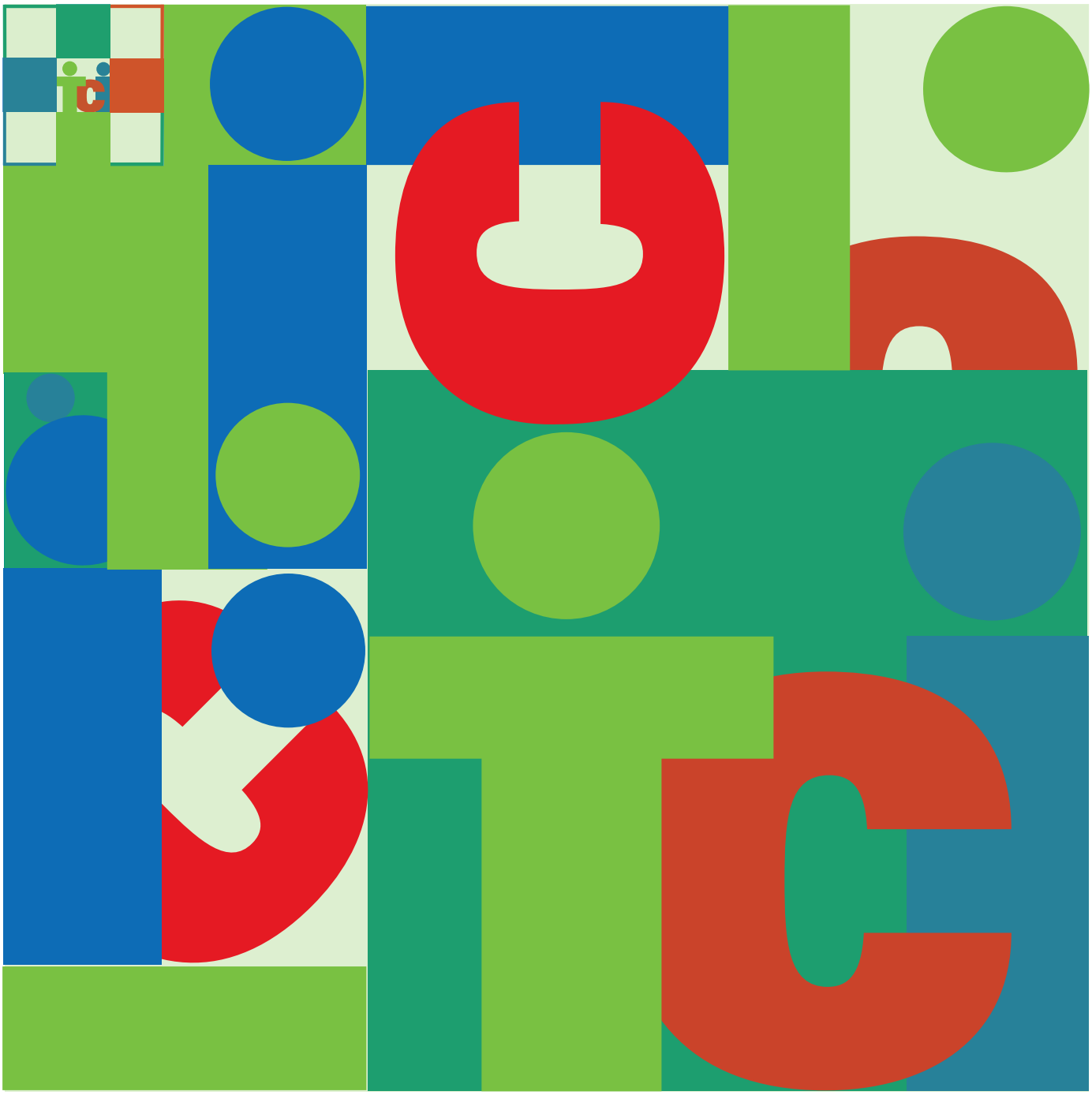
Therapeutic Crisis Intervention System, Edition 7



RESIDENTIAL CHILD CARE PROJECT | BRONFENBRENNER CENTER FOR TRANSLATIONAL RESEARCH | CORNELL UNIVERSITY

Dear Colleague,

Enclosed you will find information about our Therapeutic Crisis Intervention (TCI) system.

In 2020, we launched the 7th edition of our TCI system, celebrating 40 years of supporting residential organizations in their efforts to provide safe and quality care for children and young people. When implemented with fidelity, TCI has increased the ability of staff to manage and prevent crises, thus often reducing the use of high risk interventions such as physical restraints. Implementation studies have also shown increased knowledge and skill on the part of all staff to handle crisis episodes effectively and a change in attitude regarding the use of physical restraint.

If TCI is to be an effective crisis management system for your organization, you need to address six general criteria: (a) leadership and program support, (b) child and family inclusion, (c) clinical participation, (d) supervision and post crisis response, (e) training and competency standards, and (f) critical incident monitoring and feedback. The description of these criteria and the TCI Theory of Change in this brochure will help you decide whether TCI is right for your organization.

If you need any other additional information, please contact Andrea Turnbull at ajt78@cornell.edu

Sincerely,

Martha J. Holden
Director, Residential Child Care Project

Therapeutic Crisis Intervention System, Edition 7

Information Bulletin

Residential Child Care Project
Bronfenbrenner Center for Translational Research
College of Human Ecology
Cornell University, Ithaca, NY USA

Contents

The Residential Child Care Project

The Residential Child Care Project (RCCP) is housed in the Bronfenbrenner Center for Translational Research (BCTR), which is part of Cornell University's College of Human Ecology. The BCTR's mission is to expand, strengthen and speed the connections among cutting-edge research and the design, evaluation, and implementation of policies and practices that enhance human development, health, and wellbeing. The RCCP advances the BCTR mission through ongoing development, dissemination, evaluation and research involving its two signature programs, Therapeutic Crisis Intervention (TCI) and Children and Residential Experiences: Creating Conditions for Change (CARE). TCI has been adapted for foster care and school settings. This brochure describes the TCI system in detail.

The aim of the CARE program model is to bring agencies' current practices closer to well-researched best practices in residential care and to help them achieve congruence among all levels of the organization in order to improve how the organization works as a whole.[1] CARE is listed on the California Evidence Based Clearinghouse (CEBC) as of 2017 with a Scientific Rating of 3 (Promising Research Evidence) and a High Child Welfare System Relevance Rating.[2] The CARE program model is built on six principles that form the foundation for creating conditions for change in residential care. CARE is: (a) developmentally focused, (b) family involved, (c) relationship based, (d) competence centered, (e) trauma informed, and (f) ecologically oriented.

The RCCP is an interdisciplinary team that has developed and implemented organizational interventions in child service settings since 1979. The project's primary settings for programming and research include residential care, foster homes, and schools. These settings serve mental health, developmental disability, and juvenile justice as well as child welfare populations. About 2,000 organizations currently implement TCI, CARE, or one of the adaptations of these programs for foster care or school settings.

The RCCP has been self-sufficient since 1984 through fee-for-service and contract dissemination of the TCI system and the CARE program model as well as grants for the development and/or evaluation of other programs for residential and child serving organizations. Previous funders have included the National Center on Child Abuse and Neglect, The New York State Department of Social Services, the South Carolina Association of Children's Homes and Family Services, the South Carolina Department of Social Services, and The Duke Endowment Foundation. Current funders of grants and contracts include the New York State Office for Child and Family Services, the Substance Abuse and Mental Health Administration (SAMHSA), and the National Institute of Justice. RCCP's two grants from SAMHSA facilitate work with the National Child Traumatic Stress Network. This work focuses on facilitating trauma-informed care for children in residential settings and the development of a training program for therapeutic foster parents and the organization staff who work with them that adapts, updates, and integrates The Therapeutic Crisis Intervention for Family Care Providers, the 7th edition of TCI, and CARE.

The impact of RCCP programs has been acknowledged in several ways. In 2006, the American Public Human Services Association recognized RCCP's leadership and staff for significant achievement with the Therapeutic Crisis Intervention crisis prevention system. In 2007, the project received the Outstanding Accomplishments in Extension/Outreach award from the Director of Cornell University's Cooperative Extension Service. In 2016, the American Public Human Services Association (APHSA) awarded Martha J. Holden, the Director of RCCP, the Career Achievement Award for their affinity group, the National Staff Development and Training

Association (NSDTA). This prestigious award is presented to an individual who has made a career commitment to the profession of human service training and development; making significant contributions in terms of leadership, new ideas and education as measured by improved organizational outcomes, impact on the field of human services training, and improvement in state and national best practices.

Endnotes

1. For additional information, please go to: http://rccp.cornell.edu
2. For additional information, please go to: http://www.cebc4cw.org/program/children-and-residential-experiences-care/detailed

Notes

Research Foundations of TCI

Overview

The RCCP seeks to maintain a leadership role in discovering new knowledge, establishing new approaches to knowledge dissemination, and developing innovative programs to enable organizations to serve children, families, and staff more effectively by building strong linkages among research, outreach activities, and evaluation efforts. These relationships are viewed as cyclical: research leads to the development of innovative and effective outreach programs, which are carefully evaluated. Evaluation activities contribute directly to the adaptation and improvement of outreach programs and may also contribute to new research. In-house and external evaluations have been essential in modifying intervention strategies and protocols to improve the TCI system's effectiveness for a wide range of organizations (see Figure 1).

The Need for TCI

The goal of TCI is to prevent and de-escalate potential crisis situations before they reach a point where imminent harm requires use of a high-risk intervention such as a restraint. Research has documented both injuries[1] and fatalities[2] resulting from restraints. RCCP researchers have conducted two studies of restraint fatalities that together cover a span of 26 years (1993-2018). Between 2003 and 2018, seventy nine restraint fatalities were documented. Examination of the circumstances surrounding the 79 restraint fatalities suggest that these fatalities were not due to one apparent factor but to a confluence of medical, psychological, and organizational factors and dynamics, all of which are under an agency's power to resolve.

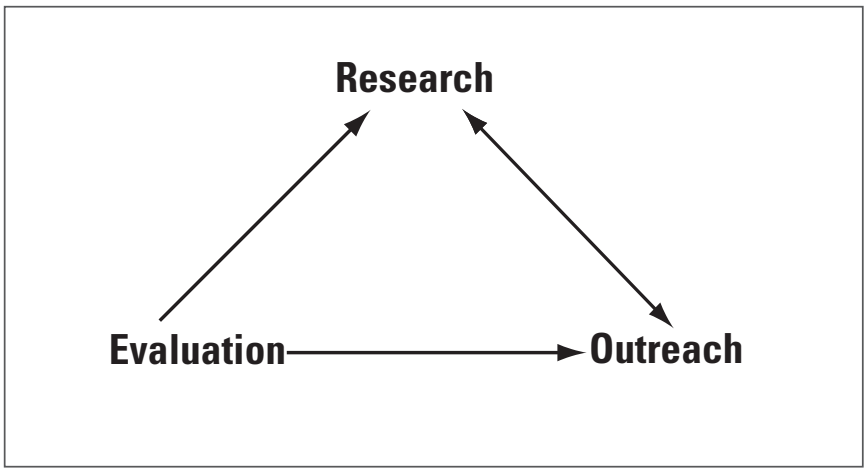


Figure 1. Research, Practice, and Evaluation Cycle

Evidence Supporting TCI Effectiveness

Study 1: From October 1994 through March 1996, RCCP researchers implemented and evaluated TCI in a medium size residential facility in the Northeastern United States.[3] Three of four units participated in the study. Direct care staff completed a 30-item knowledge test before and immediately after participating in the 5-day TCI training program. Staff completed the knowledge test again 9 months after training was completed.

Direct care staff increased their percentage of correct answers from pre-test scores of 50% to post-test scores of 83%. Staff who completed the knowledge test 9 months later retained most of the knowledge with 79% of questions answered correctly. Direct care staff also completed 10 Likert based confidence questions before and after participating in the 5-day TCI training program. A comparison of the pre/post confidence items indicated statistically significant increases in confidence levels in four major areas:

1. staff ability to manage crisis
2. confidence in co-workers managing crisis
3. knowledge of organization policy and procedures concerning crisis management, and
4. staff ability in helping children learn to cope.

In addition, the amount of variation among staff responses to the confidence questions decreased in post-implementation compared to pre-implementation. This decrease in variation indicates greater consistency among staff in their level of confidence. Figure 2 illustrates the decrease in the use of physical restraints. In Unit B, which accounted for 84% of the children served, the total number of physical restraints reported decreased from 101 pre-implementation to 64 during implementation and 31 during post- implementation, a statistically significant reduction. The number of children in care remained the same throughout the study.

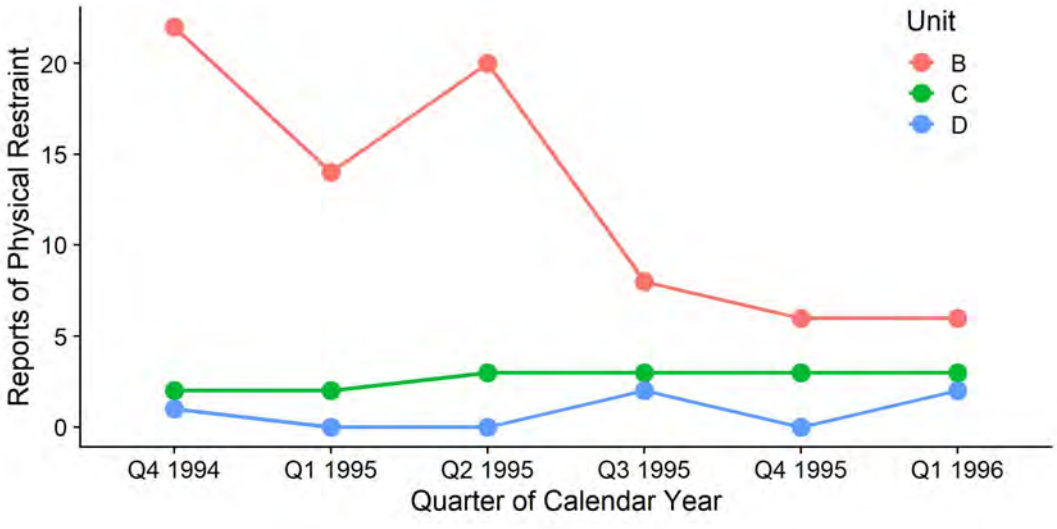


Figure 2. Reduction in Reports of Physical Restraints after Implementation of TCI

Evidence Supporting TCI Effectiveness, cont.

Study 2: Holy Cross Children's Services (HCCS) provides residential and community services for children and families in 78 of Michigan's 83 counties. The residential services include 4 campuses and 6 group homes. In the 1970's HCCS adopted the Positive Peer Culture for its residential services. In January 2007, HCCS averaged about 250 restraints per month across its residential facilities.

In 2007, HCCS leadership decided to move from the Positive Peer Culture model to TCI. Over a 2-year period HCCS implemented TCI and reduced the number of restraints per child as illustrated in Figure 3.[4] In addition, the number of critical incidents decreased by 50%.

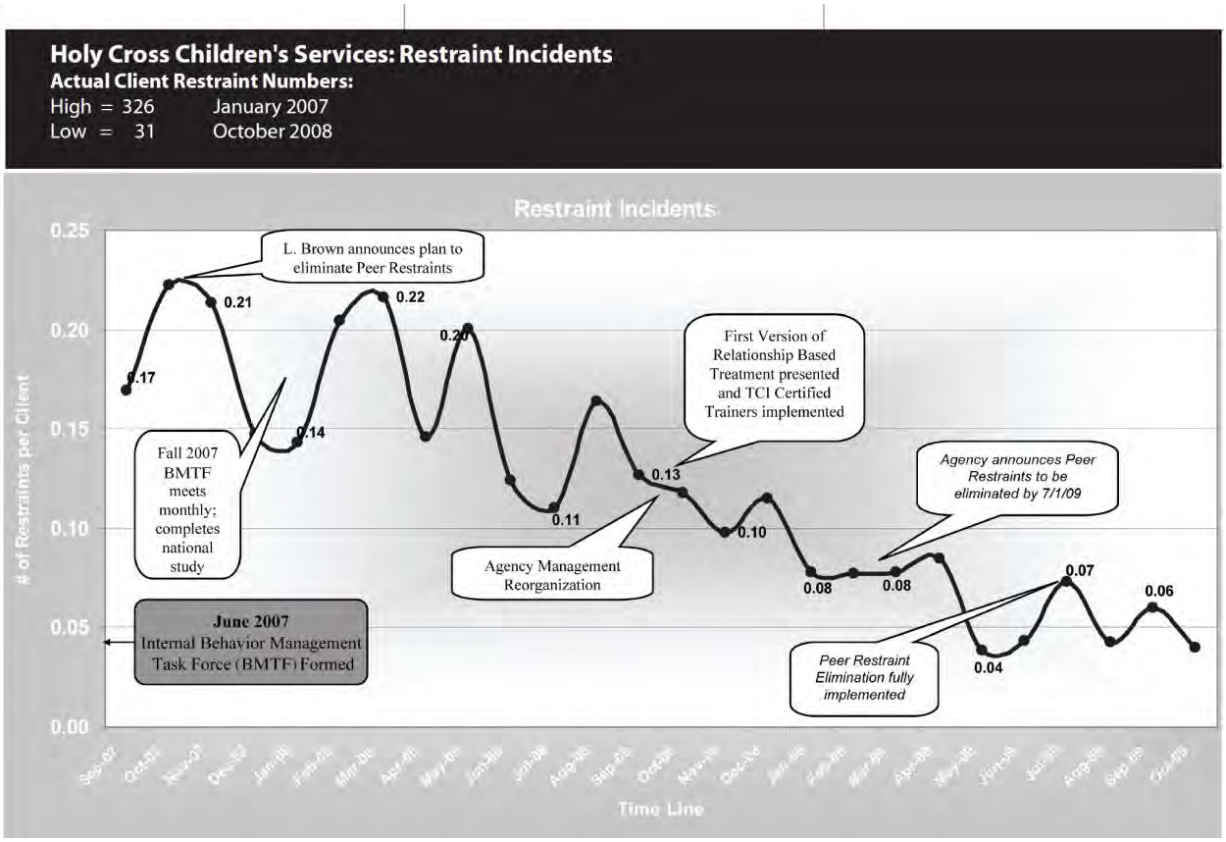


Figure 3. Holy Cross Children's Services: Restraint Incidents

Evidence Supporting TCI Effectiveness, cont.

Study 3: Over a 12-month period, a residential treatment center in New York reduced the average number of restraints per month by 80%, from an average of 45 to 8.6 restraints per month in the first quarters of 2000 and 2001, respectively.[5] Significant decreases in physical aggression, injuries, running away, and property damage were also observed. The organization provided TCI training for their staff along with implementation of the other components of the TCI System—committed leadership, focused supervision, clinical participation, and documentation that is regularly and systematically reviewed.

Study 4: The leadership of an organization in the Midwest undertook to improve the implementation of TCI because of their concern about both the number and frequency (the number of restraints per care day) of restraints taking place.[6] Organization staff were trained in TCI, but in studying the issue leadership and staff identified two problems:

1. "drift" in the application of core TCI concepts and
2. insufficient or ineffective use of TCI's Life Space Interview (LSI) technique.

The LSI is a powerful tool for teaching self-regulation skills and values. It uses children's reactions to difficult situations as a way to help them gain insight and understanding into their own feelings and behaviors. To reduce the use of restraints, a team from the organization identified steps to increase the use of the LSI. To do so, staff were retrained in the LSI technique, documentation of the completion of an LSI was required for every restraint that took place, and monthly reports of physical restraints and the accompanying LSI documentation were reviewed by site directors and supervisors. After undertaking these steps, the total number of restraints dropped from an average of 207 to 100 per quarter, a 52% decrease. Similarly, the rate of restraints decreased 50%, from 0.026 to 0.013 restraints per Care Day.

Endnotes

1. Bystrynski, J., Braun, M. T., Corr, C., Miller, D., & O'Grady, C. (2021, June). Predictors of injury to youth associated with physical restraint in residential mental health treatment centers. In *Child & Youth Care Forum* (Vol. 50, No. 3, pp. 511-526). Springer US.

2. Nunno, M. A., Holden, M. J., & Tolar, A. (2006). Learning from tragedy: A survey of child and adolescent restraint fatalities. *Children and Youth Services Review,* 25(4), 295-315; Nunno, M. A., D. E., & Holden, M. J. (2022, June). A 26-year study of restraint fatalities among children and adolescents in the United States: A failure of organizational structures and processes. In *Child & Youth Care Forum* (Vol. 51, No. 3, pp. 661-680). Springer US.

3. Nunno, M. A., Holden, M. J., & Leidy, B. (2003). Evaluating and monitoring the impact of a crisis intervention system on a residential child care facility. *Children and Youth Services Review,* 25(4), 295-315. https://doi.org/10.1016/S0190-7409(03)00013-6

4. Brown, L. B., Tester, G. (2010). Holy Cross Children's Services and TCI: A Partnership for Success. *refocus: The Residential Child Care Project Newsletter,* 15, 1-5.

5. Farragher, B. (2002). A system-wide approach to reducing incidents of therapeutic restraint. *Residential Treatment for Children & Youth*, 20(1), 1-14.

6. Greenlee, S. (2014). Reports from the Field: Nexus/Onarga Academy. *refocus: The Residential Child Care Project Newsletter,* 19, 6-7.

Notes

Notes

The Therapeutic Crisis Intervention System: A Trauma-Informed Approach

The majority of children in out-of-home care have suffered much adversity and trauma in their lives. It is essential that the adults caring for these children understand the effects of trauma and adversity so they can respond in a way that decreases the child's stress. When adults understand how trauma effects children's ability to manage their emotions, the adults avoid confrontation. They respond to children with understanding and empathy when children are struggling to stay in control of their emotions. Adults who are trauma informed also know the importance of children's perception of safety within the context of trusting relationships.

The Therapeutic Crisis Intervention (TCI) system helps organizations create a trauma-sensitive environment where children and staff are safe and feel safe[1] and all staff, including leadership, clinical, supervisors, and direct caregivers, understand the effects of trauma and adversity.[2] The goal of the TCI system is to prevent and de-escalate potential crises, build the capacity of staff to manage aggressive and violent behaviors avoiding potential injuries, and to create a learning culture where everyone, children and adults, learn from experience.

Children whose lives are saturated with trauma and adversity (e.g., abuse, neglect, loss of a parent, witnessing violence) often develop problems managing their emotions and behaviors. They have developed patterns of pain-based behaviors (expressions of trauma and pain) and stress responses such as aggression, rigidity and inflexibility, withdrawal, impulsive outbursts, and self-injury.[3] A trauma-informed organization supports and facilitates trauma-informed care through its policies, procedures, and practices that recognize and respond to the traumatic events children have experienced.[4] Specifically, this involves ensuring that staff:

The TCI System Helps Organizations

Prevent crises

De-escalate potential crises

Manage acute physical behavior

Reduce potential and actual injury to children and staff

Teach children adaptive emotional regulation skills and coping strategies

Develop a learning organization

Figure 4. TCI Benefits

1. understand what trauma is and how it impacts all individuals within the system and the system itself (i.e., children, families, staff),
2. are able to recognize when behaviors and patterns reflect the children's and staff's past or present trauma experience,
3. know how to avoid re-traumatization by responding to and interacting with children and families in ways that convey safety, trust, support, collaboration, and autonomy, and
4. are sensitive to children's unique perspectives and circumstances.

Given the importance of establishing a safe environment and a sense of safety for children[5] who have experienced trauma, residential settings require a sound, well established organization-wide crisis prevention and management system to foster and maintain a physically and emotionally safe environment[6] for children and staff.

Agencies that have implemented TCI have reduced incidents of aggression and decreased use of high-risk interventions.

- After the implementation of TCI, **the frequency of child restraints decreased**[8]
- While TCI strategies were implemented over a one year span, **the use of restraints decreased by 80%**[9]
- Over an 18-month period from pre- to post-TCI implementation, aggressive and belligerent actions by children and young people that resulted in **physical interventions decreased by 66%**[10]
- After systematically increasing the use of the Life Space Interview, the total number of restraints dropped from an average of 207 to 100 per quarter, a 52% decrease. Similarly, the rate of restraints decreased 50%, from 0.026 to 0.013 restraints per care day.[11]

Figure 5. Results of TCI Implementation

The premise underlying the TCI system is that pain-based and high-risk behaviors can often be prevented by creating a setting in which emotionally competent adults meet children's needs and allow children to heal and thrive through caring and developmental relationships. Developmental relationships are characterized by attachment, reciprocity, progressive complexity, and balance of power.[7] These four criteria work together to help children grow, develop, and thrive. When in a developmental relationship, the adult engages in reciprocal or "give and take" interactions with a child. For example, a child shows interest in learning to catch a ball. The adult tosses a ball to the child, who, in turn, tosses it back to the adult. Through this back and forth, reciprocal and fun activity, a relationship is developed. As the adult engages in on-going, non-coercive reciprocal interactions with a child, attachments are formed and enhanced. Attachment, in this context, is a positive emotional connection that provides a secure base for the child. The adult helps the child feel safe. Through sustained and shared activities with the child, the adult can assess the child's competence and adjust expectations, tasks, and their own level of support as the child successfully learns more and more complex skills. The adult tosses and catches the ball with the child, judges the child's skill level, and increases the distance or speed as the child becomes more competent. This is progressive complexity. As the child engages in more and more complex patterns of behavior and is able to exert more emotional and behavioral control, the balance of power shifts from the adult to the child. The child may begin setting the distance or the speed. The child starts playing catch with others independent of the adult.

Adults in the child's life space who have caring and developmental relationships with children can help children learn and practice more positive or adaptive responses to stressful situations. With support and practice, children are able to achieve a higher level of functioning and interpersonal maturity. This allows them to engage more fully in their social networks and educational opportunities as well as negotiate everyday problems and stressful situations. The TCI system offers an organizational approach to creating a safe, calm, predictable environment and developmental relationships that help to prevent and de-escalate potential crisis situations as well as manage crises as they unfold.

TCI System Theory of Change

In order to implement and sustain TCI, organizations need to embed fully the TCI concepts and strategies within practice, as well as provide robust organizational support and accountability. Figure 6 summarizes the TCI System Theory of Change, including the pathways that lead to improved child outcomes. The TCI system identifies roles and tasks as well as desired practice at all levels of the organization that, when implemented, create a consistent approach to crisis prevention and management within a nurturing, safe, and predictable environment. Through TCI training and technical assistance, these tasks and practices are learned and applied by leadership, supervisors, and direct caregivers. The result is strong leadership creating a culture of high support and high accountability, supervisors providing supportive and reflective supervision, and staff with the knowledge, motivation, and practices necessary to prevent, de-escalate, and safely manage potential high-risk situations. Leadership provides the necessary infrastructure support and guidance so that supervisors are adequately prepared to mentor and coach staff as they learn and apply the TCI concepts and strategies. Organizational self-assessment, reflective practice, and continuous quality improvement help create a learning organization and a culture of collaboration and self-reflection.

As the staff adopt the TCI approach to preventing and managing children's stress responses and pain-based behaviors, they are better able to assess and intervene early in potential crisis events and help children manage stressful situations and regulate emotions.

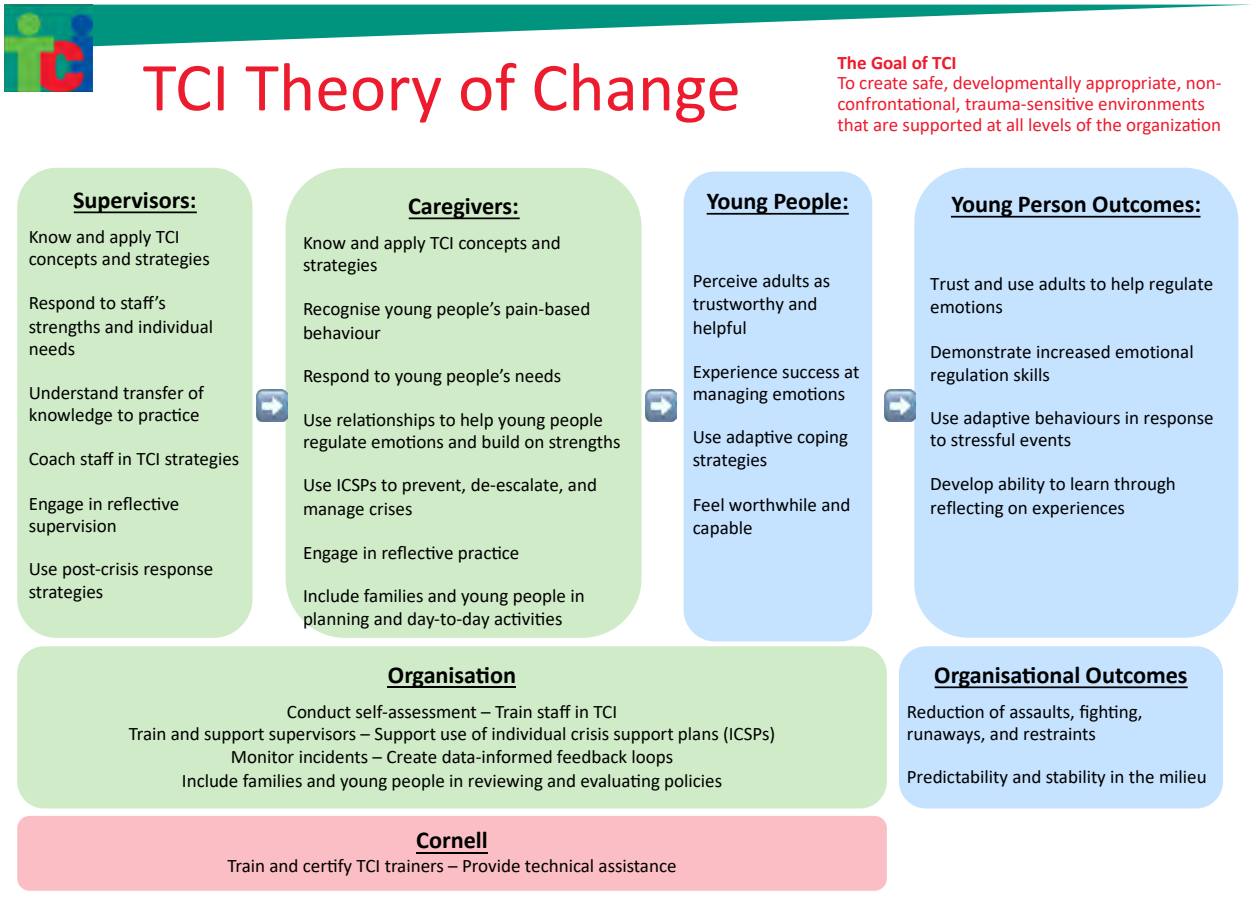


Figure 6. TCI Theory of Change

The TCI system includes a training component to teach staff how to interpret children's aggressive behaviors as pain-based, and use strategies and skills that respond to the child's needs while reducing the potential for adult counter-aggression. Children feel safe and learn to regulate their emotions with help from caring adults (co-regulation). When the child is calm they can discuss the incident with a trustworthy adult and develop better ways to handle stressful situations in the future. Once children are able to manage their emotions they can negotiate potentially stressful situations occurring throughout the day on their own.

Notes

The TCI System: The Six Domains

In order for an organization to become a learning organization creating a culture of shared learning and reflection, leadership must foster openness, collaborative decision making, professional development, and a shared vision of how the organization should work. Leadership needs to set high expectations and goals for staff and children and provide the support and resources necessary to achieve the goals. Implementing TCI with the goal of reducing the need for high-risk intervention strategies and creating a safe place for children and staff to practice new skills requires that organizations put in place a system to promote learning and reflective practice. Reflective practice is the ability to reflect on one's actions and engage in a process of continuous learning. For TCI to be an effective crisis management system, the following six general domains need to be addressed as shown in Figure 7.

Figure 7. Six Domains of TCI

Leadership and Program Support

The TCI system is an organization-level intervention, requiring that staff develop new ways of understanding the children and families with whom they work and develop new skills for interacting therapeutically with them. Sustaining norms and practices that meet the relationship and developmental needs of children, requires organizational policies and procedures that provide ongoing expectations and support to personnel at all levels of the organization.

Achieving the level of effectiveness required to prevent and reduce the need for high-risk interventions begins with and depends on leadership's commitment to creating a culture that values developmental and therapeutic practice.[12]

When leadership is fully informed about the TCI system and understands its foundation, leaders can support the necessary components that are integral to its implementation and maintenance. Policies, procedures, and guidelines that are clearly written and communicated, assist staff in knowing what to do when confronted with potential crises. Staff throughout the organization should know how to prevent, de-escalate, and contain a child's aggressive and pain-based behavior in ways that are congruent with organizational guidelines.

A clear program philosophy and framework of care are essential for establishing an organizational culture that promotes the growth and development of children living with the effects of complex trauma. Establishing organizational practices that are in the best interests of the children[13] is paramount. Leaders can promote an organizational culture that establishes an environment where children can thrive by valuing developmentally appropriate and therapeutic practice above control and expediency. When leadership promotes and engages in reflective practice, it provides the safe space required for all staff members to openly self-assess their strengths as well as their challenges and improve their own practice.

With a positive, trauma-informed program that is culturally sensitive in its approach to working with children and families, an organization can decrease its reliance on punitive and coercive practices as well as its use of restrictive interventions.[14] By providing sufficient resources including adequate and qualified staff, skilled and supportive supervisors, time for reflection and planning, support for regular external and internal monitoring, and clear rules and procedures that have safeguards against abusive practices, leadership promotes positive programming and an organizational culture to sustain the TCI system.

Rights of Children

The United Nations Convention on the Rights of the Child ensures all children have the right to be heard and protected from harm and provides guidance for serving children's best interests.

Figure 8. United Nations Rights of the Child

Child and Family Inclusion

Child and family inclusion means that both the child and the family are active and meaningful participants in making decisions regarding the child's care and treatment. Leadership and staff actively recruit and include children and families in all activities. Children and families have a role in reviewing and evaluating organizational policies and practices. This can make the organization more responsive to children and families and more respectful of their individuality. This move toward inclusiveness requires honest and open relationships underpinned by respect, trust, and cultural competence.

When implementing the TCI system, it is critical to promote the dignity and wellbeing of children. The Convention of the Rights of the Child adopted by the United Nations in 1989 ensures all children have the right to be heard and protected from harm. Very often in reviewing or making decisions about the use of restrictive practices, the focus can be on the intentions of staff instead of the impact on the child. It is important to not only protect the children's physical and emotional well-being but to respect their right to autonomy.[15] This means ensuring the child's participation and involvement, as much as possible, throughout their journey through placement. There should be a focus on choice, participation, voice, and informed consent.[16]

As active participants, children have input into their own care plans, crisis plans, and treatment options. In addition, children have a voice in how policies, procedures, routines, and activities are designed and carried out. When plans and programs are written with the children, labeling and institutional jargon are avoided.

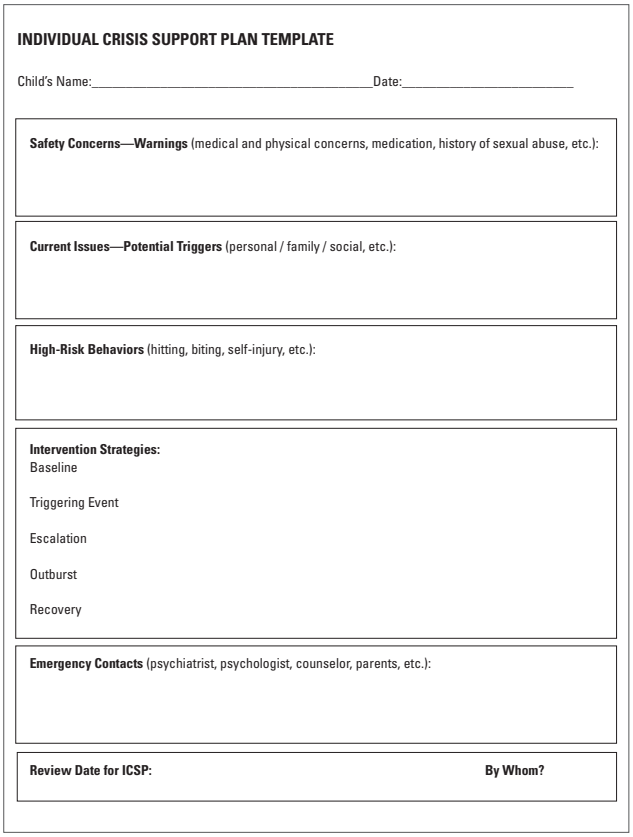
Every child has a family. When and wherever possible, it is important to keep the family in the parenting role by seeking family input into planning and programming as well as helping the family stay active in daily activities (e.g., shopping, trips to appointments, meetings at school, meals, recreation). Families will need time, support, and information in order to have a meaningful role in the decisions made concerning their child. This requires a true partnership between staff, the organization, and the family.[17] Families need to be fully informed of the organization's policies, procedures, strategies, and interventions to prevent, de-escalate, contain, and manage aggressive, self-destructive, or violent behavior. The family can provide important cultural context when developing plans and designing activities and interventions for their child.

Clinical Participation

Clinical and social work services play an important role in overseeing and monitoring children's responses to stressful events and helping staff to use trauma-informed intervention strategies. Developing and implementing an Individual Crisis Support Plan (ICSP) for children who exhibit high-risk behaviors is critical to responding appropriately and therapeutically to a child in crisis.[18] (See Figure 9.) These plans are most effective when they are written by clinical or social work staff with input from team members as well as the child and their family. Equally important is writing the ICSP in clear and concise language so that the care staff can implement the plan as intended. At intake, a risk assessment of the child's likelihood to exhibit high-risk behaviors and the conditions that have triggered these behaviors in the past can provide valuable information.

The child and family can contribute valuable information about what has worked (or not worked) in the past as well, as give staff important cultural context. Families should be involved in developing the ICSPs and be informed when their child has had a crisis event.[19]

Well-developed ICSPs include strategies for preventing, de-escalating, and managing potential high-risk behavior specific to the child. Included in the plan are strategies to prevent undesirable setting conditions and possible triggers occurring simultaneously for each individual child. Specific techniques, to help de-escalate the child such as redirecting behaviors, prompting, offering to go for a walk; as well as techniques to avoid that might escalate the child, are included. And finally, specific physical interventions, if appropriate, or alternative strategies if physical intervention is not an option, are prescribed. For example, the provision of unobtrusive personal protective equipment where needed reduces the risk of injury and the need to respond with a physical intervention. It is important to screen all children for any pre-existing medical conditions that would be exacerbated if the child were involved in a physical restraint. Any medications that the child may be taking that would affect the respiratory or cardiovascular system should also be noted. If there is a history of physical or sexual abuse that could contribute to the child experiencing emotional trauma during a physical restraint, it is equally important to document this in the plan. Ongoing reviews of the child's ICSP with revisions as the child's condition changes will help staff develop more effective ways to prevent and intervene with the child's high-risk behaviors. (See Figure 9).



INDIVIDUAL CRISIS SUPPORT PLAN TEMPLATE

Child's Name:_____Date:_____

Safety Concerns—Warnings (medical and physical concerns, medication, history of sexual abuse, etc.):

Current Issues—Potential Triggers (personal / family / social, etc.):

High-Risk Behaviors (hitting, biting, self-injury, etc.):

Intervention Strategies:
Baseline

Triggering Event

Escalation

Outburst

Recovery

Emergency Contacts (psychiatrist, psychologist, counselor, parents, etc.):

Review Date for ICSP: **By Whom?**

Figure 9. Individual Crisis Support Plan (ICSP) Template

Supervision and Post-Crisis Response

Frequent and ongoing supportive supervision, mentoring, and coaching are essential for creating and sustaining an organization's ability to maintain good quality care and reduce the need for high-risk interventions.[20] Reflective practice and supportive supervision is built into the implementation and ongoing monitoring of the TCI system. Supervisors who are fully trained in all of the prevention, de-escalation, and intervention techniques can provide effective supervision, coaching, and monitoring of their staff members. Fully trained and effective supervisors hold reasonable expectations with realistic time frames and schedules for staff so that staff can accomplish tasks and respond to children's needs in a thoughtful and well planned manner. Supervisors play an important role in reinforcing the culture of high support and high accountability.

The integration of a well-developed post-crisis response system ensures that all children and adults receive immediate support and debriefing following a crisis as well as a brief medical assessment. When children return to normal functioning, staff conduct Life Space Interviews to look for strategies that can help the children calm themselves in the future when they are overwhelmed with stress and anxiety. Once things return to normal functioning, adults involved in the crisis event can deconstruct the incident to develop strategies for intervening in the future. It is important to document the incident and notify the family when these events occur. Building a discussion of crisis incidents into team/unit meetings helps everyone learn from these situations and provides accountability and support at the highest level.

Training and Competency Standards

Training and professional development are a cornerstone of any professional organization. Programs that keep emotionally competent staff informed and updated on the special needs of the children in their care can enhance treatment and child outcomes. A comprehensive training agenda includes prevention, de-escalation, and management of crises as well as child and adolescent development, trauma-informed interventions, cultural competence, and individual and group behavior support strategies.[21]

Children who have experienced complex trauma often have difficulty regulating emotions even in routine, everyday situations. Consequently, all staff need support, guidance, and training in using developmentally appropriate strategies to prevent, de-escalate, and manage a situation in which an upset child uses socially inappropriate or aggressive behavior. That is, staff need to understand that trauma often underlies challenging behaviors. Staff must have skills that facilitate the prevention and de-escalation of crisis situations.

TCI training can only be conducted by a certified TCI trainer. (See Figure 10.) The TCI training should be 4 to 5 days in length with a minimum of 28 classroom hours. If the training is less than 28 hours, the physical restraint techniques should not be taught. TCI trainers are required to attend a Cornell University sponsored TCI Update and pass evaluation requirements at least every 2 years (1 year in New York State and in the United Kingdom and Ireland) in order to maintain their certification.

Training for direct care staff to refresh skills is required semiannually at a minimum. Refreshers are designed to give staff the opportunity to practice de-escalation skills, Life Space Interviewing, and physical restraint skills as well as deepen their knowledge base and increase their skill level. At the completion of the original training and each refresher, staff are expected to perform the TCI skills at an acceptable standard of performance. These standards should be established by the organization and consider the abilities of staff

Direct Training Requirements

TCI training should be 4 to 5 days, with a minimum of 28 classroom hours.

The minimum requirement for TCI refreshers is 12 hours, annually, to be delivered a minimum of 6 hours every 6 months, and should include de-escalation skills, physical restraint skills, and Life Space Interview Skills.

RCCP recommends quarterly TCI refreshers, based on best practice findings.

TCI certification renewal is determined by semi-annual physical restraint testing, and annual knowledge testing.

TCI training can only be conducted by certified TCI trainers.

Figure 10. Direct Training Requirements

to perform the skills in real-life situations. Documentation of these training events and staff's level of competency is critical in order to maintain the TCI system and ensure that staff can competently use high-risk physical interventions. In addition, the health and fitness level of all staff members trained in the use of physical interventions should be considered.

Documentation, Incident Monitoring, and Feedback

Documentation, data analysis, and feedback to all levels of staff teams are an important part of the TCI system.[22] Data management includes the documentation of staff supervision and training and the documentation and monitoring of behavioral incidents. An organization-wide committee appointed by leadership with the authority and responsibility to track the frequency, intensity, duration, location, and type of incidents as well as any injuries or medical complaints that occur, helps to monitor the effectiveness of the TCI system. This documentation and monitoring system allows the organization to review incidents, make decisions about individual and organizational practice, and recommend corrective actions that will improve practice.

In addition to an organization-wide incident review committee, a clinical review of incidents and a team or unit review can assist organizations in making changes to reduce the number of high-risk situations. These reviews focus on different aspects of the incident and provide feedback or suggestions to the team, clinician, or administration.

Some type of benchmarking or red flagging should call attention to any situation that exceeds the norm and requires a special review. For example, this red flag might appear when the number of incidents per month exceeds a set number, when restraints exceed a certain length of time, or when specific complaints or injuries that are unlikely to occur during a restraint are reported.

Organizations have been able to reduce aggressive behavior and physical restraints by effectively implementing the TCI system. TCI implementation has resulted in an increased ability on the part of staff to manage and prevent crises. Implementation studies have also shown increased knowledge and skill on the part of all staff to handle crisis episodes effectively, and a change in staff attitude regarding the use of physical restraint when TCI is implemented as designed.[23]

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TCI Assessment Tool

For TCI to be an effective crisis prevention and management system, six general domains need to be addressed continually. Please use this assessment tool to review your implementation of TCI and make note of the strengths and needs of your organization in each domain. If your organization is not currently using TCI, this assessment tool can be applied to your current crisis prevention and management model. Once an assessment is complete, plans can then be developed with focus on specific domains.

Questions for TCI Implementation: Assessment

1. Leadership and Program Support

System consistent with mission

- ☐ Does TCI support the organization's mission?
- ☐ Does the organization have a well thought out program model based on the population and overall mission of the organization?
- ☐ Does the program model include strength-based programming and trauma-informed principles?

Administration

- ☐ Does the leadership of the organization understand and support TCI as the crisis prevention and management system?
- ☐ Are there adequate resources at the organization to support the TCI system, i.e., training hours, adequate staffing patterns, strong program, skilled supervisors?

Policies, rules, and procedures

- ☐ Do the policies and procedures clearly describe intervention strategies taught in the TCI training?
- ☐ Are the procedures understandable and communicated to all staff?
- ☐ Are there clear guidelines against abusive practice?

External and internal monitoring

- ☐ Are there supports for an ongoing monitoring system?
- ☐ Are external monitoring organizations engaged to review the organization's practice?
- ☐ Do children and advocates play a role in informing organization practice and policy?

Culture

- ☐ Does the organizational culture value developmentally appropriate practice above control and expediency?
- ☐ Do staff feel supported in using the techniques they learn in TCI training?

Program appropriate to child's needs

- ☐ Is TCI an appropriate and effective crisis management system based on the type of children served?

TCI Assessment Tool, cont.

2. Child and Family Inclusion

- ☐ Do children and families play a role in informing organization practice and policy?
- ☐ Do children have input in their Individual Crisis Support Plans?
- ☐ Do children have a voice in how routines and activities are designed and carried out?
- ☐ Do families have input into their child's plan and programs?
- ☐ Are families involved in debriefing after incidents?
- ☐ Are families active in their child's daily activities?

3. Clinical Participation

Individual Crisis Support Plans

- ☐ Has the team completed a functional analysis of each child's individual high-risk behavior?
- ☐ Is there an individual plan to eliminate the need for external controls by helping the child develop better and more functional coping behaviors?
- ☐ Is there a specific strategy for intervention tailored to the needs of the child?
- ☐ Is the child involved in identifying de-escalation preferences and triggers?
- ☐ If physical restraint is inappropriate based on the special needs or situation of the child, are there alternative interventions described?

Medical screening

- ☐ Has each child been medically screened for pre-existing conditions that might contraindicate physical restraint?
- ☐ Is there documentation about any medication prescribed or combinations of medication taken and the effects on the child?

Documented ongoing reviews

- ☐ Is the Individual Crisis Support Plan reviewed on a regular and frequent basis for progress or modification of intervention strategies?

4. Supervision and Post-Crisis Response

Supervisors fully trained in TCI

- ☐ Have the direct care supervisors been trained in TCI so that they can coach, support, and have reasonable expectations of staff members?

TCI Assessment Tool, cont.

4. Supervision and Post-Crisis Response, cont.

Types of supervision

- ☐ Do supervisors provide on-the-job training in the form of coaching staff in early intervention and Life Space Interviewing (LSI) skills?
- ☐ Is supervision supportive, frequent, and ongoing?

Post-crisis multi-level response

- ☐ Do supervisors provide on-the-spot debriefing and support in a crisis situation?
- ☐ Does staff conduct LSIs with the child after a crisis?
- ☐ Does staff have time and support to immediately document incidents?
- ☐ Do supervisors conduct a process debriefing with staff workers within 24 hours of the incident?
- ☐ Are incidents discussed in team meetings in order to share information and develop better intervention strategies and improve programming?

5. Training and Competency Standards

Basic/core training

- ☐ Do direct care staff workers receive core training in skills necessary to be a competent care worker, i.e., child development, activity planning, group processing, separation and loss, routines and transitions, relationship building, trauma assessment, and re-traumatization practices?

Crisis intervention training

- ☐ Do all staff receive the minimum number of hours of training: 28 hrs (if restraint is taught) or 20 hours if no physical interventions are taught?
- ☐ Are there additional training sessions if the children have special needs that should be considered?
- ☐ Is the training safe?
- ☐ Is training delivered by certified trainers?

Ongoing staff development

- ☐ Do staff members attend additional, ongoing training that is relevant to the children and program?

Refreshers

- ☐ Do staff members attend TCI refreshers every 3 months? or at least every 6 months?
- ☐ Do staff members practice and receive corrective feedback on the main skills, i.e., LSI, physical intervention techniques, behavior support skills, co-regulation strategies during these refreshers?

TCI Assessment Tool, cont.

5. Training and Competency Standards, cont.

Credentialling based on achieving a level of competence

- ☐ Are staff members tested by a certified trainer in the core skill areas?
- ☐ Is the level of competency of each staff person documented and maintained in that individual's personnel file?
- ☐ Are staff members required to demonstrate competency before using crisis management skills with children in crisis?

6. Documentation and Incident Monitoring and Feedback

Incident review committee

- ☐ Is there an organization-wide committee that reviews incidents?
- ☐ Does that committee have some authority to recommend and implement policy and changes?
- ☐ Are advocates and/or children involved in monitoring incidents?

Peer review

- ☐ Is there clinical oversight of incidents and interventions?

Team review

- ☐ Does the team or unit review incidents on a regular basis?

Data monitoring

- ☐ Are incidents documented in a timely and comprehensive manner?
- ☐ Is the following information collected: frequency, location/time, circumstances surrounding the event, child/staff frequency of events, child/staff injuries?

Feedback loop

- ☐ Is the information collected and reviewed by committees fed back into the system to inform the program?

Red flags/benchmarks

- ☐ Are there benchmarks that, when surpassed, call for review of different strategies?

TCI should be one part of a comprehensive staff development program that provides core training as well as specialized training based on the population served. TCI training is only to be conducted by a trainer who has successfully completed a Cornell-sponsored Training of Trainers course. TCI training is designed to be co-trained with a ratio of 1:10 participants per trainer. The direct TCI course should be 4 to 5 days in length with a minimum of 28 hours if all physical intervention techniques are taught. TCI trainers are required to successfully complete a Cornell University sponsored update at least every 2 years in order to maintain their trainer certification status (1 year in New York State and in the United Kingdom/Ireland). Figure 11 outlines the requirements for in-house TCI training.

Training that refreshes skills should be conducted with all staff at a minimum of every 6 months, but preferably, quarterly. Refreshers should give staff the opportunity to practice de-escalation techniques, Life Space Interviewing, and physical restraint skills. At the completion of the original training and after refreshers, staff can be expected to perform the skill at an acceptable standard of performance. This performance should be documented and staff should be held to a certain competency level of performance in order to use high-risk interventions.

Therapeutic Crisis Intervention Training-of-Trainers: Program Description

A child in crisis needs help. What kind of help and how it is given make a crucial difference between the child's learning from the experience or being set back. The goals of TCI training are to provide immediate emotional and environmental support in a way that reduces the stress and risk and teaches better, more constructive, effective ways to deal with stress or painful feelings.

Training-of-Trainers in TCI presents a crisis prevention and intervention model designed to help staff prevent potential crises, de-escalate crises when they occur, and assist children to learn constructive ways to handle feelings of frustration, failure, anger, and hurt. In addition, physical intervention techniques that respect the dignity of the staff and the child are practiced. The program also gives participants the tools to teach therapeutic crisis intervention techniques in their own agencies. There is an opportunity to practice and gain immediate training experience. The course stresses crisis prevention by teaching a continuum of intervention skills.

Program Objectives

Participants will be able to:

- proactively prevent and/or de-escalate a potential crisis situation with a child
- manage a crisis situation in a therapeutic manner, and, if necessary, intervene physically in a manner that reduces the risk of harm to children and staff
- process the crisis event with children to help improve their capacity to regulate their emotions and use positive coping strategies
- effectively deliver TCI training in their agencies

Who Can Train TCI?

(1) **Only certified TCI trainers** may conduct direct TCI training in their organization.

(2) **Before attending a TCI Train-the-Trainer course**, participants must complete direct TCI training delivered by a certified TCI Trainer that includes a minimum of 28 hours if the participant will be training all physical interventions.

(3) Certification must be **maintained** by completing TCI Updates within the required timeframe.

(4) RCCP recommends that direct TCI training be delivered by **two certified TCI trainers (co-training)**. Trainers may train alone at a 1:10 trainer-to-participant ratio.

Figure 11. Who Can Train TCI?

This course is for trainers, managers, counselors, and care workers capable of training therapeutic crisis intervention techniques. Participants are required to pass written and competency-based testing and be capable of moderate physical activity if training in the physical restraints.

Staff Selection Criteria

Using a train-the-trainer approach, RCCP staff will instruct selected supervisory and training staff to deliver TCI in-service training to all levels of residential child care staff. The selection of candidates for the TCI train the trainer program is critical to the success of TCI in your organization. Given the nature of their responsibility to play a key role in implementation, the training participants should have "hands on" experience in supporting children in crisis. If they are effective role models for new and experienced care workers they can instill positive and supportive values to child care staff and can coach and give corrective feedback to staff more effectively. The participant should be committed to conducting ongoing training for staff for a period of two years. It will be helpful to have training responsibilities written into the job description.

Materials

Participants receive a trainer's manual containing a complete curriculum, a flash drive with a PowerPoint™ presentation, and videos. They also receive corresponding student workbook and testing materials to use in their direct training.

Technical Assistance

- Conduct training skills workshops for TCI trainers
- Observe TCI training and give feedback
- Assess TCI trainers in delivering direct training
- Observe programs to assess the transfer of learning
- Assist in implementing and testing an evaluation system

Some technical assistance may be adapted for virtual delivery.

TCI Certification Process

The certification program is designed to develop, maintain, and strengthen the standards of performance for individuals who have successfully completed the requirements of the 5-day TCI training. This process affirms our commitment to ensure that TCI is implemented in child caring agencies in a manner that meets the developmental needs of children, and the safety of both children and staff. Certification includes an agreement to practice in accordance with TCI principles, which provides a framework for TCI practice and training and general standards that include levels of certification, regulations, and requirements for continuing or maintaining the certification process.

Associate Certification

Certification represents a high standard of professional practice. An associate certification is granted at the completion of training if the participant successfully completes the training and evaluation requirements. To maintain associate level certification, certified trainers must attend a Cornell sponsored TCI update at least every 2 years (1 year in New York State and in the United Kingdom/Ireland).

Basic requirements for associate certification

- Successful completion of the training of trainers program. Successful completion is defined as complete attendance and a passing score on a written test and on skill demonstrations in key competency areas.
- Participants agree to practice in accordance with TCI principles and follow the guidelines for training and implementing TCI.

Privileges associated with associate certification

- Certification to provide direct TCI training according to the TCI guidelines within your organization
- Eligibility for professional certification after a minimum of 1 year
- Eligible to apply for professional certification after a minimum of 1 year and facilitation of at least four direct training programs

Professional Certification

The second level of certification is the professional level. After a minimum of 1 year as an associate certified TCI trainer, applicants have to perform at a professional level for the predetermined number of competencies and submit portfolios of their work. To maintain professional level certification, certified trainers must attend a Cornell sponsored TCI update at least every 2 years (1 year in New York State and in the United Kingdom/Ireland).

Basic requirements for professional certification

- Successful completion of a TCI update program designed for professional certification. Successful completion is defined as complete attendance and a passing score on a written test and on skill demonstrations in key TCI competency areas.
- Successful completion of a minimum of four direct training programs of a prescribed length with prescribed evaluation instruments within their associate certification period. Successful completion is defined by acceptable trainee performance on selected evaluation instruments and a review of actual video footage of a prescribed number of training activities.

Privileges associated with professional certification

- Certification to provide direct training within your organization and direct training sponsored by your organization
- Certification to provide direct training outside of your organization
- Eligibility to participate on a certification committee

Notes

Agenda: TCI Training-of-Trainers

MONDAY
8:45 am
Introduction to Course
Implementation of the TCI System
Break
Therapeutic Milieu and Crisis Prevention
Intentional Use of Self
Lunch
Knowing the Child
Break
Stress Model of Crisis
Assessing the Situation
Assignments for Tuesday distributed to participants
5:00 pm Session adjourned

TUESDAY
8:45 am
Refocus
Assessing and Responding
Crisis Communication and Active Listening
Break
Behavior Support Techniques
Emotional First Aid
Lunch
The Power Struggle
Nonverbal Communication in Crisis Situations
Break
Training assignments for Wednesday or Thursday
5:00 pm Session adjourned

WEDNESDAY
8:45 am
Refocus
Elements of a Potentially Violent Situation
Help me Help Myself: Crisis Co-regulation
Break
Post-Crisis Multi-Level Response
Life Space interview
Lunch

WEDNESDAY, cont.
Responding to Violence: Reducing Risk of Harm
Protective Interventions
Standing Restraint
Seated Restraint
Small Child Restraint
Break
Supine Restraint and Transferring Control
Prone Restraint and Transferring Control
Training assignments for Thursday
5:00 pm Session adjourned

THURSDAY
8:45 am
Refocus
Crisis Intervention Role Plays
Break
Safety Intervention: Considerations
Practicing Physical Interventions
Safety Concerns and Recommendations for Reducing Risk
Lunch
Practicing Physical Interventions
The Letting go Process
Practicing with Resistance
Break
Documentation
5:00 pm Session adjourned

FRIDAY
8:45 am
Life Space Interview After an Outburst
Certification Discussion
Implementation of TCI System and Action Planning

Break
Testing:
Physical Intervention Techniques
LSI
Close of Program
4:00 pm

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