# Children And Residential Experiences:

## Creating Conditions for Change

care

# Children
# And
# Residential
# Experiences:
## Creating Conditions for Change

*Information Bulletin*

Hello,

Thank you for your interest in CARE. CARE is a program model (foundation) that we developed to assist child and family service agencies in improving outcomes for the children in their care. This bulletin provides a description of the CARE model, including our theory of change. We also include an article, written by James Anglin, Ph.D., School of Child and Youth Care, University of Victoria, CA, who studied our implementation process with our first eight CARE agencies.

Our experience over the last few years has been that the implementation support we give to agencies is as important as the efficacy of the model. Our implementation strategy is an on-site model working with the organization(s) since the organization is the unit of change. We travel to deliver training and technical assistance to the organization 3 or 4 times a year for a 3-year period to assist them in fully implementing the model. Our implementation package for the CARE model is a 3 year contract. This agreement includes training, on-site technical assistance (one agency site), and evaluation services for a total of USD $105,000.00 (2017 fee schedule) for the 3 years (this cost is in part dependent on the size of the organization) and includes all of our travel expenses and materials. If your organization does not have an effective crisis prevention and management system in place, a combination Therapeutic Crisis Intervention (TCI) and CARE implementation project can be developed. If the TCI system is included in the proposal, the agreement is extended to four years at a cost of USD $146,000 (2017 fee schedule). For countries outside of the US, costs will vary for both the CARE and the TCI/CARE implementation projects.

This bulletin includes a sample proposal/scope of work for the implementation agreement. If you have several organizations interested in adopting CARE, we can discuss a system wide implementation and evaluation proposal.

Let me know if you have any questions or would like additional information or if you would like to speak to other organizations that have implemented the model.

Sincerely,

Martha J. Holden
Project Director
Residential Child Care Project
Cornell University/BCTR
Beebe Hall
Ithaca, NY 14853
TEL 607 254-5337
FAX 607 255-4837
mjh19@cornell.edu
RCCP Web site: http://rccp.cornell.edu

If you are interested in having more in-depth knowledge about the CARE model, our book, *Children and Residential Experiences (CARE): Creating Conditions for Change*, is available from the Child Welfare League of America:

**http://www.cwla.org/pubs/pubdetails.asp?PUBID=1262**

It is also available on our website:

**http://rccp.cornell.edu/rccpv4/res_2_center_carematerials.html**

This book describes the CARE model and is required reading for agency staff when we contract with an organization to implement CARE.
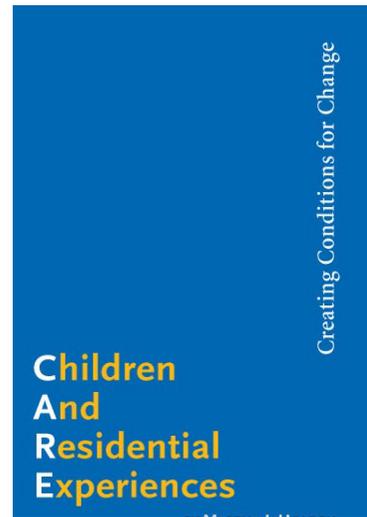
There is also an article, *Children And Residential Experiences: A Comprehensive Model for Implementing a Research-Informed Model for Residential Care*, in the special issue of *Child Welfare* on residential care and treatment:

> Holden, M. J., Izzo, C., Nunno, M., Smith, E. G., Endres, T., Holden, J. C., et al. (2010). Children and residential experiences: A comprehensive strategy for implementing a research-informed program model for residential care. *Child Welfare*, 89(2), 131-149.

We are in the process of submitting a journal article discussing additional outcomes from our 5-year quasi-experimental study of CARE implementation in 14 agencies and have a chapter in a book entitled, *Therapeutic Residential Care with Children and Youth: Identifying Promising Pathways to Evidence-Based International Practice*, published by Jessica Kingsley Publishers. (2014).

## Contents of This Bulletin

# The CARE Program Model

**Children And Residential Experiences: Creating Conditions for Change (CARE)** is a multi-level program model for improving services for children in out-of-home care (Holden, 2009). This model enables child caring agencies to organize and deliver quality care of children according to research-informed principles based on the best interest of the child. The CARE program model reflects the following six practice principles.

***Developmentally focused.*** All children have the same basic requirements for growth and development. Activities offered to children need to be appropriate to each child's developmental level and designed to provide them with successful experiences on tasks that they perceive as challenging, whether in the realm of intellectual, motor, emotional, or social functioning. Research and theory have shown that activities that are developmentally appropriate help to build children's self-efficacy and improve their overall self-concept.

***Family involved.*** Children need opportunities for constructive family contact. Contact with family and community is one of the few indicators of successful treatment that has empirical validation. Children benefit when their families work in partnership with the child caring organization. Retaining children's connections to family and community bolsters their resiliency and improves their self-concept.

***Relationship based.*** Children need to establish healthy attachments and trusting, personally meaningful relationships with the adults who care for them. These attachments are essential for increased social and emotional competence. Healthy child-adult developmental relationships help children develop social competencies that can be applied to other relationships. A child's ability to form relationships and positive attachments is an essential personal strength and a manifestation of resiliency associated with healthy development and life success.

***Trauma informed.*** A large percentage of children in care have a history of violence, abuse, and neglect resulting in debilitating effects on their growth and development. Adults need to respond sensitively and refrain from reacting coercively when children exhibit challenging behavior rooted in trauma and pain. Trauma sensitive responses help children regulate their emotions and maintain positive adult-child relationships.

***Competence centered.*** Competence is the combination of skills, knowledge, and attitudes that each child needs to effectively negotiate developmental tasks and the challenges of everyday life. It is a primary responsibility of caregivers and the organization to help children become competent in managing their environment as well as to motivate them to cope with challenges and master new skills. Learning problem-solving, critical thinking skills, emotional regulation skills, and developing flexibility and insight are all essential competencies that allow children to achieve personal goals and increase their motivation for new learning. All interactions and activities should be purposeful and goal oriented with the aim of building these competencies and life skills.

***Ecologically oriented.*** Children engage in dynamic transactions with their environment

as they grow and develop. To optimize growth and development, children must live within a milieu that is engaging and supportive. Caregiving staff must understand that their relationships with the children are part of a larger social-ecology; their face-to-face interactions with children, the activities they promote, and the physical environment in which they work all have an impact on the developmental trajectories of children. Competent staff using skill sets informed by the CARE principles can only be effective when they are working in an ecology of care that will allow them to use their skills.

## Relationship Between the CARE Principles and a Congruent System of Care

Congruence based on a set of common principles that address the child's best interests is an essential ingredient in effective and high-quality residential care (Anglin, 2002). Within an organization, caregivers, support staff, and administrators must be congruent in their application of core principles that advance the best interests of children. If staff at all levels of an organization make decisions based on CARE's common principles and if they apply these principles congruently, then the experiences of children and families are likely to be more positive and associated with improved outcomes. CARE lends itself to such congruence since its principles apply to various levels of an organization's structures and processes and to all of its units of service delivery such as foster family care, group living, residential treatment, and other educational and therapeutic settings. External to the organization, adherence to CARE principles by placement and regulatory agencies will increase congruence since it unifies child assessments and service decisions, requires service in the child's best interests, and expects positive child outcomes.

## Implementing the CARE Program Model

The CARE program model incorporates research-informed findings from the social sciences literature, specifically from the fields of developmental psychology, residential care and treatment, social work, youth development, clinical psychology, and organizational development. The model is implemented through research-informed strategies such as organizational and personal self-assessment, active and targeted data analysis, and training and technical assistance. Research has identified several aspects of organizational climate (e.g., fairness, role clarity, cooperation) that promote effective, innovative, and high-quality service, and ultimately result in positive child outcomes (Glisson & Hemmelgarn, 1998). Thus, the CARE implementation strategies work to facilitate activities and mechanisms that improve the organizational climate at all levels of the agency. Active data collection and analysis is continually fed back to agencies throughout implementation in order to further promote service quality and to improve child outcomes.

## Evaluating the CARE Program Model

The CARE program model takes a comprehensive strategy to advance evidence-based practice in out-of-home care. There are three avenues through which the

evidence can inform practice:

a. Developing practices guided by a sound theory of change *(See Figure 1 on page 7)* that reflects state-of-the-art research on factors that facilitate healthy child development and promote healing,

b. Studying the CARE model with a rigorous evaluation that allows for sound conclusions about its impact on children's well-being, and

c. Systematically reporting evaluation findings back to practitioners and administrators to guide program improvement efforts and refinements to the theory of change.

In the states of North and South Carolina (US) a specially funded research project, supported by both The Duke Endowment and Cornell University, used a quasi-experimental design comparing seven agencies implementing CARE to seven matched non-implementing agencies. Cornell collected data on implementation, organizational functioning, and staff and child outcomes. This study offered an opportunity to conduct a robust evaluation of the CARE model that may have implications for residential care nationally and internationally, as well as to qualify the model as an evidence-based program for residential child care (Holden, Izzo, Nunno, Smith, Endres, Holden, & Kuhn, 2010).

## Data Collection

The CARE implementation project has a process and outcome based evaluation component to measure the impact of the

model on reported critical incidents, staff's use of CARE principles in their work, and aspects of organization climate and culture. Baseline data collection for all CARE agencies includes an agency-wide survey containing the University of Tennessee's Organizational Social Context survey (organizational culture and climate), staff knowledge and beliefs, staff current practice, and youth perception surveys. These surveys and instruments are administered and re-administered, analyzed and discussed with the organization at different intervals throughout implementation to assist in decision-making and allocation of resources to the project and to measure effects.

The agencies' internal data (e.g., incident reports, intake and discharge data, staff turnover, student academic and psychometric testing) are also analyzed and considered throughout the project to help guide implementation efforts, reinforce data informed decision-making, and measure child outcomes.
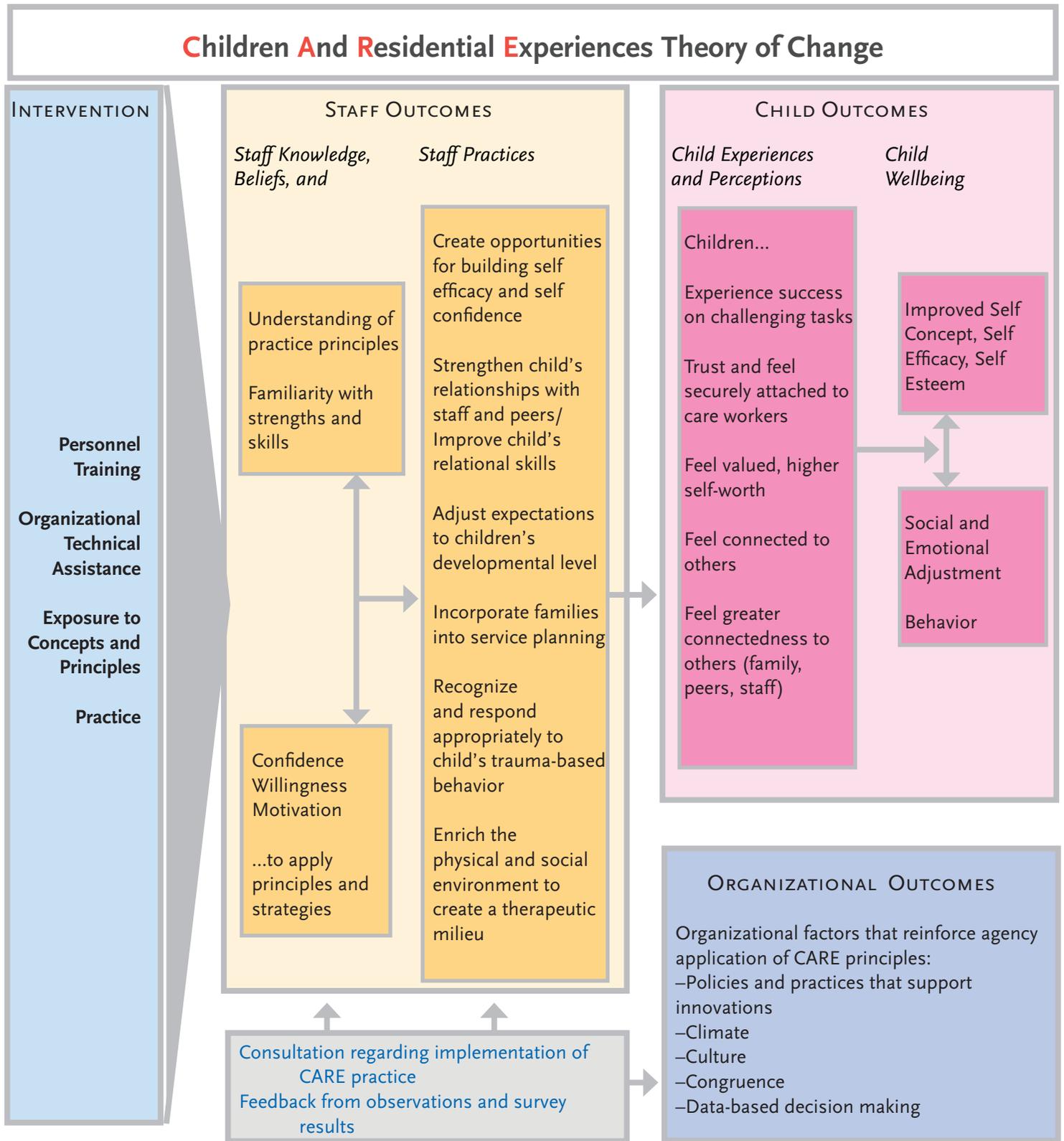
# Children And Residential Experiences Theory of Change

## INTERVENTION

Personnel
Training

Organizational
Technical
Assistance

Exposure to
Concepts and
Principles

Practice

## STAFF OUTCOMES

### Staff Knowledge, Beliefs, and

Understanding of practice principles

Familiarity with strengths and skills

Confidence
Willingness
Motivation

...to apply principles and strategies

### Staff Practices

Create opportunities for building self efficacy and self confidence

Strengthen child's relationships with staff and peers/ Improve child's relational skills

Adjust expectations to children's developmental level

Incorporate families into service planning

Recognize and respond appropriately to child's trauma-based behavior

Enrich the physical and social environment to create a therapeutic milieu

## CHILD OUTCOMES

### Child Experiences and Perceptions

Children...

Experience success on challenging tasks

Trust and feel securely attached to care workers

Feel valued, higher self-worth

Feel connected to others

Feel greater connectedness to others (family, peers, staff)

### Child Wellbeing

Improved Self Concept, Self Efficacy, Self Esteem

Social and Emotional Adjustment

Behavior

Consultation regarding implementation of CARE practice
Feedback from observations and survey results

## ORGANIZATIONAL OUTCOMES

Organizational factors that reinforce agency application of CARE principles:
–Policies and practices that support innovations
–Climate
–Culture
–Congruence
–Data-based decision making

Figure 1. CARE Theory of Change

# Origins of the CARE Program Model

## Background and Research

In 2005, the South Carolina Association of Children's Homes and Family Services reviewed the training needs of South Carolina residential care staff. The Association sought a training model built on best practices for direct care staff that would support and reinforce strong programmatic elements common to a variety of residential care treatment models.

As a result of the training needs assessment, the Association considered ways to have a model curriculum designed specifically for its South Carolina member agencies and approached the RCCP. The Association requested that Cornell University's RCCP develop a competency-based curriculum based on best practices and current research to support strong programmatic elements in residential care.

James P. Anglin, Ph.D., a professor at the School of Child and Youth Care at the University of Victoria in British Columbia, Canada, undertook a multi-year study and developed a theoretical framework for understanding group care that can be used as an organizing framework for staff competencies necessary for good residential group care. Based on this theoretical framework, education and training needs have been identified for the various levels of staff involved in providing residential services. These competencies are also reflected in the North America Association for Child and Youth Care Practice competencies (2001), the United Kingdom Quality Assurance Agency for Higher Education (2000), and the British National Occupational Standards for Children's Homes.

During 2005 an international group of experts, including Dr. Anglin, convened by Cornell selected 80 key competencies from researched and published national and international child care worker competencies (United Kingdom Quality Assurance Agency for Higher Education, 2000; North American Association for Child and Youth Care Practice, 2001; Anglin, 2002; Scottish Social Services Council, 2004). Over 100 South Carolina residential child care personnel including supervisors, clinicians, and managers verified the importance of the selected competencies to their work. After two years of research, curriculum development and training activity testing, field testing the curriculum, as well as piloting specific training implementation and evaluation strategies it became apparent to Cornell and the field test agencies, that what had been developed was more than a training curriculum, but a best practice model for working with children in out-of-home care. In 2007, the model was ready to pilot. In South Carolina pilot agencies for implementation included Miracle Hill Ministries, Inc., Tamassee DAR School, Epworth Children's Home, Connie Maxwell Children's Home, Generations group Homes, Inc., Carolina Youth Development Center, and Billie Hardee Home for Boys; in New York the pilot agency was Hillside Family of Agencies, Varick Campus.

In 2009, based on the success of the field test in the pilot agencies, The Duke Endowment, a private foundation serving North and South Carolina, awarded the RCCP a 5-year grant to support a comprehensive evaluation of the CARE model using a sophisticated quasi-experimental design (research methodology) involving 14 residential

**The Bronfenbrenner Center for Translational Research** (BCTR) was established by New York State legislation in 1974. The Center's mission is to expand, strengthen, and speed the connections between cutting-edge research and the design, evaluation, and implementation of policies and practices that enhance human development, health, and well being. **The Residential Child Care Project** (RCCP), established in 1982 by funding through the National Center on Child Abuse and Neglect, is one of several projects in the BCTR relevant to the lives of children, families, and care agencies. The RCCP's goal is to develop therapeutic residential environments that provide safe and appropriate psychosocial processes that promote child and youth development. Research efforts undertaken by the RCCP include studies to determine what contributes to safe and developmentally sound treatment in foster care environments and to identify the primary, secondary, and tertiary intervention protocols and strategies that produce and maintain the psychosocial processes and interactional dynamics in safe and developmentally sound therapeutic environments.

Web links:

**BCTR**    http://www.bctr.cornell.edu

**RCCP**    http://www.rccp.cornell.edu

agencies in North and South Carolina. The initial results from this study are positive and being distributed in journal articles and conferences.

In 2010, Dr. James Anglin conducted a grounded theory study of the implementation processes in the pilot agencies. *(See Dr. Anglin's article on page 11.)* Dr. Anglin's (Anglin, 2011) findings concluded that the starting point for any agency seeking to implement the CARE program model was the unequivocal commitment and "hands on" involvement of the senior leadership. Anglin found that support from the senior agency leadership was critical for successfully changing individual care workers' mindsets and for reinventing the organizational culture to embrace CARE practices and thinking. In addition, Anglin noted that this process was

not linear, but rather a cyclical one in which agency members re-commit, re-embrace, re-understand, re-work, re-experience, and re-gain confidence in the CARE program model as an effective philosophy and approach to working with young people. In looking at Cornell's consultancy role, he concluded that the consultants/facilitators were instrumental in creating the context for change through developing a level of trust with agency participants sufficient to allow for a supportively challenging engagement.

## Objective of the CARE Model

The CARE model aims to provide organizations with a set of research and standard-informed principles to guide decision making and practice choices that are in the best interests of the children and

families they serve. These best practice principles provide carers with clear objectives for daily routines, leisure activities, and staff-client interactions, and establish a framework for all staff in their interactions with clients, other staff members, and external organizations. The goal of this program is to establish a framework for practice based on a valid theory of how children change, grow, and develop that is consistent with the needs of the children, motivates both children and staff to adhere to routines, structures, and processes, and minimizes the potential for interpersonal conflict. A framework for practice provides consistency in message and approach with the children and families and congruency throughout the organization. In order for these principles to be integrated into practice, an agency's leadership must

1. Support an organizational climate and culture that expects these principles to be integrated into practice,

2. Develop professional learning and accountability systems to ensure their use on-the-job through creating a community of practice, and

3. Support participatory and collaborative management practices that address active use of data and data analysis to promote organizational learning that sustains and manages the CARE model and its long-term utilization.

**Notes**

**Translating the Cornell CARE Program Model into Practice:
Lessons from the Pioneer Agencies on
Changing Agency Cultures and Care Practice**

**James P. Anglin, PhD**
**School of Child and Youth Care, University of Victoria**

## Background

In September, 2009, a meeting of the early adopter agencies was held in Columbia, SC, and the verbal accounts provided by agency representatives indicated strong positive experiences with the CARE program model overall. It was apparent from the feedback that, for many, transformational changes had taken place. During the course of discussions regarding the next phase of agency involvement, involving a new set of agencies implementing the CARE program model, it was evident that the evaluation as initially designed would capture important information on the outcomes of the change process, but that it was not designed to capture an understanding of the elements and dynamics of the change process itself. It was suggested that a more qualitative research process be considered to complement the original evaluation.

While there are some published anecdotal accounts of agency change, there is a lack of sound and relevant theory which offers an understanding of the elements and dynamics of such agency change processes. Therefore, with the agreement of The Duke Endowment, it was decided that a grounded theory study of the South Carolina-Cornell CARE implementation experience would be undertaken. The central purpose of this study was to develop a theory of change implementation grounded in the experience of the Pioneer agencies that could help guide future implementation efforts. It is evident from the existing literature that governments, associations and agencies all over the world are looking for, and are in need of, such a framework.

The grounded theory (GT) approach has proven effective in many studies over the past 40 years, and was the research method utilized to articulate the theoretical framework which underpins much of the Cornell CARE Curriculum (Anglin, 2002; Glaser, 1978, 1992, 1993, 1994). A GT study of the implementation processes in the Pioneer Agencies would provide a companion theory to the theory of organizational congruence originally developed by Anglin (2002).

## Research Method

GT is one of the most utilized approaches in current social science research. Anglin (2002) has outlined the method in some detail (pp. 26-48). The main purpose of the method is to develop theory that is grounded in the realities of the phenomenon being studied. The theory emerges from a rigorous process of data gathering and data analysis grounded in direct observation and involvement in the process being studied, and which the study seeks to understand and explain. A good grounded theory "fits, works, and is relevant" (Glaser, 1978) to those involved in the phenomenon in question, and thereby can offer an effective tool for practice, training, policy development and evaluation.

*Anglin, J.P., Translating Cornell CARE Program Model into Practice, July 2011*

**Research Sites**

At the time of this study (2010), seven "Pioneer" agencies had already been involved in implementing the CARE program model for two to three years. Interviews were held with 70 CARE participants including with a wide range of staff members, administrators, trainers, and Board members across the seven agencies, as well as with the Cornell trainers. In addition, some relevant documents were reviewed and  the researcher participated in a week-long training session.

**Research Timeline**

The initial interviews were undertaken in July and August of 2010, with additional interviews completed in the fall of 2010 and participation in a training session in March, 2011.

**Initial Findings**

Several key characteristics of the CARE program model became apparent during the interviews, namely:

- The agency is the locus of learning. Rather than seeking training outside of the agency, the agency itself becomes the primary learning site.

- The agency is the unit of learning, rather than the individual (or even the team). While individuals are engaged and learn, the emphasis is on transforming the organization as a whole.

- The CARE consultants are engaged in a co-learning and co-creation process alongside the agency staff members; all participants are learners.

- CARE recognizes and seeks to bring forth the potential of adult learners to address the experiences and needs of the children.

- Key to the success of CARE are processes that keep the dialogue and critical thinking moving forward through ongoing conversations throughout the agency, both within and across organizational  levels.

- CARE recognizes the true complexity of child care work.

It also became evident that a number of interlocking "nested" elements are involved in the translation of CARE into practice. The fundamental touchstone *is the best interests of the children*, and *six core principles* have been defined and proven effective for guiding practice decisions. In addition, each worker's beliefs, attitudes and assumptions must be challenged and either modified or reaffirmed through a process of change facilitation led from outside the agency. Through the process of change facilitation, workers engage in an ongoing process of *integrating the CARE program model* into their behavior and into the overall *organizational climate and culture.* These elements and their sequence are illustrated in Figure 1, opposite.

*Anglin, J.P., Translating Cornell CARE Program Model into Practice, July 2011*

**Figure 1: Interlocking "nested" elements in translating the CARE program model into practice**
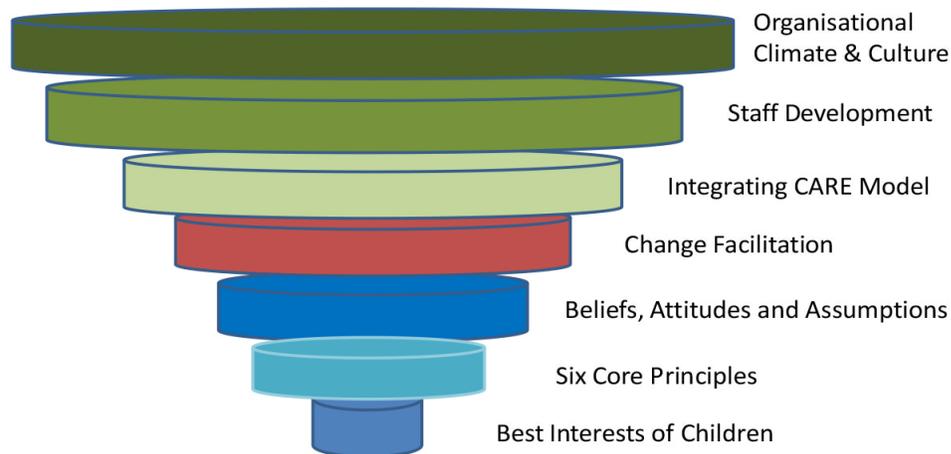


While every agency thinks it is acting in the best interests of the children, in fact many are not, at least not in any consistent manner. What enables workers to translate the best interests intent into action are the six foundational principles of: developmentally-focused, family-involved, relationship-based, competency centered, trauma-informed and ecologically-oriented. However, using these principles to guide and shape beliefs, values and attitudes requires an expert-led process of facilitation.
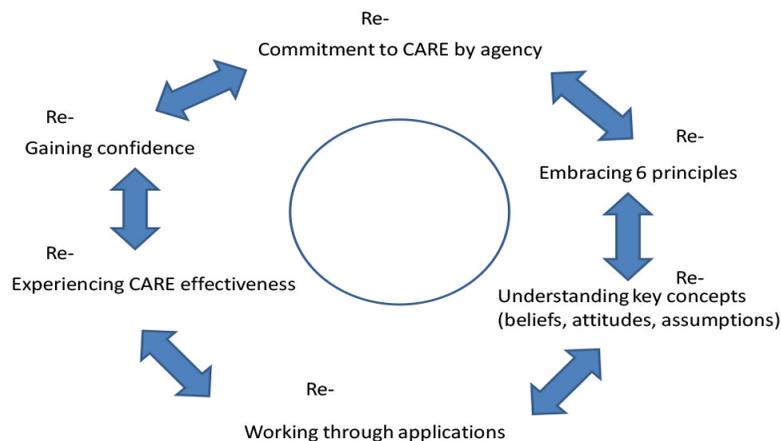
The experiences of the seven agencies in this study suggest that the process of transforming an agency into one that consistently operates according to the CARE program model (i.e. about 80% of the time, or more) takes about two years of concerted effort. However, when asked how long after the completion of the initial training session it took to see a difference in the children, the workers' answer was consistently "right away".

The external consultants/facilitators are instrumental in creating the context for change through developing a level of trust with agency participants sufficient to allow for a supportively challenging engagement. It was apparent that the co-creation and co-development orientation of the facilitators was an important element in the change facilitation process, and in achieving the level of congruence required.

At the heart of the change process is the cycle of integration of the CARE philosophy and approach as set out in Figure 2.

**Figure 2. Integration of the CARE Philosophy/Approach**

Re-
Commitment to CARE by agency

Re-
Gaining confidence

Re-
Embracing 6 principles

Re-
Experiencing CARE effectiveness

Re-
Understanding key concepts
(beliefs, attitudes, assumptions)

Re-
Working through applications

The starting point for any agency seeking to implement the CARE program model is the unequivocal commitment by the senior agency leadership. This commitment is required given the fundamental shifts in both the mindsets of the workers and nature of the structures and cultures of the agencies necessary to implement CARE. During the training process, the first stage is embracing the six core principles. It is important to note that not one respondent over the seventy interviews disagreed with any of the six principles. Therefore, quite quickly in the training process, the staff members involved become engaged in understanding and re-understanding a multitude of their beliefs, attitudes and assumptions. Through a process of attempting to apply the six principles to actual or simulated situations, the participants begin to experience the effectiveness of the CARE approach. It is neither a smooth nor linear process, and workers integrate the approach at different rates of speed, but those who persist start to gain confidence in their new competencies and thereby contribute to the CARE commitment of the agency as a whole.
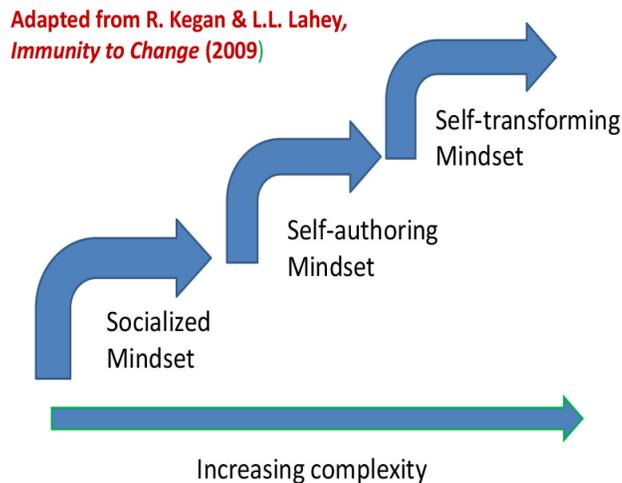
This process is not linear, but rather is a cyclical one in which agency members re-commit, re-embrace, re-understand, re-work, re-experience and re-gain confidence in the CARE program model as an effective philosophy and approach to working with young people. In some instances, participants indicate that they start to approach their own children, spouses and other family members differently in accordance with the CARE principles.

**Summary and Conclusions**

The data gathered in this study fit hand-in-glove with the adult developmental learning research findings of Robert Kegan (Kegan and Lahey, 2009).  Kegan identifies three major stages of adult learning, with  the major core dimension being increasing mind-set complexity (Figure 3). Such increased complexity is necessary in order for workers to respond effectively and confidently to the true complexity of residential care work.

**Figure 3. Adapted from R. Kegan & L.L. Lahey, Immunity to Change (2009)**



Adapted from R. Kegan & L.L. Lahey, *Immunity to Change* (2009)

Self-transforming Mindset

Self-authoring Mindset

Socialized Mindset

Increasing complexity

For work of a technical nature, a "socialized mindset" (i.e. concrete, rule-focused, lacking in self- awareness, and comfortable following authority) is often perfectly adequate to the task. However, the findings from this research suggest that to be able to implement CARE, one needs to have developed, or at least be willing and able to begin the task of developing, a "self-authoring" mindset (i.e. comfortable with abstract concepts, able to adapt to new and complex situations, generally self-directed, self-aware and self-critical, and able to question authority). It is also preferable if supervisors are functioning to a significant degree at this level in order to model and support others to progress in this direction. Some agency leaders demonstrated characteristics of a "self-transforming mindset" (i.e. able to create new concepts, thinks systemically, can change own beliefs, highly self-aware, comfortable with ambiguity, and comfortable leading others with sensitivity).

Workers in CARE agencies often report that things are more calm and peaceful in the cottages, there is less fear, there are fewer confrontations and power struggles, and fewer restraints (in one case none). Many workers report they are happier and feel more satisfaction in their work.

*Anglin, J.P., Translating Cornell CARE Program Model into Practice, July 2011*

**Implications**

CARE engages in challenging and transforming mindsets and, therefore, challenging the identity and sense of self of many of the participants. Understanding the current mindsets of staff can assist in the provision of individualized training (support for development) and supervision, and help with the selection of staff for supervisory and leadership roles and responsibilities.

This initial analysis of the CARE implementation process suggests that consideration should be given to further developing the adult learning components of CARE in line with new theories and understandings about how adults can increase their mental complexity (i.e. change their mindsets).

In addition, each of the six CARE principles has extensive literature that can be drawn upon even more deeply as a useful resource for staff and agency development. It would appear that the CARE learning process is ongoing, ever deepening, and never-ending.

**References**

Anglin, J. P. (2002). *Pain, normality and the struggle for congruence: Reinterpreting residential care for children and youth.* Binghamton, NY: Haworth Press Inc.

Glaser, B. (1978). *Theoretical sensitivity.* Mill Valley, CA: Sociology Press.

Glaser, B. (1992). *Basics of grounded theory analysis.* Mill Valley, CA: Sociology Press.

Glaser, B. (Ed.). (1993). *Examples of grounded theory: A reader.* Mill Valley, CA: Sociology Press.

Glaser, B. (Ed.). (1994). *More grounded theory methodology: A reader.* Mill Valley, CA: Sociology Press.

Kegan. R. & Lahey, L.L. (2009) *Immunity to change: How to overcome it and unlock the potential in yourself and your organization.* Boston: Harvard Business Press.

# Implementing CARE in Your Agency

## Technical Assistance Offered

The CARE implementation strategy is designed in concert with key agency personnel. This process begins with the formation of a CARE implementation team, responsible for the coordination and monitoring of CARE activities, made up of key leadership and a cross section of agency  personnel. The following shows the range of activities that might take place through quarterly visits throughout the life of the project:

1.  Identify a core group of leaders including a cross section of agency staff members to serve as the CARE implementation team.

2.  Perform an organizational assessment including assessment of culture/climate, current practice, and program.

3.  Train staff in the CARE principles and develop agency CARE trainers in order to maintain a competent and skilled workforce.

4.  Train agency supervisors in activities that provide support and accountability for the use of CARE principles.

5.  Provide technical assistance to agency leadership in collaborative management strategies to support CARE practices and to ensure long-term maintenance and sustainability.

6.  Provide technical assistance to agency personnel in data informed decision-making to support CARE practices and to ensure positive child outcome.

7.  Provide technical assistance to support, enhance, and maintain the use of CARE principles in daily activities throughout the organization, i.e. observations, implementation team meetings, case reviews, in-service training.

## Sample Proposal/Scope of Work Agreement

The following pages contain a sample proposal/scope of work agreement for organizations interested in adopting CARE. If there are several organizations interested in adopting the program, the RCCP will discuss a system-wide implementation and evaluation proposal.  If the organization does not have an effective crisis prevention and management system in place, a combination Therapeutic Crisis Intervention (TCI) and CARE implementation project can be developed.

# Sample CARE Proposal

## Overview

Cornell University's Residential Child Care Project proposes to work with agency in order to implement and integrate Children And Residential Experiences (CARE): Creating Conditions for Change practice model throughout the organization. This residential care practice model will enable the agency to organize and deliver quality services to children and families according to evidence-based principles based on the best interest of the child. The CARE model focuses on professional interactions and decision-making to provide for children's safety, permanency, and well-being. Cornell University is committed to assist agencies to design and support congruent organizational climates and cultures that support these principles and their implementation into professional practice and decision-making. This partnership with Cornell University would extend over a three-year period at a cost of USD $105,000 (2017 fee schedule). If the TCI system is included in the proposal, the agreement is extended to four years at a cost of USD $146,000(2017 fee schedule). For countries outside of the US, costs will vary for both the CARE and the TCI/CARE implementation projects.

## Background

The CARE practice model is founded on six research and standards-informed principles designed to guide residential child care staff's practice and interactions with children and families in order to create the **conditions for positive change** in children's lives. The research-informed principles support care and treatment that is developmentally focused, family involved, relationship based, competency centered, trauma informed and ecologically oriented. These best practices principles are grounded in theory, in evidence-based practices, in practice wisdom, and in quality child care standards. The principles were established after literature reviews, surveys of experienced caregivers, supervisors, and leadership and standards reviews.

## Project Activities

The CARE integration and implementation strategy is designed in concert with key agency personnel. This process begins with the formation of a CARE implementation team responsible for the coordination and monitoring of CARE activities made up of key leadership and a cross section of agency personnel. The following are the range of activities that might take place through regularly scheduled visits (approximately 28-30 days on-site) throughout the life of the project as designed by the project implementation team:

1. Perform an organizational assessment including assessment of culture/climate, current practice, and program.

2. Conduct a CARE Leadership Retreat for a cross section of the organization including leadership and potential CARE implementation team members and CARE trainers.

3. Identify a core group of agency leaders and staff to serve as the CARE implementation team.

4. Develop CARE trainers within the organizations to provide CARE training to all agency personnel.

5. Train agency supervisors in activities that provide support and accountability for the use of CARE principles.

6. Provide technical assistance to agency leadership to support CARE practices and to ensure long-term maintenance and sustainability.

7. Provide technical assistance to support, enhance, and maintain the use of CARE principles in daily activities throughout the organization, i.e. observations, implementation team meetings, case reviews, focus groups, in-service workshops, activity planning.

8. Work with agency personnel to develop the capacity to collect, analyze, and use data to inform decisions regarding programming, training, and daily interactions with children, families, and staff.

## Project Outcomes

1. All personnel trained in the CARE principles with support will integrate those principles into their practice at the appropriate level.

2. Staff knowledge of CARE principles will increase as measured through knowledge based testing.

3. Staff will increase the use of the CARE principles in their practice. (Measured through current practice surveys, observation, and supervision).

4. Organizational climate will be positively influenced as evidenced in the climate survey.

5. Children and young people will have improved perceptions of staff and staff behavior.

6. Numbers of incidents such as aggressive behavior, fighting, running away, property damage will be reduced as evidenced in agency's documentation and data collection system.

7. Training capacity to continue training staff in the CARE practice model will be developed.

8. A data collection system that allows staff to use data to inform decision-making throughout the organization will be established.

**Project Time Table** *(may vary according to the size and needs of the organization)*

### First Quarter

- Conduct start up meeting and begin base line data collection
- Conduct organizational assessment (including the University of Tennessee's OSC Culture/Climate Survey to be completed by 100% of agency personnel)
- Schedule Leadership Retreat for key leadership/supervisory/potential training staff

### Second Quarter

- Conduct four-day Leadership Retreat and review survey results and develop an initial implementation plan
- Schedule next training delivery (either training of trainers or co-training opportunity)
- Set up data collection and monitoring system for evaluation and feedback on CARE integration

### Third Quarter

- Meet with implementation team to review progress
- Conduct training of trainers or co-train the CARE principles to agency staff with designated agency CARE trainer(s) and conduct testing/evaluation
- Plan for roll out of training to all staff

### Fourth Quarter

- Meet with implementation team to review training results and integration of CARE principles throughout organization
- Provide workshops/training sessions (supervisor workshops) if indicated by on-going assessment of progress toward implementation/integration of CARE principles
- Provide support to agency CARE trainers as they train all agency staff
- Provide technical assistance through observing program activities, interactions, group dynamics, and/or meetings
- Monitor data collection and analysis for targeting technical assistance

Sample CARE Proposal | 3

**Fifth Quarter**

- Meet with implementation team to review integration of CARE principles throughout organization
- Provide workshops/training sessions if indicated by on-going assessment of progress toward implementation/integration of CARE principles
- Provide technical assistance through observing program activities, interactions, group dynamics, and/or meetings
- Monitor data collection and analysis for targeting technical assistance

**Sixth to Eighth Quarter**

- Meet with implementation team to review integration of CARE principles throughout organization
- Conduct mid-term leadership retreat to review progress and adjust implementation plan
- Plan for mid-term survey data collection and mid-term leadership retreat to review progress and adjust implementation plan
- Provide technical assistance through observing program activities, interactions, group dynamics, and/or meetings
- Monitor data collection and analysis for targeting technical assistance

**Ninth to Eleventh Quarter**

- Meet with implementation team to plan for sustaining and maintaining the CARE model
- Provide workshops/training sessions if indicated by on-going assessment of progress toward implementation/integration of CARE principles
- Provide technical assistance through observing program activities, interactions, group dynamics, and/or meetings
- Monitor data collection and analysis for targeting technical assistance

**Final Quarter**

- Conduct post implementation surveys, testing, (i.e. the University of Tennessee OSC instrument and the relevant agency outcome instruments) to assess progress toward achieving goals on implementation plan
- Conduct a CARE review to assess level of CARE implementation/integration throughout the organization
- Meet with implementation team and leadership group to develop the sustainability and fidelity plan for CARE and provide results of post implementation surveys, testing, and CARE review

*Sample CARE Proposal | 4*

## Cost of Project and Payment Schedule

The cost of the CARE Implementation Project is $105,000 or the CARE/TCI Implementation Project is $146,000(2017 fee schedule). USD to be paid in quarterly payments over the three or four-year period. This cost includes the technical assistance and training services provided by Cornell University faculty and staff, travel costs incurred by Cornell University faculty and staff,  training materials for training delivered by Cornell faculty, and survey materials and analysis. The schedule of payments can be adjusted if necessary. Payment is due upon receipt of the invoice.

# Bibliography

Alwon, F. (2000). *Effective supervisory practice.* Washington, D.C.: Child Welfare League of America, Inc.

Anglin, J.P. (2002). *Pain, normality, and the struggle for congruence: Reinterpreting residential care for children and youth.* Binghamton, NY: Haworth Press.

Anglin, J.P. (2012). *The process of implementation of the care program model.* Paper presented at the EUSARF / CELCIS Looking After Children Conference, Glasgow, Scotland. September 6, 2012.

Anglin, J. (2011). *Translating the Cornell CARE program model into practice: From the pioneer agencies on changing agency cultures and care practice.* (unpublished paper)

Barth, R.P. (2005). Residential care: From here to eternity. *International Journal of Social Work*, 14, 158-162.

Barth, R.P., Greeson, J.K.P., Guo, S., Green, R.L., Hurley, S., & Sisson, J. (2007). Outcomes for youth receiving intensive in-home therapy or residential care: A comparison using propensity scores. *American Journal of Orthopsychiatry,* 77(4), 497-505.

Bloom, S. (1997). *Creating sanctuary: Toward the evolution of sane societies.* London: Routledge.

Detoni, A.F., & Comello, L. (2010). *Journey into complexity* (A. L. Naia, Trans.). Lexington, KY: Amazon.

Durant, M. (1993). *Residential treatment: A cooperative, competency-based approach to therapy and program design.* NY: W.W. Norton & Company, Inc.

Fixen, D., Naoom, S., Blase, K., Friedman, R., & Wallace, F. (2005). *Implementation research: A synthesis of the literature.* Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Glisson, C., & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse & Neglect: An International Journal,* 22(5), 401-421.

Goleman, D. (1998). *Working with emotional intelligence.* New York: Bantam

Hawkins-Rodgers, Y. (2007). Adolescents adjusting to a group home environment: A residential care model of re-organizing attachment behavior and building resiliency. *Children and Youth Services Review,* 29, 1121-1141.

Holden, M.J. (2009). *Children And Residential Experiences: Creating conditions for change.* Arlington, VA: CWLA.

Holden, M.J., Anglin, J., Nunno, M., & Izzo, C. (2014). Engaging the total therapeutic residential care program in a process of quality improvement: Learning from the CARE model. In J. Whittaker, F. del Valle, & l. Holmes (Eds.), *Therapeutic residential care for children and youth: Developing evidence-based international practice.* London, UK: Jessica Kingsley Publishers.

Holden, M.J., Izzo, C., Nunno, M., Smith, E.G., Endres, T., Holden, J.C., & Kuhn, I.F. (2010). Children and residential experiences: A comprehensive strategy

for implementing a research-informed program model for residential care. *Child Welfare,* 89(2), 131-149.

Izzo, C., Anglin, J., & Holden, M. (2012). *Assessing organizational change: Preliminary findings from a multi-method and multi-site evaluation of the care program model.* Paper presented at the EUSARF / CELCIS Looking After Children conference, Glasgow, Scotland. September 6, 2012.

James, S. (2011). What works in group care? – A structured review of treatment models for group homes and residential care. *Children and Youth Services Review,* 33(2), 308-321. doi: doi:10.1016/j.childyouth.2010.09.014

Kahn, W.A. (2005). *Holding fast: The struggle to create resilient caregiving organizations.* London: Brunner-Routledge.

Kotter, J. (1995). Leading change: Why transformation efforts fail. *Harvard Business Review*, January 2007 hbr.org.

Lee, B.R., & Barth, R.P. (2011). Defining group care programs: An index of reporting standards. *Child Youth Care Forum,* 40, 253-266.

Li, J., & Julian, M.M., (2012). Developmental relationships as the active ingredient: A unifying working hypothesis of "what works" across intervention settings. *American Journal of Orthopsychiatry,* 82(2), 157-166.

Maier, H. (1987). *Developmental group care of children and youth.* New York: Haworth Press.

Maier, H. (1991). Developmental foundations of youth care work. In J. Beker & Z. Eisikovits (Eds.), *Knowledge utilization in residential child and youth care practice* (pp. 25-48). Washington, D.C.: Child Welfare League of America.

Masten, A. (2004). Regulatory processes, risk, and resilience in adolescent development. *Annals of the New York Academy of Sciences,* 1021, 310–319.

Mohr, W.K., Martin, A., Olson, J.N., Pumariega, A.J., & Branca, N. (2009). Beyond point and level systems: Moving toward child-centered programming. *American Journal of Orthopsychiatry,* 79(1), 8-18. doi: 10.1037/a0015375

Monahan, K.C., Goldweber, A., & Cauffman, E. (2011). The effects of visitation on incarcerated juvenile offenders: How contact with the outside impacts adjustment on the inside. *Law and Human Behavior,* 35, 143-151. doi: 10.1007/s10979-010-9220-x

Phelan, J. (2008). Building developmental capacities: A developmentally responsive approach to child and youth care intervention. In G. Bellefeuille & F. Ricks (Eds.), *Standing on the precipice: Inquiry into the creative potential of child and youth care practice* (pp. 73-106). MacEwan Press: Edmonton.

Schon, D. (1983). *The reflective practitioner: How professionals think in action.* New York: Basic Books.

Schon, D. (1987). *Educating the reflective practitioner: Toward a new design for teaching and learning in the professions.* San Francisco: Jossey-Bass.

Shaffer, A., Egeland, B., & Wang, K. (2010). Risk and resilience among children referred to protective services: A longitudinal investigation of child well-being in multiple domains. In M. B. Webb, K. Dowd, B. J. Harden, J. Landsverk & M. Testa (Eds.), *Child welfare and child well-being: New perspectives from the national survey of child and adolescent well-being* (pp. 83-106). Oxford, U.K.: Oxford University Press.

Smith, M. (2003, 2009). *Communities of practice,  the encyclopedia of informal education*, www.infed.org/biblio/communities_of_practice.htm.

Vygotsky, L. (1978). *Mind and society: The development of higher mental processes.* Cambridge, MA: Harvard University Press.

# RCCP Faculty, Instructors, and Staff

## Extension/CARE Facilitation Team

**Martha J. Holden, M.S.,** is a Senior Extension Associate with the BCTR, principal investigator and Director of the RCCP. Ms. Holden provides technical assistance and training to residential child caring agencies, schools, juvenile justice programs, and child welfare organizations throughout the United States, Canada, the United Kingdom, Ireland, Australia, and Israel. She is the author of *Children and Residential Experiences (CARE): Creating Conditions for Change*, a best practice model for residential care organizations. Ms. Holden has published in the *Children's and Youth Services Review, Child Abuse and Neglect: An International Journal, Journal of Emotional and Behavioral Problems, Residential Treatment for Children & Youth,* and the *Journal of Child And Youth Care Work.* She has co-authored chapters in the books, *Therapeutic residential care for children and youth: Developing evidence-based international practice; For Your Own Safety: Examining the Safety of High Risk Interventions for Children and Young People; International Perspectives on Inclusive Education, Volume 2, Transforming Troubled Lives: Strategies and Interventions with Children and Young People with Social, Emotional,* and *Behavioural Difficulties; Understanding Abusive Families: An ecological approach to theory and practice.* Previously Ms. Holden served as an administrator overseeing the day-to-day operations of a residential treatment agency for adolescents, including its education resources.

**Thomas J. Endres, M.A.,** is an extension associate with the BCTR. Mr. Endres has extensive experience working in residential and group care settings. He has held multiple positions including residential supervisor, clinician, program management and development. Mr. Endres provides training and technical assistance to agencies implementing CARE and TCI across North America.

**Franklin Kuhn, Jr., Ph.D.,** is a Senior Extension Associate with the BCTR. A clinical psychologist, Frank has worked in clinical, educational and administrative positions with child welfare organizations and universities for over 35 years. He has served as medical school faculty and has provided consultation and training to agencies across the U.S. Dr. Kuhn provides training and technical assistance to agencies implementing CARE and TCI throughout North America. He currently serves on the editorial board of the *International Journal of Child, Youth and Family Services.* Research interests include implementation and evaluation of program models in human service organizations and facilitation of positive organizational change.

**Andrea Turnbull, M.A., LMHC, QS,** is an extension associate with over 20 years experience working with young people in residential and foster care settings. She has held positions such as direct care worker, milieu coordinator, program director, training director and clinical coordinator. In addition to her work as a TCI instructor providing training and technical assistance for the Residential Child Care Project, she also helps coordinate the TCI program.

**Gregory B. Wise, M.A., i**s an extension associate with the BCTR. Mr. Wise has extensive experience working with mentally ill, developmentally disabled and emotionally disturbed populations. He has held positions as director, program director and residential supervisor. Mr. Wise provides training to residential child care agencies, schools, juvenile justice programs and child welfare organizations for the RCCP.

**Eugene Saville, A.As.,** is the administrative assistant for the Residential Child Care Project. He is responsible for scheduling training programs, handling registration, and coordinating materials for all of the RCCP training programs. In addition, he oversees the web site and provides information and assistance to the public in regard to the many programs of the RCCP.

**Alissa Medero** helps coordinate National and NYS TCI trainings as well as being one of the primary contacts for information regarding training information/location for our NYS and National TCI programs. She handles the training registrations for TCI at the RCCP. She sends out confirmation letters, training materials and corresponds with participants to ensure a productive training for all.

**Debra Mojica** works for the RCCP in administrative services. She assists the RCCP by setting up hotel contracts for New York State and national trainings, arranging media services, organizing logistical arrangements, entering pertinent information into a data base, and mailing confirmation letters and training materials.

## Research and Evaluation Team

**Michael Nunno,** D.S.W., is a Senior Extension Associate with the Bronfenbrenner Center for Translational Research (BCTR), and the co-principal investigator of the RCCP.  He has expertise in social policy, regulation, and legislation related child welfare issues as well as specific expertise in the identification, prevention, and etiology of child abuse and neglect in residential care.  More recently Dr. Nunno has been working with therapeutic and residential child-care organizations to measure the impact of Cornell University's Therapeutic Crisis Intervention system and its Children and Residential Experiences program model on critical incidents.  Dr. Nunno has published in the *Child Protective Services Team Handbook,* as well as in *Children and Youth Services Review; Child and Youth Care Forum; Child Welfare; Child Abuse and Neglect: An International Journal; Children and Society; Protecting Children; The American Journal of Orthopsychiatry; Psychiatric Services* and the *Journal of Child and Family Studies.* He was editor of the *Journal of Child and Youth Care's* dedicated issue on institutional maltreatment and co-editor of the book, *For Your Own Safety: Examining the Safety of High-Risk Interventions for Children and Young People.*

**Charles Izzo, Ph.D.,** studied Clinical Psychology with a specialty in the design and evaluation of community-based services to improve family functioning.  His work has focused on applying social science research and methods to improve the quality of human service programs, particularly those that target caregiving.  He has published in journals such as *Prevention Science,*

*International Journal of Child and Family Welfare,* and the *Journal of Prevention and Intervention in the Community.*

**Elliott G. Smith, Ph.D.,** is the Associate Director of the National Data Archive on Child Abuse and Neglect where he oversees archiving, licensing, and dissemination for several major child welfare data collection efforts. He provides expertise in research design, data management, and statistical analysis in his role as a Research Associate at the Bronfenbrenner Center for Translational Research. Currently, Dr. Smith serves as the statistician for the evaluation of Children and Residential Experiences (CARE), a practice model for residential care programs. His research has appeared in numerous journals, including *Pediatrics, the Journal of the American Medical Association, Developmental Psychology, Prevention Science, Children and Youth Services Review,* and *Development and Psychopathology.*

**Lisa McCabe, Ph.D.,** is a Research Associate in the Bronfenbrenner Center for Translational Research and Director of the Cornell Early Childhood Program at Cornell University. Her research focuses broadly on early childhood education and care issues. Current and recent projects have examined supports for professional development, program fidelity, and quality in a variety of settings including residential child care programs, family child care homes, and child care centers.

**Deborah E. Sellers, Ph.D.,** is the Director of Research and Evaluation for the BCTR. She is a sociologist specializing in quantitative research methods who received her PhD from the University of Massachusetts-Amherst and

a MS in biostatistics from the Harvard School of Public Health. Before coming to the BCTR Debbie was the Principal Research Scientist and Director of Research and Development at the Center of Applied Ethics, Division of Health and Human Development at the Education Development Center in Waltham MA. where she served as project director on five multi-year, multi-component research projects (e.g. Goff, Sellers, et al, 1998; Dawson, Sellers et al, 2005; Solomon, Sellers et al, 2005; Sawicki, Sellers, & Robinson, 2008; Sellers et al, in press).

**Cathy Norton-Barker, BA,** is a former doctoral student in Clinical Psychology. She served as a cottage director at a residential agency for two years where she provided individual, group and family therapy, conducted assessments, prepared treatment plans, represented the agency in family court and worked to establish a therapeutic milieu for the ten teenage residents under her care. She came to Cornell University in 2005 to join an educational outreach program for youth using interactive virtual worlds to promote school engagement. Cathy managed the program, supervised a team of 20 college student mentors, worked in schools, provided teacher training, grew an online community and conducted program evaluation and research. She continued that work for six years before coming the RCCP as a Research Support Specialist in 2011.

**Kristen Carlison** supports the data management needs of the RCCP. Within these duties she manages the data needs of TCI's certification and testing system, she manages and oversees both the TCI and CARE databases, as well as TCI and CARE implementation projects. She also has

responsibilities for the project's quarterly reports, budget proposals, and proposal development.

**Trudy Radcliffe, B.A.,** is the primary contact person for CARE, a program model for residential services. She coordinates CARE training, registration, evaluation, certification and logistics. She also coordinates TCI-SAFE and other research initiatives. She has worked in the human service field for 25+ years. Before joining the RCCP she worked with children, families and educators in the early education field teaching, mentoring, and consulting. She has presented at state and national conferences on her work with program and curriculum development.

**Holly Smith** handles the processing of testing and evaluation materials for the RCCP training. Her responsibilities include scanning and grading testing materials, e-mailing individual's test results, preparing certification letters to be mailed, emailing participants Reminder and Expiration emails and maintaining the database. She also prepares the quarterly reports for New York State, National and International.

## RCCP Field Instructors and Consultants

**Craig Bailey, B.S.,** has worked with youth in residential care and school settings since 1996. He has served youth and families through Hillside Children's Center, Monroe 2-Orleans BOCES, and Crestwood Children's Center. Craig is currently a Manager in Organizational Development and Learning with Hillside Family of Agencies, located in Rochester, NY. He is a primary TCI trainer for new employees and helps coordinate the implementation of the TCI system throughout all of the service affiliates of Hillside Family of Agencies. Craig has worked as a consultant with the Residential Child Care Project since 2007 and facilitates TCI Train-the-Trainer and TCI Trainer Updates in the United States and internationally.

**Diana Boswell Ph.D.,** is the Director of Therapeutic Welfare Interventions in Canberra, Australia. She trained as a clinical child and adolescent psychologist and has worked in forensic, mental health, education and out-of-home care services as a clinician, program manager and agency director. She has a particular interest in children with autism spectrum disorders, trauma, and problematic sexualised behaviours. She also has an interest in program development and has worked with Cornell in implementing the CARE model in Australian agencies, and in offering the TCI Train-the-trainer program across the country.

**Vicki Brown BA, Dip. Ed.** worked as a secondary school teacher for many years before moving into the non-profit sector as Executive Officer for a personal development organisation, project manager for The

Multiple Sclerosis Society, Office Manager for a family welfare organisation and, currently, for Therapeutic Welfare Interventions, the organisation which oversees TCI training in Australia.

**Sharon Butcher, M.A.,** is the Director of Education at the Waterford Country School, a non-profit human service agency located in southeastern Connecticut. Her professional career began as a childcare worker in the residential treatment program at WCS before becoming a Special Education Teacher and advancing into her current role. In addition to being a TCI trainer for her agency Sharon is also a CARE trainer and is deeply devoted to the sustainability of the CARE model in the school.

**John Gibson, M.S.W., MSSc, CQSW,** is owner of Secure Attachment Matters – Ireland. He is qualified in Social Work and has worked in 4 different residential child care settings for a total of 21 years. He consults to residential child care organizations, principally in relation to development of models of care. He provides direct support to high risk foster placements, working systemically with all significant parties. He was among the first workers to train in TCI in Ireland and Britain. He joined RCCP as in Instructor in 2001. He holds post graduate qualifications in Social Learning Theory (Child Care) and in Social Work Management and Leadership. He is trained in the Child Attachment Interview at the Anna Freud Centre (London).

**Richard Heresniak** has worked in the field of residential care since 1985, beginning his career at Astor Services for Children and Families – an agency at which he remains employed on a part time basis. His primary

responsibilities at Astor are training, staff development, and providing support to Astor's school and residential programs. Richard was Cornell's first professionally certified TCI trainer, and in addition to his work at Astor, has been a consultant with the Residential Child Care Project since 2003. He provides training and technical assistance in TCI, TCIS, and CARE. His work with the project also includes curriculum design and development, as well as providing written contributions to project communications.

**Jack C. Holden, Ph.D.,** has been an instructor and project consultant with Cornell University's RCCP for nearly 30 years. Dr. Holden earned a Ph.D. in Education, specializing in Adult Learning and has presented workshops and research nationally and internationally and has authored, *Developing Competent Crisis Intervention Training,* and co-authored a chapter, *Preventive Responses to Disruptive and High-Risk Behaviours,* in the book *International Perspectives on Inclusive Education.* Dr. Holden has co-authored several training manuals including *Thereapeutic Crisis Intervention for Schools, (TCIS)* and published in the *Journal of Child and Youth Care Work,* and *Journal of National Staff Development and Training Association.*

**Beth Laddin, L.M.S.W.,** works as a school social worker in Albany, NY. Previously, Ms. Laddin worked for the BCTR at Cornell as a Program Manager and as a Field Instructor. As a Field Instructor, Ms. Laddin trained child service providers in the TCI program. Other child welfare experience includes positions in Child Protective Services, Residential Facilities, administrative state positions, Facility Quality Assurance work, and program development.

**William Martin, MHSA,** has been working with children and families with special needs for over 30 years. He is the Executive Director of Waterford Country School, a non profit human service agency providing a multitude of services including residential treatment, emergency shelters, safe homes, group homes, foster care, education, and in-home services. Bill is also a CARE and TCI instructor and he and the staff of Waterford Country School are deeply involved in, and committed to TCI, TCIF, TCIS and the CARE and CARE for Foster Carers program models. Bill has a Master's degree in Human Service Administration and a Bachelors Degree in Social Work.

**Eddie Mendez** has worked with children and young people in a variety of settings including custody, Residential programs and Foster Care for more than 25 years. Nearly all of this work has been in Western Sydney, Australia. Eddie has for several years also been involved in the facilitation and development of training workshops. Eddie has been involved with the TCI program since 2000-2001. In addition to his long engagement with the welfare sector Eddie is also a foster carer.

**Marty Mineroff, M.S.,** has an extensive background in education. He retired from the New York City Department of Education in June 2008, after 29 years working with special needs students in Brooklyn, NY. He began his career as a special education teacher, became a unit coordinator, an assistant principal, and finally spent 14 years as principal of a special education school. His school in Brooklyn, NY, provided educational services for 300 students in three community schools, grades K-8. Marty became a certified TCI Instructor in May 2009 and is assisting the RCCP in implementing TCI in schools as well as training TCI.

**Andrea Mooney, M.Ed., JD,** is an original author of TCI and has been involved with the program since its inception. She has been a Special Education teacher, a law guardian, and a consultant. She is now a clinical professor at the Cornell University Law School and an attorney/trainer in private practice, specializing in child advocacy and family law.

**Nick Pidgeon, BSc,** is Director of NJP Consultancy and Training Ltd. based in Bridge of Allan, Scotland. He has many years experience in social work and over 15 years experience as an independent consultant. He has provided training and consultancy throughout Britain and Ireland and in the USA, Canada, Australia, and Russia. Since 1993 he has been a consultant to the RCCP.

**Michele A. Pierro, M.S.,** holds and M.S. in Educational Psychology, Secondary Education, and certificate of Advanced Studies in Educational Administration. For the past 40 years Michele has worked in Middle and High schools, programs for Gifted and Talented and in a maximum security facility for juvenile offenders. Ms. Pierro developed and taught a county jail youth program, and several Interdisciplinary Arts in Education Programs. She has been a faculty member at Columbia Greene Community College, a Principal and Director of Special Education at the Questar III BOCES in Castleton, NY, Director of School Safety and Positive Behavior Supports in D75 in NYC and Director of Security Resources for the NYCDOE, providing technical assistance to schools on the NYS Persistently Dangerous List. She joined the RCCP in August, 2012.

**Mary Ruberti, LMSW,** is currently the Quality Assurance/Performance Improvement Manager at the Villa of Hope in Rochester, NY. Ms. Ruberti has worked in child welfare and residential treatment for over 25 years in various positions including child care worker, residential supervisor, social worker and training coordinator. Ms. Ruberti has been a project consultant with the Residential Child Care Project at Cornell University since 1993. She has had the privilege of providing training and technical assistance for the Therapeutic Crisis Intervention (TCI) and Children and Residential Experiences (CARE) projects. She loves every minute of the work and is looking forward to another 25 years…

**Zelma Smith, LMSW,** Child Welfare Consultant and Trainer, has over 40 years of experience in the field of child welfare including training, consultation, curriculum development, supervision, and direct service delivery. Her work experience includes training in kinship care, recruitment, preparation and selection of foster and adoptive parents, residential treatment programs, child abuse and neglect and meeting planning. Formerly, she was chairperson for the National Association of Black Social Workers' National Kinship Task Force Committee and a current member of the National Kinship Advisory Committee at the Child Welfare League of America. She is a TCI and CARE instructor on the Residential Child Care Project.

**Angela Stanton-Greenwood, MA, MEd, CQSW,** has worked with individuals with complex needs for over thirty years as a practitioner with Barnardos in residential care and education and now as a Workforce Development Manager in the Hesley Group England. She is a TCI and Proact SCIP R uk instructor. Ms. Stanton-Greenwood coordinates the TCI program in Europe.

**Laurence Stanton-Greenwood, BA hons in Education and Training,** Qualified Social Worker with Qualified Teacher status has worked with a population of people with complex needs both in Social Care and Education for 34 years as a practitioner and manager. He now works as a training manager for the Hesley Group, England, coordinating and delivering a range of training programmes including TCI. He became a TCI Instructor in 2012.

**Raymond Taylor, Msc.** ,is a registered social worker and senior social work manager with one of Scotland's largest local authorities and a Visiting Senior Research Fellow at the University of Strathclyde's Glasgow School of Social Work. He has extensive experience in social work practice, education, research, and training and is the editor and joint author of a number of books and articles on children's welfare. A member of the International Advisory Board of the Encyclopedia of Social Work, and the editorial board of the Scottish Journal of Residential Child Care , he has been a TCI consultant since the introduction of TCI into Britain and the Republic of Ireland in 1992.

**Michael E. Thomas, II, M.Div.,** is a freelance organizational training consultant instructing TCI for the BCTR, on faculty with The Sanctuary Institute, and Senior Facilitator for The Energy Project. Throughout his 15 years in residential treatment services, Michael worked as a teacher/counselor, child behavior specialist, program manager, group facilitator, and training director. Publications include

contributions in Therapeutic Communities and a textbook article in Danish professional development book, *Engelsk: Paedogogisk Assistant, "Caring for Children with Special Needs,"* edited by Anne Brunstrom.

**Barbara Wells** is Principal of Wells Communications Consulting, a graphic design firm located in Ithaca, NY. Barbara has worked with the RCCP, designing materials for print and web distribution since the early 1980s. Wells Communications Consulting work was selected by Graphis Press, NY, NY, for publication in *Branding USA*, 2011 & 2009, and was one of 50 US graphic design firms showcased in *DesignersUSA3*.