Issues in the Seclusion and Restraint of Juveniles: Policy, Practice and Possibilities

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Abstract: *The appropriate use of seclusion and restraint (S/R) is an important issue among juvenile justice professionals. Recent newspaper articles have brought the issue to the attention of the United States Senate, law enforcement agencies, and the general public. The result has been a series of investigations and publications by the Senate, law enforcement, and professional associations. Despite the attention this issue has received, professionals have yet to reach a definitive agreement as to what constitutes appropriate procedure. The authors of this article review several pieces of recent legislation and the professional and popular literature regarding the use of S/R. They identify major issues currently under discussion, highlight areas of consensus, and enumerate several dimensions that require further exploration. Finally, the authors discuss the implications of S/R for social work practitioners, including the importance of education and training, monitoring, hiring, policy advocacy, and ongoing research.*

Keywords: Seclusion, restraint, juveniles, residential treatment, delinquency

The use of seclusion and restraint (S/R) to manage juveniles in custody is an important issue among practitioners. The United States Congress, the Health Care Financing Administration (HCFA), state legislatures, and professional associations have recently conducted investigations, issued statements, or initiated discussions in this area. Additionally, the Fort Lauderdale Sun-Sentinel (Kestin, 1999) and the Baltimore Sun (Probes, 1999, December 8) have published exposés of excessive and inappropriate use of S/R. The Hartford Courant (Hartford, Connecticut) published a series of articles reporting injuries and deaths in juvenile and adult facilities resulting from S/R (Eleven, 1998, October 11).

Decisions regarding the use of S/R are complex. Conditions in which juveniles are secluded exist along a continuum from voluntary, insecure "time-out" to locked, padded rooms with restraint devices. Restraint can be conceptualized along at least three continua: 1) the degree to which movement is restricted, 2) the degree of discomfort experienced, and 3) the degree to which mechanical or chemical devices are used (Cohen, 1997; United States General Accounting Office [GAO], 1999).

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Choices are further complicated by the conditions adolescents' experience. Juveniles may experience physical or psychological problems. A juvenile with diabetes or a seizure disorder may require close monitoring while in seclusion. Staff who elect to restrain a juvenile may exacerbate the violent behavior of survivors of abuse if they use a highly restrictive or aggressive technique (GAO, 1999).

Staff must also consider safety. The Hartford Courant uncovered 142 S/R-related deaths among all age groups nationwide between 1988 and 1998. Twenty-six of the victims were children. This is more than likely an underestimate, since many jurisdictions do not report these statistics (Eleven, 1998, October 11). The risk of harm extends to staff as well. According to a Congressional report, more mental health staff are injured while restraining patients of all ages than during any other activity (GAO, 1999).

Decisions regarding S/R also must be made in response to unexpected escalation of behavior. Often, there are few guidelines. Training may be deficient or absent. Frequently, there is little opportunity to consider special client needs.

Discussions among legislators, professionals, and the press might lead to the development of a policy that would assure only safe and appropriate use of S/R. These discussions have produced inadequate results, however, for several reasons. Prominent among them is the fact that the problem has been inadequately defined. That is, decision-makers have failed to consider all the dimensions of the problem and have ignored some of the issues within the dimensions they have considered. This paper contributes to the discussion of S/R by: 1) introducing the discussion from legislative, professional and popular literatures, 2) identifying the dimensions of the problem, 3) describing the issues in each dimension, and 4) discussing the implications for practitioners.

FEDERAL, STATE, AND PROFESSIONAL POLICIES AND POSITIONS

In 1999, in response to press exposés, several attempts were made to regulate the use of S/R in various settings. The 106TH Congress saw the introduction of at least five bills. Several states began the process of amending their statutes. At least one lawsuit was filed to keep federal provisions from being enforced.

Federal Legislation

The Hartford Courant series (Eleven, 1998, October 11) alerted Congress to the need for legislative attention. Members authorized an investigation across jurisdictions. The results are summarized in a report by the GAO. The GAO reviewed S/R with adults and juveniles with mental illnesses or mental retardation who are in residential treatment. It also examined federal and state policies with regard to this population (GAO, 1999).

GAO investigators identified multiple problems. For example, only 15 states had mechanisms for reporting deaths. Inconsistencies in regulations between types of facilities (such as psychiatric facilities and detention centers) were identified. Some had training and well-defined procedures. Others offered no training or guidelines.

Investigators also discovered several program characteristics that appear to reduce the inappropriate instances of S/R. These characteristics included: 1) clearly defined policies and procedures, 2) reporting requirements, 3) staff training, and

4) requirements for monitoring. The study suggested that HCFA improve reporting mechanisms and standards, establishing guidelines for federally-funded facilities (GAO, 1999).

In response to the report, Congress introduced five bills. One of those bills became law during the 106TH Congress. The others are currently at various stages in the legislative process.

The bill that became law was S. 976, the Youth Drug and Mental Health Services Act (YDMHSA). It became P.L. 106-310, the Children's Health Act (CHA).

CHA affects facilities receiving federal funds for juveniles by forbidding the use of S/R for discipline or convenience. CHA specifies that S/R may only be used to assure the safety of residents and staff, and then only with a written order by a physician or authorized practitioner. The order must specify the length of time and the circumstances under which the restraints may be imposed. It also attempts to assure that all persons who may need to administer restraints be adequately trained and skilled in their use (CHA, P.L. 106-310).

CHA also addresses the reporting of S/R-related deaths. It requires that death occurring within 24 hours of an incident of S/R be reported within seven days. The law also defines both restraint and seclusion. These definitions are consistent with the language used in the other three bills.

(1) RESTRAINTS—The term 'restraints' means,

> (A) any physical restraint that is a mechanical or personal restriction that immobilizes or reduces the ability of an individual to move his/her arms, legs, or head freely, not including devices, such as orthopedically-prescribed devices, surgical dressings or bandages, protective helmets, or any other methods that involve the physical holding of a resident for the purpose of conducting routine physical examinations or tests or to protect the resident from falling out of bed or permit the resident to participate in activities without the risk of physical harm to the resident (such term does not include a physical escort); and
>
> (B) a drug or medication used as a restraint to control behavior or restrict the resident's freedom of movement and is not a standard for treatment for the resident's medical or psychiatric condition.

(2) SECLUSION—The term 'seclusion' means a behavior control technique involving locked isolation. Such a term does not include a time out.

(3) PHYSICAL ESCORT—The term 'physical escort' means the temporary touching or holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a resident who is acting-out to walk to a safe location.

(4) TIME OUT—The term 'time out' means a behavior management technique that is a part of an approved treatment program and may involve the separation of the resident from the group, in a non-locked setting, for the purpose of calming. Time out is not seclusion.

As with many pieces of legislation, much of the meaning of CHA is left to the interpretation of the Department of Health and Human Services (HHS). The law directs HHS to 1) identify what "emergency circumstances" must exist in order to preclude the approval of an authorized physician or practitioner, 2) identify which facilities will be excluded from the Act by operationally defining "non-medical, community-based facility for children and youth," 3) define state agencies to train and certify staff, provide licensure, and conduct monitoring activities, and 4) provide an interim identification of those who are competent to monitor the well-being of a child experiencing S/R.

In response to CHA, HHS issued Interim Final Rule 42 CFR, Parts 441 and 483. Among other operational guidelines, the Rule specifies which treatment facilities are excluded, who may issue orders to employ S/R, and the conditions under which those orders may be waived. Although the Rule answers some important questions, it raises some other critical issues. For example, if some treatment facilities are excluded from the guidelines, what steps will be taken to protect juveniles in those settings. In addition, the Rule requires that a board-certified psychiatrist or a licensed physician trained in mental health issues dispatch a written order before a youth can experience S/R. Alternatively, if no physician is available, a registered nurse can make the decision, then obtain the physician's signature. Although this may seem reasonable, it is impractical for many situations. S/R decisions must often be made quickly, with little opportunity to consult either a physician or nurse. Failure to do so is likely to result in injury to the juvenile or staff. Further, the order assumes competence in S/R by psychiatrists and physicians (a dubious assumption given the frequency with which these practitioners have erred on these decisions in the past), and assumes the incompetence of those who might be much more qualified, such as licensed psychologists and social workers who interact in a much more personal, much more frequent manner with juveniles who may require S/R. Clearly, although Congressional intent is excellent, both the law and the rule supporting it may require additional review and revision.

The other four S/R-related bills address different populations and contain different specifications. House Bill 837, the Mental Health Juvenile Justice Act (MHJJA), provides for cross-training among the juvenile justice, substance abuse, and mental health systems. It requires that a staff member monitor isolated juveniles once every 15 minutes and review the necessity for seclusion at least every four hours. The bill also requires that juveniles secluded for 24-hours be examined by a physician or licensed psychologist (MHJJA, H.R. 837, 106TH Congress, 1999). MHJJA was under consideration in the House of Representatives at the end of the 106TH Congressional session.

H.R. 1313, the Patient Freedom from Restraint Act (PFRA), applies to facilities serving juveniles or adults that receive Medicare or Medicaid funds. It limits the use of S/R to two consecutive hours. It requires physician approval, prohibits the use of standing orders, and allows for emergency exceptions. It specifies S/R as a last resort, and then only in a "least restrictive" manner (PFRA, H.R. 1313, 106TH Congress, 1999). H.R. 1313 remained in the House at the close of the 1999-2000 session.

The Restraint Safety Act (RSA), H.R. 3010, governs facilities receiving Medicare and Medicaid. It requires that providers use restraints only to ensure physical safety,

and then only with the written order of a physician or licensed practitioner. Facilities must develop policies that determine the duration of S/R as well as the circumstances under which it can be used (RSA, H.R. 3010, 106TH Congress, 1999). RSA was slated for further consideration by the House of Representatives during the 107TH Congress.

The Compassionate Care Act (CCA) requires hospitals and other health care facilities that receive Federal assistance to take specific steps to ensure the rights of patients. It specifies that S/R may be used only to assure the physical safety of the patient or others and then only under the written order of a physician. It also requires that states establish monitoring systems for the facilities, and stipulates the loss of federal funding for failure to comply (CCA, S. 750, 106TH Congress, 1999). CCA was being considered in the Senate at the end of the 106TH Congress.

If passed, these bills will contribute to a policy framework that assures safe, humane S/R. They are, however, only a step, because they leave gaps in the safety net. For example, three bills affect only federally-funded facilities, leaving questions about private facilities. Other gaps include a lack of definition of terms, such as "authorized practitioner" (S. 750) and "last resort" (H.R. 1313). Certainly, it is to be expected that states would fill some of these gaps, yet a lack of awareness of the severity and dimensions of the problem may inhibit states from acting as they need to act.

State Legislation

Many states have yet to create legislation governing S/R. Although the GAO (1999) report identified 15 states that had made at least some response, space precludes discussion of all state-level legislation. Two pieces of legislation, however, (Utah and Connecticut) are illustrative, and will be used as examples.

Utah State Code R547-4-17 addresses S/R with incarcerated youth. It limits the time a juvenile may be kept in "secure observation" to no more than three hours for rule violation and no more than 24-hours when they become a threat to self or others. Juveniles may also be secluded for up to 24-hours when they appear to be an escape threat. If a youth is secluded, a schedule must be established for status reviews. The reviews must include both observation and interviews, with particular attention paid to visual and auditory monitoring (Utah Administrative Code R547-4-17[10], 1999).

In Connecticut, legislation was proposed to regulate S/R with children with mental illness, emotional disturbances, or who are in need of special education. The bill specifies that a "life-threatening physical restraint" may not be used on a person who is physically or mentally disabled. Furthermore, juveniles in S/R must be continuously monitored. The bill provides that the restrained person must be "regularly evaluated," but does not define the terms "evaluated" or "regularly." It also requires that all instances of S/R be documented in the child's record (Connecticut Public Act No. 99-210, 1999).

Although the states that have begun to consider legislation are to be commended for their work, it is clear that all states have a great deal of work to do. The examples given here repeat many of the provisions of the federal bills, while ignoring other important dimensions and issues. In most cases, little has been done to describe abstract federal standards in more operational terms.

Professional Organizations and Accrediting Bodies

Many professional organizations and accrediting bodies have responded to the new legislation. Some have opposed specific provisions. For instance, the American Hospital Association (AHA) and the National Association of Psychiatric Health Systems (NAPHS) filed a lawsuit to block an interim HCFA provision. The provision requires that a physician or licensed practitioner conduct a face-to-face evaluation within one hour of the seclusion or restraint of a patient in a federally-funded facility. They argued that the requirement is clinically unnecessary because dialogue about patient care should be ongoing. Furthermore, they argued that complying with this provision would require additional staff, constituting a costly and inappropriate use of funds (NAPHS, 1999).

In general, professional organizations (including the AHA and NAPHS) have welcomed new legislation and have begun to develop professional statements and policy guidelines to support and define them. For example, in its August, 1999 Federal update, the American Psychiatric Association(APA) supported many of the provisions of the federal legislation (APA, August, 1999).

Responses to S/R have identified, defined, and addressed many dimensions of the problem of inappropriate S/R. These constitute a beginning, but only a beginning, since they neither encompass all the dimensions that need to be considered comprehensively or adequately address issues within each dimension. The responses are fragmented, so that critical issues neglected by federal legislation may also be ignored by state or professional bodies. In order to assure optimal effectiveness in regulating the use of S/R with juveniles, a comprehensive, coordinated response must be developed. To develop this response, all dimensions of the problem need to be identified, and all issues within the dimensions considered. The next section of this paper identifies those dimensions critical to an effective response and describes the issues within the dimensions.

DIMENSIONS OF THE SECLUSION AND RESTRAINT PROBLEM

The literature review revealed dimensions crucial to the discussion of S/R including: 1) types of juveniles, 2) purposes for use, 3) types of S/R, and 4) measures to assure proper S/R. There are several critical issues within each dimension.

Types of Clients for Whom Seclusion and Restraint is Used

The literature identifies five categories of juveniles with whom S/R has been used. These include juveniles who: 1) act out, 2) require behavioral intervention, 3) are mentally retarded and are acting out, 4) are mentally ill and are acting out, and 5) are in custody but are not acting out. Decision-makers have been unclear as to how S/R should be used with some of these groups.

S/R techniques are used with juveniles who are acting out, sometimes to prevent them from harming self or others, and sometimes as behavior modification (GAO, 1999). The appropriateness of S/R for these purposes will be discussed in the section below, but it is important to note that there is often disagreement as to when safety becomes an issue. Moderate forms of seclusion, such as sending a youth to an unsecured "time-out" room, may be appropriate for those whose behavior had begun to escalate but has not yet reached a dangerous level. Other behavior mod-

ification techniques may also be used with juveniles who are not behaving dangerously. On the other hand, it is sometimes difficult to predict, particularly with unfamiliar juveniles, who will become dangerous. Furthermore, escalating behavioral problems by violence-prone youth do not always indicate that dangerousness is imminent. Policies and supportive materials must be developed that help practitioners distinguish between dangerous and non-dangerous situations.

Some juveniles suffer from mental disorders that are conducive to acting-out behaviors. The presence of youth with bipolar disorder, hallucinations, explosive disorder, and other conditions has implications for practitioners. Other juveniles experience mental retardation and may be prone to harmful behavior when frustrated or angry (GAO, 1999). Abuse survivors comprise another group of juveniles who may exhibit behavior problems in state custody (Ellis, O'Hara & Sowers, 2000). These youth may have particularly strong reactions to restraint and seclusion (GAO, 1999). Research has shown that punitive, confrontational environments may recreate aspects of the abusive situation for survivors, exacerbating emotional problems and behavior (Ellis, O'Hara & Sowers, 2000). Because large numbers of the juveniles in custody may have been abused, the use of physical force should be minimized.

The final group with whom S/R is sometimes used is juveniles who are in custody but are not acting out. An example of this situation is when youth are "locked-down" for facility management purposes or for staff convenience. Some of the federal bills and state responses forbid S/R for specific categories of youth. Others do not distinguish between those who do not experience mental disorders and those who do. The literature is consistent in condemning S/R for juveniles who are not acting out.

Purposes of Seclusion and Restraint

The literature identifies several purposes for which S/R is used. While some purposes are appropriate, others are not. The uses of S/R include: 1) safety of the juvenile, staff, and others, 2) behavior modification, and 3) staff convenience.

Many juveniles in custody either have a history of, or a propensity for, violent behavior. This behavior may constitute a threat to self or others. Consensus exists that in limited instances when a juvenile's behavior is sufficiently dangerous, it is appropriate to use S/R to assure the safety of everyone involved. However, several issues remain.

One important issue involves determining when a threat actually exists. Untrained or inexperienced staff may perceive some non-threatening actions as threatening and may overreact. Staff may be tempted to use S/R techniques to de-escalate behavior rather than use preventative measures, or they may use it to "teach the kid a lesson." Another issue involves selecting techniques that are appropriate for a particular juvenile or situation. Some situations may call for restraint, while others call for seclusion. Practitioners have also used both (for example, placing a youth in a safety jacket within a secluded room or using physical restraint until chemical measures can be introduced) (GAO, 1999; Kestin, 1999).

Physical pain associated with S/R is another issue. Certain holds and "take-downs" can be painful and dangerous. Chemicals, such as pepper spray, may also

induce pain (Cohen, 1997). Pain should be minimized in S/R intervention (GAO, 1999). Certainly, if restraint becomes a necessity, interventions designed to avoid injury to both juveniles and staff should be used.

Juveniles may also experience psychological distress. As noted above, a high prevalence of past abuse suggests that S/R may have negative effects for some youth. In addition, juveniles who are depressed, experience attachment disorder, phobias, or other disorders may experience harmful distress (GAO, 1999).

Two other important issues involve the frequency and duration of the intervention. Some juveniles in custody may never require S/R. Others may be secluded or restrained frequently. Practitioners must examine their management techniques and environmental milieu to determine whether they are producing an environment that is conducive to acting-out behavior. Practitioners should consider identification of behavioral antecedents, appropriate de-escalation techniques, effective control of environmental stimuli, and use of appropriate medication. Frequent application of S/R may be an indication of staff failure (GAO, 1999). When program conditions exacerbate the volatility of juveniles, administrators must provide staff with training, monitoring, incident reporting systems, and regular review of procedures.

The use of S/R for behavioral conditioning or staff convenience also presents several issues. The literature cites instances in which S/R techniques have been used for behavior conditioning (GAO, 1999). In these instances, staff may attempt to elicit desired behaviors from juveniles or deter them from undesired behaviors by secluding or restraining them. The literature is consistent in its condemnation of this practice. It is important to note that the voluntary use of insecure "time-out" to prevent the escalation of problem behavior is an anger management strategy rather than behavior conditioning.

Although experts agree that S/R should not be used for behavior modification, this agreement is at an abstract level. From the perspective of a supervisor reviewing an incident of S/R, the distinction between controlling dangerous behavior and punishing undesirable behavior can sometimes be unclear. Often the distinction lies in the motivation of staff, which can be difficult to assess. Operational guidelines must provide clear directions that minimize the potential for accidental or deliberate misuse of S/R.

Staff convenience is another unacceptable reason for using S/R (GAO, 1999). Staff may be tempted to deal with difficult juveniles by secluding or restraining them. In addition, staff may use S/R as a group management tool, locking down some juveniles while working with others in order to make it easier to control the entire group. The literature is relatively consistent in condemning using S/R for these purposes

Types of Seclusion and Restraint

The literature identifies several S/R techniques. Generally, they can be grouped into six categories: 1) assertive physical restraint, 2) aggressive physical restraint, 3) chemical restraint, 4) mechanical restraint, 5) voluntary seclusion, and 6) involuntary seclusion. The literature does not specifically address many of these categories.

The term "assertive physical restraint" (ASPR) was not found in the literature. It is used here to indicate physical control techniques that cause minimal discomfort. Several ASPR systems have been developed and marketed commercially. Generally, the literature supports assertive restraint, although some experts argue that no restraint should ever be necessary (GAO, 1999).

ASPR includes techniques that are less concerned with the comfort of the juvenile. Examples include take-downs, arm twisting, and striking the juvenile. Despite opposition from experts, these techniques are used in some jurisdictions (Eleven, 1998, October 11; Kestin, 1999; Probes, 1999 December 8).

Chemical restraint refers to the use of chemical products, including pepper spray, medication, and other substances. Pepper spray has received some attention in the literature. Studies have found it to be of limited effectiveness and potentially dangerous to juveniles and staff (Cohen, 1997). Medications are also used to control juveniles' behavior. It can be difficult to distinguish between appropriate use and the misuse of medications. Although it is clear that some psychological problems have a biological component and that the appropriate use of medication can help troubled juveniles normalize their lives, it is equally clear that medications are sometimes abused, even when administered under the care of a psychiatrist (Kestin, 1999).

Mechanical restraints include straitjackets, safety jackets, "four-point" chair or bed restraints, and similar devices (GAO, 1999; Kestin, 1999). There are several issues in mechanical restraint, including the degree of discomfort produced, the duration of restraint, and the circumstances in which use is appropriate. Confusing terminology complicates the issues. One author once inspected a facility in which "safety jackets" were used. On closer examination, the safety jackets were found to be little more than straitjackets designed to hold the juvenile's arms at his side rather than behind his back.

Voluntary seclusion refers to the separation of juveniles from other persons in a closed or secluded area either at the suggestion of staff or of the juvenile's own volition. Some practitioners refer to this practice as "time-out." Time-out, when genuinely voluntary, is not criticized in the literature. Since it is voluntary, time limitations are less important, although staff should closely observe and monitor juveniles.

Involuntary seclusion is the forced separation of individuals into an isolated area. The literature provides some standards for enforced seclusion. Examples include Utah provisions that limit the number of hours a juvenile may be secluded and Connecticut statutes that require regular evaluation.

Measures to Assure Appropriate Seclusion and Restraint

A variety of measures have been employed to assure appropriate S/R. Some have very effectively minimized incidents. The measures can be grouped into seven categories: 1) policy measures, 2) preparation and training, 3) preparation of juveniles, 4) monitoring and reporting, 5) supervision of staff, 6) staffing, and 7) adequate facilities.

S/R-related policy measures include guidelines for appropriate selection and use of S/R techniques, requirements for reporting and monitoring, requirements for

staff training, and specifications as to what categories may not be secluded or restrained (Connecticut Public Act No. 99-210 (1999), Utah Administrative Code R547-4-17[10], 1999, YDMHSA, Senate Bill 976, 106TH Congress, 1999). Unfortunately, the framework of these policies is not comprehensive. Both the variety and degree of protection varies among jurisdictions. There are gaps caused by failure to address some of the dimensions and issues of the problem, lack of coordination between federal and state lawmakers, and lack of consensus among professionals.

Clear, comprehensive policies and procedures related to S/R must be developed (GAO, 1999). Policies should address the dimensions discussed above and should authorize only techniques that meet legal and professional requirements. Procedures should be clearly written and clearly specify the consequences of failure to observe them. Staff must be trained in safe, effective techniques and help to develop the necessary decision-making skills (GAO, 1999). Training should include hands-on practice and role-play in effective de-escalation and anger management techniques.

The manner in which a juvenile is introduced into a detention or treatment environment is very important (Office of Juvenile Justice and Delinquency Prevention [OJJDP], 1996). Rules and consequences for violating those rules must be clearly explained. Juveniles entering the facility might also be paired with youths who have a stable record of behavior so as to provide peer mentoring.

Several states have reported that incidents of S/R decreased when systems for reporting incidents were implemented (GAO, 1999). These systems must exist, both internally and externally, for programs and facilities. Internal systems of reporting must provide a mechanism for assuring that incidents are reviewed. These reviews should include both an evaluation of the propriety of the actions taken and an examination of the preventative measures that might have been taken to avert the incident. External systems should include a review of the incident reports and a random sampling of juvenile records. To avoid unnecessary duplication of effort, government and accrediting agencies might conduct simultaneous, coordinated monitoring visits.

Adequate supervision of staff is another key to minimizing problems (OJJDP, 1996). Harried staff who are not adequately supervised may cut corners and ignore safeguards. Adequate staff is also a key to reducing inappropriate incidents of S/R (OJJDP, 1996). When there are sufficient staff present, situations that can lead to behavioral escalation may be recognized and attended to promptly. Furthermore, if S/R becomes necessary, an adequate number of staff must be present to execute the technique.

IMPLICATIONS FOR SOCIAL WORK PRACTITIONERS AND LAWMAKERS

The issues described above demonstrate the importance of practitioners' involvement in developing a policy framework for the appropriate use of S/R. It is clear that there is sufficient knowledge to develop this framework. This knowledge exists, however, at various levels of the system. To develop an effective response, practitioners at all levels need to play a role. These levels include direct practitioners, administrators, advocates, advisors, and researchers (Ellis & Sowers, 2000).

Parents, juveniles with experience in the system, and other citizens should become involved as advocates, using their influence to press for the necessary changes.

Implications for Direct Practitioners

Direct practitioners should educate themselves in appropriate techniques of prevention, de-escalation, seclusion, and restraint. Where training is available in their agencies, practitioners should take advantage of such opportunities. When opportunities are not available, they should use such resources as professional organizations and professional literature to gain an awareness of appropriate procedures.

Practitioners must also monitor the activities of their co-workers. They should share the information they gain and encourage others to use it. When necessary, they should report policy violations. Practitioners can also advocate for appropriate procedures and techniques in their agencies. They can share information with their supervisors and participate in groups to develop agency policies regarding S/R.

Implications for Agency Administrators

Administrators must assure that agencies use thorough hiring procedures, carefully formulate policies, use effective training programs, implement effective monitoring systems, and participate in ongoing education. They can help develop policy statements for professional organizations and draft legislation. Self-regulation is often preferable to government intervention. Responsible action on the part of agency administrators may help to minimize the need for government involvement.

Implications for Advocates and Advisors

Practitioners who advocate for change and who advise key persons within the system have a vital role to play. Advocates and advisors should educate themselves about each of the dimensions and issues relevant to S/R. They should work with decision-makers to assure that the framework is comprehensive and seamless (including all types of programs that serve juveniles, both publicly-funded and private).

Implications for Researchers

Researchers should investigate safe and effective practices with regard to facility management, prevention, de-escalation, seclusion, and restraint. Their studies should include all the dimensions and issues related to S/R. They should also consider both the physical and psychological well-being of juveniles and practitioners.

Implications for Professional and Accrediting Organizations

Professional and accrediting organizations must develop strong, comprehensive position statements. They must enforce corrective measures for failure to comply. Professional organizations can also be involved in training and research, either by conducting these activities or by collaborating with educational and research institutions.

Implications for Legislative Bodies

Several effective policy innovations have been identified above. Innovations that should be considered include: 1) clear standards for reporting incidents, 2) standards for reporting the degree of discomfort that may be caused by an intervention, 3) standards for the level of danger of an intervention, and 4) standards for testing products used in S/R. In addition, state and federal legislators should coordinate responses, so that issues not addressed at one level are addressed at another. Sanctions other than loss of funding must also be developed. The withdrawal of funding may further complicate staffing problems and result in agency closure. When agencies fail, many juveniles are thrust into an already overburdened system, thus worsening conditions lawmakers intended to improve.

SUMMARY

Issues that regard the use of S/R in managing juvenile offenders are serious and are of great concern to both professionals and the American public. Legislative, professional, and popular literature provides some guidelines for practitioners. Further discussion and research are needed to assure that S/R techniques are appropriately used and that the potential for harm to juveniles and staff is minimized.

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