

refocus

THE RESIDENTIAL CHILD CARE PROJECT NEWSLETTER • VOL. 14, 2009

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2006-2008 Prone/Supine Perception Survey

by Jack C. Holden PhD, Michael Nunno DSW, & Brian Leidy PhD

Introduction

Last year this study was reported in *REFOCUS* after two years of surveys and literature reviews. The concern for safer physical restraints continues to be a conversation centered on prone physical restraints versus supine physical restraints. In 2008 this study was continued and the following discussion looks at the updated results.

A perception survey was conducted in one (1) New York State children's residential center in 2006, 2007, and 2008 at approximately 12 month intervals. The agency uses both the Office of Children and Family Services (OCFS) approved prone restraint and the Office of Mental Health (OMH) approved supine restraint and included staff that had experience using both techniques for a total (n=354) for all studies. The literature review represented 121 total articles; 88 were included in the study while 33 were excluded for reasons of non-relevance.

Methodology

This quantitative study used a Likert scale to measure staff perception in one (1) agency currently using both a prone and supine restraint. The data collected for the study was derived from a staff perceptions survey and included the mean and paired sample correlations as well as an analysis of the variables (ANOVA). A narrative review of the literature was also incorporated.

Prone Vs. Supine, continues on page 4.

NEW: TCI Curriculum Sixth Edition Revision To Be Released in 2009

by Martha J. Holden

In the spring of 2009, the Residential Child Care Project will release the 6th edition of the Therapeutic Crisis Intervention curriculum. Since the curriculum's inception there have been five major revisions. The revision process has generally included (1) examining the evaluation results and research conducted by the RCCP, (2) reviewing related literature and research, (3) conducting surveys of organizations using the TCI system, (4) talking to other crisis management training providers, (5) seeking input from TCI trainers, and (6) convening a group of experts for consultation and review.

Evaluation and Research

The RCCP supports vigorous and ongoing in-house evaluation of TCI training and implementation efforts through testing participants' knowledge and skills, a certification program, formal assessment, and direct monitoring of agencies' use of high risk interventions. The RCCP seeks to maintain a leadership role in discovering new knowledge, establishing new approaches to knowledge dissemination, and developing innovative programs to enable child caring agencies to serve children, youth, and families more effectively by building strong linkages among research, outreach activities, and evaluation efforts. These relationships are viewed as cyclical: research leads to the development of innovative and effective outreach programs, which are carefully evaluated. Evaluation activities contribute directly to the adaptation and improvement of outreach programs and may also contribute to new research. In-house and external evaluations have been essential in modifying intervention strategies and protocols to improve the TCI system's effectiveness for a wide range of organizations (see figure 1 on page 2).

Reducing the Need for High Risk Interventions

Research on the effects of trauma on brain development and emotional regulation, resiliency, and protective factors, and the use of high risk interventions provides much of the underpinning of this sixth edition of the TCI curriculum. Not only must we provide a therapeutic milieu where young people are physically safe and protected, we must involve young people in activities that promote caring relationships, positive growth and development, and opportunities to participate and contribute. Our agencies must maintain order and physical safety as well as provide programs aimed at changing young people's frameworks and values.

TCI Curriculum, Edt. 6, continues on page 2.

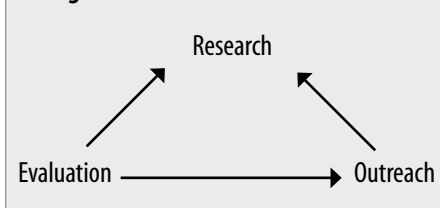
TCI is Reaccredited by BILD



TCI was resubmitted for reaccreditation against the BILD standards for behaviour support programmes in June 2008. This meant submitting a proposal, assessment by a BILD assessor over a training event and an office visit to audit systems. Not only was TCI reaccredited for 3 more years but it received glowing feedback about the quality of its submission, the above standard quality of recording and auditing and its willingness to respond to the feedback and support that BILD have offered.

TCI Curriculum, Edt. 6, continued from p. 1.

Figure 1. TCI Effectiveness Model



An organization can prevent most crises by providing a competent work force able to respond to children in emotional pain in a caring and therapeutic manner. Adults who build caring relationships, establish routines and activities that meet individual and group needs, and understand the complexity of challenging behavior help establish an organizational culture that will result in positive child outcomes.

Choosing Safety Interventions

In 1999, Cornell University's Residential Child Care Project began a multi-year fatality study to help inform the Therapeutic Crisis Intervention (TCI) system. Although the TCI system is primarily focused on organizational components such as policy, clinical management, supervision, training and quality assurance to prevent and de-escalate aggression and violence, physical interventions are taught as safety interventions if supported by a organization's policy, accreditation bodies, and regulation. By studying and understanding the frequency and nature of, as well as the circumstances surrounding restraint fatalities, the RCCCP provides agencies with valuable safety information that helps prevent tragedy. What the RCCCP discovered did not point to any one factor but a pattern of child care practice that had its roots in inadequate supervision and training, insufficient review and monitoring of restraints, and organizational cultures that support physical management as a strategy for program compliance.

As a reaction to the serious injuries and fatalities that have occurred in residential care, some state organizations have banned certain restraint techniques, specifically prone restraints and basket holds. Although the facts around these incidents question the effectiveness of banning prone restraints as a way to prevent restraint fatalities, it appears to be a trend and many agencies are finding themselves in a difficult position in trying to support staff in their efforts to manage violent behavior. As a response to agencies that are experiencing changes in these regulations, the RCCCP has developed additional restraint techniques to offer alternatives to the small child and prone restraints. The present TCI restraint techniques are still included and may still be used. Agencies may choose to train their staff in all, some, or none of the physical techniques. Participants attending the TCI Training of Trainers Program, may apply for certification to train all, some, or none of the physical techniques.

This edition of TCI includes a supine restraint technique and a seated hold that are bio-mechanically acceptable for children and young people in care, as well as staff who perform them. In addition, a letting go process consistent with TCI physical interventions and a staff transfer strategy during the supine intervention is presented. The supine restraint technique requires three staff – two on the upper body and one on the legs. The seated hold can be applied by two staff members with an additional staff for added security.

Please note that the RCCCP cannot claim with any certain quantitative or qualitative evidence that any supine intervention is safer or less traumatizing than the prone restraint. Both the prone and the supine position carry risks that with some children or young people may be unacceptable if used or misapplied (See Prone/Supine Perception Study p.1). TCI training will contain information about any foreseeable risks and outline proper

staff training and testing procedure and practice to minimize these risks during actual use.

Transitioning to the Revised TCI Model

The RCCCP recommends that TCI agencies develop a plan to transition into the revised TCI system. Certified TCI Trainers who have not yet been certified in the revised 6th Edition TCI course cannot present the revised course. TCI agencies need to plan how to get their certified TCI trainers through the *TCI Update: Curriculum Revisions, 6th Edition* (see side bar on page 3) for the revised course, as well as how to retrain their staff. Very large agencies may want to retrain staff and implement the changes unit by unit. Smaller agencies may be able to transition quickly and all at once. We do not have a deadline for this transition although we recommend that once the TCI trainers have been certified, they begin training as soon as possible so that they do not have to relearn the changes months later.

The *TCI Update: Curriculum Revisions, 6th Edition*, will be offered continually for presently certified TCI trainers until April 2011. After April 2011, TCI trainers will be able to receive the 6th Edition revision and apply for certification by attending a week long Training of Trainers course.

Assessing The Agency's Current Implementation of TCI

If an agency or organization is interested in assistance in implementing the TCI system or would like specific technical assistance in one or more areas of implementation, the RCCCP is able to assist with this process. A full implementation package is described on our web site (rccp.cornell.edu) and RCCCP consultants are also available to do specific technical assistance tasks. Please call for specific information and costs. ★

Martha Holden, MS, is a Senior Extension Associate with the FLDC and director of the RCCCP.

TCI Update: TCI Curriculum Revisions, Edition 6

Program Description

This update is a two-day program at which current TCI trainers learn the new additions to the TCI curriculum, Edition 6, focus on restraint reduction strategies for their agencies, and practice new restraint techniques. Topics that will be discussed include reducing the need for high risk interventions, organizational culture and climate, setting conditions and crisis prevention, the effects of trauma on children and young people, co-regulation and self-regulation, emotional competence, and the importance of the therapeutic relationship. In addition to reviewing minor revisions in the TCI curriculum, new techniques and skills to help prevent, de-escalate, and manage crises will be demonstrated and followed with practice sessions. These techniques include assessing setting conditions, providing emotional first aid, crisis co-regulation, seated restraint and supine restraint.

Program Objectives

Participants will

- identify additions/changes to revised TCI materials
- describe the effects of trauma on children
- demonstrate emotional first aid technique
- demonstrate crisis co-regulation skills
- demonstrate new restraint techniques
- describe new safety issues

Program Outline

- Day 1 provides an overview of the new additions in the TCI curriculum, 6th edition, including the following topics, restraint reduction strategies, the effects of trauma, co-regulation and self-regulation skills, and providing emotional first aid. Additions to the physical intervention techniques include a two person seated restraint and a supine restraint.
- Day 2 continues with practicing crisis co-regulations skills and the physical intervention techniques and discusses safety issues associated with the new techniques.

Materials

Participants successfully completing the update, receive a reference guide, activity guide, student workbook, CD, DVD and testing materials to use in their direct training.

Agenda

DAY ONE	DAY TWO
9:00 am	9:00 am
Introduction to course	Refocus
Crisis Prevention and the Therapeutic Milieu	Help Me Help Myself: Crisis Co-regulation
The Importance of Emotional Competence	Crisis Role Plays
Behavior Support Techniques	Physical Restraint Practice
Emotional Support	Practicing with Resistance
Physical Restraint Practice	Safety Concerns
5:00 pm Session Adjourned	Physical Skills Testing
	Written Testing
	5:00 pm Session Adjourned

Excerpt from TCI Edition 6 Trauma and Co-Regulation Skills

by Martha J. Holden

The Effects of Trauma on Children and Young People

Exposure to trauma affects how children think, feel, behave, and regulate their biologic systems. Trauma in childhood can permanently alter the way the brain functions. How much psychological damage children experience depends on the age at which they are first traumatized, the frequency of their traumatic experiences, the degree to which their caretakers contribute to the trauma, and the intensity of the trauma. This damage may result in problems with self regulation, aggression, impulse control, attention and dissociative problems, physical problems, and poor interpersonal relationships (Garbarino, 1999; Ledoux, 2002; Perry, 1997, 2002; Schore, 2001; van der Kolk, 1994, 2006).

Traumatized children tend to re-enact trauma by exhibiting challenging behavior. This behavior takes many forms including impulsive outbursts, aggressive acts, running away, self injury, defiance, and inflexibility. These types of responses may be triggered when a child or young person feels a loss of control, is reminded of a traumatic event (consciously or unconsciously), or feels threatened or vulnerable. These behaviors can be referred to as pain-based behaviors since they are a result of the psychological and emotional pain children and young people feel when they are experiencing a stress response (Anglin, 2002). During a crisis a stress response is biological first, then emotional, as children's "fight or flight" response is engaged. Care workers need to be able to assess the feelings behind the child's behaviors, understand the meaning of the behavior, and respond in a manner

Excerpt from TCI 6, continues on page 4.

Excerpt from TCI 6, continued from p. 3.

that helps calm the child (Anglin, 2002; M.J. Holden, 2007; van der Kolk, 2003).

Because of their inability to regulate their own emotions and control their own impulses, once triggered, children go into crisis—unable to self regulate or even co-regulate their emotions or manage their behaviors (van der Kolk, 2003). Care workers need to be able to help children and young people co-regulate emotions by assessing the feelings behind the behaviors, understanding the meaning of the behavior to the child, and responding in a manner that meets that child's needs in that moment (Anglin, 2002; M.J. Holden, 2007; van der Kolk, 2003). Helping children calm themselves when triggered is an effective strategy to de-escalate potential crises.

Co-Regulation and Self Regulation

Children develop the ability to regulate their emotions through interactions with adult caregivers who calm and soothe them. This process is called co-regulation (Bath, 2008). Infants need the presence of a caring adult to smile, hold, coo, and communicate soothing messages to them in order to help them manage their own emotions. When a baby gets uncomfortable and stressed, the caregiver responds in a soothing manner by holding or rocking the baby, cooing and smiling, taking the baby to a calmer state. Adults manage babies' stress for them and through this co-regulation process children eventually learn to soothe and calm themselves. As caregivers start helping children learn ways to manage those emotions, self regulation skills are developed (Gerhardt, 2004; van der Kolk, 2005). Children who have not learned to manage their emotions will need adults to help them co-regulate (identify and manage) emotions throughout the day as well as during times of stress and upset, gradually teaching children how to self-regulate their emotions.

What does this child feel, need or want?

Regardless of age or skill level, everyone needs help managing emotions in times of crisis. This is a critical fact to keep in mind when faced with children and young people who are at the outburst phase of a crisis. What the young person is trying to communicate, e.g., anxiety, anger, depression, defiance, or fear, may be expressed nonverbally by actions or by angry words. Even a young person who normally can share feelings appropriately, may have a limited ability to do so during periods of great stress.

Crisis Co-Regulation. The immediate objective in a potentially violent situation is to make the situation safe. One way to accomplish this is by reducing the young person's arousal so that he or she is more likely to respond to care worker requests. When children are in crisis, they have very little ability to control their thoughts and actions. The emotions they are experiencing are scary for them and they may feel out of control. The first goal in crisis intervention is to lower the stress and risk by providing emotional and environmental support. Care workers have a responsibility to assist young people in their efforts to reduce their stress by helping them regulate their emotions so that they can respond to the situation more rationally. As always, after the situation is safe and the young person is back to baseline, staff can work with the young person to teach better alternatives and skills. More than ever care workers need to be in control of their own emotions and actions. Because of the combination of stress, anger, and arousal, the young person is more likely to interpret any action from the worker as negative. During the crisis, care workers will need to depend on all of their assessment, relationship, and communication skills. There is an opportunity to divert the crisis if staff can maintain self-control and use co-regulation strategies (Bath, 1999, 2008).

Excerpt from TCI 6, continues on page 9.

Prone Vs. Supine, continued from p. 1.

Data Analysis

2006-2008 Prone/Supine Study Summary

- The survey was conducted in 2006, 2007, and 2008 at approximately 12-month intervals
- There were n-54 respondents in 2006, n-127 respondents in 2007, and n-173 in 2008 for a total of 354 completed surveys
- In the 2008 survey, eight (8) reported they completed the 2006 survey, 15 reported completing it in 2007, and 24 respondents reported completing both previous surveys
- There was a much higher proportion of women (59%) completing the survey in 2008 as compared to prior years in which only 47% of the data came from women prior to 2008. This was the only important difference between 2008 data and prior years

2008 Prone/Supine Results

Demographics

- Of the 173 respondents, all but three (3) said they were trained in TCI/OCFS prone restraints and all but 4 said they were trained in the OMH/PMCS supine restraints
- Respondents reported that they used the prone technique more than the supine technique
- Those who used the prone technique more tended to use the supine technique more as well
- Men reported significantly greater use than women of both the prone and supine techniques
- Respondents ages 30-39 reported significantly greater use of the prone technique than those 18-25 and there was a significant increase in the use of the prone technique as years in child care increased
- Supervisors reported significantly greater

Prove Vs. Supine, continues on page 5.

Prone Vs. Supine, continued from p. 4.

use of the prone technique than direct care workers

19-Item Questionnaire Analysis

Respondents were asked their level of agreement with 19 statements which were made both about prone and supine techniques on a five (5) point Likert Scale with one (1) being strongly disagree and five (5) being strongly agree. Agree for this study includes a range of 3.26-5.0, disagree includes 1.0-2.74, and neither agree or disagree (mid range) includes 2.75-3.25. The reliability of the prone and supine scales were tested by factor analysis; using only the 173 most recently completed questionnaires, factor analysis was done for both the 19 item prone technique and the 19 item supine technique. The Cronbach Alpha for both scales was .64, which is close to the cut off of .70 the point at which a scale is considered reliable.

Most of the responder perceptions reported in 2008 indicated there were relatively no significant differences in the prone and supine techniques based on the 19-item questionnaire. This is quite different than previous years (2006 & 2007) when respondents tended to view the supine technique significantly more negatively than the prone technique.

2008 Agreement (respondents generally agree that neither technique):

- increases aggression or counter aggression more than the other
- increases spitting more than the other
- produces longer restraints more than the other
- has a negative effect on the treatment environment more than the other
- has more risk of injury to staff than the other
- has more potential for safety violations than the other
- is more secure than the other than the other

- is safer for the youth than the other
- is safer for staff than the other
- takes longer to learn than the other
- is more difficult to maintain the skill than the other
- is more likely to have injuries during training than the other
- is more difficult to perform with limiting physical conditions
- is more intrusive to the youth than the other
- has more risk of injury to youth than the other

A comparison can be drawn by using the differences in means for each of the 19 questions for the three (3) years as indicated in Figure 1 below. Except for questions 6, 7, 15, & 16 (takes more than two (2) staff, conducted by experienced staff, longer to learn and more difficult to maintain) which refer primarily to the mechanics of the techniques, the differences in the means decreased significantly in the remaining

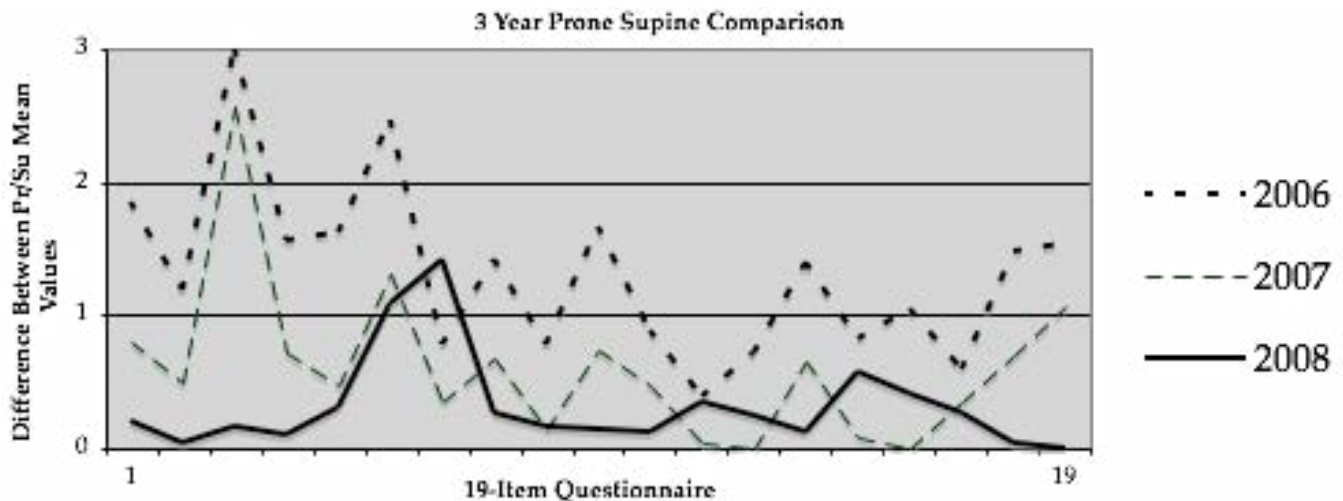


Figure 1. Prone/Supine 19-Item Questionnaire Comparison Study - 2006, 07, & 08

- | | | |
|-------------------------------------|--------------------------------------|--|
| 1 - increased aggression | 8 - negative effect on tx env | 15 - takes longer to learn |
| 2 - increased counter aggression | 9 - more injury risk to youth | 16 - more difficult to maintain skill |
| 3 - increased spitting | 10 - more injury risk to staff | 17 - more likely for training injuries |
| 4 - longer restraints | 11 - more safety violation potential | 18 - more difficult for staff w/limiting physical conditions |
| 5 - negative effect on relationship | 12 - more secure | 19 - more intrusive to youth |
| 6 - take more than 2 staff | 13 - safer for youth | |
| 7 - conducted by exp. staff | 14 - safer for staff | |

The Residential Child Care Project Receives Grant From The Duke Endowment To Advance Innovation In Child Welfare Services

The Duke Endowment has funded a three-year project "A comprehensive model for implementing and evaluating a research-based model in residential care" with Cornell University's Residential Child Care Project to implement and to evaluate the Children and Residential Experiences: Creating Conditions for Change (CARE). CARE is a program model for improving services for children in residential care.

CARE is a multi-level model that involves (a) providing residential child care personnel with the capacity to implement a set of core practice principles that are solidly grounded in current social science literature and best practices standards, (b) facilitating organizational changes to support and sustain the implementation of those core principles at all levels of the organization.

CARE will be evaluated using a sophisticated quasi-experimental design in which seven South Carolina agencies where CARE is implemented will be compared to seven matched non-implementing agencies. Cornell will collect data on implementation, organizational functioning, and staff outcomes. Additionally, our study facilities will provide us with multiple waves of high-quality outcome data on children through the University of North Carolina, Charlotte, Child Outcomes Study. Together, these unique data resources, offer a rare opportunity to conduct a robust evaluation of the CARE model that can have implications for residential care not only throughout South Carolina but also nationally and internationally.

A highly innovative aspect of this project is the emphasis that is placed on

addressing organizational issues that support and reinforce the implementation and sustainability of CARE in residential care settings. Research has identified several aspects of organizational climate (e.g., fairness, role clarity, cooperation) that promote effective, high-quality service, and ultimately result in positive child outcomes (Glisson & Hemmelgarn, 1998). Thus, CARE works to facilitate activities that improve the organizational climate at all levels of the agencies they serve. Evaluation data will also be continually fed back to the agencies throughout the project in order to further promote service quality.

In sum, the current project takes a comprehensive approach to advancing evidence-based practice in residential care. We will create three avenues through which evidence can inform residential care practice: a) developing practices that are guided by a sound theory of change that reflects state-of-the-art research on factors that facilitate healthy child development and promote healing, b) studying the CARE model of residential care with a rigorous evaluation that allows for sound conclusions about its impact on children's well-being, and (c) systematically reporting evaluation findings back to practitioners and administrators to guide program improvement efforts and refinements to the theory of change. Ultimately, we hope that these three approaches will help to establish a model of practice that is maximally informed by sound scientific evidence.

The Duke Endowment, in Charlotte, N.C., seeks to fulfill the legacy of James B. Duke by enriching lives and communities in the Carolinas through higher education, health care, rural churches and children's services. The Endowment has awarded more than \$2.4 billion in grants since its inception in 1924. The Residential Child Care Project is a program of the Family Life Development Center, the College of Human Ecology, Cornell University. Its mission is to

prevent the abuse and neglect of children who live in treatment, educational, and correctional institutions through the use of research-based environmental, organizational and interactional interventions and supports. ✱

Reference

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

The CARE Model



The CARE model of practice incorporates well-established findings from the social sciences literature, specifically, from the fields of developmental psychology, residential care and treatment, social work, youth development, clinical psychology, and organizational development. It is a deliverable package of research-based practice principles that apply universally to all children in out of home care. The optimal residential group care experience for children should reflect the following six CARE practice principles.

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

Family involved. Children need opportunities for constructive contact

CARE Model, continued from p. 6.

with family. Contact with family and community is one of the few indicators of successful treatment that has empirical validation. Parents and children, in partnership with residential care, can facilitate a transition to the home and the community. This partnership contributes to increased social and emotional adjustment by improving children’s feeling of connection to family and community, their self-concept, and resiliency.

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

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

Competence centered. Competence is the combination of skills, knowledge, and attitudes that each child needs to effectively negotiate developmental tasks and the challenges of everyday life. Residential programs must help children become competent in managing their environment as well as motivating them to

cope with challenges and master new skills. Learning problem-solving and critical thinking skills and developing flexibility and insight are all essential competencies that help children achieve personal goals and increase their motivation for new learning. All interactions and activities in residential care should be purposeful and goal oriented with the aim of building these competencies and life skills.

Ecologically oriented. Children are engaged in dynamic transactions with their environment as they grow and develop. To optimize growth and development, children must live within a milieu that

is engaging and supportive. Residential care staff must understand that the relationships with the children in their care are part of a larger ecology. Their face-to-face interactions with children, the activities they promote, and the physical environment in which they work all have an impact on the developmental trajectories of children. Competent staff using skill sets informed by the CARE principles can only be effective when they are used in an ecology of residential care that will allow their expression. ★

From the serious fun corner, by Jack C. Holden

NAME GAME

Use stick-on name tags for this activity. For each person in the group, print the name of a known person – living or not living, cartoon character, super-hero, animals etc. (try to use names from as many cultural backgrounds as possible). Next, place the name tags on participants’ backs with the following instruction:

After everyone has a name tag on their back, move around the room trying to find out who you are by asking others questions. You may ask 3 questions of each person in the room that can be answered yes or no. Example: Am I Male? (referring to the name on the back) Am I living? Am I in sports? Continue until you guess the name on your back.

Once you have found out who you are, put the name tag on the front of you and continue to answer for others. Depending on time, you may have people give one clue to speed up. This is a good way to divide people into pairs or groups for another activity by putting the names into identifiable categories based on the number of groups you need.

Furnis, Mary, *Independent Living Resources*, State of Nebraska. Lincoln: 1988

Jack is a TCI Instructor from Ithaca, NY and a Ph.D. in Education, specializing in Adult Learning

Using TCI's Family Care Provider Training (TCIF) to Break Down Language Barriers Between Residential Treatment and Life at Home

By Josh Lechter

"This class provided much needed tools, guidance and assistance. The only program I've ever attended that provided real life tools for dealing with our unique children & situations. Spending time with the other parents & caregivers with the same needs as ours was very valuable."

"I loved this course! It really gave a lot of fantastic information! I refer to my book and notes often and it has already begun to help me better handle situations that might otherwise have escalated further. I can't think of one parent or caregiver who wouldn't benefit from this course and the techniques learned. I think that with my son coming home full-time soon this course is invaluable and I am thrilled to have been able to participate in it! I would recommend it for every Walker parent."

These quotes came from parents at the Walker School who recently completed a five-session course in TCIF. Each year, the Walker School provides intensive services for hundreds of troubled children, youth, and families. Walker's multidisciplinary programs extend specialized therapeutic environments beyond the classrooms into family homes, public schools and community settings (see Walkerschool.org). The Walker School provides a range of services: therapeutic day school, short-term hospital diversion, intensive residential and community outreach. Staff at the Walker School believe that families need not only clinical services and support but also opportunities to learn new and appropriate skills so that their children could grow and thrive in their own homes, neighborhoods and communities. Since Therapeutic Crisis Intervention (TCI) is

the crisis prevention and management system used by the Walker School staff within is residential and day programs, utilizing Cornell's TCIF course provided the Walker School with a curriculum to teach behavior management skills to foster, adoptive and biological children so that the Walker staff could expand the bounds of "the world of residential treatment". The idea was born to have parents enroll in Walker's first ever TCI class for families.

The following is a brief description of the initial TCIF program held at the Walker school. This pilot taught valuable lessons for future offerings and in this spirit we at the Walker School would like to share these lessons with others who would consider running similar programs in their agencies.

Step 1: Getting the group ready for the course

Thirteen parents enrolled for the five-session class. TCIF was divided into four major learning sessions of approximately 6 hours that were held on successive Saturdays, with the third Saturday being a review session. It was important to explain in the publicity that recruited participants for this course that TCIF was a curriculum-based class that taught crisis prevention and behavior management skills similar to those taught to The Walker School staff. Since it was curriculum-based and not a parent support group there would be certain specific "personal" problems or topics that could not and would not be addressed. This did generate some confusion and controversy with some parents who felt that some of the topics they raised during the course of the training were not properly and sufficiently addressed. The participants, although informed that this training would be more instructive in nature, seemed to be craving a more therapy based model. There were many topics raised through questions and feedback that were placed in the "parking

lot" by the trainers, thereby setting an expectation that they would be answered at some point. When they were not some parents were disappointed.

Another major note that had to be clarified for the parents was that TCIF taught only crisis prevention and proactive behavior management strategies, and techniques for dealing with children. Many parents were under the misguided impression that TCIF meant they were going to learn how to physically contain, or restrain, their children. It became necessary to state and reiterate that TCIF was not a means of physically managing children; rather it was a training program by which parents could learn to avoid such instances.

Step 2: Group Formation

The group was formed through emails and letters to all of the parents of the Walker School asking when and how long the group should run. The parents were given the choice of more numerous shorter sessions during the week or fewer, longer, weekend sessions. Walker offered child care as an option for any children who regularly attended the school. The majority of the parent responses indicated that the preferred time was Saturdays, from 10am-4pm, so this was the time chosen. While this weekend time was helpful because it allowed a more in depth class time, it also became problematic for a few reasons. First, it meant that the class happened in 6-hour blocks which can be a long time for adults who are not used to a longer learning time. In addition, it meant scheduling many breaks during the day. Re-grouping from the breaks proved to be difficult. Third, this longer time tends to keep parents performing, participating, and learning at an optimal level during the first half of the class, but performance levels dropped off during the afternoon hours. It was decided by the trainers that the next class would run as a 10-12 session class, during the week,

Excerpt from TCI 6, continued from p. 4.

Communicate Understanding. Care workers must communicate understanding to young people before they can make requests of them (Ginott, 1969). For example, an adult might say to a young person, “I see that you are frustrated and angry. Let’s go outside and discuss the problem.” Another technique is to apologize (Confer, 1987). This is when adults communicate that they understand that the situation had a negative impact on a child and they, personally feel sorry that it happened, e.g., “Mary, I understand that you feel this is unfair and I am sorry that it turned out this way.” or “I’m sorry that you don’t get to go home. I can see you are furious about that decision. When you put the rock down we can talk about this.” The child gets the message that the adult sees her point of view and understands her upset. Another de-escalating active listening technique is to affirm and validate the young person’s feeling, e.g., “Mary, you have every reason to be angry. I would be angry if my visit were cancelled. Please don’t take your anger out on others.”

In general, people do not change unless they feel understood (Stone et al., 2000). Once the young person feels understood and the care worker has the young person’s attention, the care worker can make a request that will help reduce the stress in the situation. Then the young person is more likely to change her behavior. The requests made of young people at this time should be to do something that will lower the level of arousal, e.g., take a deep breath, talk about problems, go for a walk.

Co-regulation strategies are designed for care workers to draw on their relationships with young people, make suggestions that are positive, point out the child’s strengths, and give hope for a positive and peaceful resolution. ★

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Prone/Supine, continued from p. 5.

15 questions for all three (3) years. The mean range for 2006 was .72-3.0 with an average of 1.33; 2007 was .01-2.77 with an average of .62; and 2008 was .01-1.42 with an average of .32. Overall, the decrease in mean differences would indicate that responder’s perceptions have changed considerably over the period of the study and that in general, neither prone or supine is perceived as more or less favorable.

Limitations

Perception survey

- The sampling was from one agency
- The agency had been using prone restraints primarily for years and the supine had been introduced in the past 4 years
- Injury data was not available
- Some of the survey questions scales were reversed in error and the survey results had to adjust for that reversal

Literature review

- Some of the prone restraint data included hobble and “hog-tie” application of the prone restraint
- There is no apparent data available relevant to the number of restraints used in residential care settings comparing prone, supine, and other restraints
- A few of the reviewed data had limited research cites available

Conclusions

In prior years respondents agreed that the supine technique was more likely to increase counter aggression, increase spitting, produce longer restraints, have more negative effect on the treatment environment, and was more intrusive to the youth than the prone restraint however, the 2008 survey indicates otherwise. This change seems to reflect that respondents over the course of three years for the study and as they became

TCIF, continued from p.8.

which would last for 2-3 hours.

Step 3: Group Composition and Construction

For this training class the only inclusion criteria were that the adults have a child being treated at the Walker campus and that they were available during the weekend time slot. This posed several interesting challenges worth addressing. First of all, some adults, while part of a two-parent household, came alone. Even if the adult in attendance communicated everything, there was the likelihood that some information was lost or distorted. Secondly, the group included biological, foster, or adoptive parents. This caused some unintentional offense when certain comments were made around the genesis of children’s behavioral or emotional difficulty. For example, a foster parent remarked that she (he or she here) did “not have any influence in how the child arrived to them”. The remark needed to be addressed outside of the group in family therapy with both the foster parent who made the comment, as well as the biological parents who felt hurt. Future planning around TCIF trainings may involve a more homogenous grouping to avoid these difficulties. If groups remain heterogeneous, trainers must expect that there will be inherent conflicts between the point of view of the foster and biological parents.

Step 4: Larger Community Continuity and Communication

The last and most important note for not only future groups but also the current trainers, parents and greater Walker community, is overall communication and oversight. It is imperative that in all phases of a child’s life, clinical, residential, family and school, that the communication tools and behavioral interventions are of the same mindset. In a growing multilingual

world, it would be perfect if regardless of a child’s first language, their second language be steeped in TCI. In this perfect world, a child wakes up with their mom and dad using the language of TCI and their classroom teacher speaks this same language. A child’s therapist uses the words of TCI in individual therapy and those same words are spoken in family therapy. The child’s residential staff uses the techniques of TCI and so does the child’s outreach worker. This daunting task, while seemingly unattainable, should be the focus, drive and goal for any well rounded, all encompassing treatment plan, in order for the family and the child to truly feel the power of change.

Step 5: Practice, Practice, Practice

While it became clear that the adults needed many different avenues through which to learn, one arena successfully explored was that of experiential learning. This was done mainly with role plays and practicing the various techniques that were taught. After learning a great deal of theory, the parents and trainers spent the majority of the final sessions learning a number of practical applications for these theories. They practiced new techniques and strategies to help their children through stressful situations. All parents have certain ways they deal with misbehavior or issues that arise on a daily basis, the key is to broaden and deepen this array of tools. There were various reactions to this style of training, mostly positive:

- “It was helpful to have it modeled by staff.”
- “Practicing the use of the appropriate language, how one way of speaking will net better results than another way of speaking.”
- “I think the staff did a great job of explaining each section and reinforced the content through role playing.”
- “Role playing was good. Making us

switch seats was great – mixing up the group as much as possible.”

- “I would have liked less role playing and more information.”

Measuring Success: Examine the Parents

How does the Walker School measure success in this TCIF training? Should the trainers provide a paper and pencil test at the end to discover what was learned? Does an oral exam tell us what we need to know about the training’s effectiveness? Do we use evaluation/ feedback sheets to judge learning? As a group of trainers, it will be hard to monitor success in the parents’ homes and observe their new skills; however there are some valuable observations that were made that give us an indication of our success.

Attendance remained strong and consistent. The group began with thirteen adults and eleven of them attended all of the mandatory sessions. One couple, due to car trouble, had to miss the last class.

The review class allowed trainers to measure the recall knowledge of participants. The mid-session review class provided an opportunity for trainers to ask review questions. For the most part, these questions were answered correctly by parents and this fact gave the trainers confidence that parents were learning new language and skills..

The group became more comfortable with each other as a support network. Several parents were not only able to converse about similar situations in each of their lives, but also come to the realization that they were not isolated in their parenting difficulties. Simply understanding that they were not the only ones struggling with these issues was validating. As one parent noted, “The course was a blessing. I now do not feel

TCIF, continued from p. 10.

alone in helping my children with their mental health needs.” Another remarked, “spending time with other parents and care givers with the same needs as ours was very valuable.”

Perhaps a mother’s words sum it up best, “I was someone who said my kid goes from zero to sixty [without warning], but after TCIF I see that there is a flicker, where if I use the right tool, I can put out the fire”. ★

Josh Lechter, LMHC, has worked for the Walker School in Needham, MA for over seven years. For the last three years, he has held the role of the Assistant Director of Child Care for the Community Based Acute Treatment program. Josh has been a licensed TCI trainer since 2006.

Prone/Supine, continued from p. 10.

more comfortable with the supine technique have changed their perceptions of the two (2) techniques. Respondents appear to find no significant advantages or disadvantages for either the prone or the supine technique including the most important consideration, safety for staff and youth.

The literature review indicates there is 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. Additionally, other factors such as pre-existing physical or medical conditions may affect risk more than the type of restraint that is used.

Further Work (Recommendations)

Based on the current literature available and the findings from the limited perception survey, additional extensive research remains to be done. First, a study should be initiated to determine the percentage of prone, supine, and other restraints currently being used in residential care. Next a comparison of injury data for all types of restraints should be initiated. Finally, the field might be most informed by studies related to youth perceptions of restraints, for those who reside in residential care and have been physically restrained. ★

Ask Eugene

- Q.** *I want to go to the TCI training of trainers course, but I have not been through a TCI training at my agency. Can I attend the training?*
- A.** We strongly recommend that everyone attend a direct TCI training at an agency prior to attending a TCI training of trainers course. If this is not possible, please let RCCP know prior to signing up for the training.
- Q.** *I received a letter from Martha Holden saying I need to get re-certified. Can you tell me when and where the re-certification trainings are?*
- A.** Please go to our web site at <http://rccp.cornell.edu>. There are too many offerings for RCCP staff to be able to go over the entire schedule with everyone who calls asking about updates. Everything you need is available on the site, including schedules and applications for training. Remember, to get re-certified you must successfully complete a TCI update.
- Q.** *If I take the TCI Update: TCI Curriculum Revisions – Edition 6 training, will I be re-certified as a trainer?*
- A.** Yes, just like with any of our other updates, if you are a certified TCI trainer and you successfully complete the TCI Curriculum Revisions–Edition 6 update then you will be re-certified as a TCI trainer.
- Q.** *My certification is up in January, but I want to take the TCI Update: TCI Curriculum Revisions – Edition 6 training in May, or beyond. Can I do that? What happens to my certification?*
- A.** Yes, you can wait and take the TCI Curriculum Revisions – Edition 6 update if your certification is up before it is released. Please remember, however, that by waiting you will not be certified to train from your renewal date until you successfully complete an update.

From the Instructor's Booth

The RCCP is pleased to announce our newest TCI Instructors:

Craig Bailey is the Crisis Prevention Specialist at Crestwood Children's Center, an affiliate of the Hillside Family of Agencies, located in Rochester, NY. He has been working with young people in residential care since 1996, and has been with Crestwood since 2000. Craig has been the primary TCI trainer for new employees at Crestwood during this time, and currently works alongside the Learning Institute at the Hillside Family of Agencies to deliver TCI training to new employees from all of the service affiliates. He has been a professionally certified TCI trainer since January of 2005. In 2008, Craig became a TCI instructor with Cornell University.



Diana Boswell MA, PhD Director, Thomas Wright Institute
Diana obtained her masters and doctoral degrees in school psychology from the University of Toronto, Canada. She worked with children and adolescents in forensic assessment and mental health treatment programs in Canada. Since returning to Australia, Diana has worked as a clinician, manager and director in the areas of autism and child and adolescent out of home care programs. She has been involved in presenting TCI training since its inception in Australia. Over the past eight years she has been associated with the Thomas Wright Institute, providing specialist psychological services for young people with complex and challenging behaviours, and their families. Since 2003 she has taught graduate courses at the University of Canberra in the areas of managing complex behaviours and autism spectrum disorders. For many years she has provided supervision, training and consultation to staff and programs in corrections, education, disability, and social welfare areas.

Andrea Turnbull has 15 years experience working with young people in residential treatment settings. Her 14 year tenure at a residential psychiatric center shaped her views on working with youth in crisis as she moved among the agency in positions



such as direct care worker, milieu coordinator, program director and ultimately training director. Andrea became a TCI trainer in 2001 when her agency first began training TCI. It was exciting to watch the children and staff develop skills that created a safer, more nurturing environment. Andrea, a licensed mental health counselor, is currently Clinical Coordinator at Carlton Manor, Inc. a non-profit agency providing therapeutic residential group home services for children in St. Petersburg, Florida. She may be contacted at ATurnbull@carltonmanor.org.

Professional Certification Announcements

Congratulations to the newest TCI trainers to have achieved professional level certification :

Daniel Hibbs, MSW, LCSW. Dan earned his B.A. from The University of Southern Maine in Social Welfare in 1980 and an MSW from The University of Connecticut School Of Social Work in 1983. He has been employed at Spurwink Services since September 1978. He has had several positions at Spurwink which include Direct Care Worker, Clinical Social Worker (Generalist), Associate Program Director, Program Director and Sr. Program Director of Residential Services. Daniel has been a TCI Trainer since 7/11/2003 and gained Professional level certification in 2008.



Diane Whittenburg, Staff Development Coordinator, Holston UM Home for Children, Greeneville TN, for 24 years. Diane has an Associate degree in child development, a Bachelor degree in Organizational management and a Masters degree in Education and Training. As a trainer Diane is passionate about helping others learn through interactive training. She has been teaching TCI for eight years. Diane is looking forward to expanding her ability to train TCI as a professionally certified trainer. ✨



Frequently Asked Questions

By Martha Holden

Implementing the TCI System in organizations often raises questions that are not simply answered. Regulations are changing rapidly which also results in uncertainty. We receive emails and phone calls daily from TCI trainers and organizations asking us how to adhere to best practice and TCI guidelines. This column is a brief discussion of the most commonly asked questions with our response.

Is it absolutely necessary to have medical oversight during restraints?

We do recommend that agencies that use physical restraint have access to someone medically trained to pre-screen children as well as monitor children during and after restraints. A physician needs to screen the child, indicate on the ICMP what restraint (if any) is appropriate for this individual child before anyone would apply a restraint. If a restraint is necessary, ideally a nurse would be available to monitor during the restraint. Many programs do not have nurses 24 hours a day, so at a minimum, the nurse should train staff to do enough screening/monitoring so that they can detect a problem, stop the restraint, and take the child to an emergency room if necessary.

My TCI Trainer certification has expired, do I need to take the week long training again?

Once your certification expires, you can no longer train TCI. If your certification was for 2 years, you have one year to reinstate your certification by successfully completing an update. If your certification was for 1 year, you have 2 years to reinstate your certification by successfully completing an update. After that grace period, you would have to

go through the full week of training for trainers again.

Does TCI have restraint techniques for pre-school age children?

Our regular TCI course is designed for adults who work with school age children. We do have our course "TCI for Family Care Providers" (TCIF) designed for adults who work with school aged and younger children, including preschoolers. It does not have a physical restraint component because we do not advocate using physical restraints with this age group, since the risks are too great.

We do not recommend that you teach physical intervention techniques to be applied to children under 5 years old. For example, a 3 year old child's bones and bone plates aren't fully formed and if any of these techniques are done with too much force, children will sustain permanent damage. Their rib cages are not bones yet, just cartilage, so that there is very little protection to the major organs. Their intercostals are not developed so they use their abdomen to breathe. Putting children this age in a restraint is potentially life threatening. There are developmentally appropriate ways to hold pre-school age children that parents use since these children put themselves at risk occasionally as they are unable to reason and assess the risk of the situation. As we all know, preschool age children are impulsive.

If a 3 year old is running into traffic, an adult can pick up the child and carry her/him to safety. Ask a physician how to pick up and carry a preschooler to safety if people are unsure how to do it. If the child is throwing something at another child or being aggressive to peers, the other child(ren) should be taken to a safe area. These are small children and adults should be able to protect others and themselves in these situations by structuring the environment, clearing the area and maintaining a safe

distance. Developmentally appropriate techniques include what all adults do with their preschool children when they have temper tantrums. Clear the area and get out of the way. We would advocate and reinforce the use of these developmentally appropriate responses and not try to execute any physical restraint technique.

I have staff that have not had refresher training for over 6 months. Do they need to take the entire TCI course again?

We do not have any specific time frame for staff members to retake the entire TCI course again since different licensing organizations have different requirements. Ideally this situation is covered in the organization's policies and procedures. We have established guidelines for certification of TCI trainers and make recommendations to organizations about certifying their staff. Once someone has passed their certification date and are no longer certified, they are no longer certified to apply restraints nor are they current in their crisis management skills. How long is the agency willing to allow people to work without being able to fully execute their job duties? To have them go through the entire class may be indicated if their certification has expired for a year or they can't pass the written and skills tests by just attending a refresher. Once they are a year passed their certification date, it would seem that an agency would want them to complete the entire course. It is difficult to imagine an organization allowing someone to work this long after they are no longer certified. It is important for the administration to decide and develop a policy that addresses these issues. If they can't pass the testing by attending an update, they should go through the entire course again.

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

We recommend quarterly refreshers

TCI Bookshelf

A Review of *Sisyphus and the Itsy Bitsy Spider*

by Jim Hartsell

Reviewed By Martha J. Holden

In this book, Jim Hartsell shares a personal story with three morals that exemplifies lessons learned from a lifetime of teaching. "Things are not always what they appear to be" one of the morals, could also be a moral of the book itself. *Sisyphus and the Itsy Bitsy Spider* provides the reader with a variety of concepts, examples, and insights that demonstrate how children's behavior cannot be easily interpreted and why those behaviors do not tell us the true story of the child. Jim Hartsell understands and explains with a great deal of compassion the complexity of the behavior of students who appear to interfere with the best-made plans of teachers. In this practical book, Hartsell explains the importance of knowing the child and the child's baseline behavior, knowing the reasons why the child's difficult behavior exists, knowing what replacement behavior is desired, and knowing what is within the child's zone of proximal development before challenging children to modify their behavior. In essence, one must know and understand the child before embarking on a strategy to change the child. This is a formula for successful classroom management.

The second moral of the personal story, "More power is not always the answer" highlights the importance of respecting the child and the child's unique capacity for growth and development. "A bigger hammer" only ends up with bigger problems in the long run. The most effective tool a teacher has is the relationship they build with the children. Treating children fairly, arranging lessons and expectations so that the children can succeed, forgiving children their shortcom-

ings, and forgiving ourselves when we don't behave our best, is wisdom gained from years of experience and study. Positive interactions, reasonable expectations, and forgiveness are the ingredients for a classroom environment where children can thrive.

"Life experience makes a difference" is the final moral of the story. Hartsell has certainly learned from his life experiences, a skill in itself. Examples of children's experiences in classrooms bring to life the concepts that will help teachers consider the importance of building attachments, meeting needs, and seeing children's behavior as their way of coping. Understanding how children's life experiences are reflected in their behavior gives teachers the much-needed advantage in designing a plan that will result in positive classroom experiences. It is not so different for us. We also are driven to behave as a result of our interpretation of events based on our life experiences and our desire to succeed. The more insight we have into our own motives, the better able we will be to make sure everyone succeeds.

Perhaps the greatest gift of this book is the underlying theme of respect, care and empathy. It is apparent that Jim Hartsell truly cares about and loves the students that have passed through his classroom. At the same time he understands the frustration and difficulties of working with challenging children day after day, 'pushing the rock up the hill', only to have it crashing to the base and starting anew the next day. Hartsell has compassion and admiration for the teachers that take on this Sisyphian task. By writing this book, Jim has shared strategies that will help professionals become effective teachers while enjoying *the climb*. ✨

Sisyphus and the Itsy Bitsy Spider: Working with Children (2008)
Ithaca, NY: Ithaca Press.

FAQ, continued from p. 13.

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.. 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 their certification in TCI.

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 the risk and decided that physical intervention is the least risky 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 risk assessment 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 an angry and upset young person against their will usually results in 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. Since touching or trying to 'escort' an angry child, escalates the situation and often results in a restraint, the plan should begin with a de-escalation strategy. First have a plan in place with the child in advance, so that there is an agreement that when the child starts getting frustrated (overstimulated), the child will go with the staff member and they will talk and work it out in private. Staff working with the young person should be specially trained in 1) how to anticipate the young person's escalation and avoid needing to use physical force by using the de-escalation plan, 2) 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) understanding 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 IMCP to avoid staff members resorting to physical management for program compliance whenever young people are refusing to comply with staff requests. ★

Martha Holden, MS, is a Senior Extension Associate with the FLDC and director of the RCCP.

TCI Instructor, Howard Bath, Appointed as Children's Commissioner in Australia

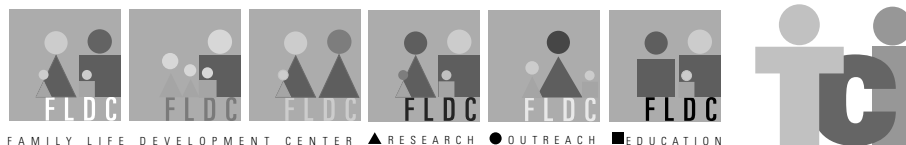
The Northern Territory Government has appointed Dr. Howard Bath to the independent position of Children's



Commissioner. The Children's Commissioner will act as an advocate for protected children and represent their best interests at all levels of government and the community and will have considerable influence to promote more effective care for our most vulnerable children. The Commissioner will also oversight and manage complaints about services for children in care and provide advice to Government on strengthening the child protection system.

Dr. Howard Bath is recognised in Australia as a leading clinician and program developer with extensive experience in the children's and youth sector, particularly youth with complex needs and challenging behaviours. Dr. Bath is a registered clinical psychologist and has studied and taught in both Australia and the United States and is widely published in the areas of behaviour management, out-of-home care, family preservation, and more recently the treatment of young people with problematic sexual behaviours. He was the inaugural chair of the Child and Family Welfare Association of Australia (CAFWAA). Dr. Bath has been a TCI Instructor and contributor to the Residential Child Care Project since 1998.

The new office commenced operation in June 2008. ★



TCI USA 2009 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT)

Jan. 26-30/09	Knoxville, TN
Mar. 9-13/09	Denver, CO
Mar. 23-27/09	Peoria, IL
Apr. 20-24/09	Cincinnati, OH
May 4-8/09	Hartford, CT
Jun. 1-5/09	Atlantic Beach, NC
Jun. 22-26/09	Ithaca, NY
Jul. 13-17/09	Pittsburgh, PA
Jul. 27-31/09	Ithaca, NY
Aug. 10-14/09	Ithaca, NY
Sep. 14-18/09	Sacramento, CA
Sep. 28-Oct. 2/09	Peoria, IL
Oct. 19-23/09	Atlantic Beach, NC
Nov. 2-6/09	Mesa, AZ
Nov. 16-20/09	Hartford, CT
Dec. 7-11/09	Ithaca, NY

TCI UPDATES

Developing Professional Level TCI Training Skills

Feb. 19-20/09	Pittsburgh, PA
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Designing Refresher Training

Mar. 19-20/09	Peoria, IL
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TCI For Developmental Disabilities

Feb. 9-10/09	Ithaca, NY
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Post Crisis Response

Jan. 22-23/09	Knoxville, TN
Mar. 5-6/09	Denver, CO

TCI Curriculum Revisions, Edt. 6

Apr. 16-17/09	Cincinnati, OH
Apr. 30-May 1/09	Hartford, CT
May 28-29/09	Atlantic Beach, NC
Jul. 9-10/09	Pittsburgh, PA
Jul. 13-14/09	Ithaca, NY
Jul. 16-17/09	Ithaca, NY
Aug. 24-25/09	Ithaca, NY
Sep. 21-22/09	Sacramento, CA
Sep. 24-25/09	Peoria, IL
Oct. 15-16/09	Atlantic Beach, NC
Oct. 29-30/09	Mesa, AZ
Nov. 12-13/09	Hartford, CT
Dec. 3-4/09	Ithaca, NY

TCI CANADA 2009 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT)

Apr. 27-May 1/09	Toronto, Canada
Jun. 1-5/09	Toronto, Canada

TCI UPDATES

Designing Refresher Training

Feb. 4-5/09	Toronto, Canada
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Post Crisis Response

Mar. 3-4/09	Toronto, Canada
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TCI Curriculum Revisions, Edt. 6

May 5-6/09	Toronto, Canada
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One-Day: Conflict Resolution*

Feb. 3/09	Toronto, Canada
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TCI EUROPE 2009 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT)

Mar. 23-27/09	Dublin, Ireland
May 11-15/09	Glasgow, Scotland
Aug. 10-14/09	Dublin, Ireland
Sep. 28-Oct. 2/09	Doncaster, UK
Oct. 19-23/09	Glasgow, Scotland
Dec. 14-18/09	Dublin, Ireland

TCI FOR FAMILY CARE PROVIDERS TRAINING OF TRAINERS (TXT)

Nov. 9-13/09	Dublin, Ireland
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TCI UPDATES

Designing Refresher Training

Feb. 18-19/09	Dublin, Ireland
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TCI For Family Care Providers: Designing Refresher Training

Jun. 24-25/09	Glasgow, Scotland
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Post Crisis Response

Feb. 11-12/09	Glasgow, Scotland
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TCI Curriculum Revisions, Edt. 6

Mar. 30-31/09	Dublin, Ireland
Apr. 6-7/09	Glasgow, Scotland
Apr. 21-22/09	Bournemouth, UK
Apr. 27-28/09	Penrith, UK
May 18-19/09	Glasgow, Scotland
May 20-21/09	Glasgow, Scotland
May 26-27/09	Dublin, Ireland
Jun. 8-9/09	Belfast, N. Ireland
Jun. 22-23/09	Glasgow, Scotland
Jun. 29-30/09	Dublin, Ireland
Jul. 1-2/09	Dublin, Ireland
Sep. 10-11/09	Stevenage, UK
Sep. 14-15/09	Penrith, UK
Sep. 16-17/09	Leeds, UK
Oct. 5-6/09	Dublin, Ireland
Oct. 26-27/09	Glasgow, Scotland
Oct. 28-29/09	Glasgow, Scotland
Nov. 16-17/09	Dublin, Ireland
Nov. 18-19/09	Dublin, Ireland
Nov. 23-24/09	Glasgow, Scotland
Dec. 8-9/09	Belfast, N. Ireland
Dec. 10-11/09	Dublin, Ireland

One Day: Conflict Resolution*

Feb. 10/09	Glasgow, Scotland
Feb. 17/09	Dublin, Ireland

TCI AUSTRALIA 2009 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT)

Sep. 28 - Oct. 1/09	Sydney, Australia
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TCI FOR FAMILY CARE PROVIDERS TRAINING OF TRAINERS (TXT)

Feb. 23-27/09	Brisbane, Australia
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TCI UPDATES

TCI For Developmental Disabilities

Feb. 19-20/09	Canberra, Australia
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TCI Curriculum Revisions, Edt. 6

Sep. 24-25/09	Sydney, Australia
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**Note: ONE-day updates are ONLY available to TCI trainers who have successfully completed BOTH Designing Refresher Training AND Post Crisis Response.*