Strengthening the Culture of Care in Child Care Agencies

by Vonda I. Wallace and Jean Carpenter-Williams

The 2005 Child Welfare League of America (CWLA) report *Best Practices in Behavior Support Intervention* identifies two key elements for achieving success in child care agencies: changing an organization's culture and training programs. This report supported a notion that began in Missouri two years earlier, and that notion evolved into a statewide initiative.

In 2003, state and private sector leaders in Missouri came together to discuss the need for best practice resources that would enable residential child care agencies to create or enhance and maintain a positive, nurturing culture of care. The Missouri Children's Division (CD) Residential Program Unit (RPU) requested assistance from the University of Oklahoma National Child Welfare Resource Center for Youth Development (NCWRCYD) to facilitate discussions and support developing a training curriculum focused on strengthening the culture of care.

RPU asked that the focus of efforts remain on creating a safe and nurturing environment in residential treatment facilities. An initial group of licensed residential child care providers from around the state was identified to participate in a conference call to discuss current issues and identify action steps.

The initial teleconference took place in May 2003, and resulted in the decision to invite all licensed residential child care providers to one of two planning meetings in Kansas City and St. Louis, Missouri. The objective of the meetings was to provide an opportunity for dialogue about the current residential treatment environment, to define *culture of care*, and to gain support for further work on developing a culture of care through training opportunities.

A focused, facilitated conversation generated a number of topics. Several of these were seen as positive aspects or opportunities regarding the work that was currently being done. Some, however, were viewed as a weakness or threat to the future of residential child care in Missouri.

A number of themes also emerged as a result of the process. The more common included:

- hiring, training, and retention of quality staff;
- uncertainty regarding funding resources; and
- providing of comprehensive, strengths-based, individualized services to the children, youth, and families of Missouri.

After some discussion, the group's general feeling was that many of the most pressing issues could be addressed through the development of a more comprehensive training approach throughout the state.

Volunteers recruited from the public/private stakeholders meetings met in August 2003 to continue examining the culture of care within Missouri

residential child care agencies. The group consisted of approximately 20 program directors, training coordinators, consultants from NCWRCYD, and RPU staff. Many of the private providers were also members of the Missouri Coalition of Children's Agencies (MCCA), the statewide coalition of child care agencies.

Using the workshop method of group input utilized at the initial meetings, the following three themes were identified as necessary for a professional development program that supports a safe, nurturing culture of care:

- administrative issues—leading through example,
- direct care issues—building ownership by valuing staff, and
- collaborative issues—joining together to work better.

Members then self-selected subcommittees based on these themes. These groups agreed to identify and develop training and other supportive material related to the chosen area, which was then presented to the large group in October 2003.

The purpose of the October meeting was to finalize the curriculum components and supportive materials for each of the three elements. At this meeting, the Administration Group joined with the Collaborative Issues work group, thinking the work being done in the administrative group would enhance collaborative issues. The final training curriculum and an *Executive Director Handbook* were developed during these meetings.

Initiative Curriculum

The Missouri Initiative Culture of Care training curriculum is a blend of nationally recognized best practices with successful tools and programs used throughout Missouri. It is based on four core principles—youth development, collaboration, cultural competence, and permanent connections—identified by the National Child Welfare Resource Center for Organizational Improvement at the University of Southern Maine, and the National Resource Center for Youth Services at the University of Oklahoma. With these principles in place, experts in the field believe programs are more likely to be successful, regardless of the services provided.

The *Executive Director Handbook* provides a history of the project, a summary of the foundation and principles of the training, an overview of the training modules, and a best-practice resource guide. The handbook also emphasizes the need for commitment to creating and strengthening a positive culture of care beginning at an organization's administrative level. In July 2005, 58 executive directors participated in a

roundtable discussion in Jefferson City, Missouri, where the *Executive Director Handbook* was presented.

The basic foundation for the curriculum, adapted from The University of Oklahoma National Resource Center's *Residential Child and Youth Professional Curriculum* (RCYPC), drives the content and concepts presented in the materials. NCWRCYD staff adapted the RCYPC to meet the specific needs identified by the planning committee. The key concepts identified include issues related to a strength-based approach, learning opportunities, youth empowerment and involvement, relationship development, the programmatic culture of care, and collaboration with a number of resources.

The values represented in theses premises have an effect on every aspect of our work with children, youth, and their families. They support a competency-based approach and are reflected throughout the training modules. By supporting the strengths of young people, we can provide more effective care and enable them to make a more successful transition when they leave our programs.

The Missouri Initiative training curriculum provides a cost-effective resource for residential agencies to use at their discretion. Training modules are designed to allow an agency to use the entire curriculum, or only specific parts as needed. RPU and NCWRCYD staff facilitated train-the-trainer sessions in Kansas City and St. Louis in August 2005 for licensed Missouri residential child care providers. Approximately 25 agencies across the state are using the curriculum.

Burrell Behavioral Health Inc., Children's Residential Treatment Services, operates two licensed residential child care facilities, serving 30 male and female children, ages 8–13 years. According to Mary Jane Harmless, former Director of Children's Residential Treatment Services, "Burrell began restructuring their department…to be better positioned to enact the culture of care philosophy and principles in day-to-day programming and interactions."

Efforts are showing a positive effect on staff retention, professionalism, consistency in care, and accountability to youth. Burrell has used the curriculum and resources from the handbook to develop a mandatory, progressive train-

ing program (implementation is expected in spring or summer 2006), as well as interview questions for all level hires that are geared toward gaging receptiveness to philosophy and ability to implement appropriate interaction with children. Exercises from the curriculum are used at staff meetings. Burrell plans to sponsor one of three upcoming three-day training sessions on the initiative curriculum in spring 2006.

Valley Springs Youth Ranch (VSYR), in rural southeast Missouri, provides residential treatment services to 86 boys, ages 6–21. VSYR began using the curriculum by offering segments of the training in weekly child care worker meetings, but found this was less effective than anticipated.

In May 2005, VSYR implemented a three-day workshop covering the entire

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curriculum. Program Director Shelia Pigmon says, "By giving our direct care staff the complete picture, rather than bits and pieces, we were able to convey the direction we wanted to take with our residential treatment."

VSYR also provides a one-day refresher course, *Strengthening the Culture of Care,* and invites administrative, maintenance, dietary, and other support staff to participate. The intent is for all employees who come in contact with children and youth on VSYR's campus to be well-versed in the organization's treatment goals. Professionals from other agencies have participated in the one-day course, which has provided an excellent opportunity for networking and information sharing. Pigmon reports, "I have found the information in *Strengthening the Culture of Care* invaluable in improving the treatment we provide for the youth in our care."

Located in St. Louis, Youth in Need (YIN) provides a range of services,

including emergency care, residential treatment, and transitional living for 33 children, both male and female, birth to age 21. Karen Brown, YIN Training Director, says

Youth in Need has always used a positive youth development approach and a strengths-based philosophy when working with youth in its residential programs. However, direct care staff sometimes struggled to translate these foundational ideas into practical intervention. After participating in the Culture of Care *training, it seemed second nature to be able to incorporate its curriculum into our programming.*

The activities and explanations for why we do what we do with youth made teaching the philosophy much easier. The concept of having a culture of care from administration throughout all positions within the agency provides a continuum that is desperately needed in agencies that strive to provide quality services to both youth and their families.

The Missouri Initiative curriculum is taught in agency-wide YIN staff trainings on a quarterly basis, and is built on year-round in weekly in-service trainings. YIN has found this promotes communication between staff and youth, as well as between staff and supervisors, and strengthens personal accountability and professionalism.

Collaboration and Future Efforts
Public and private child welfare professionals across Missouri formed a true partnership throughout the development of the training curriculum and the *Executive Director Handbook*. Licensed residential child care agencies, state residential program unit staff, and MCCA leaders developed and strengthened communication skills, shared success and failures within their organizations, and opened doors for future collaborative efforts.

Current efforts include planning three-day train-the-trainer sessions, facilitated by NCWRCYD staff, to be held in three locations around the state in 2006. MCCA and the Missouri Children's Division are partnering to host the training sessions, and are discussing how to best facilitate a statewide network to assist with future train-the-trainer sessions. The MCCA

Improving Restraint Monitoring with Pulse Oximetry

by Kim J. Masters

The monitoring of individuals subjected to physical restraints (being restrained by people) and mechanical restraints (being restrained by mechanical devices such as straps or papoose boards) has included measuring pulse, respiration, and blood pressure. The purpose of these measurements is to ensure safety and prevent cardio respiratory catastrophes such as asphyxiation, arrhythmias, and death.

Unfortunately, this approach has not been completely successful. In a recent Joint Commission on Accreditation of Health Care Organizations (JCAHO) review of 3,000 situations causing severe injury or death, 114 were associated with restraints (Croteau, 2005). In another study of 45 physical restraint-related deaths, 29 (64%) were due to asphyxiation (Nunno et al., in press).

What keeps our monitoring from preventing these deaths? It is antiquated: The ability to count pulse and respiration was available to King Tutankhamen 4,300 years ago. The ancient Egyptians also may have known about blood pressure, although the prototype for the modern blood pressure machine was not invented until 1881. What other medical procedure besides restraint employs 4,300-year-old strategies and 130-year-old devices for monitoring? Could you imagine a surgeon counting respiration and pulse during heart surgery today?

The monitoring system is inaccurate, at best, and useless at worst. Both pulse and respiration increase with anxiety and anger. Who gets restrained without either of these happening? Both of these measures are contaminated by factors that make them inaccurate measures of medical conditions such as arrhythmias and suffocation. Blood pressure is difficult to obtain in an agitated person, and when it drops, the person typically has already suffered a cardiorespiratory catastrophe.

Can we do better?

Pulse oximetry is a noninvasive procedure that offers an opportunity to measure oxygen saturation in blood, independent of anxiety or agitation. The pulse oximeter is the size of a pocket notebook and has an attached probe that can clip to a person's finger or toe. Adaptors are also available, which may not be as accurate, for use on earlobes or in a headband. In an oximeter,

A source of light originates from the probe at two wavelengths (650nm and 805nm). The light is partly absorbed by hemoglobin [in] amounts which differ depending on whether it is saturated or desaturated with oxygen. By calculating the absorption at the two wavelengths, the processor can compute the proportion of hemoglobin which is oxygenated (Fearnley, 1995).

Oxygen saturation readings below 90–95% indicate that the person may be hypoxic (an inadequate level of oxygen in the blood). In a restraint situation, an oxygen saturation of below 95% could indicate airway compromise due to chest compression, reactive airway disease, bronchospasm, aspiration, or cardiac dysfunction. Oximetry might provide an early warning of breathing difficulties, because its measurements might drop before obser-vers detect clinical abnormalities. Early recognition of low oxygen saturation might allow time to stop the restraint and provide necessary treatment before a cardiorespiratory crisis occurs.

Pulse oximeters are available in battery-operated models that cost $200–$600. Measurements are easy to obtain and take between 5 and 10 seconds, thus allowing for multiple measurements over a brief period of time, if needed (Modica, 1991; Middleton & Henry, 2000). Oximeter use can be taught quickly, probably in less than 30 minutes, and does not require a medical background to understand. Continuous portable oximetry monitors are also available to provide ongoing oxygen saturation monitoring.

The pulse oximeter who use has an indicator that is activated when the oxygen saturation measurement is read as inaccurate. The machine also records pulse, making a separate measurement unnecessary.

Certain conditions confound the oximetry measurement, but they usually provide artificially low oxygen saturation readings. These conditions include heart failure or volumes of low body fluid seen in cases of dehydration. Most of these conditions would not apply to children and adolescents or healthy adults in restraint. Low readings can also occur with some nail varnishes. Obtaining baseline readings before restraints, however, should identify those patients, either allowing for choosing alternate body sites for oximetry measurements, or requesting a patient to keep one fingernail free of varnish.

My staff began using pulse oximetry to monitor oxygenation during physical restraints at New Hope Carolinas, and more recently at ABS Pines Charleston and ABS Pines Midlands in South Carolina, and at FHC Cumberland Hall in Chattanooga, Tennessee. Initially, we trained the nursing staff to understand the principles of oximetry and how to use an oximeter—in our case it was Criticare Systems Mini SPO2T (Model 503 DX). They in turn explained to our staff and patients our plan to use it to monitor restraints, with the hope of improving their safety. Baseline readings were taken on all patients. Our initial observations have been published (Masters & Wandless, 2005).

We now obtain oximetry measurements with all of our restraints, either

by using a finger or the first toe as a measurement site. A survey of nurses who take oximetry measurements in all of the facilities has shown that both the staff and those being restrained feel oximetry is a useful safety measure. In the heat of a restraint, however, some teenagers refuse to give their fingers for measurements. If permitted to turn on the oximeter, however, some then allow the oximetry.

Usually there is no objection to measurement after the restraint is over. This is an important time to measure oxygen saturation because broncho-spasm, asthma, and cardiac arrhythmias can occur after restraint. In fact, these may be causes of post-restraint deaths. No evidence shows that oximetry makes anyone feel complacent about using restraints. Rather, the opposite has occurred: Restraints are understood to be dangerous procedures that affect the physiology of the cardiorespiratory sys-tem and, hence, have the potential for adverse medical consequences.

In two situations with my staff, oximetry measurements were abnormal. In one, a baseline oxygen saturation reading was 99% and the restraint read-ing 95%. The person being restrained requested the use of her inhaler, and the restraint ended. In this case, the oxime-ter appears to have detected a respirato-ry problem when it developed.

In another, a person in a restraint, who had been very aggressive, suddenly became withdrawn and quiet after an intramuscular ziprasidone (Geodon) injection. Pulse oximetry showed that his O_2 saturation had dropped from 98, baseline, to 89. The restraint was termi-nated, and he was encouraged to sit up and talk with staff. A subsequent O_2 measurement was again 98. In this situ-ation, oximetry may have identified an early developing case of respiratory compromise (Masters, 2005).

This case is especially interesting because the older literature on therapeu-tic holding assumed the person being held had "learned to give up control" if they calmed down (Trieschman, 1969). That the person might have been oxy-gen deprived or undergoing a respirato-ry compromise or cardiac arrhythmia,

causing a change in his or her level of consciousness, was never considered.

Oximetry is not a panacea, of course. It does not replace the impor-tance of avoiding restraint use or of de-escalation training. Also, it may not identify the early stages of respiratory compromise, which may show rapid breathing in an attempt to compensate for airway constriction or cardiac dys-function (Reeves & Ladner, 2005). Repeated readings, however, should be able to detect decompensation, particu-larly if compared to baselines.

Why are we using oximetry now?
Only recently have people realized restraints can potentially kill people. Since this information made headlines, most training efforts have rightly been devoted to strategies that minimize the use of seclusion and restraint. Once these efforts began producing culture change in facilities that employed restraints, some of us belatedly became aware that no one had attempted to modernize the monitoring of seclusion and restraint. Oximetry, which is a reli-able, cost-effective procedure, became an obvious assessment choice. Whether it will help reduce the use of restraints and prevent injury and death depends on more experience with its use.

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Male and Female Brains and Autistic Spectrum Disorder

by Nick Pidgeon

In our work with children and youth, we make use of relationships and communication skills. We talk about feelings, problems, and hopes. We talk about the effects of behavior on others. This is the currency we use.

Recent work in psychology has shed new light on these areas, on the capacities and abilities of boys and girls, on average, to respond to the currency we use, and their ability to tune into the whole field of relationships, emotions, and communication skills. This new theory also says a lot about the disability we call autistic spectrum disorder.

History

When I was growing up in the 1960s and 1970s, it was fashionable to claim that the brains of newborn male and female babies were identical. Any differences in behavior between older boys and girls was believed to be the result of conditioning and culture. That was why boys preferred competitive games and girls cooperative games. That was why boys liked to play with guns and girls with dolls. These children had been steered towards these stereotypical behaviors by adults who, for example, gave boys guns to play with and girls dolls. That was the theory.

The trouble was that a number of irritating facts didn't fit this theory, like the folk psychology that continued to talk of women's intuition and men's superior sense of direction, and the fact that, given the opportunity to make their own choices, most young boys would choose guns or action toys and most young girls would choose dolls or cooperative play.

In the 1980s and 1990s, assumptions of similarities between male and female brains began to drift. There was the pop psychology, such as John Gray's

Men are from Mars, Women are from Venus, and Alan and Barbara Peases' *Why Men Don't Listen and Women Can't Read Maps*, but there was also the science. The work of Doreen Kimura, for example, showed there are real differences in the average man and woman's verbal and spatial abilities (Kimura, 1999.) And there was also evidence of minor, but significant, structural differences in male and female brains (Pinker, 2002). But these research results showed no pattern. An overarching theory was needed to put the emerging differences into a framework.

> *Baron-Cohen's theory, in summary, is this: On average, women are better at a group of skills he categorizes under the heading "empathizing." On average, men are better at a group of skills he categorizes under the heading "systemizing."*

The Baron-Cohen Theory

Such a framework has now arrived in the work of British psychologist and psychiatrist Simon Baron-Cohen. Baron-Cohen's theory, in summary, is this: Women, on average, are better at a group of skills he categorizes under the heading "empathizing." Men, on average, are better at a group of skills he categorizes under the heading "systemizing." Additionally, the theory provides

an understanding of the disabilities known as autism and Asperger syndrome, which can be thought of as extreme forms of the male brain.

Before expanding on the Baron-Cohen theory, I need to make one thing clear: he does not claim that all males think one way and all females another, that all females are better at empathizing than are males, and all males are better at systemizing than are females. The theory is a theory of averages, of significant statistical differences. For a man to say, "I know a woman who is way taller than me," does not diminish the truth that, on average, men are taller than women. In the same way, while many men will score high on tests of empa-thizing, statistically the bell curve of scores for women will have a higher average than the bell curve of scores for men—in the same way the bell curve for scores for men on systemizing will have a higher average than the bell curve of scores for women.

Empathizing

So what is empathizing? It is the skill to react to emotions in others. Empathizing has two components: First, the cognitive element consists of the ability to recognize different emotional states in other people. This ability is often referred to as "theory of mind" and does not develop in children until about age 4. The second element to empathizing is the affective component—being aware of another's emotional state and responding to that state, tuning into someone else's world, caring how they feel, and reacting appropriately.

Systemizing

Whereas empathizing is about how we respond to other people, systemizing is about how we respond to aspects of our

environment that involve analysis, laws, and prediction. This covers a range of areas including science, mathematics, economics, logic, music, computer programming, and sports. In fact, it covers any area where a three-step process applies: First is input (information or analysis), second is an operation (something changes), third is output (a prediction of the effect of the operation).

Average Male and Female Differences

One attraction of the Baron-Cohen theory concerns how the scattered research findings on male-female differences can fit into this empathizing-systemizing framework. He claims females, on average, are better empathizers and that males, on average, are better systemizers. Or, to put it another way, female brains are characterized by empathizing, male brains by systemizing. Baron-Cohen provides evidence of this, both observational and experimental. Below are examples. He quotes 102 references for these claims, all found in his book, *The Essential Difference* (2003).

Evidence for the Female Brain as Empathizer

- Styles of play: Girls, on average, are more cooperative, concerned with fairness, and better at sharing, whereas boys are more self-centered and competitive.
- Girls develop theory of mind earlier and with greater skill.
- Evidence exists that women are better at interpreting facial expression and tone of voice. They score better on tests of these skills, including the Profile of Nonverbal Sensitivity and the Reading the Mind in the Eyes tests.
- Male and females differ in what they value in relationships. Females typically value cooperation, altruism, and intimacy; males typically value dominance, competition, and shared interests.
- Social style: Differences are neatly revealed when children break into a group of strangers. Girls typically watch and then try and fit in with ongoing activities; boys typically try to take over a game and acquire a dominant position in the group. Even by age 6, groups of girls are more welcoming and attentive to newcomers; boys often ignore newcomer's attempts to join in.
- Women, on average, score higher than men in a direct assessment of empathizing—the Empathy Quotient test developed by Baron-Cohen and his collaborators.
- Communication: A host of differences are noted in conversational style, summarized in Figure 1.

Evidence for the Male Brain as Systemizer

- Styles of play: Evidence shows boys use play involving systemizing, such as mechanical and constructional play.
- A preponderance of males are in careers associated with systemizing: mathematics, physics, and engineering. It has been argued that this is because of a prejudice against female applicants, but evidence exists that these careers are more attractive to males.
- On average, males have greater skills in solving mathematical problems.
- Males score higher, on average, in tests involving predicting physical systems, understanding physical systems, or mental rotation.
- Males, on average, are better at systemizing object motion, in other words, throwing an object to hit a target or catching a ball.
- And finally, males score higher in Baron-Cohen's and his collaborators' own test of systemizing, the Systemizing Quotient test.

Autism as an Extreme Male Brain

Although it's early, and a lot more work needs to be done, it looks as if Baron-Cohen might be on to something. The differences between typical male and female brains possibly can be explained in terms of the two dimensions of empathizing and systemizing. But what about people who score well on tests of both empathizing and systemizing? Not surprisingly, he describes these people as having balanced brains. And what about people who score very high on empathizing but very low on systemizing— what could be called the extreme female brain? We don't know. There is no condition or syndrome that can answer this description.

But here's the interesting question: What about people at the other extreme—those who score very low on empathizing but very high on systemizing; those who have great difficulty tuning into what others are thinking and feeling but who have an almost obsessive interest in routine and systemizing the world?

This might sound familiar. It's a description of the disabilities known as autism and Asperger Syndrome. *Autism* is defined in the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* as being characterized by abnormalities in social development and communication with unusually strong obsessive interests from an early age. It is usually accompanied by an intellectual impairment. People with Asperger Syndrome have the same communication difficulties and obsessive interests without an intellectual

Figure 1.

Gender Differences in Communication	
FEMALE	MALE
Social themes	Systems themes
Concerned with others	Self-centered
Cooperative, collaborative	Dominating
Indirect expressions of anger	Direct expressions of anger
Expression of feelings other than anger	Withdrawal of contact if offended
Agreement	Domineering exchanges
Good listening skills	Interruptions
Ability to keep conversation going	Short exchanges
Modest claims	Demonstrations of knowledge
Compliments to each other	Bragging about self

impairment. These two conditions form a continuum of disability known as Autistic Spectrum Disorder (ASD).

Baron-Cohen wasn't the first to come up with the idea of autism as an extreme male brain. Consider this statement made in 1944: "The autistic personality is an extreme variant of male intelligence. Even within the normal variation we find sex differences in intelligence…In the autistic individual, the male pattern is exaggerated to the extreme."

This statement can be attributed to none other than Hans Asperger himself. The idea went unnoticed for nearly 50 years until these words were translated into English. If we understand Asperger's term "intelligence" in the broadest sense, meaning personality, skills, and behavior, this is the Baron-Cohen theory.

Implications for Our Work

The theory is fascinating in itself. It tells us a lot about ourselves. It answers questions like: How can my wife be in a restaurant for 30 seconds before turning to me and whispering, "See those two people over there? They're not married. They're having an affair," while I have no idea how she arrives at this conclusion? But after two hours of careful observation, I might concede she is right. And it explains why I can fit twice as much into the dishwasher as my wife. But the theory also raises a lot of questions about our work with troubled young people, such as:

• How many of the boys we work with, particularly those who really struggle with consideration of the effects of their behavior on other people's feelings, have undiagnosed Asperger Syndrome?
• And what about those who don't fall within the range for diagnosis with Asperger Syndrome but who are toward the extreme end of the range of normal male behavior? Do we expect too much of them? Do these boys find it very difficult to sit down and discuss their thoughts and feelings? Do they find it particularly difficult to think about the effect of their

behavior on other people? Do they struggle to understand and respond to emotions in others?
• What about boys in general? If the currency of our work with young people is to talk about relationships and feelings and the effect of behavior on others, are boys going to struggle with this more than girls do? Is sitting down and talking about these areas a journey into alien territory for many boys? Do we need to develop different counseling styles for boys and girls?

I don't know the answers to any of these questions. What I do know is that Baron-Cohen's work should make all of us who work with children and youth stop and think.

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training committee has worked to revise the MCCA Child and Youth Care Worker Certification Training. This group is using the Missouri Initiative curriculum to meet many of the competencies outlined within the certification program.

The initiative and resulting curriculum is also a part of Missouri's Performance Improvement Plan (PIP), in response to the federal Child and Family Services Review (CFSR) conducted in 2003. Inclusion in the PIP allows RPU continued access to training and technical assistance from NCWRCYD consultants. NCWRCYD is a service of the U.S. Children's Bureau and provides free technical assistance and training focused on building capacity within states and tribes to effectively meet the needs of youth in out of home care.

The division has recognized that a safe and nurturing environment facilitates more effective care for young people and a reduction in the number of reports of preponderance of evidence for child abuse/neglect from residential child care agencies. Missouri experienced an 85% reduction in such incidents from May–July 2004 to January–March 2005. Ongoing data collection will help determine the effect the Missouri Initiative training curriculum has had on the reduction of these reports.

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Q: *What is the best congregate care setting for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth?*

POINT: Population-specific programs for LGBTQ youth have been proven to effectively address the particular needs of these youth.

COUNTERPOINT: LGBTQ youth are better served when integrated into general population programs.

by Rob Woronoff

by Amy R. Rhodes

"I got jumped by some guys in my group home, and when I told the director, he said, 'Well, if you weren't a faggot they wouldn't beat you up.' It's not fair."

"Right now I'm in a shelter. I don't like it there because most people there are very homophobic. I got a room alone. I got into a fight just because I'm gay. And people don't accept the fact that I'm gay. I've been there for three months. I'm trying to get the heck out of there."

"When I came to [the LGBTQ group home], I was very happy. I felt that I had made a lot of progress in rehab, although I felt that I could have made more progress in rehab if I was in a more supportive environment. I was happy to come here. I previously didn't know that there was a program specifically for young gay people. It's a very satisfying feeling to wake up every day and to look around me and to know that it's a supportive environment."

"Once I got to [the LGBTQ group home], I think I started to get better. I was really nervous, but once I got there, I saw residents around me. And everyone was just like me. I felt safe because I was in a place where I could be myself without getting harassed. I've been there for about six or seven months and I've made so many improvements."

These statements were made by young people in care of the child welfare system who participated in a series of regional listening forums convened by CWLA with its LGBTQ initiative partner, the Lambda Legal Defense and Education Fund (Lambda Legal). They highlight the experiences of children in care who identify as lesbian, gay, bisexual, transgender (LGBT), or who are questioning (Q) their sexual orientation or gender identity. Clearly, the above statements illustrate very different experiences. As you read them, think to yourself, as a child welfare professional, would I prefer to work with youth

Some young people may require a specialized setting due to the current lack of appropriate programs that are sufficiently equipped to address the specific needs of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth.

Specialized programs create a protective environment where the young people are free to express their feelings and opinions without fear of being ridiculed, harassed, threatened, or harmed. This setting, however, does not create a real world experience for youth. Isolating LGBTQ youth in a specialized program has its benefits, but it does not give youth the same kinds of experiences they are likely to encounter after leaving the program. Unfortunately, society as a whole is neither accepting nor welcoming of those who are considered to be outside of what is generally accepted as the norm; therefore, LGBTQ individuals are sometimes subjected to discrimination and negative and disrespectful comments and behavior.

Residential care settings should provide all residents with safe, quality care based on producing the best outcomes for the young person (Lambda Legal Defense and Education Fund, 2001). Either during or following the LGBTQ youth's residential experience, he or she will enter a school system, the workforce, and society at large, which is, unfortunately, not tolerating or accepting of LGBTQ individuals. I am not suggesting that they hide who they are; they must be prepared to handle themselves with pride, dignity, and a sense of self-worth.

In addition, other youth who reside in the same programs will be afforded the opportunity to be educated about and develop sensitivity and acceptance toward LGBTQ youth in an unbiased and supportive environment. While the other youth become better informed on the issues impacting LGBTQ youth, the LGBTQ youth can share their insights and experiences, as well as help transform their peers into becoming

who say things like, "It's not fair," and "I'm trying to get the heck out of there," or would you rather work with youth who say things like, "It's a very satisfying feeling to wake up every day and to look around me and to know that it's a supportive environment," and "I've been there for about six to seven months and I've made so many improvements?"

A study conducted on behalf of the Urban Justice Center in New York City found that "once placed in a foster care setting, as many as 78% [of LGBTQ youth] are removed or run away due to anti-LGBT violence and harassment.

The choice seems to be clear. Most people working in child welfare would like to work with young people who feel safe and satisfied with the services they are provided. But for many young people in care who identify as or are perceived to be LGBTQ, few choices exist.

The treatment they receive can include complete disregard for their very existence, as illustrated by a statement made by a representative of a state department of child welfare services, who said that working with LGBTQ youth is not an issue because "there are no LGBT youth in the state's foster care system." Or youth can face outright hostility, as was related by the experience of the young person quoted above whose group home director thought it appropriate practice to call the young man a "faggot."

There is no real way to determine how many LGBTQ youth are in care of the child welfare system. Because the system has traditionally not been a safe and supportive place for LGBTQ youth, many have learned to hide, exploiting their invisibility to better survive in care.

Others have fled the system altogether and are homeless.

A study conducted on behalf of the Urban Justice Center in New York City found that "once placed in a foster care setting, as many as 78% [of LGBTQ youth] are removed or run away due to anti-LGBT violence and harassment. Fifty-six percent of LGBTQ youth interviewed in the study spent time living on the streets because they felt 'safer' there than they did living in their group or foster home" (Feinstein et al., 2001).

A needs assessment conducted in San Diego County in 2003 found that, among the 400 homeless LGBTQ-identified youth interviewed, two-thirds had had at least one previous placement in the child welfare system (Berberet, 2004). Many said they preferred to live on the streets because it was safer than the child welfare system.

The primary goal of the child welfare system is and always will be to find permanent families for youth in care. Perhaps one day, enough families will open their homes and hearts to children in need of a family. But that day has not arrived, so the need for congregate care settings still exists.

LGBTQ youth face the same challenges regarding permanency as other youth. Enough families simply do not exist to meet the needs of every young person in care. But the challenge for child welfare professionals trying to find permanent homes for LGBTQ youth face an added burden: Many families who are willing to care for a youth in foster care simply are not willing to open their homes and hearts to a lesbian, gay, bisexual, transgender, or questioning youth. So, unless we want these young people living on the street, congregate care must be a viable option.

Approximately 10,000 licensed residential care facilities exist in America. About a half-dozen are designed specifically for LGBTQ youth. LGBTQ-specific residential programs, ranging from group homes, to independent and transitional living programs, to shelters, currently exist in Atlanta, Boston, Detroit, Los Angeles, New York City, and San Francisco. A group home for LGBTQ youth will soon open in Philadelphia.

Clearly, these programs represent only a tiny fraction of the total number of available congregate care programs nationwide.

CWLA, in its partnership with Lambda Legal, is working toward the day when every placement throughout the nation's child welfare system, whether family-based or congregate care, is safe and supportive of LGBTQ youth. But as we wait for and work toward that day when enough families are available to love all youth in care, we are also waiting for and working toward the day when the entire child welfare system welcomes and affirms LGBTQ youth.

That day isn't here yet and may not be in the near future. So in the meantime, group homes designed to address the specific needs of LGBTQ youth are showing very good outcomes and providing these young people with the safety and support they need to transition more safely to adulthood.

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Having developed one of the nation's handful of residential programs designed specifically for LGBTQ youth (Waltham House, a program of The Home for Little Wanderers, located near Boston), I have seen first-hand the positive difference they can make in the lives of children and their families. I've long said that over the next five years, I'd like to see at least one LGBTQ group home open in every state. But then 10 years from now I'd like to see none. By then we won't need them.

Thanks to a growing movement of hundreds of individuals and organizations across the country, the child welfare system is beginning to understand and address the needs of the LGBTQ youth in their charge. All residential programs should be safe, welcoming, and affirming places for LGBTQ youth. Presently, many are not. If all group care facilities were open to working with LGBTQ youth, if they all displayed posters with rainbows or LGBT Safe Zone stickers, and if all child welfare professionals were trained on LGBTQ issues, then the need for specialized programs would not exist.

The goal is not to ghettoize these children. The goal is to keep them safe while they learn to navigate through a world where sexual orientation or gender expression is not always valued by the larger society. The goal is to help them feel good about who they are so that they can become the healthy, productive adult citizens that those working in child welfare want them to become.

The need for permanent, loving families for every young person in care will always remain the primary goal of the child welfare system. But there are young people in the system right now who are not being cared for properly within existing services. So I always see it as a both/and situation, rather than an either/or.

We need safe, supportive group homes for LGBTQ youth right now, *and* we need to do a much better job of recruiting, training, and providing ongoing support to families who will love and care for these children for the rest of their lives. The question should not be: "Should LGBTQ youth be segregated into specialized programs *or* integrated into general population programs?" We need to be working toward a system in which LGBTQ youth are safe and valued in every setting, *and,* until they are, we need places for them right now where they can feel safe and valued.

In Boston, we had great success reunifying youth from the LGBTQ youth group home with their families, because it afforded them a safe place to sleep while in the care of trained program and clinical staff who supported them. But as soon as a youth came into the program, if there was any chance at all of reunification, the family immediately went into therapy so they could develop an understanding of the issues that brought their child to the program in the first place. I'll use one specific example to illustrate.

One youth was referred to the program from a transitional care unit (TCU) of a hospital after attempting suicide. The 15-year-old boy was convinced his parents would never accept his homosexuality.

During therapy, the youth and the family started to work together on communication skills and conflict resolution. But the group home allowed them all the time they needed to digest what

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they learned in family therapy and to gradually put it all into their daily practice. All the while, the young person had a safe place to stay and could focus on schoolwork and developing a plan for his future, rather than hiding his identity and being stuck in the cycle of anger and frustration.

The boy learned to express his fears of rejection. And the family learned to embrace their son's sexual orientation. Then home visits started. One night, the boy ran away from the program. He had had experience as a prostitute and knew how to survive on the street. But he did not run to the street, and he did not prostitute on the night he ran from the program. He ran home. He wanted to sleep in his own bed and to be near the family he had once been convinced would never accept him.

Once it looked like the family could maintain their open communication and strategies to resolve conflict, the youth was returned. Ongoing follow-up care was provided so the youth could continue to live with his family in their community, attend his neighborhood school, and maintain his relationships with his friends.

This outcome could not have been achieved had the youth not had an opportunity to find affirmation in his placement, or if the parents had not had access to staff well-versed in issues of sexual orientation and the role that familial rejection, based on one's sexual orientation, can play on a young person's sense of self-worth.

Another example of the efficacy of the services provided in a specialized program was a male-to-female transgender youth who had had many failed family and congregate care placements because none affirmed her gender identity and expression. All of her previous placements had categorically refused to refer to or acknowledge her as a girl. She had always been referred to as a boy, had been forced to dress in boys' clothing, and had been placed on boys' floors in residential programs.

When she was placed in Waltham House, she was always acknowledged and referred to as a girl. She could wear girls' clothing, and she was placed in a room with another female. She found the group home to be such a safe and supportive environment that she could focus all her energies on her studies rather than on her safety or on the anger she had previously felt at being so thoroughly denied her own identity.

As her graduation from high school approached, she applied to and was accepted by five colleges and universities. She was also encouraged to develop and maintain community connections, one of which resulted in an ongoing relationship with an elderly woman she met at church who gave her a place to live once she aged out of care. She now had a home to go to for Thanksgiving and during school breaks.

These are precisely the outcomes

every child welfare professional hopes a youth in their charge will attain. Clearly, the model works.

Residential programs designed with specific needs of LGBTQ youth in mind offer safe, welcoming, affirming living environments for young people who have few other options. And they can provide the types of supportive services to families that can result in lasting bonds between parent and child.

So what does safety look like for LGBTQ youth? It looks like a residential program that displays posters of gay people who have accomplished great things, such as James Baldwin, Virginia Woolfe, Walt Whitman, Martina Navratalova, or Rosie O'Donnell so that young people can become aware of role models.

Safety also means a LGBT Safe Zone sticker on a program director's door, staff intervening when they hear someone called a "faggot" or a "dyke," or staff abiding by the recommendations of every professional association, such as the American Psychological Association, the American Psychiatric Association, the National Association of Social Workers, and the American Academy of Pediatrics. These organizations state that it is unethical and damaging to attempt to change a child's sexual orientation.

Safety for LGBTQ youth also means a place where young people are paid the respect of being referred to by pronouns that reflect their gender identity, even if that identity is in conflict with their biological sex. It looks like a program in which all residents are offered training on understanding issues of sexual orientation and gender identity so that they treat their fellow residents with the respect that every child in care deserves.

Safety means a program in which LGBTQ youth are made to feel welcomed and affirmed so they never have to spend a moment of their day or night worrying that if someone finds out that they are lesbian, gay, bisexual, transgender, or questioning of their sexual orientation or gender identity, they will encounter harassment, intolerance, or rejection. And it looks like a program

that makes it a priority to ensure LGBTQ youth are loved and cared for by families.

If you work in a residential program, ask yourself, does this sound like my program? Will LGBTQ youth feel safe, welcomed, affirmed, and respected? If so, that's wonderful. If not, then we all have much to do before the day comes when the need for specialized residential programs designed for LGBTQ youth will not exist.

Every child welfare professional can speed the arrival of that day by making a commitment to ensuring the safety and well-being of LGBTQ youth in their charge right now. They can do this by helping families understand issues of sexual orientation and gender identity so that they can continue to love and support their children for who they are.

To learn more about CWLA's efforts to support LGBTQ youth in care, visit our website: www.cwla.org/programs/culture/glbtq.htm.

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more understanding and accepting of those who are different from them.

Although specialized programming can be an important resource for some young people, we should not assume that all LGBTQ youth want to be placed in a separate facilities. In fact, some young people might not want or be ready to disclose their sexual orientation (The Correctional Association of New York, 2006). According to the National Center for Lesbian Rights, approximately 5–10% of the youth in the foster care system are lesbian, gay, bisexual, transgender, or questioning— the figure may actually be higher since LGBTQ youth are overrepresented in the foster care system due to discrimination and abuse they encounter (National Center for Lesbian Rights, n.d.). In addition, this number only represents youth who have been identified as LGBTQ; youth not identified would still be integrated into existing programming. Existing facilities, therefore, need to ensure that programming provides an environment that fosters safety, security, and acceptance of all young people served.

Yes, first and foremost, every youth should be protected and respected in any program, regardless of his or her sexual orientation or other circumstances. Residential settings have been charged with the responsibility of serving all youth placed in their programs. The setting is required to create programming to address each young person's unique needs, as well as to develop a strength-based individualized treatment plan that actively involves youth and their families in its development.

Although integrating young people into existing programs is the best option, it still requires agencies to take a careful look at their policies, procedures, and practices (Lambda Legal Defense and Education Fund, 2001). Residential settings must develop a definition of cultural competency that is based on respecting people of all sexual orientations, cultures, races, ethnic backgrounds, and religions. They should develop policies and procedures that are culturally competent and ensure this theme is embraced within their mission

statements. Once cultural competency policies and procedures have been developed, the challenge remains to effectively integrate those policies and procedures into practice (National Center for Lesbian Rights, n.d.).

In addition, these settings must demonstrate a commitment to cultural competency by reflecting the values and principles associated with cultural competence throughout their programming. The agency's Board of Directors and leadership should champion these efforts and allocate necessary resources to effectively address such an initiative. Leadership needs to view cultural competency as a continual process that requires allocating the necessary resources, trainings, and attention.

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

Question: Should states include structural/institutional racism as a factor in how they mitigate racial disproportionality and disparity of outcomes?

Point: By focusing on the correlation between poverty and maltreatment, and individual and family levels of dysfunction, states can reduce racial disproportionality and disparity of outcomes.

Counterpoint: States must include struc- tural racism in their approach to addressing and mitigating racial disproportionality and disparity of outcomes. Segregation, exclu- sionary practices, and other inequities found throughout U.S. history have had an impact on public systems. It is imperative that structural racism be included with the same level of attention as poverty and mal- treatment, and individual and family levels of dysfunction.