

REFOCUS

CORNELL UNIVERSITY'S RESIDENTIAL CHILD CARE PROJECT NEWSLETTER • VOL. 8, 2003

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Anger: Troublesome Emotion or Therapeutic Challenge?

by John Gibson, MSc., MSW

In this article I focus on the occurrence of staff anger in residential youth and child care. More frequently than not attention to anger tends to focus on youth anger (Dangel et al., 1989). However, in the past year, I have carried out a small-scale survey on the frequency of staff anger. The context of the enquiry asked about anger during incidents of crisis behaviour by young people. As I will describe later this survey also provides an additional component to Activity 13 "Anger and the Crisis Cycle" in the TCI Curriculum. This survey was carried out in conjunction with direct TCI training to staff in residential settings, and while training trainers in Ireland, Britain, and in America. I report on these findings later in the article.

To provide foundation I want to start with one of those myriad "30-second encounters" between a single youth and a single adult in the context of residential group living.

Brief Encounters

The setting event for this encounter was a difficult 24-hour period in which a group of young people displayed dangerous and violent behaviour. The main topic of discussion at the change-over meeting

between shifts on the following day was the events in the preceding 24-hour period. As I left the office in which the meeting took place a 13-year-old female resident confronted me. She had not been involved in the events but as this was a small group home her right to privacy and peace was certainly disrupted. She looked directly at me and asked, "What are you in a bad mood about?" My retort was immediate, sharp and ill tempered, "I'm not in bad mood." Fortunately the brief dialogue continued with a more considered tone. My next comment was an explanation, "I'm not in a bad mood but I am angry. I'm angry about last night's disruption and acting out." The reply from the young person came with a mixture of sympathy and assertiveness, "I know, I know, but just don't take it out on me." We separated. She went to a common room and I went to my office. The encounter was fleeting. The outcome was pleasingly and surprisingly therapeutic; it was so for me and perhaps for the young person. Had I not "caught" my own anger in this fleeting interaction I could easily have been caught in a crisis cycle in which nobody wins.

This young person became my "therapist." I felt better for her intervention.

She helped me process my anger. The emotion of anger was converted into an appropriate action. Because I talked it out, I neither acted it out nor did I internalise it as unhealthy stress. It was communication of meaning that we could both understand and live with and not react negatively to what passed between us. The seeds of a negative exchange and of an escalatory spiral were there also.

My reflective thought in the moments after this episode was that I had been angry. My role in this facility was team manager. In the change-over meeting I controlled my anger and if my colleagues were aware of it they did not comment. I was angry at the acting out youth and I was angry with some of the staff team who in my estimation had been neglectful during the previous shift and then condemned and wanted to punish the young people for their behaviour. A further reflection was on the power of facial expression and tone of voice. The young person read my mood.

So, what is the role and function of anger in child and youth care settings whether residential or not? How can it be therapeutically channelled? My reflective thought now as I look back over 20 years in residential child care is that there were many other encounters with young people and with colleagues that might have been more productive if I had made better use of my anger, this "troublesome emotion."

“ It is only with the heart that one can see rightly; What is essential is invisible to the eye.”

—The Little Prince, by Antoine-Marie-Roger de Saint-Exupery

Anger, Cont. from page 1.

Strong Emotions

The setting of residential child care is a place of strong and of “parallel emotions” (Davis, 1977). There is no essential difference in the range of emotions experienced by both carer and cared for. The Guided Fantasy activity on Day 1 in the TCI curriculum proves the point that workers and young people share the same range of feelings and emotions. These emotions can be felt second by second during every 24-hour period. Sometimes they are obvious, out in the open, up for discussion and part of a shared dialogue informed by therapeutic processing. Sometimes they are unhealthily repressed into “the space between the floorboards” (Balbernie, 1966) and denied or acted out or projected outward and blamed on the young people, their families, or on to management. It is the quality and multiplication of these “micro-moments” (Gibson and Turtle, 1996) like the one I just described that in part determine the climate and culture of a residential child care facility. Each fleeting encounter has its own beginning, middle, and end. True, there are other components that create climate, like the “mix” of the resident group and the “mix” of the staff team but the emotional quality of these “I thou” moments and these “micro-moments” is critical.

My concern here is adult anger in these moment-by-moment interactions with children and young people in out-of-home care.

Anger in Residential Care

Two British researchers (Swaffer and Hollin, 1997) used a qualitative approach to investigate adolescents’ experience of anger in residential care. They note that whereas there is a “substantial literature” (p.567) on the subject of anger as it relates to various populations little is known about adolescent experience of anger. These

researchers interviewed 15 teenagers in a secure residential facility. The young people were asked to recall and describe exactly their most recent experience of anger. They were then asked specific questions about the provoking person, about the location of the interaction, about any conversation that took place, and what if anything they did to control their anger. In total 18 instances of anger provoking events were recorded. It was slightly more likely at a 56% occurrence rate that the perceived provocative action came from a staff person than another peer 44%. In the majority of incidents, 61%, other people were likely to be present and the most frequent location, 45%, was the lounge area. Only 27% of the young people said that they informed the person who provoked them that they were getting angry, 47% of the young people said that the provoking person should have known that they were getting angry.

The stated causes of anger in this study were:

- disrespectful treatment
- perceived unfairness and injustice
- personal irritation
- annoyance
- enforced compliance with the rules of the establishment

This study along with discussions among the TCI Instructors raised my curiosity about the occurrence of adult anger in residential child care. As a place to begin I carried out a small-scale research study that also acts as a useful addition to Activity 13.

The Research Question

The research question is fairly straightforward. I wanted to discover the extent to which adult anger in residential care is a contributory or fuelling factor in incidents of challenging or crisis behaviour. I defined “contributory” or “fuelling factor” to mean adult responses that might add to an already volatile or potentially volatile situation. In essence this question is nothing more than a place to begin. I acknowledge

that to research this topic thoroughly requires more scientific rigour than that described here.

The principle aim in exploring this question was to discover if the results would provide further underpinning importance to Activity 13.

Method

By using the method described here two objectives are achieved simultaneously.

- Relevant data is collected.
- The results are immediately available to everyone and serve to give an added sense of immediacy to Activity 13.

During TCI direct training, update training, and on train-the-trainer events at the commencement of Activity 13 participants are asked to take part in a short anonymous exercise. Each participant is given a small Post-it Note™ or sticky paper and is asked to write down a response to the following question: “*What in your opinion is the percentage of incidents of challenging behaviour that are fuelled or escalated by worker anger?*” Participants are asked to fold the Post-It Note™ so that no one else can see it. The trainer collects these in a large envelope or box.

The trainer then directs participants to gather round a flip chart stand. The trainer places each Post-it Note™ on the flip chart one at a time. When all the papers have been posted the trainer facilitates a discussion on participants’ reactions to whatever the results show. This is discussed in more detail in the following section. I followed this procedure with 11 successive groups.

Results

Table 1 shows the results of the survey carried out with 11 training groups. Ten of these training events were carried out in Britain and Ireland and 1 was carried out New York State. The groups ranged in size from 11 to 18 members. Eight

of the groups were comprised of direct care workers the other 3 groups were TCI trainers or those training to be trainers. The survey results for each individual and for each group are shown in Table 1. The average scores on a group basis range from 78% to 31% while the overall average works out at 56%. Care must be taken in not making false connections between different research studies. However, it is interesting to note that the Swaffer and Hollin study (Swaffer and Hollin,1997) found that 55% of anger-provoking behaviours were initiated by care staff and the study reported in this article found that the average number of incidents of challenging or crisis behaviour that are fuelled by adult anger is 56%. It seems that these 2 small-scale studies have something critical to say about the occurrence of adult anger in residential care settings.

Anger, continues on page 12.

Leadership and Administrative Support: Strong and Well-resourced Programs

by Martha Holden, MS; and John Gibson, MSSc., MSW

Strong overall program structure and philosophy is essential to successful residential and group care that meets the needs of the young people who reside there. No matter what type of out-of-home setting young people are placed in, their care depends on the set of guiding principles that provides the framework for managing the milieu (daily activities and routines). The stability of the milieu and the relationships of the people who work there are critical in

order to provide corrective experiences and developmentally appropriate opportunities to offset damaging experiences. Strong program structure gives a facility an identity and signature to their services. It helps articulate clinical and educational objectives, addresses remedial and corrective services, and delineates both primary and secondary treatment modalities. Strong program structure drives individual treatment and/or care plans, addresses routines, rules, and staff and young people's interactions. Strong program structure motivates both young people and staff to adhere to routines, structures and processes. Strong program structure minimizes the potential for interpersonal conflict. These qualities of strong program structure also establish a firm basis for evaluating child outcomes.

When an organization takes on the task of fully implementing a comprehensive

Leadership continues on page 4.

Table 1. SURVEY RESULTS: Percentages of Challenging Behaviour Incidents Estimated to be Escalated by Worker Anger

Participant	Group 1 Ireland	Group 2 Ireland	Group 3 TCI Update Britain	Group 4 Ireland	Group 5 Ireland	Group 6 N.Ireland	Group 7 Ireland	Group 8 Ireland	Group 9 N. Ireland	Group 10 New York	Group 11 N. Ireland
	Direct Care Workers	Direct Care Workers	TCI Trainers	Direct Care Workers	Direct Care Workers	Direct Care Workers	TxT	Direct Care Workers	Direct Care Workers	TxT	Direct Care Workers
1.	90	95	90	85	75	100	90	60	80	97	80
2.	80	90	90	70	75	99	80	58	80	90	75
3.	40	85	85	62	75	98	80	55	75	90	75
4.	50	80	85	60	60	95	75	50	60	89	75
5.	30	78	83	60	55	90	75	40	50	85	60
6.	93	75	80	60	54	90	75	40	25	80	50
7.	80	70	80	60	40	87	75	35	25	80	25
8.	75	65	80	59	40	80	70	32	20	75	15
9.	30	50	75	50	35	80	70	30	15	70	10
10.	80	47	75	50	35	70	70	20	15	50	10
11.	80	35	75	50	15	70	65		10	50	10
12.	70		70	25		65	60		10	28.	10
13.	25		70	20		60	55		10		5
14.	77		70	20		60	40		5		0
15.			65			50	40		3		0
16.			60			50	5				0
17.			50								
18.			40								
AVERAGE %	64%	70%	75%	52%	51%	78%	64%	42%	32%	68%	31%

Leadership, Cont. from page 3.

and developmentally driven crisis prevention and management system, the process of change often will point out weaknesses in the system. Many times these weaknesses stem from ill-defined or incongruent programming. For example, there is no match between the organization's "theory of change" or "treatment model" and the day-to-day social, behavioral, and psychological interventions. For some agencies, the crisis management system IS the program instead of a part of the continuum of care. The result of this is a heavy dependency on physical management to keep the daily activities, routines, and expectations on track. When there is a change in the organization's policy around "use of force," care staff feel powerless and left with no way to manage the young people and the routine.

The consequence of weak program structure and philosophy is that there is little direction or context given to necessary organizational components of leadership, supervision, clinical oversight, training, daily living activities and routines. Weak or inconsistent program structure and philosophy can undermine a care worker's confidence and ability when interacting with children in day-to-day routines. Enforcement of rules and obligations becomes less dependent on programmatic needs and more dependent on the personal needs of the young person and the care worker. Child-adult interactions become laden with power struggles to enforce rules, and incidents involving aggression and counter-aggression increase.

Organizations need a theory and philosophy of change and growth that leads to a working model which guides staff's work with the young people. This working model needs to address the specific needs of the type of clients it serves. These programs can be sophisticated treatment programs or simple guiding principles that provide the young people with a nurturing, consistent,

and developmentally appropriate environment. A program should include:

- a statement of the organization's mission (function and purpose)
- a theory of change, growth, and development that is consistent with the needs of the client population it serves
- a model/framework for managing the milieu (daily activities and routines)
- a model/framework for all social, behavioral, and psychological interventions
- training for staff to carry out required interventions and activities with the young people and their families
- staff supervision that includes reflective practice principles that lead to individual and organizational learning
- a schedule of daily activities that meet the basic, developmental and therapeutic needs of the young people

Everyone has a theory of how young people grow, change, and develop. Organizations need to adopt a theory that leads to a working model that defines the program.

There are a range of programmatic models for residential care available today which stem from several basic approaches to the treatment of children and young people: psychodynamic, developmental, behavioral, group interaction, and psycho-educational. These models include medical/psychiatric models, cognitive behavioral models, family teaching models, peer group models, re-ed models, social learning models, relationship models, and behavior modification strategies, to name a few. These models are designed for specific populations of children, and all stress various behavioral, teaching, and group intervention methods tailored to their target populations. It is essential that organizations examine their client populations, their brick and mortar facilities, their staff strengths and weaknesses, their capacity and potential, and their intake needs and then implement a program that would well serve their clients and organization mission.

With a strong program philosophy

daily routines, leisure activities, staff-client interactions as well as therapy have a therapeutic purpose. Staff have clear objectives for daily activities with a focus on helping the client achieve mastery. Without this structure there is little connection between treatment and daily living activities. This often results in lost opportunities throughout the day to use routines, staff-child interactions, and recreational activities to help clients achieve developmental and treatment goals. These activities and interactions are more likely used as behavior modification tools and very often are withheld as "punishment."

If a crisis prevention and management system is to be effective, it must be integrated within a strong well thought out program that meets the needs of the clients and promotes therapeutic interactions between clients and staff. Without this the focus is on crisis management, not crisis prevention.

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Leadership continues on page 15.

“ Step with care and great tact
 And remember that life's a Great Balancing Act
 Just never forget to be dexterous and deft
 And never mix up your right foot with your left.”

—Dr. Suess, Oh, The Places You'll Go

TCI Updates

TCI Trainer Certification

In April 2001, the Residential Child Care Project began a certification process for TCI trainers. This program is designed to maintain and strengthen the standards of performance for TCI trainers. We believe that this process will help child caring agencies implement TCI in a manner that meets the developmental needs of young people and provides a safe environment for both young people and staff. As of June 2002, over 2000 TCI trainers have received full associate certification status.

Maintaining Trainer Certification

In order to maintain the Associate or Professional level TCI certification, TCI trainers must agree to practice in accordance with TCI principles and follow the guidelines for training TCI. They must also attend and successfully complete a TCI update every 2 years. Approximately 3-4 months prior to TCI trainers' official re-certification date, they will receive a letter from the RCCP notifying them of the timeframe for their re-certification. TCI trainers will have a 6-month window (3 months prior to their certification date to 3 months after that date) to attend and successfully complete a TCI Update. For example, if the certification date is June 10, 2001, the TCI trainer can attend an update to be re-certified from March 2003 until

September 2003. When the TCI trainer has successfully completed an Update within that time frame, the new certification date will be June 10, 2003. If TCI trainers do not attend and successfully complete a TCI Update during the re-certification timeframe, they will lose their certification status. They can re-establish their certification status by successfully completing a TCI Update. Certified TCI trainers may attend any of the following TCI Updates to apply for recertification.

Trainer Recertification Updates

During 2003, the RCCP will be offering a variety of 2-day TCI Updates addressing different aspects of the TCI system, TCI modifications for different populations, and TCI trainer development.

Post Crisis Response Update

Supervisors need tools and resources for working with staff to assure that the outcome of a crisis is a positive one for the young person, the staff member, and the program. This workshop addresses the emotional needs staff may have when managing aggressive clients and how front line staff can be supported.

Managing an aggressive incident with a young person is difficult and draining for staff, even if it didn't result in a crisis. At the very least, the normal day-

to-day functioning of the program has been disrupted and some effort has to be expended to get things back on track. The goal of TCI is to restore the child, the staff, and the program to a state of functioning at a higher level than it was before the crisis began. The post-crisis multilevel response model helps the young person, the staff person, and the organization learn from crises. It is also essential in maintaining the TCI system within the organization. Supervisors will learn how to 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 debriefing 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

Designing Refresher Training Update

This update will assist certified TCI trainers in designing and implementing

TCI Updates continues on page 6.



SPECIAL NOTICE FOR NEW YORK STAFF WORKING IN AGENCIES THAT ARE REGULATED BY THE OFFICE OF CHILDREN AND FAMILY SERVICES (OCFS): Please refer to the NYS Training insert included with your issue of this newsletter for current information about training updates designed for you. If you did not get the insert, please contact the RCCP at (607) 255-4528. The update information in this newsletter applies to non-OCFS agencies.



TCI Updates, Cont. from page 5.

effective and agency-specific TCI refresher training in order to enhance individual and organization performance. Factors that facilitate skill transfer and maintenance will be discussed. An effective format for presenting TCI materials using the model of discussion, demonstration and practice will be presented. Participants will be asked to design and present activities appropriate for refresher training during this update. In advance of the update, participants will be asked to bring their activity guides and bring critical incidents (identifying information deleted) for review and use during the practice activities. A heavy emphasis is placed on advancing the skill development of the participants in the areas of the early interventions strategies, I ASSIST, Life Space Interview, physical skills and risk assessment.

Program Objectives

Participants will:

- design refresher training to meet agency specific goals and objectives
- design an activity to test recall and application of TCI skills and concepts
- deliver an activity that advances skills and provides for corrective feedback
- demonstrate effective training strategies that meet the objectives of refresher training
- demonstrate physical restraint skills with moderate resistance

TCI for the Developmentally Disabled Update

This update provides materials to be used as supplemental training for those who work with children and young people who have developmental disabilities and challenging behavior. The objective of this curriculum is to supplement the core TCI

training with additional information and skills that will enable staff to provide the support and prevention strategies that are most effective with a developmentally disabled population. Topics include: causes, cues and triggers of difficult behavior in children with learning/developmental disabilities; responding to these triggers as individuals and teams; adapting the Life Space Interview for children with special needs.

Program Objectives

Participants will:

- identify exogenous and internal causes of challenging behaviors
- identify environmental causes and triggers of challenging behaviors
- develop an action plan to respond to the causes and triggers to challenging behavior
- select specific intervention approaches and behavior management strategies most effectively applied with young people with developmental disability
- demonstrate the range of LSI techniques
- describe the limitations and adaptations to physical interventions for this population

TCI for Family Care Providers Update

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

will be practice sessions focused on crisis prevention and intervention techniques designed for foster and adoptive parents.

Program Objectives

Participants will:

- understand the specific challenges that family care providers experience when caring for children with challenging behavior
- analyze behavior based on goals children have,
- select specific strategies to address misbehavior based on an analysis the goal
- demonstrate effective use of behavior management techniques
- analyze the stages of a temper tantrum
- apply developmental theory to expectations of children's behaviors
- demonstrate effective limit setting

Building a Portfolio for Professional Certification Update

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

The review process for recommending professional certification will be discussed.

Program Objectives

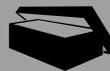
Participants will:

- establish the context of a presentation by stating goals and objectives
- use a variety of methods to stimulate

discussion and active participation

- demonstrate group processing skills and open communication skills
- apply training concepts to practice
- demonstrate TCI skills clearly and appropriately
- demonstrate coaching and feedback skills during practice sessions

Portfolio Requirements



You Must Include:

1. The training agenda that you use for training TCI. The agenda must be a minimum of 24 hours if physical intervention techniques are taught, and 18-hours if they are not taught.
2. An attendance sheet with individual test scores for 4 training programs. Please use the Residential Child Care Project's direct tests. If you are not using the RCCP direct test, please include a copy of the test you are using.
3. A videotape taken during the training(s) of the following 3 different training activities.
 - a. A presentation/group discussion of 1 of the following activities:
 1. The Stress Model of Crisis
 2. The crisis cycle
 3. I ASSIST
 4. Choosing a safety intervention
 - b. A demonstration of the team restraint by you with a co-trainer or the small child restraint. After the demonstration the tape must also include you coaching participants through the technique. If physical interventions are not taught, please substitute an active listening demonstration and coaching of participants during the active listening practice activity.
 - c. A demonstration of the LSI with a co-trainer or participant.

Please utilize a remote microphone and pay attention to camera placement to ensure that the reviewers see the training room set-up, the participants, and hear the presentations, questions and comments. Acceptance of a video tape for review is at the sole discretion of the RCCP. Submitted video tapes become RCCP property.

TCI Update Schedule 2003

Building a Portfolio for Professional Certification

- February 20 - 21Ithaca, NY
- March 4 - 5Colorado Springs, CO
- June 17 - 18Ithaca, NY
- July 8 - 9Cincinnati, OH
- August 12 - 13San Francisco, CA

TCI for the Developmentally Disabled

- July 24 - 25Ithaca, NY

TCI for Family Care Providers

- July 10 - 11Cincinnati, OH
- July 21 - 22Hull, England

Designing Refresher Training

- April 22 - 23Cincinnati, OH
- May 15 - 16Atlantic Beach, NC
- May 28 - 29Glasgow, Scotland
- June 5 - 6Dublin, Ireland
- June 19 - 20Ithaca, NY
- June 26 - 27Dublin, Ireland
- August 14 - 15San Francisco, CA
- September 9 - 10Peoria, IL
- October 16 - 17Mesa, AZ
- November 6 - 7Penrith, England
- November 13 - 14Worcester, MA

Post Crisis Response

- April 24 - 25Cincinnati, OH
- May 13 - 14Atlantic Beach, NC
- May 22 - 23Glasgow, Scotland
- June 3 - 4Dublin, Ireland
- June 19 - 20Glasgow, Scotland
- June 23 - 24Penrith, England
- July 7 - 8Ithaca, NY
- September 11 - 12Peoria, IL
- October 14 - 15Mesa, AZ
- November 3 - 4Hull, England
- November 11 - 12Dublin, Ireland
- November 11 - 12Worcester, MA

Note: Program dates above apply only to non-Office of Children and Family Services agencies. OCFS clients should consult the insert sent with this newsletter for applicable dates.

Grandfather Period for Obtaining Revised TCI Training and Certification Nears Conclusion

With the introduction of the fifth edition of the TCI curriculum in April of 2001, we granted a grandfather period of 2 years for previously registered TCI trainers to attend an update (see inset this page) and receive the revised TCI curriculum and apply for certification. In addition, during this grandfather period, any TCI trainer or TCI agency providing direct TCI training independently (fee for service basis) could immediately apply for professional certification in order to come into compliance with the new certification rules. ***This grandfather period ends March 2003.***

Associate Level Certification

As an Associate TCI trainer, you may train direct TCI training according to RCCP guidelines within your agency. You are not permitted to offer your services as an independent TCI trainer at this certification level.

Professional Level Certification

During the grandfather period, the 1 year minimum as an Associate TCI trainer before applying was waived for TCI trainers trained prior to 2001. This waiver will expire as of April, 2003. An Associate TCI trainer wishing to apply for the professional level of certification must submit a portfolio to the RCCP. Please see boxed information for instructions.

Beginning in February of 2003, we will be offering TCI Updates for Associate TCI trainers interested in applying for professional certification. (See Update article.) We highly recommend that interested trainers attend this workshop before applying for professional certification.

As a Professional TCI trainer, you may provide direct training within your organization, and fee for service training

that your organization sponsors. You may also provide TCI training independently on a fee for service basis. All TCI training must adhere to RCCP guidelines.

Notice to any TCI trainer or TCI agency offering TCI training on a fee for service basis: All registered TCI trainers providing training independently on a fee for service

prior to April 2001 will need to become professionally certified by April 2003 in order to continue training TCI independently. All agencies offering TCI training to other agencies on a fee for service basis, will have to have professionally certified TCI trainers delivering this training by April 2003 to continue this practice. ♡

TCI Update: Revisions to the Curricula and Certification Process

This refresher course is for those who have successfully completed the Training of Trainers in Therapeutic Crisis Intervention (TCI) Program prior to April, 2001 and have taught the TCI curriculum in their agencies. This update will provide participants with an overview of the revised TCI curriculum and video and allow them to apply for associate certification under the grandfather provision.

Program Objectives

Participants will be able to:

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

Offerings

- January 23 - 24Ithaca, NY
- January 30 - 31Sydney, Australia
- March 6 - 7Colorado Springs, CO

Meet Alissa Burns: New RCCP Staff

I work for the Residential Child Care Project in administrative services at Cornell (previously held by Marsha Kleine). Some of my responsibilities include sending out training materials to people registered for our training courses and answering questions people have when they call us. Before I came to Cornell, I worked at Kinko's Corporation in Rochester as a Computer Operations Technician. I majored in Human Services at Genesee Community College. I am also a volunteer rape crisis counselor. ♡





Frequently Asked Questions

by Martha Holden. MS

In these times of changes in national policy, state and licensing regulations, accreditation guidelines and funding requirements, many agencies are struggling to adjust their policies and training programs to meet not only minimum regulations, but best practice guidelines. During our training programs and delivery of technical assistance, many participants and organizations have asked similar questions as they struggle to upgrade their crisis

management system. We also receive phone calls and emails daily. The following is a brief discussion of the most commonly asked questions with our response.

Is it TCI policy that we can

Many of the questions we are asked start with what is TCI policy around escorting, number of staff needed to do a restraint, etc. Although we have recommendations concerning many of these questions, the most important issue here is to understand the difference between policy and best practice guidelines.

When we are training TCI, we are

talking about practice, not policy. Policies are developed by agencies and reflect the specific rules and procedures that the agency must follow to meet their own practice standards. TCI cannot set policy for an agency. TCI has been developed to promote the best practice guidelines that we know to date. We are recommending a system and training to implement that system that adheres to what we know (and have some evidence to back up) as best practice. Agencies are required to follow the regulations that govern their operation. They must develop their own policies

Frequent Questions continues on page 10

Ask Eugene



How do I register for a TCI Training of Trainers (TxT) or Update, and when should I contact RCCP to register?

To register for a TCI Training of Trainers or Update, you will need to submit the following:

- a completed and signed application for the appropriate class
- either a check or a purchase order, payable to Cornell University, for the proper tuition cost (At this time RCCP is unable to accept payment via credit card. We are also unable to accept any registration or payment information via telephone.)

Since the registrations RCCP receives are accepted on a first-paid first-served basis, and there is limited space in each offering, and classes have been filling up very early, we recommend that you submit your application and payment as early as possible to avoid being "shut out" of a training you would like to attend.

Who do I call at RCCP to get the information I need?

Due to an increasing volume of incoming calls you should direct your incoming calls as follows to ensure prompt responses:

- For training dates and registration information contact Alissa Burns at (607) 255-4528, or visit our web site at <http://rccp.cornell.edu>
- For information about bringing TCI to your agency, via on-site training of trainers or an implementation of the TCI system, contact Eugene Saville at (607) 254-5210, or visit our web site at <http://rccp.cornell.edu>
- For individual trainer certification status, or future certification needs, contact Kris Carlison at (607) 254-5440 or Holly Smith at (607) 255-9149

Where can I find the training schedule for Office of Children and Family Services-sponsored agencies?

This information has been included as a special insert with this publication. If you did not get a copy, please contact Alissa Burns at (607) 255-4528 or visit our web site at <http://rccp.cornell.edu>. ☺

Frequent Questions, Cont. from page 9.

and procedures on the range of behavior management techniques and restrictive procedures to be used within their organization. These policies and procedures should indicate when, how and under what conditions intervention techniques are employed. Using TCI practice standards in the development of policy and procedure is acceptable and recommended when implementing the TCI system.

It is important to set policies and procedures that set practice standards and the conditions for interventions that guide staff in their day-to-day work. If there are exceptions to the general rules, i.e. a young person that poses a special risk, an ICMP (individual crisis management plan) can be developed that prescribes special procedures to be used with that young person under certain circumstances. Staff members responsible for that young person can undergo special training in order to implement the ICMP.

If we use TCI can we use escorts?

Escorting, the temporary touching or holding of a young person's arm or hand, as a supportive intervention to encourage a young person to head off to bed or leave an area can be effective if the young person is still responsive and has a relationship with the adult. The issue of touching in order to manage behavior is addressed in the TCI material covering behavior management techniques and in the material addressing the management of noncompliant behavior. Basically, when we discuss the use of touch or escort in the TCI training, we speak of it in terms of placing a hand on someone's arm or, particularly with small children or developmentally delayed children, holding

TCI Bookshelf



Azim's Bardo.
 Written by Azim Khamisa with Carl Goldman.
 Published by Rising Star Press, Los Altos, CA.
 Reviewed by Carla Morgan.

A single shot from the 9mm handgun exploded in the night air. Tariq Khamisa, 20-year-old college student and part-time pizza deliverer, lay dead in the front seat of his car. The killer: eighth-grader Tony Hicks. So began the bardo of Azim Khamisa, Tariq's father. "Bardo" is a Tibetan Buddhist concept Azim came upon shortly after the murder. It is a gap between the end of one life state and the onset of another. The murder of his only son ended forever the life Azim had known. He was thrown into a nightmarish bardo through which he had to find his way. But his strong Islamic Ismaili faith and his determination to make his son's death meaningful transformed Azim's bardo into a remarkable journey.

This book is about that journey. As I read, I felt I was walking the path with Azim as he told the story of his family's tragedy. Thought-provoking and inspirational, it is an amazing story of forgiveness. Seeing victims on both ends of the gun enabled Azim to connect with the family of the perpetrator and find some peace that would allow him to move forward through his grief.

He also introduced me to the concept of restorative justice. An approach to criminal justice which doesn't seek just to punish, it restores wholeness to victims and communities when crimes are committed. More importantly (I think), it also offers perpetrators an opportunity to redeem themselves as contributing, responsible members of society. The process is a win-win-win one, and is especially valuable in cases involving juvenile criminals.

I would encourage all to read this book. It reminded me that it is not just my responsibility, but my duty to teach children that they have the ability -- and responsibility -- to choose nonviolent solutions to problems! 🌟

NEW!

TCI Without Physical Intervention Student Workbook

The RCCP is offering a new Student Workbook for TCI programs that do not teach physical restraint techniques. You may order copies of the workbook from RCCP: Tel: (607) 254-5210/Fax: (607) 255-4837/ Email: eas20@cornell.edu, or by downloading an order form from <http://rccp.cornell.edu/>



their hand to voluntarily walk them to a less stimulating environment. Escorting a young person who is not an immediate danger to self or others against their will or forcibly moving them, generally increases the risk of injury by escalating the young person and, more often than not, results in a restraint. This should be avoided. A restrictive 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, inevitably other safety interventions offer less risky strategies.

In the TCI system, restrictive physical intervention techniques are used only when there is a safety concern and the physical techniques have been assessed to be 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 professional judgment of the trained staff member intervening.

Can we still use removals?

Occasionally, there are situations in which a young person is presenting a safety risk in an area that is hazardous, i.e., stones on the ground, broken glass, too much furniture. To address this situation, there are techniques included in the team and small child physical restraints that allow staff members to initiate a secure hold, move that young person a few feet and then continue into a physical restraint technique. These techniques, formerly known as “removals” are explained and described within the team restraint and small child restraint activities in the TCI Trainer’s Activity Guide.

What about giving young people consequences as a part of TCI? They need to learn that they can’t get away with things. They need discipline.

The strategy of use of consequences as a teaching tool should be part of an overall behavior modification program. Providing a structure for young people that clearly outlines behavioral expectations, the rewards for following it, and the negative consequences for not complying is one method of motivating young people to adhere to program expectations and modify their behavior. This method may be effective if the young people have the skills to perform the prescribed behaviors and the skills to comply. Being able to comply (especially under stress) requires problem solving skills, adaptability, social skills, ability to modulate emotions and frustration tolerance. Behavior motivation programs make the possible more possible. They do not make the impossible, possible.

TCI is a crisis prevention and management system and addresses how to best deescalate potential crises and manage crisis situations. If the young person in crisis does not have the coping skills necessary to handle the stressful situation in a socially acceptable way, punishing the young person for their ‘crisis behavior’ does not give them the skills necessary to comply. Skill development would be a more effective intervention strategy and more likely to prevent further ‘negative crisis behavior’. At the same time, young people should understand the results of their actions. If they break something, they no longer have the use of it. If they break another young person’s possession, the young person will be upset with them. They may need to replace the item in order to restore their relationship with the other young person.

The goal of discipline is to help young people meet expectations, not punish

them when they fail. Discipline within the framework of a supportive, therapeutic or healing environment focuses on building young people’s competencies and self-esteem through encouragement, coaching, modeling and teaching them how to meet expectations.

During a two-person restraint, if a child puts his arm under his body should it be repositioned to the side, or left under the child thus avoiding a struggle?

It is not a good idea to struggle excessively to reposition arms. Any use of force to pull arms down or out from under a child may result in a spiral fracture or injury to the shoulder or wrist. Staff should wait until the child moves the arm out and then secure it. It is also important not to put any pressure on the child’s torso to secure the arm under the body, as it will inhibit breathing and it may also injure the arm. It is important not to reach under the child to secure the arm as the child could misinterpret this. ☹

Important Reminder



With the introduction of the 5th edition of the TCI curriculum in April of 2001, we granted a grandfather period of 2 years for previously registered TCI trainers to attend an update and receive the revised TCI curriculum and apply for certification. This grandfather period ends March, 2003. As of April of 2003, registered TCI trainers will have to attend a full Training of Trainers to receive the revision and apply for certification. There are only 3 more opportunities to attend one of these updates before April, 2003.



Anger, Cont. from page 3.

Discussion

This “Post-it Note™ exercise” can be completed in 10 minutes. As an optional addition to Activity 13 it does generate some “added value” to the activity. If conducted as described it adds a sense of anticipation to the training group as participants gather round the flip-chart to see the results. It provides additional focus to the activity and because of the results, which to date have shown a similar pattern, it provides a sense of ownership of an important training area.

Without exception the groups that have completed this exercise have been alarmed by the results gathered from each group. Reactions range from disbelief to resigned acceptance. Verbal comments in the groups that signify the latter tend to be “I’m not surprised” to “I suspected as much.”

When asked to speculate on reasons for such a high estimate most groups identified the following:

- lack of staff training in how to deal with their own feelings of anger
- severe provocation by young people
- lack of good team communication and honesty – some staff members are not challenged by colleagues on inappropriate interactions with young people
- staff stress due to working long hours
- use of relief staff
- absence of a shared philosophy or approach to work with children and young people
- lack of guidance on how to deal with young people
- personalised verbal abuse by young people
- use of agency staff
- absence of effective staff supervision

When asked to identify behaviours they see colleagues do that indicates

anger these participants typically list the following.

- carrying a grudge against a young person and not speaking to him or her for several days
- yelling and shouting in an attempt to gain control
- sarcasm
- expecting immediate compliance to commands
- bullying
- using abusive language
- issuing sanctions/punishments in the context of an emotionally charged encounter

A study by a Swedish psychologist (Torestad, 1989) provides further refinement on exactly what behaviours adolescents perceive as anger provoking. While no differentiation is made in this study between the actions of adults and actions of other peers the similarity of the situations reported in the Swedish study to the above list is salutary.

- situations in which self-opinionated people appear – people who “know best,” people who “do not listen to arguments,” people “who contradict”
- situations in which blame, slander, and bullying occur
- insulting, disparaging, and deprecatory, behaviours
- teasing
- situations in which personal plans “were thwarted by other people in control”
- nagging, yelling, and quarrelling
- physical harassment
- interference and or destruction of personal property
- environmental failure, for example, plans being thwarted or cancelled

Child care workers will recognise in the above list the potentiality that exists to act in ways that might well provoke anger in young people in out-of-home care. The TCI curriculum teaches that experiencing anger in the role of worker is a reality. It also teaches that a significant part of the re-education task that workers carry out in

**Serious Fun and Games
“Impulse”**



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

Stand in a circle holding hands. Put yourself in the group. Explain that the idea is simple: when you feel your hand squeezed, pass the squeeze on. Start the impulses by squeezing the hand of the person next to you, and wait for the impulse to come back to you on the other side. Try to do this faster. Try sending an impulse in both directions – they will cross on the other side of the circle. Try sending lots of impulses in both directions until everyone is confused! You can also send verbal impulses: send an “Mm” one way and “Ah” the other way. Have fun listening to it!

*Kerr T., & Straughan (1988). T.E.A.M. Challenge; Facilitator Training Manual, Ithaca, NY: Cayuga Nature Center.☺

“ Words are, of course, the most powerful drug used by mankind.”

—Rudyard Kipling

the context of group care is done through role modelling. One component of this role modelling is to provide positive and constructive examples of managing personal anger. Exactly how this is translated into practice depends on many factors. I will deal with 3, firstly, personal attitudes toward anger; secondly those uniquely personal factors that make staff persons different from each other; and finally competence in anger processing. Before I proceed to deal with these 3 factors I will briefly deal with the question, What is anger?

Defining Anger

For the purposes of this paper I have adopted the *Oxford English Dictionary* definition. It is short and to the point and captures the essentials: anger is “extreme or passionate displeasure.” It is a natural human emotion. Of itself it is neither good nor bad. With reference to how human beings internally process external events Professor Kenneth Dodge (Dodge, 1991) makes the point that “emotion is the energy level ...” that drives our thinking and observable behaviour.” Thus, we are “entitled,” when the emotion of anger is translated into observable behaviour, to make evaluative judgements as to the outcomes. So the emotional energy of anger can galvanise positive or negative actions.

Attitudes Towards Anger

Attitudes to anger vary. Some child care workers believe that anger is a bad thing, that it is to be avoided and that to express anger toward young people in out-of-home care is unprofessional and somehow damaging. An analogy that sometimes goes along with this belief is that child and youth care workers should either be “saintly” in their demeanour or never feel anger; that to feel anger is somehow like a “flaw in our character” (Braithwaite, 2001). Another analogy is that they should be “sponge like” and simply soak in or mop up all sorts of highly charged emotions, and

to do so without reaction.

The association between anger and aggressive behaviour is well documented (Torestad, 1989). I have been in highly charged situations with troubled youth where my “fight” instinct began telling my fists to clench! I know that I am not alone in that reaction. For me it was always a signal to back off and hand over to a colleague. This association between anger and aggression and actual or potential violence, certainly in British culture (Braithwaite, 2001), may be reason for a reserved attitude toward anger in which the potentially beneficial outcomes from the constructive use of anger get lost.

A final attitudinal aspect of anger is found in how workers in primary health care settings use language and labelling, perhaps as a defence, denial, or distancing mechanism from uncomfortable emotions. A British study, (Carter et al., 1997) found that workers defined client behaviour as “angry, aggressive, or violent” and defined their own reactions as being “upset or annoyed.” There is a need to find, recognise, and work with the essential common humanity between carer and cared for (Davis, 1977).

Knowing Our Own Anger

The TCI Curriculum offers a helpful framework of questions designed to facilitate on-the-spot assessments of crisis situations in which anger is likely to be the dominant emotion. The first question focuses on the worker’s emotional state in the moment. Ability to think about and find an answer to that question depends to a large extent on the individual’s capacity for self-awareness. I have adapted some questions from the study by Torestad (Torestad, 1989) mentioned previously that might be useful in development of worker self-awareness.

1. How prone to anger in general are you? Torestad refers to this as trait-anger.
2. How intense is the anger felt or experienced in particular situations (i.e., in TCI language, “when our buttons have

been pushed.” Torestad refers to this as state-anger.

3. Do you have idiosyncratic ways of expressing or dealing with anger (e.g. suppressing, displacing, inward-outward, physical-verbal)?

Child and youth care workers need to know their own anger and how it potentially energises behaviour, including interventions with youth for good or bad. Self-knowledge in this area is foundational for therapeutic processing of worker anger.

Therapeutic Processing of Anger

Workers who endure in residential youth and child care frequently mention one particular challenge in the work that helps to maintain their vitality and interest. It is the challenge of responding to the immediacy of the infinite variety of group living situations in ways that will benefit the young people in their care. Undoubtedly one of these challenges for staff is what to do with personal feelings of anger. There are two broad approaches. These are internal processing and external processing and a third approach is a combination of these two.

Internal Processing

Internal processing involves all the strategies of positive self-talk that are covered in the TCI Curriculum. Instead of allowing angry feelings to shape negative thoughts about an agitated young person and then influence our responses to them we may for example, tell ourselves that there is good cause for the young person’s agitation and remind ourselves that we can choose not to reciprocate their angry behaviour. Essentially this internal dialogue is a private event in which the worker uses internal dialogue to control his or her own emotions and responses that might otherwise generate and energise destructive behaviour.

Anger, continues on page 14.



Anger, Cont. from page 13.

External Processing

External processing involves communication with the young person. In this communication the worker speaks of his or her own anger and puts this anger into words into a short sentence, as opposed to behaving in an angry manner. My brief interaction with the young person earlier in this article is an example of external processing.

A child and youth care worker wrote to me recently on this subject of staff anger in residential child care. This person describes external and internal processing of anger in extreme circumstances whilst maintaining focus on the possible benefits for the young person that might come from the situation. Here is an abbreviated account of what happened to this colleague

"I recently experienced anger towards a youth who tried to overturn a table (while angry at another youth) and I ended up getting hit by the table—leaving a huge bruise on my wrist. I remember sitting there in pain ready to lash out because my personal space had become invaded. Having the self-awareness that "invasion" is an issue for me I was able to take a few deep breaths and calm myself before I acted in this situation (this only took a few seconds). I remember looking at this intensified youth, who actually looked terrified about what had just happened and quietly said to him, 'I need you to calm this down, I am hurt.' The youth yelled, 'I don't care if you're hurt, I hate him!' Remaining present, I firmly replied, 'I know you are really angry right now but I am hurt and you need to get it together!' The youth did calm down and we were able to discuss the situation together. Together, we were able to explore his anger and I shared my concerns about his anger. I also let him know it was not okay to become violent when angry because people get hurt. (This youth was in care because of family

violence.) I eventually received an apology and consequences for his behaviour were applied. I also believe this young boy accepted responsibility for his behaviour and has been willing to work with me on developing coping strategies for his intensified feelings."

This is a good example of external and internal processing with a real therapeutic focus and outcome.

Concluding Thoughts

In most of the residential units that I visit and or consult to there is evidence of much more happening than outbursts of angry behaviour. There is fun "serious enjoyment," therapeutic work, educational progress, family work, and more. Even so, one of the most frequently observed themes than I encounter in consultancy and while delivering TCI training to direct care staff across professional groupings is that programmes tend not to be securely anchored within a strong theoretical knowledge base. Thus, when young people become agitated in response to some internal or external trigger and begin to escalate their behaviour staff do not have a common reference point that helps them explain the behaviour and that guides their response. It is in this situation that staff responses to angry young people are most likely to be more angry responses. TCI training helps this enormously. But TCI training is not the first or only training that staff require. TCI needs to sit alongside programmes that have well-developed and articulated "models of change" (Farmer, 2000).

Examples of models of change as applied to residential child care abound in the literature. Two in particular that are compatible with TCI are Scholte and Van Der Ploeg (2000) and Moore and colleagues (1998). The first reference provides evidence for the application of a cognitive approach to the design of residential care and supports the Teaching, Directing, and Structuring

intervention styles of TCI. The second reference supports the Relating and Listening intervention styles.

Individual child care workers have a responsibility to inform themselves about how to engage therapeutically with volatile and angry young people. However the key responsibility lies at the level of agency administration and management. It is they who need to provide leadership in the design of care environments that truly support front-line staff in their task of caring for and working with vulnerable young people. That task involves encountering strong emotions in the young people and in themselves. Leadership and design of care environments includes the knowledge to understand and the skill to respond to strong emotions like anger not as a troublesome emotion but as therapeutic challenge that contains elements of danger as well as or opportunity for personal growth, development, and change.

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Anger, Cont. from page 14.

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Johnnie Gibson, M.S.W. MSSc CQSW, is an independent trainer specializing in residential care. His doctoral research is on children in secure accommodation in Northern Ireland. He has published on the recent history of residential child care in Northern Ireland, on competence in child care practice, and on the LSI.

Leadership, Cont. from page 4.

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

Professional Certification Announcement: Glenn Johnson

Glenn W. Johnson is currently the training associate for Green Chimneys Children's Services, Inc., in Brewster NY, a residential treatment center and facility for 102 youth. Over the past 22 years he has worked in various positions within the agency including experiences as a child care worker and supervisor. Recently he began training residents at his agency in a modified TCI program for young people. His hope is that with education and communication, they can become more successful at dealing with crisis and aiding their peers when they experience difficulties. Glenn has been a TCI trainer since 1986 and presented at the first International Conference in June of 2000. He is also a past presenter at the Trieschman Center International Conferences.



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

From the Instructor's Booth

The Residential Child Care Project (RCCP) is seeking to fill the following position:

Field Instructor
Extension Associate III, Family Life Development Center, RCCP, College of Human Ecology, Cornell University

Candidates who have experience in crisis prevention and management in residential child care and/or institutional abuse prevention and investigations are invited to apply for the field instructor position in the Family Life Development Center's Residential Child Care Project. The RCCP works with states, non-profit organizations and agencies to develop: 1) an integrated and comprehensive crisis prevention and management system within residential childcare facilities, and 2) state-wide institutional abuse prevention, investigation, and remediation systems.

Qualifications:
Master's degree in social sciences, social work, and 5 years of related experience in residential group-care, child welfare, and/or child protection are required. Program Management experience and work with state and non-profit agencies on an organizational level is an advantage. Demonstrated knowledge and skills in face-to-face training, curricula development, adult learning, and training techniques is required. Demonstrated verbal and written skills are essential. Must be able to work independently. Should be very organized and detail-oriented. Ability to travel throughout New York State is essential.

Please send your cover letter, resume examples of previous written work, and three references to: Lisa Rose, Cornell University, MVR Hall, Ithaca, NY 14853
Job posting will be open until filled. Early applicants will receive full consideration. Cornell University is an Affirmative Action/Equal Opportunity Employer and Educator.
<http://www.cornell.edu>
<http://chronicle.com/jobs/profiles/2337.htm>





2003 COURSE OFFERINGS

Therapeutic Crisis Intervention: Training of Trainers

- January 6 - 10Ithaca, NY
- February 3 - 7Sydney, Australia
- February 10 - 14San Diego, CA
- March 10 - 14.....Colorado Springs, CO
- March 24 - 28.....Glasgow, Scotand
- April 28 - May 2.....Cincinnati, OH
- May 19 - 23Atlantic Beach, NC
- June 2 - 6.....Penrith, England
- June 9 - 13Ithaca, NY
- July 14 - 18.....Cincinnati, OH
- July 28 - August 1.....Ithaca, NY
- August 11 - 15Ithaca, NY
- August 18 - 22San Francisco, CA
- September 15 - 19Peoria, IL
- October 20 - 24.....Mesa, AZ
- October 27 - 31.....Glasgow Scotland
- November 17 - 21Worcester, MA
- December 8 - 12.....Ithaca, NY

TCI for Family Care Providers: Training of Trainers

- June 10 - 13Hertfordsshire, England

TCI Update: Revisions to the Curricula and Certification Process

- January 23 - 24.....Ithaca, NY
- January 30 - 31.....Sydney, Australia
- March 6 - 7Colorado Springs, CO

TCI Update: Building a Portdolio for Professional Certification

- February 20 - 21Ithaca, NY
- March 4 - 5.....Colorado Springs, CO
- June 17 - 18Ithaca, NY
- July 8 - 9Cincinnati, OH
- August 12 -13San Francisco, CA

TCI Update: TCI for the Developmentally Disabled

- July 24 - 25.....Ithaca, NY

TCI Update: TCI for Family Care Providers

- July 10 - 11.....Cincinnati, OH
- July 21 - 22.....Hull, England



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

TCI Update: Designing Refresher Training

- April 22 - 23Cincinnati, OH
- May 15 - 16Atlantic Beach, NC
- May 28 - 29Glasgow, Scotland
- June 5 - 6Dublin, Ireland
- June 19 - 20.....Ithaca, NY
- June 26 - 27Dublin, Ireland
- August 14 - 15San Francisco, CA
- September 9 - 10.....Peoria, IL
- October 16 - 17Mesa, AZ
- November 6 - 7Penrith, England
- November 13 - 14Worcester, MA

TCI Update: Post Crisis Response

- April 24 - 25Cincinnati, OH
- May 13 - 14Atlantic Beach, NC
- May 22 - 23Glasgow, Scotland
- June 3 - 4Dublin, Ireland
- June 19 - 20.....Glasgow, Scotland
- June 23 -24.....Penrith, England
- July 7 - 8Ithaca, NY
- September 11 - 12Peoria, IL
- October 14 - 15Mesa, AZ
- November 3 - 4Hull, England
- November 11 - 12Dublin, Ireland
- November 11 - 12Worcester, MA