Balbernie, 1996, p. 22). In an article by John Watson (1896), the children and the first industrial school opened by Sheriff Watson in Scotland in 1841 were described as follows:

"As individuals they had no love for school, for lessons, or control of any description…The new school, however, possessed very different features from those they had heard of or experienced; there were rumours of substantial breakfasts and dinners and suppers to be had after lessons; and there were also whispers of instruction in the arts of tailoring, shoemaking, and net making, and possibly even carpenter work, printing and book binding for the older boys – all trades which the youngest of them knew to be money making and therefore, desirable acquirement..." (Watson, 1896, pp257-258)

Emphasizing the need for relationships and opportunities to do something positive, Floyd Starr founded Starr Commonwealth in Michigan in 1913 with the creed, "We believe there is no such thing as a bad boy, that badness is not a normal condition, that every boy will be good if given an opportunity in an environment of love and activity." (Brendtro, 1990, p.84). In Poland, Janusz Korczak set up an institute of youth government in his children's institution during the early 20th century, empowering young people to gain competence and confidence. Father Flanagan instituted a student government at Boys Town, Nebraska in 1926, allowing the boys to have a say and develop skills. Nicholas Hobbs the father of the Re-ED movement in the 1970s felt that competence and confidence in one's ability to be competent were essential to effective living.

When asked what the pioneers had in common, Balbernie answers that they shared a belief in people and not in institutions (Balbernie 1966, p.29).

Best Practice Guidelines Today

In 2001, the Child Welfare League of America (CWLA) convened a best practice task force of experts and professionals. The finished product, *CWLA Best Practice Guidelines: Behavior Management*, begins with an ethical and legal framework followed by the critical role the administration and leadership play in the establishment of an organizational culture that promotes the growth and development of emotionally and behaviorally disturbed youth. Modeling appropriate ways for dealing with problems, developing a caring relationship with the youth, building relationships, listening and

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Using A Prone/Supine Perception and Literature Review To Forward the Conversation Regarding All Restraints

by Jack Holden, Ph.D.; Tiesha Johnson, BSN, RN; Michael Nunno, D.S.W.; Brian Leidy, Ph.D.

The concern for safer physical restraints continues to permeate discussions for child and youth residential care facilities worldwide. The most controversial conversation appears to be centered in prone physical restraints versus supine physical restraints. In New York State, the Office of Mental Health (OMH) teaches the use of supine restraints and has banned the use of prone physical restraints in its licensed youth residential centers. The Office of Child and Family Services (OCFS) allows use of prone restraints in its licensed youth residential centers. Many youth residential centers are licensed by both agencies that had resulted in confusion and contradictions in training and program implementation. This quantitative study and literature review is designed to assess basic differences in physical and emotional risk, safety, efficiency, and training associated with using supine, prone, and all physical restraints.

Literature Review

The research was conducted using MasterFile Premier, Academic Search Premier, ERIC, and PsycINFO databases.

Introduction

Safety of both youth and staff during physical restraints is paramount for any conversation regarding restraints but even more challenging when using floor restraints (CWLA, 2002; Day, 2002, Holden et al., 2001). There has been relatively limited research comparing the use of restraints particularly the prone and the supine physical restraints. A perception survey was conducted with one agency in New York State in 2006 and a follow up study approximately 12 months later in 2007. The agency uses both the OCFS approved prone restraint and the OMH approved supine restraint and included staff that had experience using both techniques for a total (n-181) for both studies. The study included (n-54) in 2006 and (n-127) in the 2007. The literature review represented 88 total articles, 52 were included in the study while 36 were excluded for reasons of non-relevance.

Methodology

This quantitative study used a Likert scale to measure staff perception in one agency currently using both a prone and supine restraint. The data collected for the study was derived from a staff perceptions survey and included the mean and paired sample correlations as well as an analysis of the variables (ANOVA). A narrative review of the literature was also incorporated.

Data Analysis

- Survey conducted in 2006 and 2007
- (n-54) in 2006 and (n-127) 2007, (n-34) completed both surveys
- The reliability of the prone and supine scales was tested using the factor analysis; .71 and .64 (measures of correlation) indicating a moderately high level of internal consistency and reliability.
- Respondents were asked to respond to19 statements about prone and supine techniques on a five (5) point Likert Scale with one (1) being strongly disagree five (5) being strongly agree
- The agree includes a range of 3.26-5.0, the disagree includes 1.0-2.74, and neither agree or disagree (mid range) includes 2.75-3.25
- There was virtually little or no change in the retested group's responses about their perception of the supine techniques
- There was virtually little or no change of the retested group's responses about their perception of the prone restraint, however, there was a large significant increase in the level of risk for the youth respondents perceived in the prone technique
- Staff perceptions suggest the supine restraint is more likely than the prone restraint to:
  - increase aggression
  - increase counter aggression
  - increase spitting
  - produce longer restraints
  - have a negative effect on the relationship
  - take more than two staff
  - have a negative effect on the treatment environment
  - have more risk of injury to staff
  - be more likely to have injuries during training
  - be more difficult to perform with limiting physical conditions
  - be more intrusive to the youth
  - have more potential for safety violations
- Staff perceptions for both prone and supine restraints are:
  - they need to be conducted by experienced staff
  - neither have more risk of injury to youth than the other
  - neither is more secure than the other
  - neither is safer for the youth than the other
  - neither is safer for the staff than the other
  - neither is more difficult to maintain the skill than the other
  - neither takes longer to learn than the other

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Limitations

Perception survey
- The sampling was from one agency
- The agency had been using primarily prone restraints for years and the supine had been introduced in the past year and a half
- Injury data were not available

Literature review
- Some of the prone restraint data included hobble and "hog-tie" application of the prone restraint
- There is no apparent data available relevant to the number of restraints used in residential care settings comparing prone, supine, and other restraints
- A few of the reviewed data had limited research cites available

Conclusions

Conclusions were difficult to draw based on the information collected and analyzed. From the perception survey, the respondents indicated a slight preference for the prone restraint. The data collected from the participant perception surveys suggested that staff generally agreed the supine restraint increases aggression and counter aggression, produces longer restraints, has a more negative effective on relationships and the treatment environment, and is more intrusive to the youth than the prone restraint. There also seems to be agreement that neither restraint has more risk of injury to the youth, is more secure, safer for the youth or staff than the other restraint.

However, from the literature review, there does appear to be agreement that all restraints present considerable risk to the youth, are intrusive to the youth, have a negative effect on the treatment environment, and have a profound effect on those youth who have experienced trauma in their lives. Additionally, other factors such as pre-existing physical or medical conditions may affect risk more than the type of restraint that is used.

Further Work (Recommendations)

Based on the current literature available and the findings from the limited perception survey, additional extensive research remains to be done. First, a study should be initiated to determine the percentage of prone, supine, and other restraints currently being used in residential care. Next a comparison of injury data for all types of restraints should be initiated. Finally, the field might be most informed by studies related to youth perceptions of restraints, for those who reside in residential care and have been physically restrained. ✸

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From the serious fun corner, by Jack C. Holden

ZOOM-MOO

In a circle with people standing shoulder to shoulder, have the participants follow your lead. Tell them: "I will turn my head to the right, look into that person's eyes, and say 'Zoom.' This person must then turn to his or her right and do the same thing until the Zoom has gone around the group and come back to me".
Repeat this another time, going faster. Then do the same thing, only facing the person to the left and saying "Moo" instead of "Zoom." Follow the same procedure going through it twice. The next step is to send the "Zoom" to the right and quickly send the "Moo" to the left in which they will cross and both return to you.

OOH-AAH

This is basically the same procedure as Zoom-Moo but using Ooh to the right and Aah to the left. However, you can also have people shout or say Ooh and Aah any way they want and gently squeeze the hand when they pass it on.

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Contents

For Our Safety: Examining High-Risk Interventions For Children And Young People

For Our Safety: Examining High-Risk Interventions for Children and Young People

By Michael A. Nunno, Lloyd Bullard, David M. Day

On June 1-4, 2005, an international symposium entitled, *Examining the Safety of High-Risk Interventions for Children and Young People,* took place on the Cornell University campus, in Ithaca, New York. The symposium was co-sponsored by Cornell's Family Life Development Center in conjunction with Stirling University, Stirling, Scotland and the Washington, D.C. based Child Welfare League of America. Over 90 researchers, policymakers, attorneys, advocates, and intervention system providers from throughout the United States, Canada, England, Wales, Scotland, Australia, and Ireland participated in this symposium. The professions represented were from social work, law, medicine, psychology, and education. Papers were presented on topics such as the legal, ethical and historical uses of physical restraints and seclusion, their safety, their psychological and emotional impact, guidelines for their development and their use, as well as clinical and organizational strategies likely to reduce their use in children's treatment facilities.

In 2007 the Child Welfare League of America will publish, *For Our Safety: Examining High-Risk Interventions For Children And Young People*, a book born out of the papers and the presentations of this symposium. All the contributors and the book editors participated in the symposium. Rather than re-iterate and reproduce the presentations and the papers at the 2005 symposium, the authors of the various chapters have had the luxury of incorporating into these chapters much of the discussion, learning, and new research discussed at the symposium. This effort is unique in that it is one of the few volumes that is devoted entirely to the subject of,

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and the risks associated with, restraint and seclusion. The book is in five sections: (1) young people and physical restraints, (2) theoretical and historical issues, (3) ensuring safety and managing risk, (4) reducing restraints through organizational change, and (5) broader social influences.

This book is written for anyone interested in learning from the expertise and experience of a broad spectrum of North American and British academics, scholars, agency directors, clinicians, quality assurance personnel, and crisis management systems experts. While the book's point of view is varied, it is biased towards the emerging international consensus to reduce restraints and seclusion to only those matters that involve immediate safety (British Institute for Learning Disorders, 2001; Child Welfare League of America, 2002; National Executive Training Institute, 2003). The editors selected the chapters because they represent among the best work delivered at the Cornell symposium, and, likewise, represent the best that we know at this point of time. Although we know a good deal, we hope that the contents challenge the reader to move the field to fewer, safer, and more appropriate uses of restraints and seclusion.

The editors and publishers hope that this volume will contribute to the discussion on the appropriate use of high-risk interventions such as restraints and seclusion and improve the general quality of children's residential treatment services through safe and harm-free environments. We hope that this book will be used by those who want to address the impact of aggression and violence in residential care settings within the context of evidence-based practice and the national and international impetus to reduce the use of restraints and seclusions. We trust that it will help the reader to convert his or her information needs related to practice and policy into answerable questions and track down or uncover the best evidence with which to address them. The reader can then undertake a critical appraisal of this best evidence, as well as its validity, impact and usefulness, and apply the results to his or her own practice and policy decisions. The reader can also take the information and evidence presented and find ways to improve upon these practice and policy decisions.

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TCI Physical Techniques Frequently Asked Questions: A Matter of Principles

By Rich Heresniak

It has often been our experience, particularly during TCI updates, that confusion arises over some of the TCI physical intervention techniques. Participants who are closely watching the demonstrations will sometimes notice subtle differences between the demonstrations they are seeing in the update and what they saw (or recall seeing) in a previous update or during their "Train the Trainer" week. These observations about the slight disparities in the demonstrations lead to various questions regarding whether we've changed the technique, why it is "different now," and ultimately, to discussions about what exactly is the "right way" to execute a particular TCI physical skill.

There are a variety of issues that lead to the variations being observed in the demonstrations and training of the physical skills. Many of these variations are the result of physical factors including the size, strength, and flexibility of the instructors, the size and weight of the "young person," or perhaps even a minor physical limitation that requires a slight adjustment in the way a technique is executed. In other cases the differences noted are due to subtle differences in the individual techniques and preferences of the individual instructors. Occasionally, there may even be times when discrepancies occur as a result of "trainer drift."

That said, how do we go about deciphering the answer to the question about the "right way" to execute a particular TCI physical skill?

With any physical technique, whether it's hitting a baseball, swinging a golf club, riding a bike, dancing, or

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something else, there is a set of basic principles involved in executing the skill. These basic principles are designed to allow the skill to be performed at its optimal level and in most "generic" situations. Within the framework of these basic principles, there often exists the need for small adjustments or variations based upon such factors as the size, strength, skill level, and comfort level of the individual performing the technique. Such subtle adjustments make it possible for the individual to successfully execute the skill while at the same time maintaining adherence to the basic principles involved.

For example, some basic principles involved in riding a bike might include staying balanced, moving the pedals in a forward motion, and stabilizing yourself by holding the handle bars. Various factors such as the size of the person riding the bike, their leg strength, their arm length, the size of the bike itself, whether they are pedaling up a hill or on flat ground – all determine what the actual execution of the skill of riding a bike looks like to an observer. Someone riding up a hill may stand up off the seat to generate more power from their legs, while someone pedaling on flat ground may be seated; someone with short arms will lean more forward in order to hold than handle bars than might someone with longer arms; a cyclist on a race track is positioned for speed and aerodynamics, while a mountain biker is often positioned to allow for power and stability. They all look a bit different, yet each is still adhering to the basic principles of the skill of riding a bike.

This same model can be applied to the TCI physical intervention techniques as well. Each of the TCI physical skills has a set of basic principles involving such elements as safety of the young person, safety of the adult, basic steps to complete the skill, and basic body mechanics. With many of the TCI physical techniques, there are certain adjustments that may be necessary in order for the skill to be performed successfully, while maintaining adherence to the basic principles involved. Additionally, there are certain physical "positions" that, though perhaps not the most efficient in terms executing a particular technique, are allowable because they adhere to the overriding principles. That said, let's see if we can take some of the frequently asked questions about the TCI physical skills, apply the basic principles of the technique, and develop some answers that make sense.

What way should your inside hand (the one under the young person's armpit) be facing when in the yoke position?

The basic principle to be applied here relates to both the safety of the young person and the adult. First, we need to support the child all the way to the floor during the take down, and we can provide the most support by having our inside palm hit the floor as we lay the young person down from a seated position. Safety for the adult involves the fact that if one fails to turn the hand to a palm-down position as the young person is lowered to the floor; there is a high likelihood that the adult's wrist will be injured in the process.

Applying those basic principles, the answer to the question is that at least when in the yoke position itself, it doesn't matter what way the adult's inside hand is facing. As long we make sure we support the young person fully during the take down and avoid bending the wrist into an awkward position by having our palm hit the floor instead of the back of our wrist/hand, then we are adhering to the basic principles and thus, doing the technique correctly.

When approaching from behind in the team restraint or in a standing hold, does it matter how the head of the staff is positioned (tucked or pulled out of the way)?

The principles to be applied here relate to the safety of the adult and the child. Simply put – maintain a well balanced stance (not leaning too far forward or backward) and keep your head out of the way of the young person's head to avoid being head butted by the young person.

As long as we apply those principles, either technique (tucking the head or pulling it back and out of the way) is acceptable. If the adult is tall enough, they may simply move their head back a bit, or if they are close in height to the young person, they may need to tuck instead.

Which way should you tuck your chin in the release from a bar arm choke? The principle in this case involves the safety of the adult – primarily minimizing direct pressure to the trachea and thus giving us an increased chance to breathe. Tucking the chin in either direction accomplishes this and either way is fine.

Where should your inside foot be in the yoke position? What exactly does "a bit behind the young person's foot" mean?

This one is a bit more complicated, but again can be simplified by looking at the principles of this step in the team restraint. The principles involve safety of the young person, safety of the adult, as well as basic body mechanics. The materials call for the adult's foot to be "a bit behind" the young person's foot. The rationale in this case involves two of the goals we are trying to accomplish through being in this position.

First, and likely the most obvious, is that with our foot in this position, we are better able to prevent the young person from stepping backwards during the course of the technique. Less obvious is

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the more indirect effect that placing our foot in this position has on the overall execution of the technique.

A key element in the team restraint is the "hip to hip" position. It is critical that the adults be hip to hip with the young person not only in the yoke position, but throughout the takedown itself. Maintaining this position allows us to fully support the young person as they are lowered to the floor – and is a basic safety principle. The ideal position is for the hips of the adult to be a bit rearward of the young person's hips (toward the direction of stepping to the floor). By placing our foot a "bit behind" the young person's foot, we put ourselves in a much better position for this optimal "hip to hip" contact.

Applying the above basic principles (safety for the young person, safety for the adults, and body mechanics), the exact positioning of the adult's foot in relation to the young person's may differ greatly – depending on factors such as the size of the adults, the size of the young person, or whether the child steps "up and back" versus "straight back and low to the floor".

In some cases, the adult may need to place their entire foot behind the foot of the young person, while in others, simply having the foot snuggly against the foot of the young person would suffice (provided our hips are in the correct position). Again it comes down to applying the basic principle involved in this step of the technique.

When doing the small child restraint without a wall, should the child be positioned between our knees or against our thighs?

The principle in this case primarily involves the safety of the child – is the child in a stable position that doesn't compromise their ability to breathe? Depending on such factors as the size and/

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Ask Eugene

Q. *I was certified as a TCI trainer almost two years ago and I have to get re-certified. I was certified in everything but the physical interventions. When I go to the update, can I upgrade my certification so that I am able to train the physical interventions?*

A. Unfortunately, if you were not certified to train the physical interventions after completing the five-day TCI training of trainers, you will not be able to become certified to train the physical interventions in an update.

Q. *Who do I contact at RCCP to get the information I need?*

A. You should direct your incoming calls as follows to ensure prompt responses:

- For training dates and applications visit our web site at http://rccp.cornell.edu
- For individual registration/payment information contact Alissa Burns at (607) 255-4528, or ab358@cornell.edu
- For information about bringing TCI to your agency, via on-site training of trainers or an implementation of the TCI system, contact Eugene Saville at (607) 254-5210, eas20@cornell.edu, or visit our web site at http://rccp.cornell.edu
- For individual trainer certification status, or future certification needs, contact Kris Carlison at (607) 254-5440, kmc16@cornell.edu, or Holly Smith at (607) 255-9149, hs226@cornell.edu

Q. *The course is full? When I last talked to someone at RCCP, it was still open so I have already made my travel and hotel arrangements.*

A. Both TCI Train the Trainer and Update training courses fill up very quickly and usually quite early in the year. Even if you talk to someone at RCCP, and the training you asked about is open, it could be full within hours. There is no way for RCCP to predict this, so we recommend that you sign up as early as possible. Please do not make any kind of travel or hotel arrangements until you receive notification from RCCP that you are registered for the course you have applied for.

Professional Certification Announcements

Kim Draheim has worked in residential treatment for 17 years and has been a TCI Instructor since 2001. He has held a variety of positions in the field, from direct care worker to unit supervisor, and is currently a Learning Coach and Training Coordinator for The Learning Institute, Hillside Family of Agencies in New York State. He is in charge of all New Employee Training for Hillside's Varick Campus and Central Region and serves as lead TCI Instructor for all new staff in that area. Kim is also a professional musician and has incorporated this side of his life into his work with both residents and staff. He has in the past facilitated music groups with young people in care that has resulted in the recording of three CD's of original music. He currently delivers a cultural competency training of his own device titled; Music & Cultural Diversity. Kim may be contacted at kdraheim@hillside.com or ked0917@aol.com or by phone at (315) 585-3239.

Dave Gibbs works for Standards & Schools Effectiveness in the Children, Schools & Families division of Hertfordshire County Council. Dave works with mainstream and special schools as the Adviser for Behaviour. Dave has had a varied career and has worked in Children's Homes in two Inner London Boroughs, an Off Site Unit for twice permanently excluded Year11 pupils in South Bristol and has been Head Teacher of both a day and a boarding school for pupils with emotional and behavioural difficulties. He started work in his first Children's Home in 1970 and qualified as a teacher in 1977 gaining his Bachelor of Education Degree in 1978. Having spent two years teaching in the Sudan and Algeria, he returned to start work with young people with emotional and behavioural difficulties in 1981. Dave completed his Master's degree at University College Cardiff in 1991 having studied Learning and Behaviour difficulties and writing his dissertation on a History of maladjustment and special schools in Bristol 1944 – 1988. He qualified as a TCI trainer in 1999. He can be contacted at : dave.gibbs@hertscc.gov.uk

Marcy Lynch, M.S. Ed., Agency Trainer for Cayuga Home for Children in Auburn, NY. Since 1989, Marcy has worked with children in various capacities from classroom teacher to coach. She possesses a Masters Degree in Education in Training and Human Performance Improvement, and she holds professional Trainer Certifications in Life Space Crisis Intervention, Response Ability Pathways, Positive Behavior Intervention and Support, Principles and Techniques of Residential Treatment, and Strategies for Crisis Intervention and Prevention - Revised.

For the last several years, Marcy has used her experience and skills to energetically train staff in how to build relationships and work positively with emotionally disturbed children, behaviorally challenged children, developmentally disabled children, and at-risk youth.

Patricia Stratton, a graduate from Durham University with B.Ed hons, has worked for Sunderland Social Services for 28 years both as a manager of children's residential homes and, for the past eight years, as a Workforce Development Consultant for Sunderland's Social Care Children's Services. She is a registered social worker, holding both CSS and management qualifications. In 1999 Patricia became responsible for the design, delivery and commissioning of training for Children's residential, case management and fostering services. Patricia became a TCI trainer in 1999 and holds lead responsibility for the training, implementation and development of the TCI system throughout children's services. Patricia has also been instrumental in developing TCI for Family Care Providers within her organisation. Both programmes have had a major impact on reducing high-risk interventions with children and young people in Sunderland. Patricia can be contacted at patricia.stratton@ssd.sunderland.gov.uk ✷

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or history of sexual abuse, the child might be best served if positioned against the thighs of the adult. In other cases, the young person would feel more stable and secure between the knees of the adult. Either way, it comes down to whatever position allows the technique to be executed most effectively while maintaining the overall safety of the young person. When holding the legs in the small child restraint, how should the arms of the adult be posiioned? In the various TCI materials (both written and in the video) this technique is demonstrated a couple of different ways – with both of the adult's arms under (and "wrapping") the child's legs as well as with only one of the adult's arms under the child's legs. Through experience and feedback, we've also demonstrated an additional technique in training – with the "lead arm" of the adult wrapped over and then under the child's legs – with the other gently resting on top (thus preventing the child from pulling their foot through the gap between the floor and the adult's body).

If we examine these variations in the technique through the prism of the principles involved (safety of the child through being off the joints and putting no weight on the legs, safety of the adult through minimizing kicking and thrashing, and reducing stimulation though having the adult facing away from the child), we can see that while a particular position may offer more effective containment, all are acceptable.

Using the above examples, we can see that the answer to questions regarding what is exactly the "right way" to execute a physical skill is not necessarily as concrete that we, as trainers, might otherwise like it to be. It is important for us to be aware that in some instances, there are no "absolutes" involving the "right way" to execute the steps of the TCI physical skills. In the "real world", too many factors are at play to simply say "this is the right way to do this technique". There is no question that there are more efficient and perhaps effective ways to execute a particular skill, but ultimately, the "right way" comes down to the basic principles involving safety of the young person, safety of the adult, body mechanics, and the basic steps necessary to complete the particular technique. ✷

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REFOCUS is an occasional newsletter. It is our way of communicating to you, TCI trainers and interested professionals, information about current issues and events that emerge from work in crisis management and residential child and youth care. Information from the field provides important feedback for us. You can send questions and comments and ideas to us at: REFOCUS c/o The Residential Child Care Project, Family Life Development Center, Cornell University, Beebe Hall, Ithaca, NY 14853 Tel: (607) 254-5210/Fax: (607) 255-4837/Email: eas20@cornell.edu

TCI Bookshelf

A Review of *The Lucifer Effect* by Philip Zimbardo

By Nick Pidgeon

The Lucifer Effect is about a psychology experiment and the parallels with the Abu Ghraib prison abuse. *(Beginning in 2004, accounts of abuse, torture, rape and homicide of prisoners held in the Abu Ghraib prison in Iraq – also known as Baghdad Correctional Facility – came to public attention. The acts were committed by some personnel of the 372nd Military Police Company of the United States, the CIA and possibly additional American governmental agencies. –Wikipedia.)*

So why is this book relevant to our work with young people?

Because *The Lucifer Effect* is also about how easy it is for good, well meaning, honest people to tolerate, or even contribute to, an abusive system. There are important lessons here for all who have care, control and power over others.

The psychology experiment in question is the infamous Stanford prison experiment where a group of students was randomly divided into "prisoners" and "guards" in a mock prison. After only six days the experiment was stopped when the extent of the cruelty and abuse by the pretend guards became apparent. Zimbardo ran this experiment himself and accepts the blame.

When the Abu Ghraib scandal was exposed, Donald Rumsfeld claimed the abuse was the work of a few "bad apples". Zimbardo asks whether there might have been an alternative explanation: could the abuse have been produced by a "bad barrel?" In other words was it a few bad individuals or the system that led to the cruel and degrading treatment of Iraqi prisoners?

He provides page after page of convincing evidence – from years of social psychology research but also from an examination of Iraq, Guantanamo Bay and the entire "war on terror" – that bad barrels, or what he also calls "situational effects", are what lead to abuse, not bad individuals.

Here is his formula for a "bad barrel:"

- Take two groups of human beings
- Separate their status and roles so there is a clearly defined them and us
- Give one group care and almost complete control over the other group
- Label the cared for group as bad or deficient in some way
- Put the caring group under pressure, make unrealistic demands, limit resources, stress them, scare them with a fear of dangerous behaviour from those cared for
- Give the carers traditions, a "this is how we've always done things" mentality (and even exacerbate this by giving them a uniform)
- Then shut these two groups away so the outside world knows very little of what goes on between them

And what have I just described? The Stanford Prison Experiment and Abu Ghraib certainly, but there are elements here of many residential programmes for young people.

This idea is nothing new. What is new in this book is the chilling examination of how even the most caring, good natured person can end up tolerating or even contributing to serious abuse. Zimbardo describes his book as "a rather grim journey into the heart and mind of darkness". This journey has relevance for all of us associated with institutional care. ✷

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communicating, and developing and implementing activity programs were among the strategies listed.

In the United Kingdom, the 2003 Green paper, *Every Child Matters*, written in consultation with children, families, and care workers listed that what every child needs in residential care is an opportunity to:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Have economic well-being

While residential care continues to evolve from warehousing children in some centers to meeting the special emotional, physical, and developmental needs of children in others, it is important to keep in the forefront what the pioneers have long known:

"In all actions concerning children, whether undertaken by the public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration." —Article 3(1), United Nations Convention on the Rights of the Child (1989).

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The Residential Child Care Project seeks to improve the quality of residential care for children through training, technical assistance and evaluation. The project has been at the forefront of efforts to strengthen residential child care programs for children since 1982 when it was established under a grant from the U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect. The RCCP is administered by the Family Life Development Center (FLDC), the College of Human Ecology at Cornell University. The Center's Director is John Eckenrode, Ph.D. The project's Principal Investigator is Michael Nunno, DSW, and the Project Director is Martha Holden, MS. The Residential Child Care Project web site address is http://rccp.cornell.edu/

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2008 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT) NORTH AMERICA

Jan. 28 - Feb. 1/08	Knoxville, TN
Feb. 25-29/08	Pittsburgh, PA
Mar. 3-7/08	San Diego, CA
Mar. 3-7/08	Charleston, SC
Mar. 10-14/08	Denver, CO
Mar. 31 - Apr. 4/08	Peoria, IL
Apr. 28-May 2/08	Cincinnati, OH
May 5-9/08	Boston, MA
Jun. 2-6/08	Atlantic Beach, NC
Jun. 9-13/08	Toronto, Canada
Jun. 16-20/08	Ithaca, NY
Jul. 14-18/08	Pittsburgh, PA
Jul. 28 - Aug. 1/08	Ithaca, NY
Aug. 11-15/08	Ithaca, NY
Sep. 8-12/08	Sacramento, CA
Sep. 22-26/08	Peoria, IL
Oct. 13-17/08	Myrtle Beach, SC
Nov. 3-7/08	Mesa, AZ
Nov. 17-21/08	Boston, MA
Dec. 8-12/08	Ithaca, NY

TCI: TXT EUROPE

Mar. 10-14/08	Dublin, Ireland
May 12-16/08	Glasgow, Scotland
Jun. 30 - Jul. 4/08	Leeds, UK
Oct. 6-10/08	Dublin, Ireland
Nov. 17-21/08	Glasgow, Scotland

TCI: TXT AUSTRALIA

Feb. 4-8/08	Sydney, Australia

TCI TXT FOR FAMILY CARE PROVIDERS

May 19-23/08	Dublin, Ireland
Jun. 9-13/08	Ithaca, NY

TCI UPDATES

DEVELOPING PROFESSIONAL LEVEL TCI TRAINING SKILLS

Dec. 12-13/07	Leeds, UK
Mar. 18-19/08	Bournemouth, UK
Apr. 24-25/08	Cincinnati, OH
Jun. 24-25/08	Belfast, N. Ireland
Aug. 25-26/08	Ithaca, NY
Oct. 15-16/08	Glasgow, Scotland

DESIGNING REFRESHER TRAINING

Feb. 20-21/08	Glasgow, Scotland
Feb. 21-22/08	Pittsburgh, PA
Mar. 27-28/08	Peoria, IL
Apr. 1-2/08	Dublin, Ireland
May 6-7/08	Glasgow, Scotland
May 29-30/08	Atlantic Beach, NC
Jun. 2-3/08	Penrith, UK
Jul. 10-11/08	Pittsburgh, PA
Sep. 22-23/08	Penrith, UK
Nov. 13-14/08	Boston, MA

TCI FOR FAMILY CARE PROVIDERS UPDATE: DESIGNING REFRESHER TRAINING

Jun. 16-17/08	Ithaca, NY

TCI FOR DEVELOPMENTAL DISABILITIES

Mar. 10-11/08	San Diego, CA
May 12-13/08	Boston, MA
Jun. 18-19/08	Dublin, Ireland
Oct. 20-21/08	Myrtle Beach, SC
Oct. 30-31/08	Mesa, AZ

TCI FOR FAMILY CARE PROVIDERS

Dec. 3-4/07	Belfast, N. Ireland
Mar. 10-11/08	Charleston, SC
Nov. 12-13/08	Dublin, Ireland
Dec. 4-5/08	Ithaca, NY

POST CRISIS RESPONSE

Feb. 11-12/08	Canberra, Australia
Feb. 26-27/08	Dublin, Ireland
Mar. 6-7/08	Denver, CO
Apr. 22-23/08	Liverpool, UK
May 8-9/08	Dublin, Ireland
Jun. 10-11/08	Glasgow, Scotland
Jul. 21-22/08	Ithaca, NY
Jul. 24-25/08	Ithaca, NY
Sep. 4-5/08	Sacramento, CA
Sep. 10-11/08	Stevenage, UK
Sep. 18-19/08	Peoria, IL
Oct. 27-28/08	Penrith, UK
Nov. 13-14/08	Boston, MA
Dec. 2-3/08	Belfast, N. Ireland

Note: *The following NEW 1 day updates are ONLY available to TCI trainers who have successfully completed BOTH Designing Refresher Training AND Post Crisis Response.*

ADAPTING THE LIFE SPACE INTERVIEW FOR PROACTIVE AGGRESSION

Feb. 22/08	Glasgow, Scotland
Feb. 28/08	Dublin, Ireland
Apr. 23/08	Cincinnati, OH
Apr. 24/08	Liverpool, UK
May 28/08	Atlantic Beach, NC
Oct. 14/08	Glasgow, Scotland
Nov. 12/08	Boston, MA
Nov. 14/08	Dublin, Ireland
Dec. 11/08	Leeds, UK

CONFLICT RESOLUTION

Apr. 3/08	Dublin, Ireland
May 5/08	Glasgow, Scotland
Jun. 17/08	Dublin, Ireland
Sep. 9/08	Stevenage, UK
Oct. 20/08	Myrtle Beach, SC
Oct. 29/08	Mesa, AZ
Dec. 4/08	Belfast, N. Ireland
Dec. 12/08	Leeds, UK

LEGAL CONCEPTS INVOLVED IN THE USE OF PHYSICAL RESTRAINT

Jul. 23/08	Ithaca, NY