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What Contributes to the Success or Failure of TCI Course Participants? Some Alternative Explanations

by Harvey Melnick, Manager, Sweetser Training Institute

"When is a test not a test?" is not a trick question: tests must measure what they are intended to measure. In providing the general TCI curriculum, it is a challenge for some staff to acquire the course content so that they become proficient enough to perform satisfactorily at work and on the written and physical exams presented at the end of the coursework.

What Contributes?, continues on page 2.

"I HATE Being Tested!"

by Jack C. Holden, Ph.D., Instructor, RCCP Consultant

TCI began testing in earnest with the 5th edition of TCI, 2001, when the trainer certification process was implemented. From the beginning, testing presented challenges for the trainers, the evaluation department, and most importantly, the participants! After more than five years experience with the testing and evaluation process, a reflection on testing regarding its purpose and value seems apropos.

I Hate Being Tested, continues on page 2.

Shown receiving the 2006 National Staff Development and Training Association (NSDTA) Quality Award for the Residential Child Care Project (RCCP) are (left to right) Jack C. Holden, Ph.D., TCI Instructor, RCCP Consultant; Martha J. Holden, M.S., Director, RCCP; Kathleen Leeson, Board member of NSDTA; and Michael Nunno, D.S.W., Principal Investigator, RCCP. The Quality Award is given to an outstanding training organization or training program and was given to us for our Training program, Therapeutic Crisis Intervention.

Therapeutic Crisis Intervention Curriculum Wins National Award

The National Staff Development and Training Association (NSDTA) gave its Quality Award for 2006 to the Therapeutic Crisis Intervention (TCI) curriculum, which is part of the Residential Child Care Project in the Family Life Development Center, College of Human Ecology at Cornell University.

The curriculum has been used to train more than 3,000 professionals around the world who lead training programs for child and youth care staff in residential child-care facilities. These TCI trainers instruct their staff in how to help children learn constructive ways to handle crisis.

The Residential Child Care Project is an international outreach, technical assistance, and training organization that disseminates techniques and systems to prevent institutional child abuse and neglect. Its staff has conducted trainings in more than 40 states, Canada, Puerto Rico, Russia, Australia, Ireland, Israel, New Zealand, Bermuda, and the United Kingdom.

The NSDTA is an organization for professionals responsible for human service training and staff development on the local, state, or federal level. The award was presented by Kathleen Leeson, NSDTA board member, to the RCCP at the National NSDTA Conference held in Minneapolis on September 12, 2006. Michael Nunno, Martha Holden, and Jack Holden were in attendance at the conference and accepted the award on behalf of the Residential Child Care Project. ✷

Wisdom is not finally tested in the schools,
Wisdom cannot be pass'd from one having it
to another not having it. Wisdom is of the soul,
is not susceptible of proof, is its own proof.
—Walt Whitman

What Contributes?, Cont. from p. 1.

If the pragmatic goal of the TCI written exam is to review learning and assure competency rather than to assign grade scores of passing or failing, the test review process and an awareness of how individuals acquire and produce information becomes even more meaningful.

Errors reflected during training or upon taking the written exam are often attributed to problems in learning the extensive content; an apparently logical connection. However, the "real" problem may lie with the interaction between the nature of the testing process and the participant's individual learning style, rather than a lack of knowledge or competence.

At Sweetser, TCI is delivered in the 24 hour+/4 day process. For new, inexperienced employees, a great deal of important information is delivered quite rapidly over the first few days. Even with all of the excellent training components and experiential exercises TCI incorporates as part of its training process, many staff still find the course work a bit overwhelming. Over the past ten years or so of providing TCI training, we have observed that there are many alternative learners, including many learning disabled individuals in the behavioral health care professions.

One picks up "patterns of performance" over time, and there are distinct response patterns represented by the staff with whom I work. These have more to do with how people learn and how the test is constructed (literally its structure/process) and less to do with the content (memorizing and acquiring the concepts, meaning, and application of learning material the questions are intended to measure). It is the intent of any well-constructed test that the test questions as closely and accurately as possible reflect and "test" the course material to be learned or "content validity."

Some staff just cannot easily respond to certain questions, question types (i.e., multiple choice), or instructions given the manner in which the questions or directions are constructed. And some individuals demonstrate difficulty extracting the meaningfulness (intent) or subtle nuances of words used in the questions which causes them confusion. Again, this does not necessarily reflect competence in applying the information.

There are also participants who are "unsophisticated test takers" who jump to identify and "check off" an initial correct response without continuing to read on to (perhaps) check out (and off) the "all of the above" answer.

We follow up our written exams with the correct answers being reviewed to assure overall comprehension and provide the staff with the opportunity to make an appointment following the completion of the TCI course (often the next week) to review the exam. However, we require staff scoring below 80% to make an appointment with their TCI facilitator (if they are on another campus) or with me to review their written exam in person and demonstrate competency.

In my experience, I would say that the larger percentage of those few who fail (under 80%) are able to perform satisfactorily orally, in person, when they cannot seem to do so during the test process.

It is important to realize how the structure of the testing process itself presents something of a roadblock for certain alternative learners. Interestingly enough, it also validates the multi-experiential approach that TCI utilizes in its training process; the information just needs to be tapped into using a slightly different process to extract the meaning (and the correct answer…)! And if we employ this process in training, why not do so in testing?

It is important to distinguish why individuals may have some difficulty in acquiring or demonstrating the TCI course content, and to provide them with opportunities to acquire and demonstrate this information using alternative approaches. When we present initial instructions for TCI participants, we ask "those who may have experienced learning difficulties in their past" to come speak with me confidentially. By so doing, we can ascertain and keep an eye out for better methods to employ with them during the course, or better monitor how their in-class performance and participation represents how much of the course material they are actually acquiring in the manner in which it is being presented.

This has proven to be a valuable strategy, resulting in decreased "test" anxiety. It has allowed us to differentiate between some very small percentage of participants who just do not do the work from those who are trying and failing due to circumstances beyond their control. The results are better trained TCI practitioners!! ✸

Harvey Melnick is a certified TCI Trainer who has been the Manager of the Sweetser Training Institute for the past ten (10) years. He is an ABD in Clinical Child Psychology from the University of Kentucky and believes quite strongly that how we learn and how we are taught are the primary contributors to what we learn. hmelnick@sweetser.org

"I HATE Being Tested," Cont. from p. 1.

Testing plays the foremost role in any evaluative process in training since its purpose is to help instructors improve their own teaching along with helping learners improve their performance on the job (Foshay, 2001). Foshay describes four types of tests; pre-tests, lesson quizzes, summative tests (post-tests), and certification tests. The pre-tests provide information about the readiness and the needs of new learners. The lesson quizzes provide information about the learner's grasp of the lesson objectives providing ongoing feedback. The summative test provides

"I HATE Being Tested," , continues on page 3.

"I HATE Being Tested,", Cont. from p. 2.

the instructor with a competency-based final exam that is used for a course grade. Certification tests are usually a combination of different competency-based testing instruments that as a whole determine a learner's certification status and predict ability for practical application.

Josephsen (2000) discusses high-quality testing as a tool for effective teaching and uses lesson quizzes and summative tests to determine the success of the teaching. The more important question is, did learners "get it" rather than did they fail the test? The results from testing provide measurement information and feedback about what is being taught. Josephsen posits that multiple measures should be employed and that they should be competency-based. These measures may help answer the most relevant questions: can they do it and will they do it?

Nunno (2002) provides a viewpoint on the summative testing of the TCI direct training. The study was based on observations made at agency sites with TCI Associate Certified trainers. For this study a knowledge-based test, skills-based test, and a trainers-supervisor appraisal were used to evaluate the learner. The study provides information about evaluation differences including uneven quality of training and knowledge test results. The uneven quality of training showed that training quality was being "compromised by a lack of adherence to training manual instruction, simple group process, and inadequate training environments" (p. 7). It would seem from this observation that TCI trainers might benefit by more training skill development in the TCI train-the-trainer program. Another key factor in the observations was the poor knowledge test results. Direct care workers vary a great deal in reading proficiency, literacy, test anxiety, and poor preparation. Based on his findings, Nunno states, "this (TCI) is a long-term implementation and training project, and we will continue to refine both the strategies for post-training testing, and strategies for on-the-job monitoring skills" (p. 10).

Additionally, an ethical perspective should be applied in testing because, "employers have a responsibility to provide what employees need to be successful once they are selected and placed in a job" (Nilson, 2002, p. 235). Validity measurement, measurement variables, and purpose of the training form the basis for any evaluation training. It is incumbent upon an organization to insure that the interaction of these three factors affirm the highest degree of confidence possible.

So how does this information relate to the TCI program? There are two primary concerns for the TCI evaluation and testing process; the TCI Train-the-Trainer (TxT) program and the TCI direct training provided by the TCI Associate Certified trainers to staff in their agencies. The TCI TxT seems to meet most of the criteria outlined previously in this article such as validity, reliability, competency based testing based on knowledge, skill, and attitude, and an emphasis on "did they get it?" rather than "did they fail?" as demonstrated in the ongoing assessment and feedback throughout the program.

As for the TCI direct training evaluation and testing, and the "uneven quality of training" showing that training quality was being "compromised by a lack of adherence to training manual instruction, simple group process, and inadequate training environments" (p. 7) should be addressed to whatever extent possible during the TxT training. It is the lack of adherence to the standardized training model and the variety of direct workers being tested that may be problematic and require additional strategies not currently a part of the TxT program. The direct training evaluation and testing would be served by additional studies such as Nunno (2002) provided. Perhaps a shift in the TCI TxT program to include more assistance with newly certified TCI trainers regarding the training and evaluation portion of the direct training would improve testing results at the agency level.

As much as many employees loathe test taking, it does indeed serve a very practical purpose and provides valuable information for organizations.

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Jack C. Holden, has a Ph.D. in Education specializing in adult learning. Dr. Holden is President of Mueller Holden & Associates and has been a TCI instructor and consultant to the RCCP for more than 20 years. ✷

You cannot depend on your eyes when your imagination is out of focus.
—Mark Twain, A Connecticut Yankee in King Arthur's Court

Are Supine Restraints Safer Than Prone Restraints?

by Jack Holden, Ph.D. TCI instructor, RCCP consultant
Martha J. Holden, MS, Senior Extension Associate, RCCP

This is a question that is asked frequently for which we at the RCCP do not have a clear answer. Yet, many state regulatory agencies are changing their guidelines around use of restraint and have banned the prone restraint as if someone has unequivocally answered "yes" to this question. Recently, members of the RCCP have conducted studies to provide additional information on this controversial subject and to promote the conversation regarding the supine and prone restraint as well as all restraints.

Reviewing Fatalities

A fatality study (Nunno, Holden, & Tollar, 2006) reviewed 45 child and adolescent fatalities between 1993 and 2003 that involved physical or mechanical restraints. Results of the study indicated the most common immediate cause of death was asphyxia (25 cases), followed by cardiac arrest in 10 cases. Physical restraint was implicated in 38 of the 45 fatalities, 27 of those in a prone position. Of the 27 prone fatalities, 7 had multiple staff lying on the child, 6 had staff crossing the child's arms across the child's chest while prone, 4 involved a staff member sitting on the child who was lying on the ground and 2 were the result of a neck or chokehold. In 20 cases, signs of distress such as vomiting, turning blue, and statements of, "I can't breathe," were ignored by staff. Although these techniques or practices are described as prone restraints, they did not appear to be restraints that were prescribed by any recognized or reputable crisis management system since the obvious safety violations were present and signs of children's distress were ignored.

Further when the rationale for these fatal restraints was examined, information was available in only 23 of the 45 fatalities. In the 23 cases, restraints were initiated because children refused to comply with staff or program requests while in an isolation or time-out room, i.e. go stand in that corner; children would refuse to give up an object like a picture; children would refuse to put their shoes on or to take them off; or children would leave a location such as a classroom or a gym or refuse to leave the location. None of these conditions would meet the standard of danger to self or others, the criteria taught in any reputable crisis management training and governed by the vast majority of state and professional regulatory bodies.

Reviewing Perceptions and the Literature

Over the course of 2006 the RCCP conducted both a staff perception and literature survey (Holden, Johnson & Nunno, 2006). A perception survey was conducted by the RCCP in one New York State agency that uses both supine and prone restraints. This quantitative study used a Likert scale to measure staff (n-54) perception around 19 different questions related to issues such as safety, risk, training, aggression, counter-aggression, ease of use, and learning difficulty. The results suggested that staff perceived the prone restraint as less risky, easier to use, easier to learn, and evoked less aggression and counter aggression than the supine restraint.

These results were compared to a literature review of medical journals reporting on physical restraints which was conducted using MasterFile Premier, Academic Search Premier, ERIC, and PsycINFO databases. The 19 different questions used in the perception survey were compared to the literature review representing 78 total articles (48 were included in the study while 30 were excluded for reasons of non-relevance). The literature review was less conclusive than the results of the perception survey but there was agreement that all restraints present considerable risk to the youth, are intrusive to the youth, have a negative effect on the treatment environment, and have a profound effect on those youth who have experienced trauma in their lives. In cases where factors such as extreme agitation, forceful and prolonged struggling, obesity and any pre-existing condition or risk factor, the position of the person may be more relevant. Therefore the need for individualized crisis management plans is essential to the safety of the children. Some governing agencies have attempted or are attempting to reduce the risk of restraints and create safer communities by passing regulations and guidance around use of specific types of restraints. Unfortunately, what these agencies may legislate or regulate as a solution may give a false sense of safety while actually producing greater risk. Safety might be better served if risk reduction efforts focused on eliminating adverse environmental causes for aggression and violence, eliminating dangerous staff practices (sitting on children, choking or lying on them, placing weight on their upper torso and ignoring their distress signals), and strictly enforcing the restraint application standard of self-harm or harm to others. All restraint positions were represented in the fatality study and the literature review and all positions can be lethal, especially when misapplied or misused.

Holden, J., Johnson, T, & Nunno, M. (2006). *Using a prone/supine perception survey and literature review to forward the conversation regarding all restraints.* Paper presented at the Reaching for the Light. Retrieved from http://rccp.cornell.edu/Reports.htm#pronesupine.

Nunno, M, Holden, M. & Tollar, A. (2006) Learning from tragedy: A survey of child and adolescent restraint fatalities. *Child Abuse & Neglect: An International Journal.* 30 (12), 1333-1342. ✷

Reaching for the Light: High-Risk Interventions in Human Services

Reaching for the Light: High-Risk Interventions in Human Services was held at the University of Stirling, Stirling Scotland on August 28-30, 2006. More than 100 researchers, policy makers, attorneys, advocates, and intervention system providers from the United States, Canada, England, Wales, Scotland, Australia, Norway, the Netherlands, Finland, and Ireland participated. The professions represented included social work, law, medicine, psychology, and education. Presentations covered topics such as the legal, ethical, and historical uses of physical restraints and seclusion, safety, psychological and emotional impact, and guidelines for development and use, as well as clinical and organizational strategies likely to reduce use in children's treatment facilities.

This symposium provided a forum for scholarly debate on best practice in areas such as social policy, the role of the organization, models of care, audit and quality issues education and training issues, service user involvement in crisis planning, physical holding, mechanical restraint, seclusion, and post incident support for staff and service users. Stirling 0University sponsored the event with additional support from Cornell University's Residential Child Care Project. Individuals may find the program and the paper presentation at the Stirling University Department of Nursing and Midwifery website http://www.nm.stir.ac.uk/news/reachinglight_symposium.htm ✷

Children and Residential Experiences (CARE): Creating Conditions for Change

By Martha Holden and Michael Nunno

In 2005, the South Carolina Association of Children's Homes and Family Services assessed 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 this training needs assessment, the Association considered ways to design a model curriculum specifically for its South Carolina member agencies and approached the Residential Child Care Project at Cornell University's College of Human Ecology.

In April 2005, Cornell convened an international group of experts to discuss the prospect of working together on a best practices curriculum for South Carolina. The Association requested that Cornell propose 1) a plan to produce a competency-based curriculum based on best practices and current research; 2) provide the agency and organization specific on-site training and technical assistance to support the utilization of the best practices curriculum; and 3) evaluate the curriculum content, implementation process, and training effectiveness.

A philosophy of change and strong overall programmatic elements and structures are essential to successful residential and group care that supports the best interests of children. Residential child care organizations need a theory and philosophy of change and growth that leads to a working model which guides staff's work with children. With a strong framework for practice, staff members have clear objectives for daily routines, leisure activities, staff-client interactions with a focus and purpose of helping children achieve mastery. This structure is essential to create developmental and treatment opportunities through routines, staff-child interactions, and recreational activities.

Anglin (2002) constructs a theoretical framework for understanding day-to-day group home life and work that serves to improve practice and policy development as well as education and training, research, and evaluation. The framework can be relevant to multiple treatment models or guiding principles. The overriding core concept that drives Anglin's notions of good practice is "the struggle for congruence in the service for the best interests of the child." The organization's struggle for congruence encompasses three major properties: consistency in purpose, values, principles and actions; reciprocity demonstrated in the interactions between persons within the facility; and cohesiveness or wholeness within the system of care. The concept of "the best interests of the child" is widely accepted as a touchstone for child and youth care practice and is reflected in the United Nations Convention on the Rights of the Child and in child welfare and child protection literature in North America and the United Kingdom. United in mission and purpose, a well-functioning team/organization will struggle to achieve congruence in the best interests of the child when having to make difficult decisions within the realities of competing personal, organizational, and governmental needs.

In the day-to-day life of a residential facility, full organizational congruence is a struggle. If the psychosocial processes and the interactional dynamics of the struggle are congruent among all levels in residential agencies, including the youth, the struggle can lead to organizational learning, increased congruence, and improved functioning. These fundamental psychosocial processes are responding to pain and pain-based behavior, developing a sense of normality, and creating an extra-familial living environment. Anglin's interactional dynamics are listening and responding with respect; communicating a framework for understanding; build-

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CARE, Cont. from p. 5.

ing rapport and relationships; establishing structure, routine, and experience; inspiring commitment; offering emotional and developmental support; challenging thinking and action; sharing power and decision-making; respecting personal space and time; discovering and uncovering potential; and providing resources (Anglin, 2002).

In 2005 the first project phase was to lay the groundwork for this curriculum development. Anglin's (2002) matrix for understanding group care became the organizing framework for the development and selection of best practices on-the-job competencies necessary for strong programmatic residential group care. During 2005 a group of experts, including Dr. Anglin, convened by Cornell, selected 80 key competencies from researched and published national and international child care worker competencies (Anglin, 2002; North American Association for Child and Youth Care Practice, 2001; Scottish Social Services Council, 2004; United Kingdom Quality Assurance Agency for Higher Education, 2000). Over 100 South Carolina residential child care personnel including supervisors, clinicians, and managers verified the importance of the selected competencies to their work.

The second phase of this best practice curriculum effort entails curriculum development and training activity testing, piloting the curriculum, as well as piloting specific training implementation and evaluation strategies. The first pilot of the curriculum took place in August 2006 with 5 pilot South Carolina child caring organizations. Based on this pilot, revisions are being made to the curriculum with a second offering scheduled for February 2007.

The project's major product will be a curriculum that teaches and supports the approximately 80 key competencies that were selected from existing and published national and international care worker competencies. The curriculum and training design will further delineate the intellectual skills, cognitive strategies, verbal information, and attitudes (Gagne, 1985; Gagne, Briggs, et al., 1992; Gagne and Medsker, 1996) necessary for optimal competency performance. All training will be within sequenced events of instruction (Gagne, Briggs, et al., 1992).

The best practices curriculum, Children And Residential Experiences (CARE): Creating Conditions for Change will be introduced to all South Carolina Association member agencies via organizational intervention strategies that are built on quantitative and qualitative research, as well as informed practice. The best practices CARE curriculum and its intervention strategies will support safe environments, strong programmatic elements and a wide-variety of treatment programs and interventions that are trauma-sensitive and developmentally appropriate (Haugaard, 2001; Holden, et al., 2001; Hardy & Laszloffy, 2005; Webb, 2006). The best practices CARE curriculum and its intervention strategies will address organizational performance and positive child outcomes through continuous quality improvements and participation-centered management strategies (Glisson, Dukes, et al., in press; Glisson & Hemmelgarn, 1998).

The CARE curriculum will be available for national release sometime in 2008. Please watch the RCCP web site for additional announcements about this exciting new project.

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Children And Residential Experiences: Creating Conditions for Change: Outline of Curriculum

Module 1: Building a Foundation An organization with a clear philosophy of care lays the groundwork for a staff that works cohesively in the best interests of the children in their care. This curriculum involves the basic principles of an ecological approach, competency-centered, family involvement, relationship-based, developmentally appropriate, and trauma informed. The environment in which care is given can have major impacts both directly and indirectly on the children and workers who live, work, and play there.

Module 2: The Importance of Caring Attachment is one of the most basic and vital developmental goals for any child. Workers should strive to provide opportunities for all children to become involved in positive individual and group relationships. The more consistently workers meet the needs of the children in their care, the more likely the children are to develop trust and form attachments.

Module 3: Creating an Environment Where Children Can Thrive Care workers should strive to create order in the residential environment without exerting control over the residents. Order can be maintained by communication with children about expectations, observation and attention to each child and his or her needs, having realistic and positive expectations for children, listening and responding with respect, and helping children make good choices.

Module 4: Responding to Trauma and Pain-based Behavior A goal of care workers should be not only to help children deal with the consequences of trauma, but to increase the amount of resiliency factors in a child's life in order to help them withstand future traumatic events. Workers should listen to children talk about their feelings, watch for triggers and signs of re-enactments and flashbacks to traumatic events, give children choices and control over life events, and teach children to better express and deal with their emotions.

Module 5: Self Understanding and Emotional Competence In order for workers to be able to provide a tolerant environment, they must be both knowledgeable and tolerant of other cultures and their practices, as well as be aware of their own background, strengths, and weaknesses. Also important to a worker's self-awareness is emotional competence, which encompasses self-awareness, self-regulation, self-motivation, empathy, and social skills. Reflective practice enables workers to learn through their own experience and through others'.

Module 6: Creating Conditions for Change Many factors affect a child's ability to change, including the child's own strengths (40%), the relationship between the child and the adult assisting them in change (30%), hopefulness about the change (15%), and the actual technique used to change (15%). A child's ability to change is influenced by his or her self confidence, which is shaped by experience of success, modeling by peers, social persuasion, and psychological and emotional factors. A care worker's relationship with a child is a unique and powerful tool to use when helping a child change maladaptive behaviors.

Module 7: Helping Children Do Well When a child isn't meeting expectations, the goal of a good care worker should be to figure out how to help the child meet the expectation in the future or adjust the expectation if the child cannot achieve the expectation. When a child is not behaving as desired, the worker should first assess the situation, then think about what the child needs help with in order to meet expectations.

Module 8: Striving for the Ordinary in Residential Care At every age, children face developmental tasks that are necessary for them to accomplish in order to develop into competent adults. One of the goals of good residential care is to provide children with the optimal social, physical, and emotional environment in which to accomplish developmental tasks and grow into healthy adults. By teaching skills, providing opportunities for practice, and setting a child up for success, a worker can help children achieve.

Module 9: The Rhythm of Caring Even simple daily activities such as waking and mealtimes can have significant impacts on the quality of life for children in care. Well-designed routines are predictable and consistent, flexible, teach good habits, balance the needs of the group and individuals, and help to segment a child's daily life into manageable sections. The way the physical environment is set up can not only affect children's behavior, but can also be used as a diagnostic tool when a worker observes the way a child has arranged his or her personal space. The residential environment should be set up to invite positive behaviors and interactions, while minimizing frustration and anxiety.

Module 10: Building a Caring Community In group care, groups may be carefully constructed in order to give each member an important role and a chance to feel valued. A positive group experience doesn't just happen, care workers have a large role in forming the group and maintaining it. Participation in work and service opportunities teaches children responsibility and investment in the community; play aids social, physical, and cognitive development; both activities provide opportunities for care workers to build relationships with children.

Module 11: Essential Connections Life is about making essential connections to one's environment, peers, and protectors. Nine essential connections have been identified as critical to the healthy development of all human beings. Many essential connections may have been missing from a child's life when they come in to care, and those they do possess may be negative. It is the all-encompassing job of the care worker, the group, and the home to provide as many opportunities for positive connections as possible.

Module 12: The Struggle for Congruence in the Best Interests of the Child Working with children in care is a team effort that includes the care workers and other staff, the families, and the children themselves. The goal for all residential homes should be service in the best interests of the child. With that goal in mind, and a working knowledge of the principles of good care, workers can make the right decisions for the children in their charge.

TCI Bookshelf

Examining the Safety of High-Risk Interventions for Children and Young People

edited by Michael Nunno, Cornell University, Ithaca, NY; Lloyd Bullard, Child Welfare League of America, Washington, DC; David M. Day, Ryerson University, Toronto, Canada

In late winter or early spring 2007 the Child Welfare League of America will publish an edited volume entitled *Examining the Safety of High-Risk Interventions for Children and Young People*. This book was born out of the papers and the presentations delivered at a symposium of the same name held at Cornell in June 2005. To our awareness this book is the only volume that is devoted entirely to the subject of, and risks associated with, restraint and seclusion. The book is organized into six sections—young people and physical restraints, theoretical and historical issues, ensuring safety and managing risk, reducing restraints through organizational change, and broader social influences.

This book is written for anyone interested in learning from the expertise and experience of a broad spectrum of North American and British academics, scholars, agency directors, clinicians, quality assurance personnel, and crisis management systems experts. While the book's point of view is varied, as a whole it is biased towards the emerging international consensus to reduce restraints and seclusion to only those matters that involve immediate safety (British Institute for Learning Disorders, 2001; Child Welfare League of America, 2002; National Executive Training Institute, 2003). The editors selected the chapters because they were among the best work delivered at the Cornell symposium, and, likewise, represent the best that we know at this point of time. Although we know a good deal, we hope that the contents challenge the reader to move the field to fewer, safer, and more appropriate uses of restraints and seclusion.

As soon as the book is available for purchase, the RCCP website:
http://www.rccp.cornell.edu
will direct the reader to the appropriate part of the Child Welfare League of American's website where copies of the book may be obtained. ✷

Frequently Asked Questions About Professional Certification

Beginning 2001, TCI trainers were given the opportunity to apply for professional level certification. This provided professionally certified TCI trainers an opportunity to train independent from their agency. There are currently 23 TCI trainers certified at the professional level.

In an interview, one professional level trainer described the process as time consuming, but rewarding:

"The requirements are very specific and it takes a lot of thoughtful planning." The professional trainer went on to say,

"The process allowed me to take my training skills to the next level. For me, this was more about professional satisfaction and less about the ability to charge for training outside my agency."

Inquiries about the process for applying for professional certification have increased dramatically. Here are some frequently asked questions:

When am I eligible to apply for professional certification?

Applicants may apply for professional certification one year after receiving the associate level certification. They must

FAQ: Certification, continues on page 9.

Do you work with young people with aggressive behaviours in residential care, foster care, special schools, juvenile justice facilities, mental health settings, and other community settings? If so, mark the dates of this two-day Symposium in your 2007 calendars:

"Crisis And Opportunity" – Exploring Best Practice In Behavioural Crisis Management
March 22 & 23, 2007 at the Hotel Heritage, Goyder Street, Narrabundah, Canberra, Australia

This symposium features international presenters, trainers, and researchers from Cornell's Residential Child Care Project, and from Australia. The format will include plenary presentations, workshops and shorter papers on topics including:

- Implementing and "embedding" crisis management systems within organisations
- The crisis management implications of recent brain development research
- Connection and engagement with young people who have experience relationship trauma
- The use and misuse of intrusive management techniques such as chemical (medication) restraint, physical restraint, isolation and exclusion
- New approaches to teaching impulse and emotion-regulation skills to young people

Featured international presenters will include Dr. Michael Nunno and Ms. Martha Holden of Cornell University's RCCP.

This Symposium is presented by the Thomas Wright Institute in conjunction with the Cornell University RCCP. Details may be obtained by contacting the Thomas Wright Institute, P.O. Box 4260, Kingston, ACT, Australia, 02 6295 6255.

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have completed a minimum of four direct core TCI trainings. Each training class must be conducted in a minimum of 24 hours and have been 4 or 5 days in length. Physical intervention should have been included in the training. If the training did not include the physical intervention component, the training must have been a minimum of 3 days with 18 hours of instruction.

I noticed there are new requirements that went into effect this year. For instance, applicants must first submit a letter of intent and a mentor will be assigned. Why was this added?
The letter of intent allows RCCP staff to become aware that a potential applicant is pursuing professional certification. This will help to provide guidance and support to the applicant at the earliest phase in this process, and will help to avoid time delays or unnecessary work on the applicant's part. Mentors are experienced TCI instructors who review professional portfolios submitted by applicants. They are trained to provide specific feedback and helpful tips to applicants moving through the process.

Is there flexibility to what I submit in my portfolio, or must I strictly follow the stated requirements?
No, the requirements are strictly followed without exception. This allows for the requirements to be standardized, thus allowing for a fair and equal process for everyone. Each requirement is designed to provide demonstration of a specific training skill. It is important for applicants to follow the requirements and if they are unclear about a requirement, they should ask their mentor for guidance. Here are two specific requirements that recently needed clarification:

Applicants must submit a self-reflection of their video taped training demonstrations. Applicants may use the instructor evaluation and feedback instrument located in the TCI update: Developing Professional Level TCI Training Skills Participant Guidebook. Portfolio evaluators are interested in learning whether applicants can identify areas for improvement in their video demonstrations. Applicants are credited with their awareness of areas for improvement.

When submitting video demonstration of physical intervention techniques, there must be examples of the applicant coaching several participants through the technique after it was demonstrated. Reviewers do not have enough information to evaluate the applicant's coaching skills when only one example is submitted.

What should I do if my initial portfolio submission is rejected?
Try again! It took many current professionally certified trainers multiple attempts before they received their certification. If your application is not approved for professional certification, you will receive corrective feedback on how to improve your portfolio. Work with your mentor who will be happy to offer you guidance and support as you prepare for the resubmission of your portfolio.

Do I need to send in another application fee if I am resubmitting my portfolio? By the way, what is the application fee used for?
Once you have paid the initial application fee, you will not be charged for resubmitting your portfolio. This is a one-time fee. The application fee is used to offset the time and work of the evaluators who review your portfolio. These folks include other professionally certified trainers and training consultants on the project who have agreed to review portfolios "on their own time." They take their role seriously and put forth an incredible amount of time and effort evaluating portfolios. This is a way to defray some of their time and to let them know how important their work is to the project.

Do you have any helpful tips when creating my video recording?
First, it is very important that you use a remote microphone. This is the only way to clearly hear the applicant's presentation and the participants' discussion. Second, pay attention to camera placement. Reviewers need to see the training room set-up and the participants. Finally, relax and be yourself!

What do I need to do to keep my certification active?
You will need to attend a TCI update every 2 years (outside the state of New York) or annually (inside the state of New York, Ireland, and the UK). You may sign up for any of the update offerings listed. You will need to show complete attendance, pass the written test and physical skills test (unless you are certified without the physical intervention skills).

You are required to bring to the update documentation of any training that you have conducted independent of your agency. These records should include attendance lists and records of participant test scores. These records will be collected by the update instructors and reviewed by the Evaluation Department at the RCCP.

If you have further questions about professional certification, you may direct them to Thomas Endres, extension associate at (607) 254-2761. ✸

Frequently Asked Questions About TCI Europe

Over the last year, certain administrative and service functions have changed in the TCI Europe program to respond to the growth and demands of the program and our ability to provide different types of support to individual agencies. The administration of the TCI training courses is the responsibility of Angela Stanton-Greenwood who can be contacted at tcieurope@cornell.edu. The mailing address for TCI Europe (United Kingdom and Ireland) is PO Box 3959, Chesterfield S44 9AE. In addition to providing training courses, TCI Instructors will also provide agency support through assessment and planning meetings as needed.

Please find below some of the most frequently asked questions from TCI trainers and applicants for training in the UK and Ireland.

How do I find out which classes are available?
Go to the Cornell website, http://rccp.cornell.edu and look for the TCI train the trainer or update courses that are relevant for you.

Which sections of the application form should I fill in if I am from the UK or Ireland?
Sections A and F. Please print clearly and put your email address in the appropriate case.

Can I provisionally book a place by emailing in advance?
Places are booked on a first come first served basis including the receipt of payment.

When can I move on to a one day update?
When you have completed the Post Crisis Response (not the older Recovery for staff) and Designing Refresher Training updates.

What are the different levels of TCI physical intervention training?
Level 0 – No physical intervention.

Level 1 – The protective interventions, breaking up a fight and the standing hold.

Level 2 – All of the physical interventions.

How do I choose which physical intervention level I should train to?
This is determined by several factors. They include your physical fitness level, and the needs of the people and agency you will be training in. The agency will have determined the levels of physical interventions that you need to train through a behavioural audit of typical interventions that have to be used operationally. This then influences what level you should train to.

What if our agency does not use or train physical interventions?
There is a four-day training-of-trainers program called, "TCI Without Physical Interventions," that is available for organisations that do not use physical interventions. ✷

Professional Certification Announcements

Wendy Brophy Wendy works for AimHi Prince George Association for Community Living, an organization that provides a variety of services to people with developmental disabilities, children with special needs and their families. AimHi is located in Prince George, British Columbia, Canada. She began her career in Community Living in 1991 at AimHi and has worked in a variety of roles, beginning with direct care with Adults and Children in the Life Skills Program teaching daily living skills and promoting independence. After 7 years, she moved into a management position where she was responsible for 3 supported living homes, including one for children.

She first attended the 5 day TCI Train-the-Trainer program in 2002 and has provided training to new and existing employees of her Association since that time. The TCI program has been effective in shifting the way our employees view crisis prevention and how they assist people to effectively learn new skills. It is making a difference for people we support.

John Dahl works as a Program Coordinator in an intensive residential treatment program for complex needs youth at Hull Child and Family Services in Calgary, Alberta. The program serves adolescents with a developmental delay, severe social competency deficits and multiple mental health diagnoses. John has over 15 years experience in intensive residential programs and community initiatives. He has worked both front line and management positions and currently hold a position that blends both. He has taught TCI for the past seven years and was professionally certified (without physical interventions) in 2005. He is a professionally certified child and youth counselor through the Child and Youth Care Association of Alberta and has a diploma in Criminology and a BA in Sociology. He is completing his Master's Degree in Counselling Psychology with a thesis in crisis intervention training. He coordinates training externally through Applied Behavioural Technologies, providing training and support to agencies in Alberta. He may be contacted by at 403-470-1065 or at jdahl@shaw.ca.

Dean Kazakoff has worked in Community Living for 17 years and has been a TCI Instructor since 2002. He has held various positions within AimHi Prince George Association for Community Living, ranging from Skill Trainer to Acting Program Manager. He earned his professional certification in 2006 and may be contacted at dean.kazakoff@aimhi.com. AimHi is located in Prince George, British Columbia, Canada.

Oliver B. Levy Oliver has been working with at-risk youth for 15 years at The Edwin Gould Academy in New York, NY, and has been a TCI trainer since 1998. He began his career as a teaching assistant and eventually became the Director of Student Services and Staff Development. He is also trained as a Positive Peer Culture Group Leader. He currently runs his own behavior management consulting firm working with schools that service at-risk youth. Oliver received his Professional Certification in November 2005 and may be contacted at OBSR@aol.com.

Michael Thomas Having worked in the mental health field for the past 14 years, Michael Thomas is currently the President and Managing Director of the Tomato Group, Inc., New York, NY. This past spring 2005, Michael presented his original workshop on staff training at Cornell University's annual international TCI conference in Dublin, Ireland. Shortly thereafter, he also received his professional certification as a trainer in Cornell's Therapeutic Crisis Intervention model. Michael has worked as the Training Director of the Andrus Children's Center, Yonkers, NY; a freelance writer for The Princeton Review's textbook publishing division; and as group facilitator for teenage group homes at St. Christopher's Group Homes in Westchester and New York City. Michael's article, "Creative Thinking and Talking in Residential Care," was published in the 2005 spring edition of *Therapeutic Communities*. He may be contacted at MT10701@aol.com.

Ask Eugene

Q: I am a TCI trainer and I need to renew my certification. How do I get re-certified?

A: You must successfully complete a TCI update to renew your certification as a TCI trainer. Successful completion of any update, regardless of the title, will renew your certification.

Q: What about these one-day updates that are now available? Can I take one of those one-day updates, or does it have to be a two-day update?

A: That depends on what updates you have successfully completed. TCI trainers can get re-certified by successfully completing a one-day TCI Update if they have successfully completed BOTH TCI Updates: Post Crisis Response AND Designing Refresher Training. If you have not taken both of these updates, you will not be able to get re-certified via a one-day update.

Q: Where are the TCI trainings and how do I sign up?

A: Everything you need to register for TCI training is available on our web site at http://rccp.cornell.edu

Q: I have questions about TCI, my trainer certification, on-site TCI training, when and where is training being held, or whether a training I want to go to is open. Where do I go?

A: Our web site, http://rccp.cornell.edu, is always the best place to start if you have questions about TCI, or about what we are doing as a project other than TCI. Chances are good that your answers are there.

If you are not able to get what you need from the web site, please contact us. We do ask, however, that you contact the correct person to avoid any response delays due to an ever-increasing volume of correspondence. See below:

- For information about training dates for open enrollment TCI training, as well as registration information, please contact Alissa Burns via email at ab358@cornell.edu, by phone at 607-255-4528, or visit our web site at http://rccp.cornell.edu.
- For information about bringing TCI to your agency, via on-site training of trainers or an implementation of the TCI system, please contact Eugene Saville via email at eas20@cornell.edu, by phone at (607) 254-5210, or visit our web site at http://rccp.cornell.edu to download our on-site training brochure.

Excerpt From the CARE Curriculum

By Martha Holden

Trauma and Pain-based Behavior

It is easier to blame the victim than to deal with the cause. —Anonymous

Imagine punishing a child for crying, screaming, and demanding attention after receiving a cut on the leg in a fall from a bicycle. No reasonable adult would do this. But many children are punished in schools, homes, and residential care when they express their emotional pain. No child should be punished for behavior that is a result of pain – either physical or emotional. That would be adding injury to injury which would only increase the damage.

Recent research on trauma, brain development, and cognitive, social, emotional, and behavioral functioning, has resulted in new understandings of children's challenging and difficult behaviors (Ledoux, 2002; Perry, 2002; van der Kolk, 1994). After intensely studying 10 group care facilities, Jim Anglin identified many of the emotional and behavioral problems of youth in care as "pain-based behavior" (Anglin, 2002; Brendtro, 2004). The ability to deal with children and youth's psychological and emotional pain without inflicting additional painful experiences on them is one of the biggest challenges for care workers.

What is Trauma?

"Traumatization occurs when both internal and external resources are inadequate to cope with external threat" (van der Kolk & Ducey, 1989). Many people experience traumatic events, such as a car accident, a flood, or the death of a loved one. Although most of these people experience great emotional pain and a period of disorganization or dysfunction, they are able to eventually return to

Excerpt, continues on page 13.

Excerpt, continues from page 12.

normal functioning with or without some professional assistance.

Children with a history of abuse, neglect, abandonment, devaluation, and exposure to chronic family and/or neighborhood violence face a more complicated and debilitating situation. Depending on the child's age and the extent and duration of the threat, brain development and functions may be permanently effected by traumatic experiences (Perry, 1997; Schore, 2001). For example, when someone is under threat, the mind and body respond to the threat by either preparing to fight or flee. The brain is designed to sense, process, perceive, act, and store information from the internal and external world. When an internal condition such as thirst or dehydration or an external threat such as a quickly approaching stranger persists, this places stress on the system. The brain then adjusts the body's emotional (level of arousal), cognitive (style of thinking), and physiological state (heart rate, muscle tone, rate of respiration), in order to respond to the stress/threat. Once a person has quenched the thirst or the stranger has walked by, the stress is reduced, and the body relaxes and returns to baseline. The more stressful or threatening the situation, the more regressed or primitive the thinking and behavior becomes as different parts of the brain control and organize the response. This is all part of the brain's stress response system designed to help people survive in hostile and threatening situations. It is a human's fight or flight mechanism. Low-level stress during a child's early years is necessary for healthy development. In the arousal - relaxation cycle, the child feels discomfort, cries, is comforted, and the child's stress is relieved. The child develops an attachment and a sense of security and can then take risks and explore the world as he/she grows up. With a consistent, available, and safe caregiver as a base, the child learns how to cope with stress and emotions.

Dramatic, rapid, unpredictable, or threatening changes in the environment activate the stress-response system. If these events are prolonged, chronic, or severe, the child's brain and body stay in this survival mode. During childhood when the brain is still developing, traumatic events such as exposure to violence, chronic abuse and neglect can result in changes to the brain such that the child is in a permanent state of arousal even when there is no threat. Children who are exposed to violence often develop emotional, behavioral, thinking, psychosomatic, and sleeping disorders (Garbarino, 1999). These children may be impulsive, easily distracted because of attention problems, or addicted to danger. They may perceive events that seem harmless to most people as if they presented a high level of danger. For example, a child walking past a table in the cafeteria, bumps the table. Bobby's milk is spilt when the table is bumped. Bobby jumps up and hits the child who walked past. The other children thought it was an accident, Bobby perceived it as a hostile act. Eventually this condition can lead to many emotional and behavioral problems such as aggression, violence, self-injury, and/or substance abuse.

Living in a World With Violence

Even children in care who have not been abused and neglected have often been exposed to violence in the home, in the neighborhood, at school or in the media. In many ways, violence is accepted as a legitimate way to resolve conflict in our society. It is prevalent in movies, on television, and in music. Although all children are susceptible, some are more vulnerable than others. Children are more at risk if they experience multiple traumas, such as violence both at home and on the streets. Some children are also more vulnerable to soaking up the violence they see (Garbarino, 1995). Many of the children most exposed to violence and violent imagery already face serious developmental risks due to poverty, racism, devaluation, family instability, and drugs.

The effects of exposure to violence can emerge quickly or appear slowly over time, and can affect children to varying degrees and in many different ways. Many young children are left feeling scared, hopeless, and unsafe - even in their own homes. Others may experience sleep disturbances, intrusive thoughts, emotional numbing and diminished expectations for the future. The trauma of violence can produce significant psychological problems that interfere with learning and appropriate social behavior in school. Children have difficulty learning when they are feeling afraid. Many children develop a pattern of aggressive behavior, which, if left unchecked, can lead to serious acts of violence. Research indicates that the amount of aggression exhibited by a child at age 8 predicts the level of violence at age 30 unless there is intervention to change the direction of that child's life (National Research Council, 1993). The experience of violence creates enormous challenges for children and the people who care for them (Garbarino & Holden, 1997).

Children Handle Trauma as Best They Can

In a threatening situation, the normal response is for the child to go to the adult caregiver for help. If no response is received, i.e., the caregiver is absent, unresponsive, incapacitated by the threat, or the caregiver is the threat, the child soon abandons this strategy and generally responds in two ways: hyperarousal and dissociation (Perry & Pollard, 1998). These two responses have profound effects on the child's future physical, emotional and behavioral responses to perceived stressful situations.

Children who dissociate may become detached, emotionally numb, and compliant, often with a decreased heart

Excerpt, continues on page 14.

Grown-ups never understand anything for themselves, and it is tiresome for children to be always and forever explaining things to them.
—Antoine de Saint-Exupery (1900 - 1944), "The Little Prince", 1943

Excerpt, continues from page 13.

rate. They usually disengage from the circumstance and focus on internal stimuli; essentially, they freeze as a rabbit does when it senses danger. When observing these children, they may look like they are defeated or in a day dreaming state. They exhibit avoidant behaviors and may actually be immobilized in a threatening situation and experience short-term memory loss.

If hyperarousal is the response to threatening situations, the child initially experiences an alarm response that starts with anxiety, builds to fear, and then culminates in terror. If this response is triggered repeatedly, the child will eventually be fearful most of the time even when there is no threat, when the child is at baseline. These children are easily traumatized and may perceive threat in almost any circumstance. They often become aggressive, manipulative, defiant, oppositional, and inflexible. The result for all these children is difficulty in forming relationships, problems with calming themselves (self –soothing), and additional behavioral and emotional problems.

Separation and Loss and Trauma

Separation and loss is a part of life. In fact, it is a necessary part of a child's development. Children's ability to separate and manage on their own is based on the security of their attachments combined with their skills to attach and interact with others and their environment. With each stage of development, there is a gain and a loss. When children learn to walk, they gain mobility but lose the security of being held and carried by a parent. When children enter school they gain friends but lose the constant attention of an adult caregiver. At each step, the child experiences anxiety, but with a consistent, caring, competent, and supportive caregiver, the child works through the feelings of loss and separation and adjusts to the new freedoms and opportunities. This is a normal, necessary part of life.

When separations and losses are sudden, unexpected, dramatic, extreme, and/or repeated, essentially traumatic events, children become overwhelmed with anxiety and may develop feelings of guilt, anger, shame, and helplessness. The ability of children to move through the grieving process depends on their age, the circumstance of the loss, their overall emotional level of functioning, and the support they receive. All children in residential care have experienced at least one loss by coming into residential care. Being able to understand and respond to children's expression of loss-the grieving process- is a critical skill for care workers.

Tangible and Intangible Loss

There are two types of losses that children and adolescents experience. Tangible loss involves something physical, i.e., a loss of a pet, a home, a favorite toy; intangible losses are mostly emotional or psychological and are more difficult to manage, i.e., a sense of safety, future, self-esteem, or joy. Children in residential care are usually children who have suffered multiple and repeated losses, most of which have never been grieved or healed. When a loss remains unacknowledged and unmourned it becomes devalued and dehumanized (Hardy 2005). As a result the child feels devalued and unworthy.

Resiliency and Coping

Research on resiliency and child maltreatment has resulted in some significant findings for those who care for children who have experienced traumatic events (Masten, 2001; Zielinski & Bradshaw, 2006). Some children are able to develop into healthy functioning adults even though they have suffered traumatic experiences. The research has uncovered certain attributes or conditions that exist for these children that have assisted them in overcoming the obstacles thrown in their path. Positive emotional relationships to competent and caring adults has been identified as one of most important protective factors (Bernard, 2004; Siegel, 1999, Werner 1990). If children have a stable, caring, supportive, and positive relationship with a primary adult caregiver, they are more able to withstand the damaging effects of traumatic events. Other attributes that contribute to children's resiliency include cognitive and self-regulations skills, social competence, autonomy, problem solving skills, self-confidence, sense of purpose, and motivation to succeed (Bernard, 2004; Masten, 2001). It is important to remember that resiliency is not absolute; everyone has a breaking point. Subject a child to enough trauma and risk factors, such as poverty, punitive or emotionally unavailable parents/caregivers, or abusive treatment, and even the most resilient children will succumb to emotional and behavioral problems.

Excerpt, continues on page 15.

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 Director is 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/

Care workers can help young people facing even extreme challenges grow and develop into healthy adults by tapping into what is known about resiliency. Building relationships, problem solving, autonomy and a sense of competence are developmentally driven. In a nurturing environment filled with caring adults, opportunities to develop a sense of belonging, competence, and self-efficacy contribute to a sense of hope. Focusing on children's strengths, having high positive expectations, and providing opportunities for participation and contribution lead to positive develop and successful outcomes (Bernard, 2004).

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Martha J. Holden, M.S., is a Sr. Extension Associate with the FLDC and the director of the RCCP. As project director, she participates in the development, implementation, and evaluation of TCI in residential child care organizations; a program in TCI for Family Care Providers; and training programs in violence prevention, the Investigation of Institutional Maltreatment, and Institutional Assessment. These programs are offered throughout the U.S., Canada, the United Kingdom, Israel, Ireland, Australia, and Russia. Ms. Holden also provides training and technical assistance to violence prevention projects for the U.S. Army and U.S. Marine Corps. Ms. Holden has published in the Children and Youth Services Review, Journal of Emotional and Behavioral Problems, Residential Treatment for Children & Youth, and the Journal of Child and Youth Care Work, and co-authored a chapter in the book, Understanding Abusive Families.

Jack C. Holden Ph.D., President of Mueller Holden and Associates and a TCI Instructor has presented workshops nationally and internationally on a variety of topics in the human services field and been a project consultant to Cornell University's Family Life Development Center since 1985. Dr. Holden has co-developed the following curriculum, Recovery for Staff - Therapeutic Crisis Intervention, Cornell University, 1995, Connecting: Essential Elements of Residential Child Care Practice. supported by the Child Welfare Institute in Atlanta, GA. In addition, he has published in Training and Development in Human Services, The Journal of the National Staff Development & Training Association, and Child Abuse and Neglect. Prior to 1985, Dr. Holden was a child care worker, supervisor, and program coordinator at a residential treatment center.

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, Beebe Hall, Ithaca, NY 14853 Tel: (607) 254-5210/Fax: (607) 255-4837/Email: eas20@cornell.edu

The Residential Child Care Project • Cornell University
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2007 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS
January 22-26 ..... Ithaca, NY
February 5-9 ..... San Diego, CA
February 12-16 ..... Pittsburgh, PA
March 5-9 ..... Colorado Springs, CO
March 12-16 ..... Myrtle Beach, SC
March 12-16 ..... Leeds, UK
March 19-23 ..... Peoria, IL
April 16-20 ..... Cincinnati, OH
April 23-27 ..... Toronto, CA
May 7-11 ..... Worcester, MA
May 14-18 ..... Dublin, Ireland
June 4-8 ..... Atlantic Beach, NC
June 25-29 ..... Ithaca, NY
July 16-20 ..... Pittsburgh, PA
July 30-August 3 ..... Ithaca, NY
August, 20-24 ..... Ithaca, NY
September 10-14 ..... Sacramento, CA
September 24-28 ..... Peoria, IL
October 22-26 ..... Myrtle Beach, SC
October 29-November 2 ..... Mesa, AZ
November 12-16 ..... Warwick, RI
November 12-16 ..... Penrith, UK
November 19-23 ..... Dublin, Ireland
December 10-14 ..... Ithaca, NY

TCI WITHOUT PHYSICAL RESTRAINT: TRAINING OF TRAINERS
March 26-29 ..... Brisbane, Australia

TCI FOR FAMILY CARE PROVIDERS: TRAINING OF TRAINERS
June 11-15 ..... Ithaca, NY

TCI UPDATES

TCI FOR FAMILY CARE PROVIDERS UPDATE: DESIGNING REFRESHER TRAINING
June 18-19 ..... Ithaca, NY

DEVELOPING PROFESSIONAL LEVEL TCI TRAINING SKILLS
March 1-2 ..... Colorado Springs, CO
March 5-6 ..... Dublin, Ireland
July 12-13 ..... Pittsburgh, PA
September 20-21 ..... Peoria, IL
December 12-13 ..... Leeds, UK

TCI FOR DEVELOPMENTAL DISABILITIES
May 14-15 ..... Worcester, MA
October 4-5 ..... Glasgow, Scotland
October 25-26 ..... Mesa, AZ

TCI FOR FAMILY CARE PROVIDERS
March 20-21 ..... Canberra, Australia
August 27-28 ..... Ithaca, NY
December 3-4 ..... Belfast, N. Ireland

DESIGNING REFRESHER TRAINING
February 1-2 ..... San Diego, CA
March 15-16 ..... Toronto, CA
March 19-20 ..... Myrtle Beach, SC
March 19-20 ..... Bournemouth, UK
April 12-13 ..... Cincinnati, OH
April 26-27 ..... Liverpool, UK
May 10-11 ..... Dublin, Ireland
May 17-18 ..... Toronto, CA
May 31-June1 ..... Atlantic Beach, NC
June 25-26 ..... Belfast, N. Ireland
September 6-7 ..... Sacramento, CA
September 12-13 ..... Hertfordshire, UK
October 18-19 ..... Myrtle Beach, SC
October 29-30 ..... Glasgow, Scotland
November 8-9 ..... Warwick, RI

POST CRISIS RESPONSE
February 8-9 ..... Pittsburgh, PA
February 8-9 ..... Belfast, N. Ireland
February 19-20 ..... Glasgow, Scotland
February 20-21 ..... Toronto, CA
February 22-23 ..... Toronto, CA
March 26-27 ..... Peoria, IL
April 2-3 ..... Dublin, Ireland
May 2-3 ..... Glasgow, Scotland
June 7-8 ..... Penrith, UK
June 19-20 ..... Dublin, Ireland
July 19-20 ..... Ithaca, NY
September 17-18 ..... Penrith, UK
November 8-9 ..... Warwick, RI
November 26-27 ..... Dublin, Ireland
December 6-7 ..... Ithaca, NY

Note: *The following NEW 1 day updates are ONLY available to TCI trainers who have successfully completed BOTH Designing Refresher Training AND Post Crisis Response.*

ADAPTING THE LIFE SPACE INTERVIEW FOR PROACTIVE AGGRESSION
April 4 ..... Dublin, Ireland
April 11 ..... Cincinnati, OH
May 1 ..... Glasgow, Scotland
May 9 ..... Dublin, Ireland
May 30 ..... Atlantic Beach, NC
June 18 ..... Dublin, Ireland
September 11 ..... Hertfordshire, UK
November 7 ..... Warwick, RI

CONFLICT RESOLUTION
February 28 ..... Colorado Springs, CO
October 3 ..... Glasgow, Scotland
October 17 ..... Myrtle Beach, SC
October 24 ..... Mesa, AZ
November 28 ..... Dublin, Ireland

LEGAL CONCEPTS INVOLVED IN THE USE OF PHYSICAL RESTRAINT
July 18 ..... Ithaca, NY