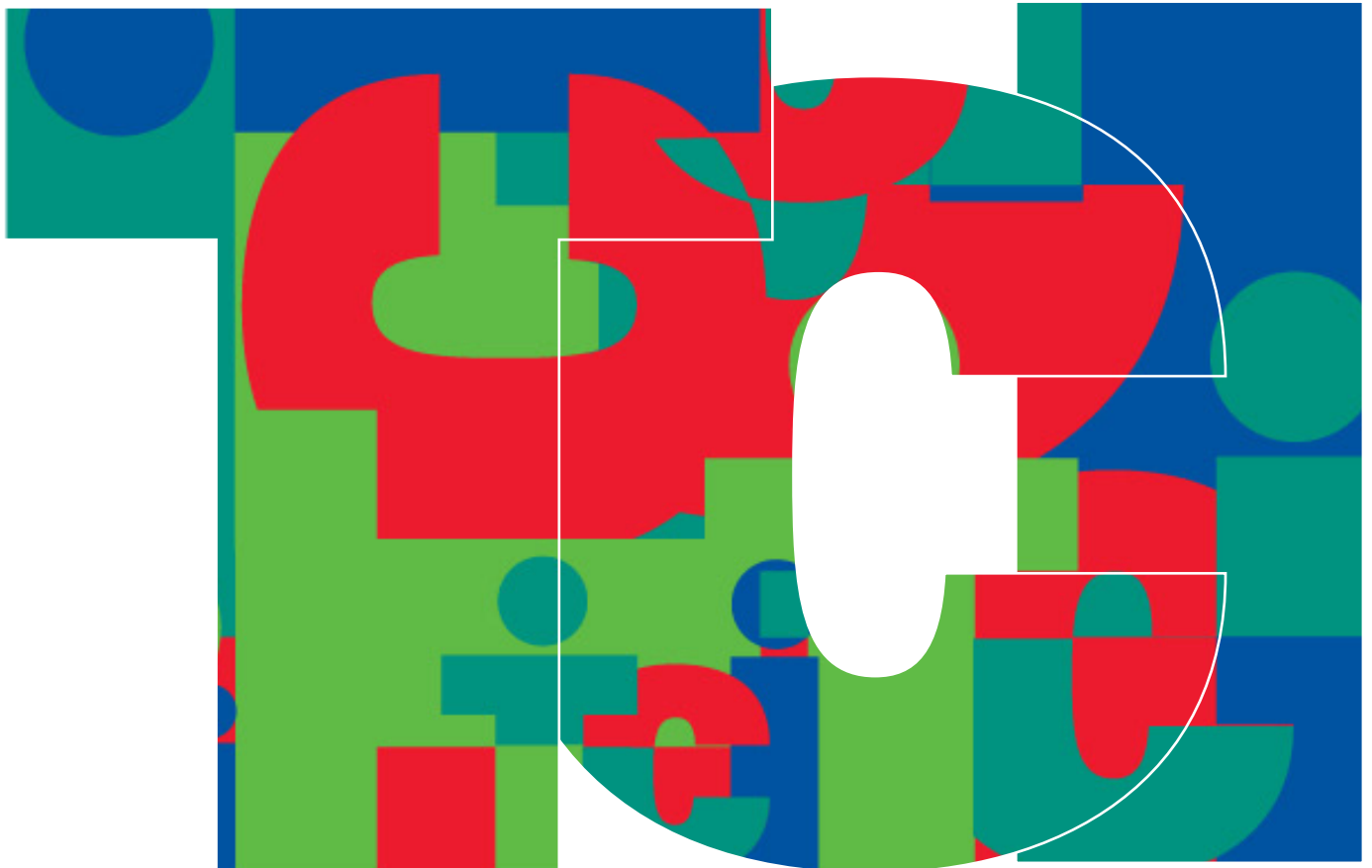
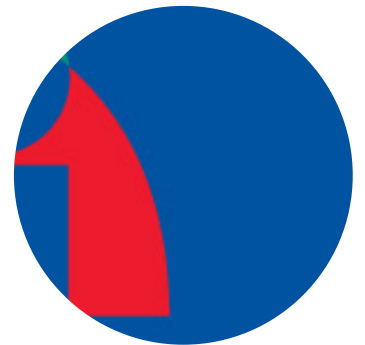




# The Therapeutic Crisis Intervention System





# **Therapeutic Crisis Intervention System**

## ***Information Bulletin***

### **The Residential Child Care Project**

*Family Life Development Center*

*College of Human Ecology*

*Cornell University, Ithaca, NY USA*

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# Preface

## The Family Life Development Center

The Family Life Development Center (FLDC) was established by New York State legislation in 1974. The Center's mission is to improve professional and public efforts to understand and deal with risk and protective factors in the lives of children, youth, families, and communities that affect family strength, child wellbeing, and youth development. The Therapeutic Crisis Intervention (TCI) system is one of several programs delivered by the FLDC relevant to the lives of children, families, and care agencies.

In the early 1980s, under a grant from the National Center on Child Abuse and Neglect, Cornell University developed the TCI crisis prevention and intervention model for residential child care organizations as part of the Residential Child Care Project (RCCP). The TCI system assists organizations in preventing crises from occurring, de-escalating potential crises, managing acute physical behavior, reducing potential and actual injury to young people and staff, teaching young people adaptive coping skills, and developing a learning organization. This model gives organizations a framework for implementing a crisis prevention and management system that reduces the need to rely on high-risk interventions.

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

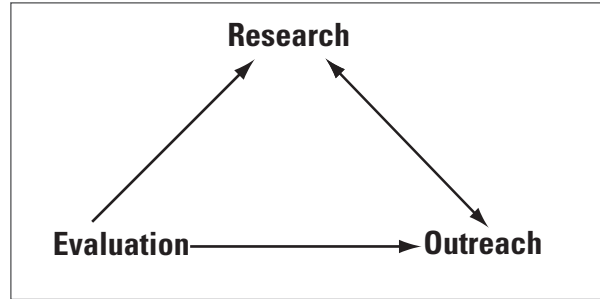


Figure 1. Research, Practice, and Evaluation Cycle

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).

Since the curriculum's inception there have been five major revisions. The revision process has generally included (a) examining the evaluation results and research conducted by the RCCP, (b) reviewing related literature and research, (c) conducting surveys of organizations using the TCI system, (d) talking to other crisis management training providers, and (e) convening experts for consultation and review.

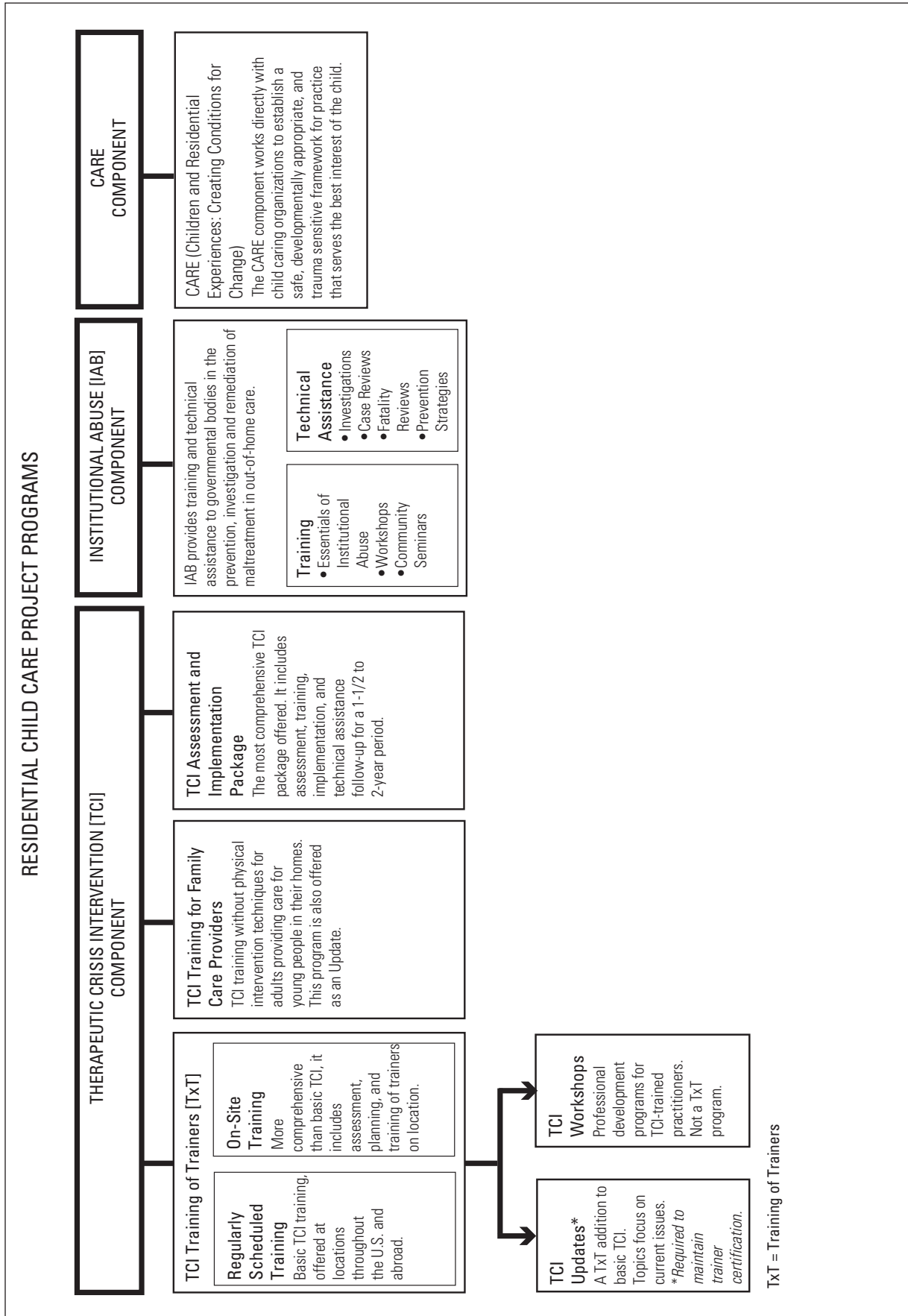


Figure 2. RCCP Programs

# Research Foundations of TCI

## TCI Implementation Study

### Project Overview

The purpose of the implementation and evaluation project involving Cornell University's Family Life Development Center and a residential facility in the Northeastern Region of the United States was to introduce a crisis prevention and management program, Therapeutic Crisis Intervention (TCI), into a residential setting and evaluate its effect.

Developed by Cornell University under a grant from the National Center on Child Abuse and Neglect in the early 1980s, TCI is a crisis prevention and intervention model for residential child care facilities that assists organizations in preventing crises from occurring, de-escalating potential crises, managing acute physical behavior, and reducing potential and actual injury to children and staff. This model gives child and youth care staff the skills, knowledge, and attitudes to help young people when they are at their most destructive. It also provides child care workers an appreciation of the influence that adults have with children who are troubled, and the sensitivity to respond to both the feelings and behavior of a youth in crisis. In all phases of this process, from prevention, to de-escalation, to therapeutic crisis management, the program is oriented toward residential child care personnel helping the child learn developmentally appropriate and constructive ways to deal with feelings of frustration, failure, anger, and pain.

### What Did Cornell Expect TCI To Accomplish?

As a result of implementing TCI, it was anticipated that agency staff would be able to prevent, de-escalate, and manage crisis situations with children and young people in residential care. More specifically, child care workers and supervisors would:

- more effectively manage and prevent crisis situations with children
- feel more confident in their ability to manage crisis situations, and
- work as a team to prevent, de-escalate, and manage acute crises

As a result of the implementation of TCI, the facility would see:

- fewer physical restraint episodes after implementation and training
- fewer injuries to children and staff as a result of physical restraints
- increased knowledge and skill on the part of facility personnel to handle crisis episodes effectively, and
- an attitude change among staff and supervisors on the use of physical action in crisis situations

It was recognized that, immediately after TCI training and implementation, the facility might see an increase in the numbers of incident reports due to better reporting, documentation, and monitoring of incidents.

### What Was Cornell's Implementation and Evaluation Plan?

The implementation and evaluation project was designed to be completed in three phases over 18 months, from October 1994 to March 31, 1996 (See Figure 3 on page 8).

**The pre-implementation phase:** During the first phase of this project (October, 1994 to March, 1995) prior to implementation of TCI, Cornell staff collected incident reports, and developed a computer-based data collection instrument to facilitate analysis and record incidents.

**The training and implementation phase:** During the second phase of this project (March 1995 to September 1995), Cornell staff met with the residential care staff to administer pre-tests, conduct interviews (all tests and interviews were confidential and anonymous). Four trainers from the organization attended Training of Trainers in Therapeutic Crisis Intervention workshops sponsored by the Residential Child Care Project. Throughout the training and implementation phase all levels of residential child care personnel attended TCI training conducted by the Cornell-trained residential staff. In addition, supervisors attended special sessions conducted by Cornell staff to consider implementation, monitoring, and supervisory issues.

Overview of Evaluation Design and Timeline				
Month:	1	6	12	18
	<ul style="list-style-type: none"> <li>• Incident baseline data (6 months before implementation and training)</li> <li>• Interviews with child care staff</li> <li>• Pre-implementation confidence data</li> </ul>	Implementation and Training  Pre-post to test mastery of crisis intervention training		<ul style="list-style-type: none"> <li>• Incident post-data (6 months after full implementation)</li> <li>• Post-implementation confidence and knowledge data</li> </ul>

Figure 3. Overview of Evaluation Design and Timeline

**The post-implementation phase:** The post-implementation phase (October 1995 to March 1996) began after staff had been trained and the program had been implemented. Cornell staff administered post-tests and conducted interviews. Technical assistance was available throughout the life of the project as needed both via telephone and on-site. Incident data were collected from October 1, 1995 to March, 1996 and contrasted to the incident data collected prior to implementation. Confidence scales and knowledge based post-tests data collection continued at periodic intervals.

Throughout the life of this 18-month project, incidents were input in a data collection set in order to track the types and numbers of incidents and the effects of TCI implementation. An advisory/implementation group selected by the agency’s director, and made up of supervisors and clinical staff, met with Cornell staff throughout the project to help facilitate the project.

Integral to the implementation of this TCI methodology was a multi-method evaluation design which (a) provided baseline and follow-up data on crisis episodes within the residential care agency for an 18-month period; and (b) evaluated the effectiveness of both the crisis intervention methodology and the strategy for its implementation via training and technical assistance (See Figure 4). The evaluation design was a mix of qualitative and quantitative methods designed to discover current

crisis intervention practices and to assess whether the project had reached its goals. This multi-method approach gave the implementation team methods to check and recheck the reliability of both qualitative and quantitative data gathered. It also offered the project team tools to study the phenomenon of crisis events within an organization.

**Methodology: Evaluation of Outcomes**

The incident reports, the pre- and post-implementation interviews with staff and supervisors, the confidence scale and the pre- and post-training knowledge tests were the principal data collection methods for evaluating the effectiveness of the crisis intervention methodology. The effectiveness of the project’s implementation process was measured by positive changes in staff confidence levels, a decrease

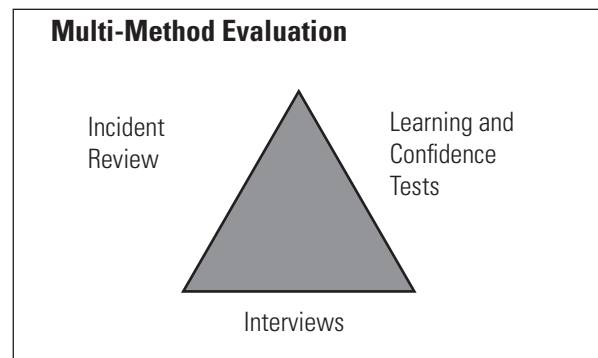


Figure 4. Multi-Method Evaluation

in the number of restraint episodes, and an increase in the knowledge and skill levels of staff ( See Table 1 on page 10).

### **What Did Cornell Learn?**

During the 18-month implementation period in which Cornell worked with the residential agency, the following results were evident: increased staff confidence, greater consistency in approaching children in crisis, documented reductions in incidents, increased staff knowledge of crisis dynamics, and an in-house training system (See Table 2 on page 11).

#### **Confidence**

- Staff members were more confident in their ability to manage crisis situations
- Staff members increased their confidence as a team in handling crisis situations

#### **Consistency in approaching children in crisis**

- Staff members and supervisors indicated a more consistent approach to children in crisis

#### **Reductions in incidents**

- Evidence of reductions in fighting, serious verbal abuse, restraints, and assaults was documented in the three units that implemented TCI
- Statistically significant reductions in physical restraints occurred in Unit B

#### **Increased staff knowledge and the development of an in-house training system**

- Staff members increased their knowledge of crisis intervention, and this increase in knowledge persisted up to 10 months after training was completed
- Selected supervisory staff members learned basic and sophisticated techniques to conduct effective and long-lasting training programs

### **Study Limitations**

There are limitations with the evaluation methodology in this study. Although the agency appears representative of numerous small to medium-

sized not-for-profit organizations throughout North America, a major question remains about the process of implementation and the incidence reduction results being generalizable to other organizations. The agency did volunteer for TCI implementation, and by doing so is a self-selected group. An argument could be made that this agency would have achieved the same results with any other crisis prevention and management system simply because it was ready to incorporate an agency-wide program.

Other fundamental questions remain, for example, about whether the incidence reductions were due to TCI's prevention and de-escalation strategies, or whether the existing leadership through tighter supervision and monitoring alone could have produced the same reduction. What is necessary is a methodology that incorporates a more sophisticated pre- and post-design with a sample of organizations in differing geographic areas throughout North America. The basic pre-post design might follow a staggered schedule of training for units within an agency, as well as for differing agencies. Implementing this design can help maintain the internal validity of the project, while supporting its evaluation and monitoring strategies. Such a staggered approach to training is often necessitated by institutional concerns of scheduling and resources, but can be used to the advantage of the evaluation effort. The strength of this design derives from the ability to compare baseline data with follow-up data within each group, but also adds a meaningful comparison between the follow-up data of like agencies and units. If these two comparisons yield similar results, then rival hypotheses regarding differences between the groups or temporal changes other than the training can be ruled out.

Future evaluation design could well be carried out by independent evaluation staff. The introduction of control or comparison organizations into the evaluation methodology, and an independent evaluator would provide more confidence in any results.

<b>Overview of the Evaluation Design</b> <i>Implementing, Monitoring, and Evaluating a Therapeutic Crisis Intervention Methodology in a Residential Child Care Facility</i>						
<i>Information Domains</i>	<i>Agency and Personnel Profile</i>	<i>Effective Management</i>	<i>Confidence</i>	<i>Teamwork</i>	<i>Restraint Episodes</i>	<i>Increased Knowledge and Skill</i>
<i>Instrument</i>	General Questionnaire	General Questionnaire and Interview Guide	General Questionnaire and Interview Guide	General Questionnaire and Interview Guide	Incident Report	Multiple Choice Pre-Post-test
<i>Type of Data Gathered</i>	Demographic Data	Qualitative & Quantitative (Likert scale)	Qualitative & Quantitative (Likert scale)	Qualitative & Quantitative (Likert scale)	Quantitative	Quantitative Number of Correct Responses
<i>Type of Score Produced</i>	Single Item Indicators	Total Score	Total Score	Total Score	Total Episodes	Item Analysis and Total Score Compared from Pre- to Post-testing
<i>Data Synthesis and Findings Summary</i> 1. Report findings which support or refute projected outcomes or hypotheses. 2. Report on questions raised that warrant further study. 3. Develop an information management system to assess incidents for a residential child care agency.						

Table 1. Overview of the Evaluation Design

<b>Results of Implementation and Evaluation Project</b>		
<i>INTERVIEWS</i>	<i>TESTS</i>	<i>INCIDENTS</i>
<p>Supervisors report:</p> <ul style="list-style-type: none"> <li>• an increase in staff skills</li> <li>• a consistent strategy for intervention</li> <li>• higher level of practice standards</li> </ul> <p>Workers report:</p> <ul style="list-style-type: none"> <li>• more consistent incident reporting</li> <li>• consistency in follow-up</li> </ul> <p>Supervisors and workers reported differing perceptions of whether a debriefing session occurred and how effective it was</p> <ul style="list-style-type: none"> <li>• TCI was implemented in Units B, C, D</li> <li>• TCI was not implemented in Unit A</li> </ul>	<p>Confidence: Tests indicate significantly increased levels of confidence in:</p> <ul style="list-style-type: none"> <li>• managing crisis</li> <li>• working with co-workers to manage crisis</li> <li>• knowledge of agency policy and procedures</li> <li>• helping children learn to cope</li> </ul> <p>Training: Knowledge tests indicate:</p> <ul style="list-style-type: none"> <li>• a significant increase from pre- to post-test in learning scores</li> <li>• only a 5% drop in learning after 10 months</li> <li>• after training, 87% of participants plan to use the knowledge and skills</li> <li>• after training, 93% reported they were able to use the knowledge and skills</li> </ul>	<p>Documented reductions over the 18 month study in:</p> <ul style="list-style-type: none"> <li>• fighting</li> <li>• serious verbal threats</li> <li>• physical assaults</li> <li>• runaways</li> </ul> <p>for the entire agency</p> <p>Statistically significant reductions in physical restraint reports in Unit B over the 18 month period</p> <p>Statistically significant increases in physical restraint reports occurred in Unit A (contrast group) over the 18 month period</p>

Table 2. Results of Implementation and Evaluation Project

## Project Successes

**Leadership.** Despite the limitations of our evaluation methodology, the success of this project points to the necessary elements of leadership, cooperation, and collaboration among executive, clinical, and supervisory staff within an organization. Through the executive leadership the project gained remarkable access to the inner workings of a residential agency. The executive director clearly understood and supported the notion that any crisis prevention and management system needed to be consistent with the organization's mission and philosophy of child care, and had to be supported through clear and well-known policies and procedures. Through the executive director's leadership, time and money were allocated to allow the entire residential services staff to attend TCI training delivered by agency TCI trainers. Supervisors supported the project by implementing the behavior management and intervention strategies on a unit basis. TCI trainers who were also agency supervisors then were able to monitor their use on a day-to-day basis. The supervisor-trainer then was able to integrate what was learned on the unit into subsequent training and refresher courses offered to agency staff. Executive staff, supervisors, clinical staff, and direct care workers, as well as project implementation and evaluation staff shared leadership and learning throughout the organization.

### **TCI principles and organizational mission.**

It was obvious from the project that one of the important lessons from implementation was that the organization leadership, clinical, and supervisory staff had little difficulty with TCI's essential philosophy that a child's behavior is an expression of a child's needs. Implementation success as measured by a reduction in incidents may suffer if any organization finds this philosophy too much of a concept shift.

**Incident monitoring.** Another significant outcome is the development of a monitoring and evaluation system to assess the impact and effectiveness of an agency's crisis prevention and management intervention system, and on quantifiable outcomes such as the frequency and

kinds of incidents. This simple design can be used by clinical or administrative staff to assess the impact of their decisions, policies, or plans, on caregiver/child interactions. For example, this monitoring and evaluation design can offer administration the capacity to track periods of the day when children and staff may be more vulnerable. Using this type of data in management decisions is not a new concept and has been in the human services literature during the past decade with the rise of computer-based information management and quality assurance systems. A crisis intervention strategy is a necessary and critical aspect of a residential child care agency's treatment and behavior management for children who have the potential for aggressive and self-destructive behavior.

## Conclusions

Clearly, this modest study showed that this organization benefited from the implementation of TCI during the study period. The benefits were evident on different levels. Direct care staff increased and retained their crisis intervention knowledge and techniques, and they were more confident in their ability to manage crises as they arose. Staff reported that their confidence working with colleagues as a team increased, and overall there was a more consistent approach to children in crisis across units, and among staff shifts within units. In addition to building staff knowledge and confidence levels, selected supervisory staff learned techniques for conducting effective training programs and assisting staff cope with crises. This project provides limited but promising evidence that increasing staff workers' knowledge and skills, improving their confidence, and utilizing comprehensive prevention, de-escalation, crisis, and post-crisis strategies and techniques can result in substantial reductions in the most aggressive child behavior and offer significant reductions in physical restraint interventions.

## Learning From Tragedy: The Results Of a National Study of Fatalities in Out-of-Home Care

### Introduction

Recent newspaper stories in the United States have drawn attention to fatalities that have occurred over the past decade where physical and mechanical restraints, psychotropic medication, isolation, and seclusion appeared to play a major role in the deaths of both adults and children. The 1998 series in the newspaper, *The Hartford Courrant* documented, over a 10-year period, 142 fatalities of individuals whose ages range from 6 years to 78 years where a combination of physical and mechanical restraints, psychotropic medication, isolation, and/or seclusion contributed to death. As a result of this series, as well as other media attention on subsequent deaths, federal and state legislation and regulations have been proposed which would limit the use of physical and mechanical interventions with children, and well as banning outright certain techniques. Professional organizations and accreditation organizations have followed suit and have outlined restrictions on the use of physical and mechanical interventions and techniques. Often these legislative and regulatory shifts have taken place with little but newspaper accounts of the fatalities to inform these modifications.

### Survey Methodology

In 1998 Cornell University's Family Life Development Center surveyed how children die in foster care, kinship care, group homes, residential care, and juvenile correction facilities. The survey had two distinct strategies: a mailed survey approach and an internet newspaper search. A 43-question survey was mailed to each of the 50 states, as well as the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands. The survey asked child welfare, youth correction, mental health, and developmental disability officials for child (age 18 or under) fatality information for the years 1996, 1997, and 1998 from their sponsored or licensed facilities.

The survey resulted in a return of 71 surveys from 42 states and the District of Columbia. This represents a 39% return rate. This mail survey was augmented by a second strategy: an internet search for fatalities to children in out-of-home care due to restraint and isolation.

### Survey Findings

Our mailed survey indicates that the vast majority of children who died in residential care died from a chronic disease or condition. Other circumstances (in much smaller numbers) included fatalities due to homicide, suicide, accidents, and isolation and restraint. The remainder of this review will only address those deaths that had physical or mechanical restraints as causative or contributing factors.

Our internet search uncovered 18 such fatalities, while our traditional survey documented only 8 of these 18 fatalities. The 17 of the 18 fatalities uncovered by the internet search were reported in the 1998 *Hartford Courrant* report.

- **Age and gender.** The overwhelming majority of the fatalities were males (n=14). Both males and females ranged from 6 to 17 years in age with a mean of 14 years.
- **Immediate cause of death.** Positional asphyxia was listed as the leading cause of death (n=8). Cardiac arrhythmia or cardiac arrest occurred in four cases, while the remaining causes were listed as strangulation (n=1), aspiration (n=1), unspecified or unknown (n=4). While psychotropic medication appeared to play a part in two fatalities, the psychotropic medication history was unknown in the vast majority of cases.
- **Circumstances surrounding the fatalities.** Four fatalities occurred in some form of mechanical restraint, while 14 fatalities were a result of physical intervention. In 7 of the 14 cases of physical restraint, there was only 1 staff worker involved. In three of the physical intervention fatalities, two staff workers were involved, and in the remaining four physical intervention fatalities, the number of staff workers involved was unknown. In two

cases children were known to be on psychotropic medication. In one case the child was restrained over a lengthy period of time or multiple times.

## Discussion

This fatality survey raises many more questions than it answers. Still there are common causes and circumstances of the restraint deaths we have described:

- weight on the child's upper torso, neck, chest, or back
- restricted breathing due to a child's position
- restraints conducted without assistance or monitoring
- signs of the child's distress were ignored
- a child's agitation prior to restraint
- a combination of psychotropic medication and the child's agitation

Residential Child Care Project staff members have been involved in an in-depth analysis of some of these fatalities, and other serious events. A careful analysis reveals when the above circumstances exist within an organizational culture that does not have built-in monitors for safety, serious injury or death can result. Some of the ingredients within an organization's culture that can lead to serious injury and fatalities are described below:

- Restraints are so commonplace within the organization that they are accepted as appropriate interventions to enforce program compliance and alleviate problems due to staff shortages, scheduling, and program deficits. Staff has little or no awareness of the potential dangers inherent in restraints, and feel that they are safe practice because "no one usually gets hurt."
- With a high frequency of use and a dependence on physical interventions, there is little or no monitoring or processing of the events to prevent future occurrence. Often there are so many interventions, they are perceived as a normal part of the job.

- "Home grown" training and crisis intervention packages without "expert" screening abound in the field, with in-house trainers and training further isolating the methods from review. A variation of this is when organizations at one time used an outside expert-based package, but did not keep the trainers and training resources current. The physical intervention methods are handed down with each generation of trainers who add their own spin or ideas. Eventually some of the physical techniques taught evolve into dangerous techniques.
- Little supervision and coaching occur with line staff, and new staff are often left to "figure it out themselves" and get trained by other staff "on-the-job" (often in questionable practices).
- There is no consistent monitoring by supervisors or colleagues. An attitude of professional "courtesy" develops that translates into, "You know what you are doing, and I won't question it." "I will not interrupt any intervention you make, even if I don't agree."
- There is little or no clinical oversight or medical screening, and what information is gleaned from screening is often not conveyed to line staff. For example, children are given a variety of medications and staff workers have no idea of the side effects of any individual medication, much less combinations of medicines. Staff is not routinely informed of medical conditions. If workers are told, they are not given alternative strategies to use if physical restraint is contraindicated.

## Recommendations

1. **Leadership:** The level of effectiveness of a crisis management system to help staff members prevent and reduce potentially dangerous situations depends on leadership's commitment to its implementation. Leadership must provide adequate resources, including an adequate and qualified staff, support for regular external and internal monitoring, and clear rules and procedures that have safeguards

- against abusive practices. Leadership should promote an organizational culture that values developmentally appropriate interventions and therapeutic practice above control and expediency.
2. **Clinical oversight:** Clinical services play an important role in overseeing and monitoring clients' responses to crisis situations. Developing and implementing an individual crisis management plan is critical to responding appropriately and therapeutically to each child in crisis.
  3. **Supervision:** Frequent and ongoing supportive supervision should be built into the implementation and ongoing monitoring of the crisis management system. Supervisors should be fully trained in all of the prevention, de-escalation, and intervention techniques so that they can provide effective supervision, coaching, and monitoring. A post-crisis multilevel response should be built into the practice. The child and staff member should receive immediate support and debriefing following a crisis. Discussing crisis incidents should be built into team/unit meetings so that all staff members can learn from these situations.
  4. **Training:** Crisis prevention and management training should be one part of a comprehensive staff development program that provides core training as well as specialized training based on the population served. Refreshers should be conducted with all direct care staff members as recommended and required. At the completion of the original training and refresher training, staff members can be expected to perform the skills at an acceptable standard of performance. This performance should be documented and the staff should be held to a certain competency level of performance in order to use high-risk interventions. Trainers should be required to attend refreshers in order to maintain their training status.
  5. **Documentation and critical incident monitoring:** Documentation is critical, and includes the documentation of staff supervision and training, and the documentation and monitoring of critical incidents throughout the agency. This documentation and monitoring system allows the organization to review incidents and make decisions about individual and organizational practice.

# TCI System Implementation Criteria

## A Model for Eliminating the Need for Restraint

In his book, *The Fifth Discipline, The Art and Practice of the Learning Organization* (1990, p. 3), Peter Senge defines learning organizations as:

*...organizations where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning to see the whole together.*

Organizations can only learn when the people who make up the organization learn. Leadership must foster openness, collaborative decision making, professional development, and a shared vision of how the organization should work. Leadership needs to set bold goals and high expectations for staff and children and provide the support and resources necessary to achieve the goals. Implementing TCI with the goal of reducing the need for high-risk management strategies requires that organizations put in place a system to promote learning and reflective practice.

For TCI to be an effective crisis management system, the following five general domains need to be addressed: (a) leadership and program support, (b) clinical participation, (c) supervision and post crisis response, (d) training and competency standards, and (e) incident monitoring and feedback (Nunno et al., 2003). (See Figure 5).

**Leadership and program support.** The level of effectiveness to prevent and reduce the need for high-risk interventions depends on and begins with leadership's commitment (Bullard, Fulmore, & Johnson, 2003; Carter, Jones, & Stevens, 2008; Colton, 2008; CWLA Best Practice Guidelines, 2004; Donat, 1998, 2005; Farragher, 2002; Hellerstein et al., 2007; Huckshorn, 2006; J. A. Miller et al., 2006; Murphy & Bennington-Davis, 2005; NASMHPD, 2003; Nunno et al., 2003; Paterson et al., 2008; Petti et al., 2003; Stefan & Phil, 2006; Thompson et al., 2008). When

leadership is fully informed about the TCI crisis prevention and management system and understands its foundation, leaders can support the necessary components that are integral to its implementation and maintenance. Policies, procedures, and guidelines that are clearly written and communicated assist staff members in knowing what to do when confronted with potential crises. Staff members throughout the organization know how to prevent, de-escalate, and contain a young person's aggressive and acting out behavior in line with organizational guidelines.

A clear program philosophy and framework of care are essential for establishing an organizational culture that promotes the growth and development of children and young people with emotional and behavioral difficulties and for establishing organizational practices that are in the best interests of the children (Anglin, 2002; M. J. Holden, 2009). Leaders can promote an organizational culture that establishes an environment where children can thrive by valuing developmentally appropriate and therapeutic practice above control and expediency. With a positive, trauma sensitive, and strength based culture and climate an organization can decrease its reliance on punitive and coercive interventions and restraints (Bullard et al., 2003; Colton, 2008;



Figure 5. Implementation Criteria: Organizational Cornerstones of the TCI System

Farragher, 2002; Hellerstein et al., 2007; Huckshorn, 2006; J. A. Miller et al., 2006; Murphy & Bennington-Davis, 2005; NASMHPD, 2003; Paterson et al., 2008; Petti et al., 2003; Stefan & Phil, 2006). Organizations that decrease use of restraints can have positive child outcomes (Glisson, Dukes, & Green, 2006).

By providing sufficient resources including adequate and qualified staff, support for regular external and internal monitoring, and clear rules and procedures that have safeguards against abusive practices, leadership promotes positive programming and an organizational culture to sustain the therapeutic milieu.

**Clinical participation.** Clinical services play an important role in overseeing and monitoring children's responses to crises. Developing and implementing an individual crisis management plan (ICMP) is critical to responding appropriately and therapeutically to a young person in crisis (Bullard et al., 2003; Carter et al., 2008; CWLA Best Practice Guidelines, 2004; Donat, 1998, 2005; Farragher, 2002; Hellerstein et al., 2007; Huckshorn, 2006; Murphy & Bennington-Davis, 2005; NASMHPD, 2003; Nunno et al., 2003; Paterson et al., 2008; Salias & Wahlbeck, 2005; Stefan & Phil, 2006). These plans are most effective when developed with input from team members and the child and the child's family, and are written in clear and concise language so that the care staff can implement the plan.

At intake, a risk assessment of the child's propensity to engage in high-risk behaviors and the conditions that have provoked these behaviors in the past can provide valuable information. Key questions to address are: (a) How can high-risk behaviors be prevented? (b) Is there a need for an ICMP? (c) What intervention strategies should be used if an ICMP is necessary?

Well-developed ICMPs include strategies for preventing, de-escalating, and managing potential high-risk behavior specific to the child. Included in the plan are specific physical interventions, if appropriate, or alternative strategies if physical intervention is not an option. It is important to

screen all young people in care for any pre-existing medical conditions that would be exacerbated if the young person were involved in a physical restraint. Any medications that the young person may be taking which would affect the respiratory or cardiovascular system should also be noted. If there is a history of physical or sexual abuse that could contribute to the young person experiencing emotional trauma during a physical restraint, it is equally important to document this in the plan. Ongoing reviews of the young person's crisis plan with revisions as the child's condition changes will help staff develop more effective ways to prevent and intervene with the child's high-risk behaviors.

**Supervision and post crisis response.** Frequent and ongoing supportive supervision, mentoring, and coaching are essential for creating and sustaining an organization's ability to reduce the need for restraint and maintain good quality care (Bullard et al., 2003; Colton, 2008; CWLA Best Practice Guidelines, 2004; Donat, 1998, 2005; Farragher, 2002; Huckshorn, 2006; J. A. Miller et al., 2006; Murphy & Bennington-Davis, 2005; NASMHPD, 2003; Nunno et al., 2003; Petti et al., 2003; Ryan, Peterson, Tetreault, & van der Hagen, 2008; Thompson et al., 2008). Reflective and supportive supervision is built into the implementation and ongoing monitoring of the TCI crisis management system. Supervisors who are fully trained in all of the prevention, de-escalation, and intervention techniques can provide effective supervision, coaching, and monitoring of their staff members. Fully trained and effective supervisors have reasonable expectations with realistic time frames and schedules for staff so that staff can accomplish tasks and respond to young people's needs in a thoughtful and well-planned manner.

This post crisis response system ensures that all young people and staff receive immediate support and debriefing following a crisis as well as a brief medical assessment (Bullard et al., 2003; CWLA Best Practice Guidelines, 2004; Farragher, 2002; Huckshorn, 2006; J. A. Miller et al., 2006; Murphy & Bennington-Davis, 2005; NASMHPD, 2003; Nunno et al., 2003; Petti et al., 2003). Once things are back to normal, all staff members involved in the restraint can deconstruct

the incident to develop strategies for intervening in the future. It is important to notify families when their child has been involved in a physical intervention. Building a discussion of crisis incidents into team/unit meetings helps staff learn from these situations and provides accountability and support at the highest level.

**Training and competency standards.** Training and professional development are a cornerstone of any professional organization. Programs that keep staff informed and updated on the special needs of the young people in their care can enhance treatment and child outcomes. A comprehensive training agenda includes prevention, de-escalation, and management of crises as well as child and adolescent development, trauma sensitive interventions, and individual and group behavior support strategies (Bullard et al., 2003; CWLA Best Practice Guidelines, 2004; Donat, 2005; Farragher, 2002; M. J. Holden & Curry, 2008; Huckshorn, 2006; Murphy & Bennington-Davis, 2005; NASMHPD, 2003; Nunno et al., 2003; Paterson et al., 2008; Petti et al., 2003; Ryan et al., 2008; Thompson et al., 2008).

TCI training is only one part of a comprehensive staff development program that provides core training, as well as specialized training based on the population served. TCI training is only to be conducted by a certified TCI trainer. The TCI training should be 4 to 5 days in length with a minimum of 28 classroom hours. If the training is less than 28 hours, the physical restraint techniques should not be taught. TCI trainers are required to attend a Cornell University sponsored TCI Update and pass testing requirements at least every 2 years (1 year in New York State and in the United Kingdom and Ireland) in order to maintain their certification.

Training for direct care staff to refresh skills is required semiannually at a minimum. Refreshers are designed to give staff the opportunity to practice de-escalation skills, Life Space Interviewing, and physical restraint skills. At the completion of the original training and each refresher, staff are expected to perform the skills at an acceptable standard of performance. Documentation of these training

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

**Documentation and incident monitoring and feedback.** Documentation, data analysis, and feedback to all levels of staff teams are an important part of restraint reduction efforts (Bullard et al., 2003; Carter et al., 2008; CWLA Best Practice Guidelines, 2004; Donat, 2005; Farragher, 2002; Huckshorn, 2006; J. A. Miller et al., 2006; Murphy & Bennington-Davis, 2005; NASMHPD, 2003; Nunno et al., 2003; Petti et al., 2003; Stefan & Phil, 2006; Thompson et al., 2008). Data management includes the documentation of staff supervision and training and the documentation and monitoring of incidents throughout the facility. An agency-wide committee appointed by leadership with the authority and responsibility to enforce documentation requirements and track the frequency, location, and type of incidents as well as any injuries or medical complaints that occur in the facility helps to monitor the effectiveness of the TCI system. This documentation and monitoring system allows the facility to review incidents and make decisions about individual and organizational practice and recommend corrective actions.

In addition to an agency-wide restraint review committee, a clinical review of incidents and a team or unit review can assist organizations in making changes to help reduce high-risk situations. These reviews focus on different aspects of the incident and provide feedback on any information or suggestions to the team, clinician, or administration. Some type of benchmarking or red flagging should call attention to any situation that exceeds the norm and requires a special review. For example, this red flag might appear when the number of incidents per month exceeds a set number, when restraints exceed a certain length of time, or when specific complaints or injuries that are unlikely to occur during a restraint are reported.

Residential child caring agencies have been able to reduce physical restraint episodes and aggressive behavior by following these guidelines and effectively implementing the TCI system. Implementation of TCI has resulted in an increased ability on the part of staff to manage and prevent crises. Implementation studies have also shown an increased knowledge and skill on the part of all staff to handle crisis episodes effectively, and a change in staff attitude regarding the use of physical restraint when TCI is implemented as designed (Nunno et al., 2003).

## Questions For Implementation Assessment

### Leadership and Program Support

#### *System consistent with mission*

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

#### *Administration*

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

#### *Policies, rules, and procedures*

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

#### *External and internal monitoring*

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

#### *Culture*

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

#### *Program appropriate to child's needs*

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

### Clinical Participation

#### *Individual crisis management plans*

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

***Medical screening***

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

***Documented ongoing reviews***

- Is the individual crisis management plan reviewed on a regular and frequent basis for progress or modification of intervention strategies?

**Supervision and Post Crisis Response*****Supervisors fully trained in TCI***

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

***Types of supervision***

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

***Post-crisis multilevel response***

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

**Training and Competency Standards*****Basic/core training***

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

***Crisis intervention training***

- Do all staff workers receive a minimum of 28 hours of TCI training?
- Are there additional training sessions if the children have special needs that should be considered?
- Is the training safe? Is it delivered by certified trainers?

***Ongoing staff development***

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

## TCI SYSTEM IMPLEMENTATION: Implementation Criteria

### ***Refreshers***

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

### ***Credentialling based on achieving a level of competence***

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

## **Documentation and Incident Monitoring and Feedback**

### ***Incident review committee***

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

### ***Peer review***

- Is there clinical oversight of incidents and interventions?

### ***Team review***

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

### ***Data monitoring***

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

### ***Feedback loop***

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

### ***Red flags/benchmarks***

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

# TCI Implementation: Leadership and Program Support

The effectiveness of the Therapeutic Crisis Intervention system to help staff workers prevent and reduce potentially dangerous situations depends on leadership's commitment to its implementation. TCI should be consistent with the organization's mission and philosophy. The leadership should be fully informed about the TCI crisis management system, and understand its foundation and support the necessary components that are integral to its implementation and maintenance. There should be clear policies, procedures, and guidelines in writing, communicated to all staff members. Every staff person should know what to do when confronted with potential crisis situations, and how to prevent, de-escalate, and contain a young person's aggressive and acting out behavior.

Leadership must provide adequate resources, including adequate and qualified staff, support for regular external and internal monitoring, and clear rules and procedures that safeguard against abusive practices. Leadership should promote an organizational culture that values developmentally appropriate and therapeutic practice above control and expediency. It is essential that the organization have a strong overall program structure that drives individual treatment or care plans, activities, and routines, and staff and young people's interactions. This program structure should be informed by trauma research and strength-based programming.

## Services Offered

### Assessment and Planning Meeting: Program Description

Implementing the TCI system begins with leadership. After an assessment of the organization's present crisis management system is conducted, a strategic plan can be developed to prioritize needs and target resources to facilitate the implementation of TCI. This plan provides a road map for staff members responsible for developing and maintaining the critical elements of the system. A day of assessment and planning provides the information necessary for agencies to develop a list of strengths and needs in the five areas of the system: (a) leadership and program support, (b) clinical participation, (c) supervision and post

crisis response, (d) training and competency standards, and (e) documentation and incident monitoring and feedback. Agencies will also prioritize needs and develop an action plan to implement the TCI System fully.

## Program Objectives

Participants will:

- examine the five criteria for an effective crisis prevention and management system
- assess their agency's present crisis management system based on the TCI implementation criteria
- prioritize the needs of the organization in relation to implementing TCI
- develop an action plan that addresses needs and describes the steps to be taken to implement TCI

## Intended Audience

The leadership should carefully select this work group so that it represents various expertise, disciplines, and programs. These should be staff members who have the authority and ability to carry out the implementation plan, such as the CEO, Medical Director, Quality Assurance Director, Clinical Director, Director of Residential Services, program and unit supervisors, training director and TCI trainers (present and/or those to be trained), social workers/therapists, nurses, etc.

## Program Outline

### 9:00 a.m.

- Introductions, Overview, and Expectations
- Goals of the TCI System and Goals for the Day
- TCI Implementation Criteria
- Group Assessment of Present Crisis Management System
- Prioritizing Needs

### 12:00 p.m. Lunch

### 1:00 p.m.

- Developing an Action Plan
- What to Expect When Implementation Begins
- Next Steps

### 4:00 p.m. Adjourn

## Materials

Participants will receive the *TCI Systems Bulletin* and a copy of the assessment and plan developed at the meeting.

## Additional Technical Assistance Available

- review crisis related policies and procedures
- give feedback/review programmatic issues as they relate to TCI
- do an assessment of organizational culture as it relates to crisis intervention
- meet with administrators and leaders to discuss implementation of the TCI system
- meet with the board of directors to present information about the TCI system

## Model Policy on the Use of Physical Interventions

### Definition

- Physical interventions and restraints are holding techniques, strategies, or actions that directly limit, restrict, or control a young person's bodily or physical movements.
- Physical interventions including physical restraints to contain and/or control the behavior of children and young people in care, should only be used to ensure safety and protection. Except where otherwise specified as part of an approved individual crisis management plan, physical interventions should only be employed as a safety response to acute physical behavior and their use is restricted to the following circumstance:

**Standard for use:** *The child/young person, other children, staff members, or others are at imminent risk of physical harm.*

### Risk and Safety Issues

As any physical intervention involves some risk of injury to the young person or staff worker, staff members must weigh this risk against the risks involved in failing to intervene physically when it may be warranted.

## Contraindications

Physical interventions must never be used as:

- punishments
- consequences, or
- to demonstrate “who is in charge”

Unless approved by the relevant statutory authorities and specified in an individual crisis management plan, physical interventions must never be used for:

- program maintenance (such as enforcing compliance with directions or rules or for preventing the young person from leaving the premises) or
- for therapeutic purposes (such as forming attachment as promoted by “holding” therapy advocates or inducing regressive states)

## Use

- Physical interventions should only be employed after other less intrusive approaches (such as behavior diversions or verbal interventions) have been attempted unsuccessfully, or where there is no time to try such alternatives.
- Physical interventions must only be employed for the minimum time necessary. They must cease when the child or young person is judged to be safe.

## Necessary Requirements Prior to Use

- Physical interventions may only be undertaken by staff persons who have successfully completed a comprehensive crisis management course that covers: crisis definition and theory; the use of de-escalation techniques; crisis communication; anger management; passive physical intervention techniques; the legal, ethical, and policy aspects of physical intervention use; decision-making related to physical interventions; and debriefing strategies. Staff members must also have demonstrated competency in performing the intervention techniques as measured and documented according to relevant professional and/or state regulatory guidelines.

- All staff workers involved in an incident of physical intervention must have successfully completed the agency-endorsed crisis management training. Such training should be fully implemented in the agency, and upon completion of training, staff workers should have been assessed as competent in the use of physical interventions. Staff workers must also have successfully completed a skills review within the previous 6 months.
- Only physical intervention skills and decision-making processes that are taught in the comprehensive crisis management course and approved by the agency (and any relevant statutory authority) may be used. All techniques (including decision-making processes) must be applied according to the guidelines provided in the training and in this policy.

### **Process for Use**

- Where possible, staff members must consult with peers and supervisors prior to initiating any physical intervention.
- Two or more staff members should be involved in any physical intervention to help ensure safety and accountability.

# TCI Implementation: Clinical Participation

Clinical services play an important role in overseeing and monitoring children's responses to crisis situations. Developing and implementing an individual crisis management plan is critical to responding appropriately and therapeutically to a child or young person in crisis. Children should have a functional analysis of their high-risk behavior with a plan that will eliminate the need for external controls by helping the child develop replacement behaviors and more appropriate coping skills. The plan should also include a strategy for intervening that describes specific safety interventions, including physical, mechanical, or chemical restraints and/or seclusion, if appropriate, or alternative strategies if one of these techniques is not an option. This involves screening the child for any pre-existing medical conditions that would be exacerbated if the child were involved in a restraint. Medications that the child may be taking that would affect the respiratory or cardiovascular system should be noted. If there is a history of physical or sexual abuse, this should be considered as it could contribute to the child experiencing emotional trauma during a physical restraint. There should be ongoing reviews of the child's progress toward goals of eliminating the need for external controls.

## Services Offered

### Individual Crisis Management Planning Workshop: Program Description

One of the major responsibilities of clinical services in the TCI System is to assist direct care staff in preventing and monitoring a young person's aggressive and inappropriate responses to crisis situations in residential care. This preventive and monitoring role is formalized through individual crisis management plans (ICMPs). These plans include a functional analysis of a young person's high-risk behavior. The ICMPs include risk and safety screening, history of sexual abuse or trauma, pre-existing medical, psychological and emotional conditions, potential triggers to violence, and de-escalation strategies. The functional analysis of behavior and the safety screening help determine

specific behavioral and physical interventions necessary to ensure safety for the young person. These plans provide a road map for direct care staff workers when dealing with a potential crisis situation.

## Program Objectives

Participants will be able to:

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

## Intended Audience

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

## Program Outline

### 9:00 a.m.

- Introductions
- Overview of the TCI System
- Role of Clinical Services
- High-Risk Behavior
- Individual Crisis Management Plans
- Types of Aggression

### 12:00 p.m. Lunch

### 1:00 p.m.

- Assessing Aggressive Behavior
- Developing ICMPs
- Implementation Planning

### 4:00 p.m. Adjourn

## **Materials**

Participants receive a student workbook and an individual crisis management plan template.

## **Additional Technical Assistance Available**

- review ICMPs
- conduct case reviews and assist in the development of ICMPs
- observe units to monitor the use of ICMPs
- work with the team on developing a process for ICMPs
- assist in the development of a system to involve children in developing de-escalation preference strategies
- provide a review of models of trauma-informed care to enlighten practice

# TCI Implementation: Supervision and Post Crisis Support

Frequent and ongoing supportive supervision should be built into the TCI crisis management system. Supervisors should be fully trained in prevention, de-escalation, and intervention techniques so that they can provide effective supervision, coaching, feedback, and monitoring. Supervisors should have reasonable expectations with realistic timeframes and schedules for staff workers so that they can accomplish tasks and respond to childrens' needs in a thoughtful and well planned manner. A post-crisis multilevel response system should be built into the practice. All staff members should receive immediate support and debriefing following a crisis. There should also be a process debriefing once things are back to normal. Families should be notified when their child has been involved in a safety intervention. Discussing crisis incidents should be built into team/unit meetings so that everyone can learn from these situations.

## Services Offered

### The Post-Crisis Multilevel Response Workshop: Program Description

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

## Program Objectives

Participants will:

- analyze the effect of a crisis on staff members and the organization
- demonstrate immediate debriefing strategies
- demonstrate the incident review process with the staff member(s)
- demonstrate the team debriefing process
- use the ICMP in the debriefing process
- develop an implementation plan for the post-crisis multilevel response

## Intended Audience

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

## Program Outline

**9:00 a.m.**

- The Role of Supervision in the TCI System
- Stress Model of Crisis: Staff/Agency Perspective
- Direct Supervision

**12:00 p.m.** Lunch

**1:00 p.m.**

- Immediate Response
- Incident Review with Staff
- Incident Review with Team
- Implementation Planning

**4:00 p.m.** Adjourn

## Materials

Participants receive a student workbook.

## Technical Assistance

- meet with supervisor(s) to review the post-crisis response system
- conduct incident reviews with the team
- observe units to provide supervision for agency
- provide direct supervisory details in relation to TCI
- provide additional supervisory training

# TCI Implementation: Training and Competency Standards

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

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

## Services Offered

### Therapeutic Crisis Intervention Training of Trainers: Program Description

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

Training of Trainers in TCI presents a crisis prevention and intervention model designed to help staff workers prevent potential crises, de-escalate crises when they occur, and assist children and young people to learn constructive ways to handle feelings of frustration, failure, anger, and hurt. In addition,

physical intervention techniques that respect the dignity of the worker and the young person are practiced. The program also gives participants the tools to teach therapeutic crisis intervention techniques in their own agencies. There is an opportunity to practice and gain immediate training experience. The course stresses crisis prevention.

## Program Objectives

Participants will be able to:

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

## Intended Audience

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

## Materials

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

## Technical Assistance

- conduct training skills seminars for TCI trainers
- observe TCI training and give feedback
- assess TCI trainers in delivering direct training
- observe units to assess the transfer of learning
- assist in implementing and testing an evaluation system

## **Agenda: TCI Training of Trainers**

### ***Monday***

8:45 am  
Introduction to Course  
TCI System  
Crisis Prevention and Therapeutic Milieu  
The Importance of Emotional Competence  
Stress Model of Crisis  
Assessing the Situation  
Awareness of Self, Child, and Environment  
*Assignments for Tuesday distributed to participants*  
5:00 pm  
*Session adjourned*

### ***Tuesday***

8:45 am  
Crisis Communication and Active Listening  
Behavior Support Techniques  
Emotional First Aid  
Conflict Cycle  
Managing Aggressive Behavior  
Nonverbal Communication  
Protective techniques  
*Training assignments for Wednesday and Thursday*  
5:00 pm  
*Session adjourned*

### ***Wednesday***

8:45 am  
Crisis Co-regulation  
Life Space Interviewing  
Choosing a safety intervention  
Standing Restraint  
Seated Restraint  
Small Child Restraint  
Team Prone Restraint and Transferring Control  
Supine Restraint and Transferring Control  
*Training assignments for Wednesday and Thursday*  
5:00 pm  
*Session adjourned*

### ***Thursday***

8:45 am  
Crisis Intervention Role Plays  
Practicing physical interventions  
The Letting Go Process  
Safety Concerns and Documentation  
Practicing with Resistance  
Criteria for Implementing TCI System and Action  
Planning  
5:00 pm  
*Session adjourned*

### ***Friday***

8:45 am  
Implementation and Testing  
Life Space Interviewing After Restraint  
Testing  
Physical intervention techniques  
LSI  
Written test  
Certification Process  
Close of Program  
4:00 pm  
*Session adjourned*

## TCI Certification Process

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

### Associate Certification

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

#### Basic requirements for associate certification

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

#### Privileges associated with associate certification

- certification to provide direct TCI training according to the TCI guidelines within your agency and direct training sponsored by your agency
- eligibility for professional certification after a minimum of 1 year

## Professional Certification

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

#### Basic requirements for professional certification

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

#### Privileges associated with professional certification

- certification to provide direct training within your organization/agency and direct training sponsored by your agency
- certification to provide direct training outside of your organization/agency
- eligibility to participate on a certification committee

# TCI Implementation: Documentation, Incident Monitoring, and Feedback

Documentation is critical, and includes the documentation of staff supervision and training, and the documentation and monitoring of incidents throughout the agency. As part of an agency's leadership and administrative support for TCI, an agency-wide committee should have the authority and responsibility to enforce documentation requirements, track the frequency, location, and type of incidents that occur. In addition, any committee or data/management system should have the potential to monitor staff, children, and programmatic involvement in incidents. This documentation and monitoring system allows the leadership to review incidents and make decisions about individual and organizational practice.

In addition to an agency-wide restraint review committee, there should be a peer review (clinical review) of incidents and a team or unit review. These reviews focus on different aspects of the incident and feedback any information or suggestions to the team, clinician, or administration. There should be some type of benchmarking or red flagging that is put in place that will note any situation that exceeds the norm and requires a special review. For example, a red flag might appear after a certain number of incidents occur during a month, or if restraints exceed a certain length of time.

Documentation is the basis for incident monitoring at all levels of an agency's organizational structure. Although each organization determines the kind of events that are considered critical, all restraints should be documented by all workers who were involved in or who monitored a restraint. Young people may also want or need to document the restraint they were involved in or witnessed.

All physical interventions need to be documented, and documentation should be on separate incident or restraint forms. It is important to write down what happened. Regulatory requirements may dictate what is included in an incident report. Minimally, the following information should be included:

1. Who was involved?
2. Where did it take place?
3. When did it happen?

4. What were the antecedents?
5. What action did staff member(s) take to de-escalate the situation?
6. Is there is an individual crisis management plan for the child? Did these actions or procedures conform to the plan?
7. If physical contact was made, who did what? (be specific)
8. How long did the restraint last? Who was involved and how?
9. Were there any injuries? Was medical attention given to the child or staff member(s)?
10. What plan was developed in the Life Space Interview?
11. Was any follow-up needed?
12. Were staff members debriefed?
13. Statements from witnesses should include a description of what they observed.

Documentation is essential for many reasons. It is important for charting child progress, for providing clear and concise information if there are abuse allegations, for gathering information to improve services to young people and families, and for communicating with staff members and families. By taking a close look at what has happened, staff members can plan and alter the environment to meet young people's needs better and prevent future crises. Families should be notified after a restraint or crisis occurs. They should be involved so that they can offer support and guidance to the young person. Working in partnership with the family is critical when dealing with crises.

## Technical Assistance

- attend incident review meetings and give feedback
- review documentation and give feedback
- conduct workshops on deconstructing incidents and assessing risk
- assist clinical and supervisory staff in tying documentation into the individual crisis management plan debriefing

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# TCI Faculty, Instructors, and Staff

## TCI Faculty and Staff

**Michael Nunno**, D.S.W., is a Senior Extension Associate with the Family Life Development Center (FLDC), and the co-principal investigator of the Residential Child Care Project (RCCP). Dr. Nunno has published in the *Child Protective Services Team Handbook*, as well as in *Children and Youth Services Review*; *Child Abuse and Neglect: An International Journal*; *Children and Society*; and *Protecting Children*. He was editor of the *Journal of Child and Youth Care's* dedicated issue on institutional maltreatment and co-editor of the book, *For Your Own Safety: Examining the Safety of High-Risk Interventions for Children and Young People*.

**Martha J. Holden**, M.S., is a Senior Extension Associate with the FLDC, co-principal investigator and Director of the RCCP. Ms. Holden provides technical assistance and training to residential child caring agencies, schools, juvenile justice programs, and child welfare organizations throughout the United States, Canada, the United Kingdom, Ireland, Australia, Israel, New Zealand, and Russia. She was the lead writer and developer of *Children and Residential Experiences (CARE): Creating Conditions for Change*, a best practice model for residential care organizations. Ms. Holden has published in the *Children's and Youth Services Review*, *Child Abuse and Neglect: An International Journal*, *Journal of Emotional and Behavioral Problems*, *Residential Treatment for Children & Youth*, and the *Journal of Child and Youth Care Work*. She has co-authored a chapter in the book *Understanding Abusive Families* and *For Your Own Safety: Examining the Safety of High-risk Interventions for Children and Young People*. In 2005 she received the Board of Directors Award for Lifetime Achievement and Outstanding Service to America's Children and Youth and For Dedication to Promoting Life-Long Learning Within the Child and Youth Care Profession from the Ohio Association of Child and Youth Care Professionals.

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**Joanna F. Garbarino**, M.S., graduated with distinction from Cornell University's School of Human Ecology in 2004. Since that time she has worked with the RCCP as a research assistant and been involved in many facets of development for the CARE and TCI curricula.

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

**Kristen Carlison** supports the data management needs of the RCCP. Within these duties she manages the data needs of TCI's certification and testing system, as well as TCI implementation projects. She also has responsibilities for the project's quarterly reports, budget proposal, and proposal development.

**Holly Smith** handles the processing of testing materials for the RCCP training. Her responsibilities include scanning test information, mailing individual's test results, and maintaining the database. She also assists in preparing the quarterly reports.

**Alissa Medero** handles the training registrations for the RCCP. She sends out confirmation letters, training materials and corresponds with participants to ensure a productive training for all.

**Brittany Burns** is responsible for managing the logistics for hotels/sites for our training programs. She packs and ships training materials for the 200+ training programs conducted annually.

**Trudy Radcliffe** is the primary contact person for CARE, a program model for residential services. She coordinates CARE training, registration, evaluation, and logistics.

## TCI Instructors

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

**Jack C. Holden**, Ph.D., an independent trainer and consultant working with residential care, foster care, and public schools has been an instructor and project consultant with Cornell University's RCCP for nearly 25 years. Dr. Holden earned a Ph.D. in Education, specializing in Adult Learning and has presented workshops and research nationally and internationally and has co-authored, *Recovery for Staff—TCI*, Cornell University; *Connecting: Essential Elements of Residential Child Care Practice*; *Basic Child Care Practices for Foster Parents*; and *Learning Life Skills: A Curriculum For Group Leaders Helping With the Move Towards Interdependent Living*. Dr. Holden has published in the *Journal of Child and Youth Care Work*, and *Journal of National Staff Development and Training Association*.

**Carla Sockwell Morgan**, M.Ed., NCC, currently employed by NC Mentor, has been in the human service field for over 25 years. She has worked in both public and private agencies as a foster care social worker, group home director, clinical coordinator, and trainer. She has worked with Cornell University since 1984 and has also presented at many state and national conferences. In 1978, she earned an M.Ed. in

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**I. Franklin Kuhn, Jr.**, Ph.D, a clinical psychologist, has worked in clinical and administrative positions with child welfare organizations for over 20 years. He has served as medical school faculty and has provided consultation and training to agencies across the U.S. Dr. Kuhn has been a consultant to the RCCP since 1988.

**Raymond Taylor**, Msc., has extensive experience in social work education, research, and training. He holds degrees in Social Administration, Social Work and Research from the University of Stirling, an Advanced Diploma in Child Protection Studies from the University of Dundee and a Master's Degree in Public Sector Management from the University of Strathclyde. He has been a TCI consultant since the introduction of TCI into Britain and the Republic of Ireland in 1992.

**Doug Bidleman**, B.A., is the Senior Learning Coach for the Learning Institute at Hillside Family of Agencies in Rochester, NY. He has over 30 years of experience providing service to children and families in a residential treatment environment. He is responsible for overseeing Hillside Children's Center Behavior Management System which addresses all aspects of crisis intervention in an effort to ensure the best practice and child and staff safety.

**Nick Pidgeon**, BSc, is Director of NJP Consultancy and Training Ltd. based in Bridge of Allan, Scotland. He has many years experience in social work and over 10 years experience as an independent consultant. He has provided training and consultancy throughout Britain and Ireland and in the USA, Canada, Australia, and Russia. Since 1993 he has been a consultant to the RCCP.

**Mary Ruberti**, M.S.W., is a private consultant specializing in teaching and technical assistance to residential programs. She has many years of experience working with emotionally disabled and

mentally ill children and youth in both residential and community-based settings. This work has included the utilization of adventure-based counseling in this population in a variety of settings. Ms. Ruberti has received training from Project Adventure, Inc., a nationally recognized ABC training provider.

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

**Angela Stanton-Greenwood**, M.A., M.Ed., has worked with a learning disabled population for 30 years as a practitioner with Barnardos, and now as a training manager for the Helsey Group, England. Ms. Stanton-Greenwood coordinates the TCI program in Europe. She is a TCI and SCIP Instructor and was staff supervisor in the program that piloted TCI in England.

**Sandy Paterson**, DPE, DRem.Ed., is a private consultant with more than 30 years of experience in residential child care. For more than 15 years he was the Principal of High Close School in the U.K., a residential school for children who have severe emotional and behavioral problems, where implementation of TCI was first piloted in the UK.

**Howard Bath**, Ph.D., is the Children's Commissioner of the Northern Territory, Australia. 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).

**John Gibson**, M.S.W., MSSc, CQSW, is owner of Gibson-Cathcart Social Work Consultancy (Ireland). He is qualified in Social Work and has worked in 4 different residential child care settings for a total of 21 years. He was among the first workers to train in TCI in Ireland and Britain. He joined RCCP as an Instructor in 2001. His doctoral research is a qualitative study into team leadership in small group homes in Ireland.

**Zelma Smith**, LMSW, Child Welfare Consultant and Trainer, has over 35 years of experience in the field of child welfare including training, consultation, curriculum development, supervision, and direct service delivery. She was the principal curriculum developer of an educational/group support program for relatives caring for children in their home. Her work experience includes training in kinship care, recruitment and preparation and selection of foster and adoptive parents, residential treatment, child abuse and neglect and meeting planning. In the mid-1980's, she had been a field instructor/extension associate at Cornell University's Child Protective Training Institute. Formerly, she was chairperson for the National Association of Black Social Workers' National Kinship Task Force Committee. She is a current member of the National Kinship Advisory Committee at the Child Welfare League of America.

**Rich Heresniak** is the Training director at the Astor Home for Children, a 75-bed residential facility for severely emotionally disturbed children, ages 5-13, located in Rhinebeck, NY. He handles crisis intervention work and is the primary TCI trainer for the facility. Mr. Heresniak worked his way up to this position, starting out as a Teacher Assistant in the Astor Learning Center, followed by Crisis Intervention and childcare worker in the RTC and RTF units.

**Craig Bailey**, B.S., 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.

**Andrea Turnbull**, M.A., LMHC, QS, 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. Ms. Turnbull became a TCI trainer in 2001 when her agency first began training TCI. Ms. Turnbull, 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, FL.





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