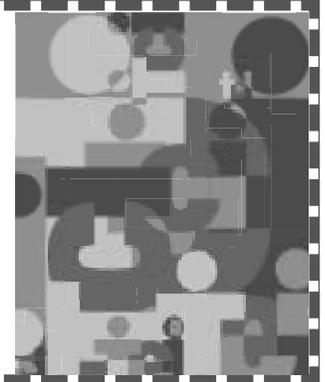


# REFOCUS

CORNELL UNIVERSITY'S RESIDENTIAL CHILD CARE PROJECT NEWSLETTER • VOL. 9, 2004

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## A System—Wide Approach to Reducing Incidents of Restraint

by Brian Farragher, CSW

In October of 1998 the *Hartford Courant* (Altemari et al., 1998) ran a 5-part series on deaths and injuries caused by the use of restraint. The authors indicated that research had substantiated 142 people had been killed in inpatient settings in the previous 10 years due to the use of restraints. The *Courant* report received national attention and suggested that people with mental illness and developmental disabilities are quite vulnerable, and are often subjected to treatment which is contraindicated and, at its worst, abusive and even criminal.

Unfortunately the legislative and regulatory backlash to these concerns have painted the issue of restraint with a rather broad brush, and suggest that restraint is inherently wrong, violates patient's rights, and subjects patients to the whim of poorly trained, sadistic staff. Like most legislation, which attempts to regulate an industry, it is conceptualized and written by people who do not appreciate the nuance of the industry that they seek to regulate and has many agencies struggling with what they will need to do to comply with new standards, and questioning whether they will be able to comply at all. I believe we need to take a more rational approach to

this issue. Good agencies should welcome the opportunity to grapple with this issue, and treat the proposed changes as an opportunity to improve services to our customers.

The reality is that restraint is not a desirable intervention. Although it is sometimes necessary when dealing with troubled children, quite honestly it is overused and fraught with problems. As an industry, we have not done enough to regulate our own performance in this area. Our lack of attention to this issue has, at least in part, created the current climate on the issue of restraint. Although fatalities resulting from the use of restraints are getting most of the airtime, these are still uncommon occurrences. The strong emphasis on fatalities, however, obscures the more common threats posed by the use of restraints. Confronting issues such as staff counter-aggression and its consequences, staff and child injuries, staff morale, and program gaps and weaknesses will help to prevent major tragedies while significantly improving overall program performance.

Of the 142 people who died in incidents related to restraint use, as reported by the *Hartford Courant*, 26% were children. Children, however, represent less

than 15% of the inpatient population. Numerous studies have suggested that children are much more likely to be subject to restraint than adults. Some studies have suggested children are up to four times more likely to be restrained than adults (Altemari, et al., 1998). One has to wonder whether these trends can be written off and attributed to children's difficulty with impulse control or authority problems. While children's issues and symptomatology tell part of the story, staff attitudes about children, and the counter-aggressive impulses and behavior on the part of the staff, are a major contributing factor to the disproportionate number of restraints employed with children (Braxton, 1995). In general, children are easier to restrain because they are usually smaller and weaker than the adults who care for them. Furthermore, society suggests that adults have both the responsibility and the right to control children. While these factors do not validate counter-aggression they do support staff persons' counter-aggressive responses.

Restraints account for a high percentage of abuse allegations made against our agency staff. Because residents often misperceive staff people's intentions and actions during times of upset, and because residents can often sustain significant injuries during holds, abuse allegations are not uncommon. Such occurrences have the potential to damage staff morale and compromise an agency's reputation.

System-Wide Approach, Cont. from p. 1.

A 1994 New York State study indicated that 94% of residents restrained or placed in seclusion had at least one complaint about the process. Fifty percent complained of unnecessary force, 40% indicated the experience was psychologically abusive, and a majority experienced the use of restraint and seclusion as punishment (Altemari et al., 1998). Our agency's experience is that many of the complaints registered by parents, children, and referral sources grow out of incidents in which one or more of these constituents feels a resident has been treated roughly or with excessive force.

Added to this, one study indicated that there are 26 injuries for every 100 mental health workers. The overwhelming majority of injuries sustained by these workers occurred when they were managing violent and aggressive residents. Injury rates in inpatient settings outpace rates reported in the lumber, construction, and mining industries. Restraints often result in injuries to staff, resulting in lost productivity, lower morale, program disruptions, and increased costs. (Altemari et.al, 1998).

Finally, when we have to hold residents physically it is because our programs, our structure, and our milieu are failing to provide an adequate holding environment for children. Excessive use of restraint can flag deeper problems with our programs, regardless of the type of program we run or the population we serve. Watching these trends closely will prompt us to make program modifications to better meet the needs of children in care. (Curles, 1997)

Reducing incidents of restraint is a very desirable goal and will have an overall positive impact on the agency and its constituents. Residents feel safe and respected; staff feel safer and achieve greater job satisfaction; families become more trusting and supportive; and the agency as a whole is less vulnerable and more compassionate. Work to reduce incidents

of restraint may be prompted by the new legislation, but getting a handle on these issues is simply good business. Our efforts should grow out of a desire to render better service, rather than simply to conform to federal statutes.

**The Andrus Model**

The Andrus Children's Center operates a 70 bed residential treatment program and a day treatment program, which provides services to another 80 children. Our children range in age from 5 to 15 years of age; all are seriously emotionally disturbed. The agency employs Therapeutic Crisis Intervention, developed by the Cornell University Family Life Development Center, as the cornerstone of its behavior management practices. Andrus does not permit the use of mechanical restraints or seclusion (Budlong et al, 1993).

In 1994, although we did not feel we had a problem with the use of restraint, we were a growing agency and needed to increase the number of TCI Trainers we employed to meet the growing training need. We sent one of our young and talented child care workers for training and upon his return he convinced me, the Residential Director at that time, to attend the weeklong training for trainers. The

experience was an epiphany for me. I was struck by the strong emphasis on de-escalation techniques and the potential for staff counter-aggression when working with aggressive children (Budlong et al, 1993). The seeds that were to grow into our current model were planted that week.

The experience at Cornell helped me identify that we did have a problem. Our behavior management strategies were deficient, our staff training was inadequate, and our program did not consistently reflect the values and beliefs, which are prominently featured in our treatment philosophy. Our staff used holds far more frequently than necessary and many of the holds seemed to grow out of power

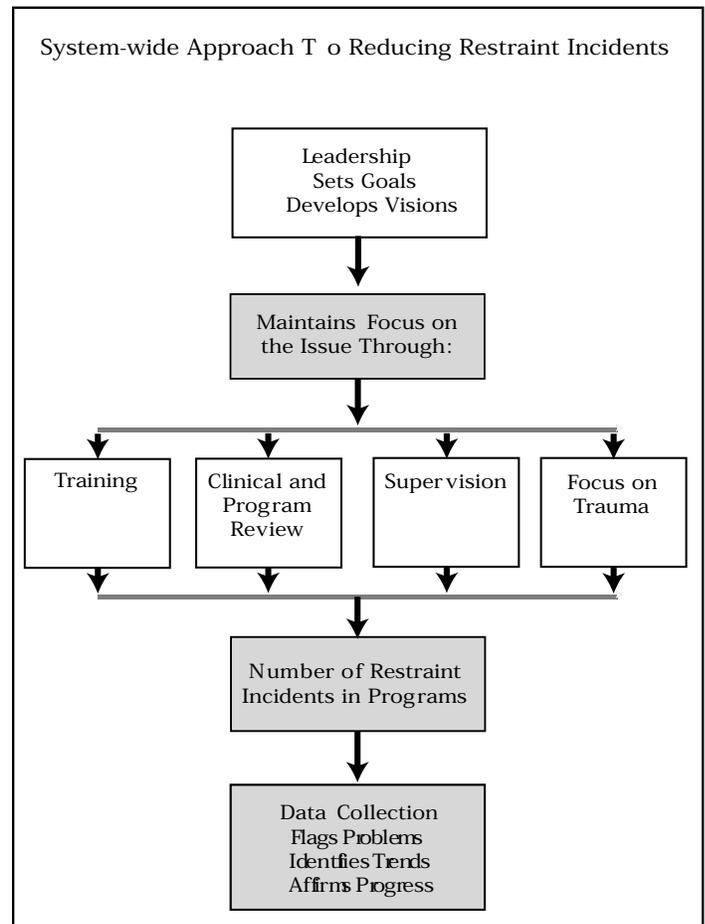


Figure 1.



struggles rather than acute physical behavior on the part of children.

Our initial efforts focused on improving staff training. I believe that training is the most effective way to make changes in staff attitudes and behavior and to improve program performance. Over time, however, it has become evident that training is not enough. Once our improvement efforts in this area plateaued, we realized there was much more that needed to be done to make significant and lasting inroads into the issue of restraint. Over the years our model, based on a Continuous Performance Improvement Model (JCAHO, 1997), has evolved to a point where we have a system that works and allows us to address the issue of restraint in a consistent and ongoing manner. We systematically gather data on restraints, then use this data to determine the scope of our problem and to plan our interventions. Program and process modifications are made which we believe will result in a reduction in restraints. We check that those modifications are being employed and continue to gather data, which lets us know whether or not these modifications are moving us in the right direction. We continually measure performance and refine our processes to achieve desired goals. Our ultimate goal is to create a zero restraint environment.

### It Starts With What You Believe

Whenever we attempt to make changes in our organization it is helpful to return to the treatment philosophy and ask ourselves what are our core values and beliefs about the work, and determine whether or not this change is consistent with those beliefs. We trust that doing this work will keep us on the right track. Our treatment philosophy is built on two core beliefs: a) we need to provide a safe environment for children and staff and b) our children must be treated with respect and dignity. Given that these values are the foundation on which our programs are

## Liabilities Involved in the Use of Physical Restraint

by Andrea J. Mooney,

In March of 1984, Randy DeShaney beat his four-year-old son Joshua so severely that Joshua fell into a life-threatening coma. In the two-year period prior to this, child protective workers from the Winnebago County Department of Social Services in Wisconsin had worked with Mr. DeShaney. Significantly, a child protective caseworker had visited the home regularly, noted a number of suspicious injuries and recorded her suspicions that someone in the DeShaney household was abusing Joshua. The caseworker did nothing to remove the child from the home. Joshua was subsequently placed in an institution for the profoundly retarded, and his father was convicted of child abuse.

When Joshua became disabled, his mother on his behalf sued the Department of Social Services (DSS), asserting that Joshua's constitutional rights had been violated. The Fourteenth Amendment to the Constitution provides that a state may not deprive an individual of life, liberty or property without due process of law. Over the course of two hundred years, American courts have determined that citizens have a "liberty interest" in being protected from harm imposed by the state.

The case went all the way to the Supreme Court. There, the Court addressed the question of whether the due process clause required the state to protect the liberty of its citizens against a private actor. It was undisputed that the actual harm had been done by Mr. DeShaney, not by any person acting for the state. However, Mrs. DeShaney's claim was that, by not interfering when they had evidence that the child was being harmed, the government (in the form of DSS) had deprived Joshua of his liberty without due process of law. She asserted that DSS knew or should have

known that Joshua was experiencing life-threatening violence, and that they should have intervened to protect Joshua.

The Court disagreed with Mrs. DeShaney. The Court emphasized that Joshua had been in his father's custody, not the state's, when he was harmed. Therefore, the state had not interfered with Joshua's liberty, even though DSS was aware of the situation in the DeShaney home.

This case has generated a great deal of commentary, many law review articles and much discussion. Many legal scholars have argued that Justice Brennan, who wrote the dissenting opinion, had the right approach. Justice Brennan argued that by setting up a child-protective system that established a child abuse reporting hotline and empowered DSS to remove children, the state was not only taking on responsibility for the welfare of abused children, it was effectively encouraging citizens who might otherwise have interfered, to step back and let the state take care of abused children.

What does all this have to do with TCI? As all TCI instructors have continuously articulated over the years: any time a staff member puts a hand on a child, even to conduct a proper physical restraint, the likelihood of injury increases. And where the likelihood of injury increases, so does the likelihood of liability. Liability is a loose term that can cover a lot of ground.

As DeShaney illustrates, the Supreme Court has declined, at least to date, to hold that a child's rights have been violated when a public actor fails to prevent a private actor from harming a child. But there are other areas of liability that may be relevant for an agency using TCI.

The Supreme Court looked at the question of liability for failure to train in the context of a case where a woman did not receive necessary medical attention while in police custody. The Court said that there would be liability only when the failure to train amounted to deliberate indifference to the rights of persons with whom the police



Liabilities, cont. from page 3.

came in contact. Similar extreme language in other cases seems to indicate that the actions of an agency or hospital in failing to train or supervise have to be egregious before the courts will find constitutional violations. A court refused to let a case go forward against a teacher and an aide who restrained a special education child in public school, stating that the standard is “whether the force applied...was so disproportionate to the need presented, and was so inspired by malice or sadism or unwise excess of zeal that it amounted to a brutal and inhumane abuse of official power literally shocking the conscience.”

However, there are a few reported cases where the courts have punished inappropriate restraint or declined to provide agencies with any immunity. In an Illinois case, a child was restrained for hours, resulting in death from positional asphyxia. The child’s parent sued and the defendants, the executive director and other employees of the facility, ironically tried to claim parental immunity. They based the claim on an earlier case that had applied this immunity to foster parents. The Supreme Court of Illinois said that the parental immunity doctrine did not apply to defendants who were exercising professional duties. The court was particularly interested in the fact that employees were replacing one another during a four-hour restraint. The court seemed to see this behavior as particularly non-parental.

In New York State, a plaintiff who was permanently mentally and physically injured after being restrained won a nine million dollar settlement against the state and against individual defendants who had participated in the restraint. The youth had been restrained twice, resulting in permanent mental and physical injuries. In the second restraint, the youth went limp after approximately ten minutes. In a chilling echo of reports provided in restraint fatalities across the United States, the youth

worker believed that the youth was feigning, and continued to restrain the youth for another twenty minutes. The court refused to provide absolute immunity to either the Commissioner of the Office of Children and Family Services, or the director of the facility. All the defendants ended up participating in a settlement after two years of litigation.

The moral of the story is that, while there is no clear picture of what liability a court might find if a child is injured during a restraint, if any, the court will look at training, supervision and the technique itself. Agencies would be wise to ascertain that they are providing the highest quality training in optimum conditions. 🍷

#### References

- DeShaney v. Winnebago County Department of Social Services, 489 U.S.189 (1989). See, for example, Mary Kate Kearney, DeShaney’s Legacy in Foster Care and Public School Settings, 41 Washburn L.J. 275 (2002). The author would like to thank Kathleen McNaught, of the American Bar Association’s Center on Children and the Law, for permission to use her research on failure to train/supervisory liability in this paper.
- Ohio v. Harris, 489 U.S. 378 (1989). See, for example, Dohlihte v. Videon 847 F. Supp.918 (MD Ala 1994), rev’d, 74 F.3d 1027 (11th Cir. 1996).
- Brown v. Ramsey, 121 F. Supp2d 911 (E.D.VA 2000).
- Wallace v. Smyth, 203 Ill.2d 441 (2002).
- Jackson v. Johnson, No. 97-CV-613, 2002 U.S. Dist. LEXIS 20203 (N.D. N.Y. Jan.2, 2002).

*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 faculty member at Cornell Law School.*

## TCI Updates

### Post-Crisis Response

Supervisors need tools and resources for working with staff to assure that the outcome of a crisis is a positive one for the young person, the staff member, and the program. This workshop addresses the emotional needs staff may have when managing aggressive clients and how front line staff can be supported. The staff member has been through a difficult situation, which, even if it didn’t result in a crisis was draining for the staff. At the very least, the normal day-to-day functioning of the program has been disrupted, and some effort has to be expended to get things back on track. The goal of TCI is to restore the child, the staff, and the program to a state of functioning at a higher level than it was before the crisis began. The post-crisis multilevel response model helps the young person, the staff person, and the organization learn from crises. It is also essential in maintaining the TCI system within the organization. Supervisors will learn how to provide coaching and feedback to direct care staff and to conduct debriefing sessions with care workers and teams.

### Designing Refresher Training

This update is designed to assist certified TCI trainers to implement effective and agency specific TCI refresher training in order to enhance individual and organization performance. Factors that facilitate skill transfer and maintenance will be discussed. An effective format for representing TCI materials using the model of discussion, demonstration, and practice will be presented. Participants will be asked to present activities appropriate for refresher training during this update. In advance of the update, participants will be asked to bring critical incidents (identifying information deleted) for review and use during the practice activities. A heavy emphasis is placed on advancing the skill

development of the participants in the areas of the early interventions strategies, I ASSIST, Life Space Interview, physical skills, and risk assessment.

### Developing Professional Level TCI Training Skills

*Associate Level TCI trainers interested in applying for Professional Level certification must attend this update.* The focus is on developing professional level trainer skills; understanding the stages of skill development and how skills are learned and maintained; and learning how to facilitate the transfer of learning from the classroom to the workplace. Setting the stage for training; improving presentation skills, group process, and communication skills; demonstrating knowledge of subject matter, as well as demonstrating skills, coaching, and corrective feedback; and managing the training will be the major topics presented. Participants will present a range of activities in order to receive feedback and enhance their skills in these areas. This update will look at every aspect of planning, delivering, and evaluating TCI training from the trainer's perspective. The review process for recommending professional certification will be discussed.

### TCI for Family Care Providers

Therapeutic Crisis Intervention for Family Care Providers is based on the TCI curriculum, but has been revised for adults caring for children in family settings. Challenges that foster and adoptive parents face when managing difficult behaviors and discussed and highlighted. This curriculum stresses crisis prevention and crisis de-escalation in ways that help children learn to avoid losing control. Activities addressing developmental issues, temper tantrums, limit setting, and Driekur's goals of misbehavior will be presented. There will be practice sessions focused on crisis prevention and intervention techniques designed for foster and adoptive parents.

### TCI for Developmental Disabilities

This update provides materials designed to be used as a supplemental training for those who work with children and young people with developmental disabilities and challenging behavior. The objective of this curriculum is to provide additional information and skills to the core TCI training that will enable staff to provide the support and prevention strategies that are most effective when serving young people with a developmental disabilities. Topics include: preventing aggression and violence, crisis communication skills, behavior management strategies, modified life space interviews, and choosing safety interventions. ♡

### Individual Crisis Management Plan (ICMP) Workshop

This one-day workshop will outline the process and steps in developing individual crisis management plans. At the end of training participants will be able to:

- differentiate between proactive and reactive aggression
- apply differential intervention strategies
- develop an ICMP that considers safety and risk issues and effective intervention strategies
- involve direct care staff in developing and updating the ICMP
- develop an implementation plan incorporating ICMPs in their own agency

### Intended Audience

This workshop is intended for TCI trainers, clinical staff and social workers, therapists, nurses, supervisors, and medical staff. Participants should have clinical and/or supervisory responsibilities within an agency and have attended a TCI training in an agency or a TCI Training of Trainers course.

### Program Outline

- 9:00 a.m. Introductions
  - Overview of TCI System
  - Role of Clinical Services
  - High-Risk Behavior
  - ICMPs
  - Types of Aggression
- 12:00 p.m. Lunch (on your own)
- 1:00 p.m. Assessing Aggressive Behavior to Developing ICMPs
- 4:00 p.m. Implementation Planning

### Materials

Participants receive a student workbook and an ICMP template.

### Cost

Tuition is \$225 per person

### Schedule of Offerings: 2004

- March 26 ..... Dublin, Ireland
- April 14..... Cincinnati, OH
- May 12..... Atlantic Beach, NC
- June 16..... Colorado Springs, CO
- July 21..... Ithaca, NY
- September 15 ..... Peoria, IL
- October 13..... Mesa, AZ
- November 10 ..... Warwick, RI ♡

### Professional Certification Announcement: Diana Heard



Diana Heard is currently the Clinical Educator/Training Specialist for Southwood Psychiatric Hospital, a YFCS facility in Pittsburgh, PA. Southwood Hospital serves children and adolescents in an Inpatient, as well as Residential Treatment Program in Pittsburgh, and Prosperity, PA. Diana has trained in a variety of subjects both within clinical and corporate settings throughout the US and Canada. ♡

## South Carolina TCI Implementation Project

by Michael Nunno, DSW

Over two years ago the South Carolina Association of Child Caring Agencies began working with Cornell University’s Residential Child Care Project to assist up to 16 member agencies to monitor and to improve their crisis prevention and management system, and to reduce the number of high-risk interventions. The program was funded through the South Carolina Department of Social Services, The Duke Endowment, and agency fees. Cornell’s Therapeutic Crisis Intervention system served as the basis for the training and technical assistance. With the ultimate aim of fortifying an agency’s organizational learning capacity, each participating agency underwent an

assessment and planning process that consisted of interviews, surveys, and meetings with key administrative, supervisory and direct care staff to determine an agency’s strengths and the needs within five critical areas of leadership, clinical services, supervision, training, and critical incident monitoring. Once through this assessment process each agency tailored an implementation plan to address their needs. Examples of agency needs articulated during this assessment process were to develop Individual Crisis Management Plans, improve supervisory debriefing post crisis, decrease the number and intensity of power struggles, decrease physical restraints, train more TCI trainers, and provide direct care workers with more de-escalation strategies. Participating agencies developed action plans that included adding more trainers to the training pool, training all staff within defined time frames, improving the documentation, developing incident

review teams, developing individual crisis management plans, improving staff management of crisis situations, avoiding power struggles, and developing personnel policies reflecting TCI certification requirements.

### Project Outcomes

Although each agency experienced different outcomes at different levels of intensity many agencies reported decreased restraints, decreased crisis events, better interactions with children, staff working more closely together within a common language, better trained staff receiving better supervision, and more frequent training that is more highly regarded. A few agencies undergoing an accreditation process reported that their process was easier since many of the same strengths and needs assessed in the Cornell project were pertinent to the accreditation process. Even with these gains, participating agencies and

### New Rules for Applying for Professional Certification

Beginning in April 2004, all Associate Level TCI trainers applying for Professional Level TCI certification must successfully complete the TCI Update: Developing Professional Level TCI Training Skills (see update article on page 5) and submit a portfolio to the RCCP with an application fee of \$100 or the equivalent in Euros or Sterling. As a Professional TCI trainer, you may provide direct training within your organization, and fee for service training that your organization sponsors. Agencies may not charge for TCI training unless the training is delivered by a professionally certified trainer. Professional TCI trainers may also provide TCI training independently on a fee for service basis. All TCI training must adhere to RCCP guidelines.

Portfolio Requirements You must include:

1. A submission letter outlining the contents of the portfolio and any details that explain the attendance sheets, test scores, or videotape.
2. The training agenda that you use for training TCI. The agenda must be a minimum of 24 hours if physical intervention techniques are taught, and 18-hours if they are not taught.
3. An attendance sheet with individual test scores for 4 training programs. Please use the RCCP’s direct tests. If you are not using the RCCP direct test, include a copy of the test you are using. The test scores should include scores for the written test and the skills tests. Please indicate what is the passing score.
4. A videotape taken during the training(s) of the following 3 different training activities.
  - a. A presentation/group discussion of one of the following activities:
    1. The stress model of crisis
    2. The crisis cycle
  3. I ASSIST
  4. Choosing a safety intervention
  - b. A demonstration of the team restraint by you with a co-trainer or the small child restraint. After the demonstration the tape must also include you coaching participants through the technique. If physical interventions are not taught please substitute an active listening demonstration and coaching of participants during the active listening practice activity.
  - c. A demonstration of the LSI with a co-trainer or participant.

Please utilize a remote microphone and pay attention to camera placement to ensure that the reviewers see the training room set-up, the participants, and hear the presentations, questions and comments. Acceptance of a videotape for review is at the sole discretion of the RCCP. Submitted videotapes become the property of the RCCP. Please send the portfolio and application fee (payable to Cornell University) to Martha Holden, Residential Child Care Project, Cornell University/FLDC, Surge 1, Ithaca, NY 14853. 📧

Cornell staff saw the need for continued improvement in debriefing staff after incidents, the development and use of individual crisis plans, improving the consistency and the skills of trainers within agencies, and documentation, data collection, and analysis.

**What did Cornell learn in the process?**

Cornell project staff learned lessons that are important to implementation.

*Leadership involvement was the key to an agency's success in the program.* Simple but vital activities such as the executive director attending assessment and implementation meetings and trainings sent a strong message to staff that this project was important.

*Strong program enhances the implementation of TCI.* When a facility's basic program is strong and consistent with the needs of the children being served, implementing TCI's practice strategies and skills are easier and more effective.

*Individual Crisis Management Plans are invaluable in providing individualized crisis management strategies.* Preparing and planning for an individual child's needs as soon after intake as possible, and preparing staff to use effective behavior management strategies that de-escalate and prevent crisis are essential tools to reducing high-risk interventions.

*Supervisor involvement and expectations set the tone for successful implementation.* Along with leadership and clinical services, supervisors play a key role in implementation. On a day-to-day basis supervisors provide the support and the accountability for staff to adhere to practice standards and agency expectations.

*Frequent TCI refreshers (every 3 months) help staff stay on task and feel more skilled.* The more often staff members have an opportunity to practice and refine skills, the more likely those skills will be maintained at a high level. A simple change in an organization's refresher schedule can have major impact on whether a staff person uses a behavior management skill effectively.  *Michael Nunno, DSW, is the RCCP's Principal Investigator.*

## TCI Bookshelf



Reclaiming Our Prodigal Sons and Daughters.  
 Written by Scott Larson & Larry Brendtro  
 Published by National Educational Service, Bloomington, IN (2000)  
 Reviewed by Gregory B. Wise

This book begins with the parable of the prodigal son and provides a fresh understanding of how we can reclaim wayward youth, regardless of their dilemma or the reasons that they strayed. Throughout the book is a much needed focus on developing values and spirituality which is refreshing and emphasizes the importance of helping our young people replace despair with hopefulness in these complicated and often violent times.

In Part One, Our Wayward Youth, today's issues and how they affect children in ways that we have not considered before are examined, and ways to identify the problems and start the process of reclaiming these young people are suggested. In Part Two, The Road Home, the Native American model for reclaiming problem youth, the Circle of Courage, is introduced as a way to help young people develop courage to be far better equipped to meet life's challenges. The four qualities of the Circle of Courage, Belonging, Mastery, Independence and Generosity are essential for the development of courage. Each quality is examined and ways to cultivate these qualities in young people are described. Also included is a blueprint for building relationships with difficult youth, an essential ingredient in reclaiming our sons and daughters. Any professional working with today's troubled youth will find practical ways to help young people restore hope and values to their lives.

I liked the way the authors identified the issues and problems facing today's youth and then formulated a practical how-to manual for practitioners to use. This book is useful not only for practitioners, but for the general public as well and I highly recommend it. 

## Professional Certification Announcement: Linda Pignataro



Linda Pignataro is the TCI Trainer for The Collaborative School, a division of the Maine Special Education/Mental Health Collaborative. The school is a day treatment program for children and youth in Kindergarten through Grade 12, and also provides behavior program development services to the public school system in Southern Maine. Ms. Pignataro's prior work experience includes over 10 years as an Associate Teacher teaching children who have emotional/behavioral disabilities. She relocated to Maine from New York City and has two children. 



## NOTICE: A Call for Partners

Cornell University's Residential Child Care Project is keen to engage with residential child-care facilities, university research and evaluation centers, and organizations to evaluate and monitor the impact of crisis prevention and management systems on residential child care facilities. A residential child-care facility is broadly defined and can be sponsored by any state or international government's child welfare, mental health, mental retardation/developmental disabilities, or juvenile corrections system. Cornell especially seeks collaboration that can lead to applications to the United Nations', World Health Organization and its affiliates, international non-governmental organizations, the United States National Institute of Health or the United States National Sciences Foundation, and private foundations and charities.

### PURPOSE

A broad range of facilities, are sought to compare and contrast the impact of various prevention, de-escalation, and management strategies on levels of aggressive and violent behavior, injury rates, child outcomes, staff retention, confidence and skill improvement. Evaluation and research designs testing the effectiveness of less intrusive, lower-risk behavior management strategies to address agitated, aggressive, and violent behavior is sought.

### REQUIREMENTS

Facilities, organizations and universities that are interested must have access to and an opportunity to exploit a range of critical incident data, including but not limited to such descriptive information as the time,

location, and duration of incidents. Child and staff oriented data elements pertaining to the critical incidents are necessary such as age, gender, diagnosis, zip code, length of time in placement, and employment. Any interested parties must have the capacity to distribute and analyze surveys, tests, perform interviews with children and staff, and monitor critical incidents such as fighting verbal abuse, runaways, and assaults, and physical interventions. Any quantitative study must use data controlled by unit census at the time of the incident, and the data must be of sufficient size and / or duration to be statistically significant, and meaningful.

Experimental or quasi-experimental designs utilizing diverse methodologies such as case study, time interrupted series, random selections are encouraged, as are creative qualitative designs and methods. Generalizing the results to larger populations is essential. Any methodology and design proposed must have a reasonable chance of producing reliable and valid results, and have the full support of the researcher's organization, facility or university. All data must be in a condition to be archived in the National Archive Data Base at Cornell for future analysis by secondary researchers, and collected and maintained according to an approved Human Subject review.

### TERMS OF THE ENGAGEMENT

There is an expectation that the findings will be presented and published in conference proceedings, newsletters, trade magazines, and peer-reviewed journals. Prior agreements between Cornell staff and the organization, facility or university

staff will determine authorship and co-authorship of any published document. All methodologies and designs must be approved in writing by the relevant human subjects review boards prior to the initiation of the research.

The Residential Child Care Project specifically seeks to collaborate on proposals and research designs that:

- 1) test an organizational strategy or combinations of strategies on the reduction of aggression and violence based critical incidents
- 2) test an organizational strategy or combinations of strategies on the reduction of aggression and violence in a child's personal life
- 3) analyze aggressive and violent critical incidents in terms of, but not limited to, child and staff demographics, child placement history, staff employment history, and staff retention;
- 4) analyze aggressive and violent critical incidents and interventions in terms of structure, analysis of function for the organization, analysis and function for the child, impact on the staff and / or impact on the child
- 5) discover any organizational or individual child or staff qualities, factors and dynamics that either contribute to or ameliorate aggressive and violent behavior in residential care
- 6) discover or analyze a) theories of aggression, b) organizational change, c) components or strategies that increase safety in a residential facility, and d) research that promotes organizational learning and child development in residential care.

For further information please contact Michael Nunno at 607 254 5127, or via e-mail, [man2@cornell.edu](mailto:man2@cornell.edu).

## Frequently Asked Questions

by Martha Holden. MS

After you attend our TCI training, return back to your agencies and begin putting the concepts and skills into practice, questions arise. We are happy to receive your phone calls and emails and answer your questions as best we can. This column is a brief discussion of the most commonly asked questions with our response.

*How often and how many hours of refresher training is "mandated" each year for agency staff?*

We recommend quarterly refreshers of about 3-4 hours, but the minimum required to maintain the TCI system is 6 hours every 6 months. There is an entire update, Designing Refresher Training, devoted to delivering effective and agency relevant refresher courses. There are suggested agendas for refresher trainings in the TCI Activity Guide in the Introduction. Agencies should develop policies that mandate how many hours of training staff must receive annually in order to maintain employment. This should include specific requirements for TCI refresher training. Staff should also be tested at least annually for recertification purposes. If staff members do not successfully complete refreshers, they should not maintain TCI certification.

*All of our full time staff have or are taking the full TCI certification training. However at times, we use relief staff. How do we deal with relief staff and TCI training?*

If relief staff are required to deal with crises and high risk behaviors that might result in the use of safety interventions as part of their job responsibility, they would have to

have successfully completed TCI training and be certified. Until they have done that, they would have to be on duty with others who could handle these high risk situations. If relief staff assume the same job responsibilities that full time direct care staff do, they need the same training as they often face the same situations that full time staff face. Although it is a significant investment to train all relief staff, it is an important one that will serve the children and agency well.

*Some participants are unable to do all of the physical intervention techniques, or get confused when they do some of them during the testing. Can we let them try again? Can they still be certified? Can they still be employed if they don't pass the testing?*

First, you need to determine what people need to be able to do in order to do their job, a job task analysis. If a person does not need to use physical interventions, then it shouldn't be a major concern if they are not certified in the physical component of TCI. If a person can do most of the techniques but cannot successfully demonstrate one or two, you can indicate on the certification documentation that she or he is not certified

to do that specific safety intervention. This is often necessary because of a staff member's physical limitations or size. Remember, you are certifying staff members to manage acting out children and young people in a way that will not hurt them and reduce the risk of the situation. Just because someone can demonstrate in a testing situation may not mean they can safely use the technique in a real situation. When certifying staff members in physical techniques, be sure that they can use them appropriately and understand under what conditions they can employ the techniques. Once certified, you are saying that this person will be able to decide when to use these techniques and can physically do them without causing harm to the young person in an actual crisis situation.

*What if we have to move a child?*

In the TCI system, restrictive physical intervention techniques are used only when there is a risk of imminent physical harm, they are indicated on the ICMP and the trained staff member has assessed that physical intervention is the least risky

Frequent Questions continues on page 10

### Professional Certification Announcement: Keith A. Bailey



Keith A. Bailey is the Staff Development Coordinator at Holston United Methodist Home for Children in Greeneville, Tennessee. He has worked with youth for over 15 years, including two years in Scotland, and has spent the last 10 years working with children in residential care. Keith has a B.A. in Psychology from Tennessee Wesleyan College, a M.Div. from Duke University, a M.S. in Child and Family Studies, with a concentration in Child Development, and a Ph.D. in Human Ecology, with a major in Child and Family Studies, from the University of Tennessee. He is married to Angela, and they have a daughter, Kaitlyn, and a son, Taylor.

### Frequent Questions, Cont. from page 9.

intervention at that moment, in that specific situation. This assessment is made based on agency policy and state regulation, previous assessment of the client and what is the most appropriate and safest intervention (ICMP), and the professional judgment of the trained staff member intervening. In our experience and research, forcibly moving an aggressive young person is rarely the least risky intervention. The result of trying to move angry and upset young people against their will is usually a restraint and often an injury. We do not recommend trying to move or carry someone who is non-compliant and potentially violent. A restrictive physical escorting technique (forcibly moving a young person who is out of control) is not taught in TCI because of the inherent dangers involved in trying to move someone who is physically out of control. The risk of injury is so high, that when assessing the situation, most often other interventions offer less risky strategies.

If the clinical team has decided that a young person should be forcibly escorted under certain conditions, this should be part of the ICMP. Staff working with the young person should be specially trained in 1) understanding how to anticipate the young person's escalation and avoiding the need to use physical force, 2) using a physical technique that has been recommended and reviewed by the young person's physician, 2) knowing under what conditions and in what situations the young person should be moved, and 3) formulating what the goal of moving the young person is and what happens once the young person is moved. This should be clearly documented and reviewed on a regular basis. Anytime the technique is used there should be an immediate review involving the staff members involved in the incident and the clinical/unit team. Staff should understand

that this intervention is to be used only with this young person and only under the conditions described in the ICMP to avoid staff members resorting to physical management for program compliance whenever young people are refusing to comply with staff requests.

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#### *What is the minimum number of participants you can have in a TCI course?*

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TCI does not have a minimum number of staff required to conduct the TCI training. It is important to know that the TCI curriculum is designed for group training. The optimal training group size is 12-18. With less than 6 participants, the training loses a lot in quality and the group's ability to benefit from the training. Once the number of participants is less than 6, it will be difficult (sometimes impossible) to practice physical techniques adequately since there may not enough of a variety of size within the training group for all participants to practice safely.

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#### *I am an associate level TCI trainer, can I train with another TCI trainer at her agency?*

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We encourage TCI trainers to co-train with other TCI trainers within their agency and combine resources with other TCI agencies. This is especially beneficial if agencies have small numbers of staff that need to be trained or have new trainers who could benefit from training with other experienced trainers. Rotating training among agencies that have formed a consortium to meet training mandates is a way to consolidate resources and enrich training experiences. Associate level TCI trainers may not charge a fee to deliver TCI training, nor can agencies charge a fee for TCI training unless it is conducted by professionally certified trainers. 🐾

### Professional Certification Announcement: Mike Panico



Mike Panico is currently the Clinical Supervisor for the Arizona's Children Association's residential treatment programs. The programs, located in Tucson, AZ, include three campus-based residential facilities and one community-based substance abuse program. Mike has been with the agency for the past 17 years and has held various positions, including unit supervisor, child/family therapist, training coordinator and program director. Prior to AzCA, he worked in hospital-based treatment programs, as a classroom teacher, and did volunteer work with adolescents. Mike currently also assists in providing training to foster and adoptive families, and is the lead trainer in TCI for residential treatment staff. Mike has been a TCI instructor since 1996, and has provided ongoing training in both the residential and family care providers curriculums.

## Where Will You Be in April, 2005?

Why not join the RCCP in IRELAND for the Second International TCI Conference? Watch for details to be published in future editions of "REFOCUS."



### System-wide Approach, Cont. from page 3.

built, it follows that we should address the issue of restraint in a systematic and ongoing way. We know that holding children who are out of control is sometimes necessary and that doing so can prevent serious injury. At the same time, this is not a benign intervention and can result in serious injury, even if done by well-trained, well-intentioned staff. We want to ensure that the use of restraint ultimately increases the safety of children in care, rather than posing additional threats.

We also know that when we hold children we assume control and the child's ability to make decisions and function autonomously is seriously compromised. When a child has lost control, restraint may be appropriate and necessary to ensure safety. Using restraint at other times, for instance when the staff person has lost control, is inappropriate. Restraint employed in this manner is inherently disrespectful, robs children of their autonomy and dignity, and conveys a message that if you are bigger, stronger or more powerful you can make people do what you want. In the final analysis, the use of restraint, for those being held or doing the holding, never seems to be a particularly dignified process. The bottom line for us is that looking at the issue of restraint and making efforts to reduce this intervention is not only supported by our treatment philosophy, it is mandated by that philosophy.

### Leadership Commitment and Vision

The second feature of our model is leadership. Agency leadership needs to make a serious commitment to reducing restraints and should set bold goals for performance. More important than setting bold goals, however, is creating a climate and providing the resources necessary to accomplish these goals. For Andrus, this meant making some changes. Leadership has had to change the program's priorities from behavioral control to behavioral containment. Years ago, when our focus

was much more on behavioral control, we used an exhaustive menu of consequences designed to punish negative behavior and exert high levels of adult authority. Today, the focus is much more on containing negative behavior. Negative behavior is met with increased adult support and positive management plans designed to reinforce a child's best efforts, which grow out of a more sophisticated clinical understanding of the child.

Moving to a "hands off" approach was met with a great deal of concern from our staff. We did a great deal of training and supervision and coached the residential child care staff to make every effort to avoid holding children. Once childcare workers began to use early intervention strategies more effectively in practice, staff in our Education and Clinical Departments often criticized them for abdicating their responsibility to control the children and allowing them to run wild. Our data showed incidents of serious physical aggression, property damage, and elopement did not increase, as everyone feared. Rather, we saw a decrease in serious incidents as the number of holds has decreased. Leadership had to support the residential staff's efforts consistently in the face of criticism from their colleagues and develop strategies for expanding training initiatives to other departments.

Making this shift has been tricky and requires a great deal of encouragement, support, and reassurance from leadership. Line staff worry about losing control, and leadership must make sure workers feel safe and secure with this shift. Adequate training and maintaining adequate child/staff ratios is crucial. Most importantly, leadership needs to be empathic and compassionate. Staff need to be reassured that mistakes will be addressed in a respectful manner which enhances the staff person's sense of confidence and integrity. Such an approach not only affirms staff people's best efforts but models appropriate confrontation skills. It is important to set bold goals; it is essential to remember that achieving these goals will be

a process. We want our staff to be partners in this process rather than roadblocks to change. We have also found it helpful to make expectations as explicit as possible. We have developed a Behavior Management Manual, which is reviewed with all staff. This manual not only explicitly spells out all our do's and don'ts but also connects our policies and practices to our values and beliefs by providing explicit instruction on how to provide maximum caring with minimal force.

### Training Continues to be the Key

Whatever behavior management system you use requires an organizational commitment. These systems provide a common ground and language for staff to talk about and define problems. We have invested heavily in Therapeutic Crisis Intervention (TCI) training and although some of the holds taught in this method have come under attack in the past year (i.e. face down holds, basketholds) I have found TCI's focus on prevention and early intervention invaluable. We train all of our senior managers, middle managers, and senior staff as TCI Trainers. Although this approach is costly, it has served to embed the values and language in our culture and ensures leadership can clearly communicate not only values but also the technical aspects of behavior management. Additionally, training Senior Workers means we generally have well-trained, knowledgeable staff people on all shifts.

All new direct care staff receive a 4-day TCI Training and are trained monthly on some aspect of the TCI curriculum. Much of our ongoing direct care staff training is focused on issues of self-awareness, disengaging from conflict cycles, and recognizing and avoiding power struggles. I am quite convinced that most holds grow out of staff people's inability to disengage when a child has gotten them angry and frustrated. Training that does not focus heavily on this issue is missing the mark.

Another crucial, yet often overlooked, aspect of staff training is periodic

System-Wide Approach, from page 11.

retreats/reviews with all TCI Trainers. The intention here is to help trainers stay true to the techniques and interventions taught in the TCI curriculum. Some recent reports of serious injuries and deaths that occur during the use of restraints were attributed to drift in intervention approaches. Staff were being taught techniques that were in fact trainer modifications of those interventions and holds, which are part of the standard curriculum. Some of those modifications proved to be dangerous. We want to avoid that at all costs.

### Staff Supervision

Our expectation is that Supervisors will review all restraint incidents with staff. All incidents are processed with special

attention to the staff person's emotional state at the time of the incident and whether or not this had an impact on the decisions made. This review also encourages supervisors to explore potential alternative interventions, reinforce agency values and beliefs, and check that appropriate techniques were employed.

Our experience is that staff initiate restraints with good intentions. They know on an intellectual level that restraint is appropriate only when a child's behavior poses a danger to her / himself or others. Problems arise, however, when staff become flooded by their own feelings of anger, frustration, fear, or loss of control. These feelings sometimes cloud decision-making and staff may project these feelings on to the children. Good supervision will help staff sort out truly dangerous behavior

on the part of children from their own anxious, angry, or frightened feelings about the situation. Supervisors need training not only in TCI techniques, but also in the area of constructive confrontation to successfully walk through this process. Our objective, whenever possible, is to correct staff behavior while keeping worker self-esteem intact, and helping workers feel more confident in approaching similar situations in the future.

### Maintaining a Focus

The issue of restraint needs to be an important one at the agency. Given the potential negative consequences of this intervention, staff must get the message that it is a serious issue and that restraints are not business as usual, but an event requiring extensive review and discussion. In order to stress the importance of this issue we have set up several processes that are followed whenever a restraint occurs. The following expectations are in place for each restraint incident:

- 1) An Incident Report is written on each restraint incident and entered into the Incident Report Database.
- 2) Each restraint incident must be reported to the immediate supervisor or administrator on call as soon after the incident as possible. This person does an initial assessment of the situation and ensures that all procedures are followed and that the situation is under control. This individual also notifies the child's family that the child has been held.
- 3) The child is assessed by the nurse immediately after the hold to ensure the child's physical welfare and to treat and document any injuries sustained.
- 4) The Supervisor conducts a review of the incident as outlined earlier. The child, who was held, is also spoken to by the supervisor and / or the clinician and reviews strategies for avoiding future incidents.

While each of these functions is

## Serious Fun and Games "Three Truths and A Lie"



This little energizer is from Jack C. Holden, President of Mueller Holden and Associates, Ithaca, NY. Mr. Holden is a consultant/trainer for the RCCP who trains internationally and has co-developed multiple human services curricula, including Recovery for Staff—TCI, Cornell University; and Connecting: Essential Elements of Residential Child Care Practice.

On a flip chart, write four statements about yourself, three of the statements being "truths" about yourself and one being a "lie" about yourself.

For example:

- I have three children
- I play a guitar
- I love going to the opera
- My favorite TV show is "Survivor"

Ask the participants to guess which statement is a lie. (For me, the last one is a lie.)

Then ask participants to take out a piece of paper and to write their own four statements, three being "truths" and one, a "lie." Once everyone is finished (about five minutes) divide the participants into groups of three or four, with people they know the least in the group, and have each person share their own three truths and a lie with their small group. The members of the groups then try to guess the three truths and a lie for each group member. This is a great warm-up activity or energizer and usually brings much laughter and fun!

\*Author Unknown. Rumor has it that it may have originated with Andrea Mooney, but this may not be true. ☹

important in and of themselves, collectively they communicate a sense of seriousness to staff and children and set the appropriate tone for this intervention.

### Documentation and Data Analysis

As mentioned earlier all incidents involving restraint must be entered into the Incident Report Database. These reports are reviewed, along with the supporting documentation (Nursing Assessment and Supervisory Review), by campus leadership to ensure interventions are being used appropriately and judiciously. On a monthly, quarterly, and annual basis we look at the aggregate of all restraint incidents with our Behavior Management Committee. The committee looks at trends and then formulates recommendations for performance improvement to the Campus Leadership Team. The Campus Leadership Team (Campus Director, Residential Director, Clinical Director and Education Director) also reviews the data independently, and also develops strategies for performance improvement. We recently instituted a monthly Campus Management Meeting, which involves all senior and middle managers. Together we look at trends in the use of restraint (as well as other key performance indicators) and develop strategies for how we will address these issues.

These activities have flagged some interesting trends which inform our Performance Improvement Activities. Among some of our observations and corrective actions are:

- 1) Approximately 10 children (less than 10% of our population) account for 60-70% of all restraints. Special Treatment Reviews have been set up to look at planning and program modification for these children.
- 2) Many incidents involving holds began with a staff person placing hands on a child with the intention of removing the child from the area of

a confrontation. We found, in most cases, such an intervention resulted in restraint because the child would inevitably struggle and lash out at the staff person who was trying to move the child out of the area. We have refined our training and instruct staff people not to put their hands on an angry child unless the child is engaging in acute physical behavior.

- 3) Children under 10 years of age (about 40% of our population) account for 70% of our restraints. We have developed a small task force of direct care staff, assigned to work with younger children, to analyze this problem and formulate some ideas for improving our performance in this area. This remains a work in progress.
- 4) New staff, those employed under one-year (approximately 25% of our direct care staff), account for 75% of the restraints performed. In response, we have increased training for new staff and have tightened supervisory oversight.
- 5) A program area is featured prominently in restraint incident reporting. Several years ago we had a high number of restraints occurring during school lunch periods. We responded by adding an additional lunch period to reduce crowding and stimulation. Restraints decreased dramatically, as did all major classes of incidents.
- 6) A staff person is prominently featured in restraint incident reporting. Staff has been required to receive more training and closer supervision has been provided.

Data collection, management, and analysis are crucial in our effort to get a handle on restraint incidents. Reliable data permits us to define the scope of our problem, to focus our interventions appropriately, and to measure whether our interventions are effective.

“ Now, here, you see, it takes all the running you can do, to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that!” (the Queen said to Alice)  
—Lewis Carroll, “Through the Looking-Glass

### Clinical Review

Children who are frequently held need to be referred to the Treatment Team for review. A child who requires frequent physical holding is not being adequately held by the milieu and likely requires a special plan. The treatment team needs to develop proactive strategies for how to manage this child without using a hands-on approach. Recently one of our young girls was being held repeatedly at bedtime. Staff were struggling as this little girl successfully tied them in knots at the end of a long stressful day. The team met to discuss the excessive use of restraint and decided to develop a plan which included bringing the overnight staff in one hour earlier to work one-to-one with this girl and provide her with a variety of quiet, soothing activities for bedtime. Holds reduced from a nightly event to a once every 3 or 4 weeks, almost immediately. Clinical review of new admissions also needs to occur and conditions which might indicate against restraint (asthma, heart condition, history of trauma) should be flagged and made available to all staff. Proactive strategies for managing these children can be developed ahead of time to reduce potential risk.

### Andrus Model Illustration

The Andrus Model begins with Leadership Commitment, which grows out of our Treatment Philosophy. Leadership is also informed by data gathered on the use of restraints. Agency Leadership develops systems, which stress the seriousness of this intervention. Staff Training, Staff Supervision, Clinical and Program Review all play a key role in maintaining this focus. Data Collection occurs on all incidents and informs future Leadership initiatives in the area of Performance Improvement.

### Conclusions

In 1994 we were averaging 65-70 holds a month. Since 1994 we have added 80 children to our day treatment program; increased our total care days almost four



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**Brian Farragher**, CSW, is the Executive VP & COO at Julia Dyckman Andrus Memorial, Inc. in Yonkers, NY. Mr. Farragher will be presenting at leadership seminars sponsored by the Residential Child Care Project throughout New York State in 2004. He is a member of the Founding Faculty of the National Executive Training Institute sponsored by NASMHPD/NTAC 🐾

*This article was previously published in Residential Treatment for Children & Youth, 20(1), 2002.*

## From the Instructor's Booth

The Residential Child Care Project is pleased to announce our newest TCI instructor: RICH HERESNIAK. Welcome, Rich! Rich Herseniak, is the Lead Crisis Counselor at the Astor Home for Children, a 75-bed residential facility for severely emotionally disturbed children, ages 5-13, located in Rhinebeck, NY. He handles crisis intervention work and is the primary TCI trainer. Mr. Hersniak worked his way up to this position, starting out as a Teacher Assistant in the Astor Learning Center, followed by Crisis Intervention and childcare worker in the RTC and RTF units. He has been a TCI trainer since 1989 and became a professionally certified TCI trainer in 2001. 🐾



## Ask Eugene



I'd like to sign up for one of your TCI training courses. Can I sign up over the phone?

RCCP cannot accept registrations via telephone. To register for any TCI training, you must submit a completed application, with a check or a purchase order. Once RCCP receives your application and payment, we will determine if there is still availability in the course and, if it is still open, you will be registered at that point.

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

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

What is "full" for the TCI training? Can I talk to someone about being added as an extra person?

The Train the Trainer is designed for 18 people. RCCP cannot allow more than that for both quality and safety reasons.

Does Cornell University give "CEUs" for TCI Training?

Cornell University does not give CEUs. We will be happy to complete any paperwork that you need or send any documentation that you require to apply for CEUs from your licensing board or university. 🐾

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



## 2004 COURSE OFFERINGS

### THERAPEUTIC CRISIS INTERVENTION: TRAINING OF TRAINERS

- January 12 - 16 .....Auburn, NY
- February 2 - 6 .....Sydney, Australia
- February 9 - 13 .....San Diego, CA
- February 9 - 13 .....Glasgow, Scotland
- February 16 - 20.....Dublin, Ireland
- March 8 - 12 .....Colorado Springs, CO
- April 19 - 23 .....Cincinnati, OH
- May 17 - 23 .....Atlantic Beach, NC
- June 7 - 11 .....Ithaca, NY
- June 7 - 11 .....Penrith, England
- June 21 - 25 .....Dublin, Ireland
- July 12 - 16.....Pittsburgh, PA
- July 26 - 30 .....Auburn, NY
- August 16 - 20 .....Auburn, NY
- September 20 - 24 .....Peoria, IL
- October 4 - 8 .....Myrtle Beach, SC
- October 18 - 22 .....Mesa, AZ
- November 1 - 5 .....Glasgow, Scotland
- November 15 - 19 .....Warwick, RI
- November 22 - 26 .....Dublin, Ireland

### TCI FOR FAMILY CARE PROVIDERS: TRAINING OF TRAINERS

- June 21 - 25 .....Ithaca, NY

### TCI UPDATES

#### TCI UPDATE: DEVELOPING PROFESSIONAL LEVEL TCI TRAINING SKILLS

- February 26 - 27 .....Ithaca, NY
- April 12 - 13 .....Cincinnati, OH
- May 10 - 11 .....Atlantic Beach, NC
- June 17 - 18 .....Colorado Springs, CO
- July 22 - 23 .....Ithaca, NY
- October 11 - 12 .....Mesa, AZ

#### TCI UPDATE: TCI FOR DEVELOPMENTAL DISABILITIES

- May 13 - 14 .....Atlantic Beach, NC
- July 19 - 20 .....Ithaca, NY

### TCI UPDATE: TCI FOR FAMILY CARE PROVIDERS

- August 5 - 6 .....Ithaca, NY

### TCI UPDATE: DESIGNING REFRESHER TRAINING

- January 22 - 23 .....Ithaca, NY
- March 4 - 5 .....Colorado Springs, CO
- March 22 - 23 .....Glasgow, Scotland
- April 20 - 21 .....Dublin, Ireland
- June 3 - 4 .....Ithaca, NY
- August 12 - 13 .....Columbia, SC
- September 16 - 17 .....Peoria, IL
- October 4 - 5 .....Penrith, England
- October 7 - 8 .....Wheathampstead, England
- November 11 - 12 .....Warwick, RI

### TCI UPDATE: POST CRISIS RESPONSE

- January 29 - 30 .....Sydney, Australia
- February 16 - 17 .....San Diego, CA
- April 15 - 16 .....Cincinnati, OH
- May 6 - 7 .....Glasgow, Scotland
- July 8 - 9 .....Pittsburgh, PA
- August 12 - 13 .....Dublin, Ireland
- September 30 - Oct.1 .....Myrtle Beach, SC
- October 14 - 15 .....Mesa, AZ
- November 8 - 9 .....Warwick, RI
- November 15 - 16 .....Glasgow, Scotland

### ICMP WORKSHOPS

- March 26 .....Dublin, Ireland
- April 14.....Cincinnati, OH
- May 5 .....Glasgow, Scotland
- May 12.....Atlantic Beach, NC
- June 16.....Colorado Springs, CO
- July 21 .....Ithaca, NY
- September 15 .....Peoria, IL
- October 13.....Mesa, AZ
- November 10 .....Warwick, RI

REFOCUS is an occasional newsletter. It is our way of communicating to you, TCI trainers and interested professionals, information about current issues and events that emerge from work in crisis management and residential child and youth care. Information from the field provides important feedback for us. You can send questions and comments and ideas to us at: REFOCUS c/o The Residential Child Care Project, Family Life Development Center, Cornell University, Surge 1, Ithaca, NY 14853 Tel: (607) 254-5210/Fax: (607) 255-4837/Email: [eas20@cornell.edu](mailto:eas20@cornell.edu)