

# refocus

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## In This Issue

Three reports from the Second International TCI Conference start on this page:

- *Conference Highlights*
- *Staff Gender Issues in Child Physical Restraint*
- *Reflections on a Conference Workshop*



*Achieving The Balance: Best Practice For Managing Challenging Behavior  
April 26 – 28, 2005 Dublin, Ireland*

- |    |   |    |   |
|----|---|----|---|
| 6  | RCCP Initiates Injury Database            | 14 | New Physical Guidelines for TCI Training              |
| 11 | New Professional Certification Guidelines | 15 | TCI Bookshelf   |
| 12 | Professional Certification Announcements  | 16 | TCI Europe News                                       |
| 12 | Symposium Presentations Available Online  | 17 | Reducing Restraint: Suggestions From Current Practice |
| 13 | Serious Fun and Games                     | 19 | Ask Eugene  |
| 13 | Three New One Day TCI Updates             | 20 | 2006 Course Offerings                                 |

## Conference Highlights

On April 26, 2005, 300 participants from Ireland, Northern Ireland, England, Scotland, Wales, United States, Canada, Bermuda, Israel, Australia, and Finland met in Malahide, Ireland to share best practices at the *Achieving the Balance: Managing Challenging Behaviors* conference. For three days delegates were immersed in a variety of keynotes, workshops, panel presentations, and round table discussions focused on how child caring professionals can provide quality services and therapeutic environments for children and young people with challenging behaviors.

Highlights, continues on page 2.

## Staff Gender Issues in Child Physical Restraint

by Sophy Cawdry

In line with the conference theme of “achieving the balance,” this workshop explored balance in the involvement of male and female staff in child physical restraint. The data underpinning the discussion had been generated from five years’ audit of physical restraint as practiced within the presenter’s workplace. Workshop participants were presented with an overview of the audit methodology and were then presented with some of the data generated, in particular the disparities that have come to light regarding the use of male and female staff in physical restraint.

Gender Issues, continues on page 4.

## Reflections on a Conference Workshop

*The “Therapeutic Diamond” and other Jewels; A presentation of conceptual frameworks and thinking tools for analysing and determining interactions and interventions in residential child care.*

by Johnnie Gibson

Do you agree or disagree with the idea that child and youth care workers are anti-theoretical—that they have an aversion to the use of theory in their work? Does theorizing and using theory stop at the classroom door? Or, do you see lots of evidence of the application of theory to practice? I have sometimes noticed that staff teams discourage members who try to make use of theory or refer to books or journal articles. Has anyone found novel ways to change or challenge these norms?

These were the key questions that I put to two audiences earlier this year. The first was the unseen and unmet audience that is the Child and Youth Care International e-mail discussion forum(1). The second audience comprised thirty five child care people from around the world and who were participants at the Second International TCI Conference in Dublin, Ireland. Interaction with the two audiences provided interesting answers and provided evidence that has moved me to a more optimistic position. I deal with the evidence and mind shift at the end of the article.

### Theory in Child Care

My interest in the subject matter of theory in child care grows out of personal experience over a twenty year period as a line manager and supervisor in two small group homes in

Reflections, continues on page 2.

## Highlights, Cont. from p. 1.

Mr. Michael Donellan, director of Trinity House, Dublin, opened the conference with pictures and comments on “Images, Perspectives and Healthy Tensions,” which included photographs of Ireland and particularly of childcare within Ireland over the last century. Mr. Brian Lenihan, Ireland’s Minister of the Department of Health and Children, then welcomed participants by focusing on the state of residential child care in Ireland. The first evening of the conference, the Deputy Lord Mayor of Dublin welcomed participants to Dublin at a wine and cheese reception allowing participants to network, meet colleagues, and enjoy the hospitality of the Grand Hotel. Wednesday evening was another opportunity to relax and make new friends at a banquet followed by dancing to Irish folk music.

Keynote speakers included Dr. Ross W. Greene, Director of the Collaborative Problem Solving Institute, MA, and author of *The Explosive Child*. Dr. Greene presented *Oppositional Behavior as a Learning Disability: The Collaborative Problem Solving Approach*. Brian Farragher, Executive VP/COO of the Andrus Children’s Center, Yonkers, NY, discussed how his agency worked toward *Getting A*

*Handle On Holds: A Systematic Approach To Reducing Physical Restraints*. Dr. James Anglin, School of Child and Youth Care, University of Victoria, BC, Canada, ended the conference by summarizing key points and putting it into the framework of his book, *Pain, Normality, and the Struggle for Congruence: Reinterpreting Residential Care for Children and Young People*.

More than 35 workshops presented by professionals from all over the world addressed issues of leadership, supervision, training, clinical oversight, and critical incident monitoring with topics such as: safety should not require holding; the strategic self-regulation program; mock trial of an injury following a restraint; understanding our behavior: the views and experiences of young people; promoting positive behavior: a strength-based approach to attaining a violence free treatment environment; a computer based monitoring system; the therapeutic diamond and other jewels; nation-wide implementation of TCI in Israel; leadership for cultural and practice change; dual diagnosed adolescents—making TCI work through individualized treatment plans; from control to collaboration; responding to professional supervision; grief and loss implications for crisis; responsive interventions in the face of “pain-based”

aggression; creative refresher training; staff gender issues in physical restraint; reducing challenging behaviors using adventure based experiential learning; and raising the professional profile of foster caregivers.

Panel presentations gave international perspectives on the major research issues in managing challenging behaviors, 21st century challenges for the social work services work force, trauma sensitive care, continuous quality improvement, and social policy.

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## Reflections, Cont. from p. 1.

Northern Ireland. A constant source of frustration for me was trying to get child care workers to use theory to inform their work. Some did, most did not. I saw in this workshop the opportunity to present several conceptual frameworks, or, “thinking tools” that I found helpful and to test out my opinion that “child care workers are anti-theoretical.”

The frustration that I have just outlined put me in the company of Joel Charon an American sociologist. Among other things he teaches symbolic interactionism at the Minnesota State University. Charon (2001) writes about his realization that his students did not carry their enthusiasm for the subject with them into the world outside the classroom. He realised that they were unlikely to do so unless they were part of a reference group or community of interacting like minded people in the real world who shared the language of symbolic interactionism. In Britain and in Ireland there is ample evidence of child care workers in residential settings gaining knowledge in the pursuit of both basic and post basic qualifications. Yet, like Charon’s sociology students the use of knowledge seems not to extend much beyond the classroom.

It seems that the predominant norm amongst child care workers is anti-theoretical. Clearly I was not alone in that opinion for as Professor James Anglin (2002, p.24) noted three years ago “many practitioners in the human services, including child and youth care workers react almost viscerally in a negative way whenever theory (or anything that even sounds like theory) is presented or discussed.” The situation on the United Kingdom and Irish side of the Atlantic Ocean is no different. It is the exception to find groups of workers who take their theory from college into the work situation. It is more common to find subtle and not-so-subtle organisational

Reflections, continues on page 3.



“The food, the service, the setting, perfect!” The Grand Hotel located on the Irish Sea provided the ideal setting for the conference with four star service.

Reflections, Cont. from p. 2.

and group controls that operate against a deliberate and creative attempt to utilise theory. One manifestation of such control is to hear team members refer as “you swot” to a colleague who mentions a child care text book or journal article or theoretical idea. I have heard and challenged other more vigorous comments, none of which stands scrutiny as helpful or encouraging!

The predominant culture of what might be termed the child care reference group or the child care community as a collective seems not to value the pursuit of knowledge other than in and for the classroom. Undoubtedly there are individual workers who read, who pursue knowledge of themselves, of theory and of frameworks and of how self and theory integrate and find expression in relationships with young people and with colleagues and others. In Ireland this may be on the increase and needs encouraging to the point where there is a “critical mass” (Miller, 2005) of such workers in every unit who are “curious and want to know as much as possible.”

I think of theory and theoretical frameworks as “thinking tools” and there are many of these in all sorts of related literature (Senge, 1990; Senge et al., 1999). Preparation for the workshop helped to see that my area of interest was broader and deeper than the application of conceptual frameworks or of techniques. The phrase, “knowledge utilization in residential child care” (Beker and Eisikovits, 1991) more closely defined my interest and captured the richness of the essential exchange that needs to take place between workers and children in all manner of group care situations. The knowledge base is more than head or book knowledge, it is more than technique, in TCI terms it is more than behaviour management techniques or I ASSIST. The most essential knowledge component is

*“Our passion is difficult kids.” Dr. Ross Green suggests that we treat aggressive and explosive behavior like a learning disability, realize the child is doing the best that he or she can, and help children develop the skills to be more flexible and handle frustration more adaptively.*



*“To sit, talk and laugh with such a vital group of people is a great privilege.” Great food, good company, fascinating discussion, dancing, and music abounded during the banquet and dance.*



knowledge of self, of who we are and what we have to offer through how we use ourselves (Fewster, 1990). Yet frameworks and techniques are part of the child care knowledge base.

The concept of “theory” is used here not in the sense of an absolute “truth” but in the sense of a set of ideas that help to organise and understand facts and that offer solutions to problems (Hughes, 2000). Kurt Lewin (1890-1947) a German-American psychologist was unambiguous and creative in the meaning that he gave to theory. It was Lewin who coined the phrase “there is nothing as practical as a good theory.” In more recent years someone has extended Lewin’s phrase into “... and there is nothing as theoretical as good practice.” Good

practice informs theory, for example, Anglin (2002) carried out a grounded theory study into small group homes in Canada. From a large bank of interview and observation data obtained from workers, young people, and others he constructed a practical theory that helps to explain and promote good practice in small group homes.

There is no shortage of theory, no shortage of good quality empirical research, no shortage of published reflective practice, no shortage of useful conceptual frameworks. In fact, our knowledge far exceeds our practices. Nancy Belknap (2001) contends thus, and also, that although much has changed in child care in fifty years the gap between what we know and what we do with it is

*"...people find it far easier to forgive others for being wrong than being right."*

—J. K. Rowling, *Harry Potter and the Half-Blood Prince*, 2005

Gender Issues, Cont. from p. 1.

St. Joseph's School is a Children Detention School, a residential centre housing up to 40 boys aged 9 to 16 years. Since the introduction of Therapeutic Crisis Intervention (TCI), all physical restraints have been documented. In 1999, it was decided to audit these restraint forms on an annual basis. Previously, each form had been scrutinised individually. However, there had been no overview available of patterns, trends or anomalies that might be arising over time. The audit was implemented by the workshop presenter in order to address this.

Following a seven-month pilot, annual audit of child physical restraint in St. Joseph's commenced in July 2000. A copy of every restraint form is sent to the auditor, who enters the quantitative data contemporaneously into a computer spreadsheet. At the end of the twelve-month audit period, the quantitative data are analysed statistically, while the qualitative material (for example, answers to the questions: What triggered the incident? What sequence of events led to the restraint?) is analysed by content. A report is then written and feedback provided to staff through training days.

The workshop shared some of the following audit findings in order to demonstrate the utility of the audit model and share some of the issues that have arisen.

A key question, and one often seen as an indicator of "successful" practice, is that of the number of restraints performed over a year. By this criterion, 2000 -01 would give most cause for concern, while 2003-04 would be deemed the most successful. However, examination of the number of different boys restrained over the year presents a very different picture, with 2000-01 emerging the most positive. Likewise, 2000-01 could be seen as the most positive year in terms of the lowest percentage of the population who underwent restraint. Discussion within the workshop concluded that any single numerical indicator is too crude a means

**Table 1: Number of Restraints**

YEAR	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
No. of restraints	91	58	86	29	48
No. of boys restrained	11	17	18	13	15
% of population	25%	35%	38%	26%	31%

**Table 2: Frequency of Restraint**

NO. OF RESTRAINTS	2000 - 2001	2001-2002	2002-2003	2003-2004	2004 -2005
1-5	6 boys	15 boys	13 boys	13 boys	13 boys
6-10	1 boy	1 boy	1 boy	-	2 boys
11-15	1 boy	1 boy	3 boys	-	-
16-20	-	-	1 boy	-	-
21-25	1 boy	-	-	-	-
26-30	1 boy	-	-	-	-
31-35	1 boy	-	-	-	-

of establishing success in what is a complex area of practice.

The frequency of restraints elaborates upon the totals cited in Table 1. The high number of restraints in 2000-01 can be accounted for by a few boys who were restrained with exceptional frequency, whereas the high number in 2002-03 is due to a larger number of boys being restrained, but at a somewhat lower rate per boy. It is seen as positive that since 2001, the vast majority of boys restrained have been so no more than five times. This trend towards low frequency of restraint has become particularly pronounced over the past two years. This possibly reflects staff embracing the broader elements of TCI and implementing interventions other than restraint at times of potential crisis.

Restraint within St. Joseph's has been audited for half a decade. Emerging common themes and variations can now begin to be asserted with some confidence.

**Common Themes**

*Most boys never restrained:* St. Joseph's can now confidently assure potential placing agencies and clients that the majority of boys within the Centre never

undergo restraint. Whilst staff have always had an intuitive sense of this, there is now statistical support for this claim.

*Triggers:* The dominant trigger for escalation across all the years has been a staff intervention. This ranges from imposition of a sanction for a given behaviour to staff intervention to move a boy, or prevent him from leaving a given area. Considerable time has been devoted in staff training sessions to the promotion of pulling back, allowing space and avoiding power struggles with an aroused child.

*Location:* Since the audit began, the most common location cited for

**Figure 1: Themes and Variations Across the Years**

- Common Themes*
- Most boys never restrained
- Triggers
- Locations of restraint
- Other behaviour management techniques
- Injury to staff
- Male staff involvement in restraint
  
- Variations*
- Number of restraints
- Age of boys restrained

Gender Issues, Cont. from p. 4.

restraint has been a bedroom. In earlier years, this was the boy's own bedroom. However, a designated supervision bedroom is now used for boys over stimulated by the group and/or at risk of an outburst, in order to avoid the contamination of a boy's own bedspace by restraint. This supervision room has now become the most common location for restraint.

**Other TCI behaviour management techniques:** The majority of forms every year (at least 70%) cite at least one other TCI behaviour management technique that was tried prior to restraint. This suggests that staff are drawing upon the broad spectrum of TCI interventions at times of crisis, not resorting immediately to restraint.

**Injuries:** The level of injury to staff and boys is emerging as a regrettable theme across the years. Until 2002-03, this rate was consistent at around one-fifth of restraints for boys and approximately one-quarter of restraints for staff. Workshop participants asked about the nature of these injuries. The injuries to boys were largely carpet burns and subjective complaints, e.g., a sore arm or back, with no objective clinical evidence of damage. Injuries to staff were more varied and included a high prevalence of bites, scratches, punches, headbutts, and kicks.

In 2003-04, the injury rates for boys and staff diverged dramatically, with an encouraging decrease for boys but an alarming increase for staff. Workshop participants were invited to speculate upon the reasons for this. It was suggested that staff might be drawing upon non-restraint TCI techniques for a broader range of situations, only moving in to restrain for the most dangerous and hence most hazardous. For the year 2004-05, restraint forms have been amended, dividing the injuries section into "before" and "during" restraint. Should it emerge that the majority of injuries arise before the restraint, further training may be needed to encourage staff to pull back; if most injuries are

**Table 3: The Percentage of Restraint Forms Citing Injury**

	2000 - 2001	2001 - 2002	2002 - 2001	2003 - 2004
TO STAFF	24%	29.5%	29%	41.5%
TO BOY	20%	20.5%	18.5%	3.5%

found to be arising during restraint, then the safety either of the holds or of their implementation may be called in to question.

**Variations**

**Number of restraints:** See Table 1.  
**Age of boys restrained:** One might expect younger, smaller boys to undergo more restraint since they might lack the inner skills to manage their own emotions, or staff might be quicker to restrain, since it might be undertaken more safely. However, across the years, this has proved not to be the case, with peaks arising at different ages over different years.

**A Common Theme: Male Staff Involvement in Restraint**

Workshop participants were presented with the following statistics derived from the audit. Since July 2000, 312 restraints have been performed within St. Joseph's. Of these:

- 194 (62.5%) were jointly performed by male and female staff
- 94 (30%) were performed by male staff only
- 24 (7.5%) were performed by female staff only
- Male staff have therefore been involved in 92.5% of all restraints performed since the audit began

Over the year preceding presentation of the workshop, 54 restraints have been performed within St. Joseph's. Of these:

- 33 (61%) were performed by male and female staff
- 16 (29.5%) were performed by male staff only

- 5 (9.5%) were performed by female staff only
  - Male staff have therefore been involved in 90.5% of restraints over the past year
- Over the past year, restraints have been undertaken by:

- 29 different male members of staff
  - 24 different female members of staff
- The most restraints undertaken by any one staff member over the past year has been:
- 7 for a male member of staff
  - 6 for a female member of staff

- Of the documented staff injuries over the past year:
- 7 male staff members have been injured
  - 5 female staff members have been injured

Childcare staff are involved in the vast majority of restraints. Of the current childcare staff:

- 67% are female; 33 % male
- The gender balance of staff deployed in restraint does not therefore reflect the overall gender balance of staff within the Centre.

Once presented with these statistics, workshop participants were divided into four groups. Each was given a question related to staff gender and child restraint. The questions were as follows, and participants were instructed: If this were to become an issue within your agency, devise an appropriate response.

- *Could this disparity reflect staff agency expectations of male and female roles?*
- *How might male and female staff differ in their approaches to a potentially dangerous situation?*
- *Do clients perceive male and female*

Gender Issues, Cont. from p. 5.

*staff differently in potentially dangerous situations?*

- *Some people believe it safer to use male staff for restraint wherever possible. What do you believe to be the pros and cons of this approach?*

The workshop presenter caught tantalising snatches of discussion emerging from the groups. When feedback was invited, ideas and questions flowed between the groups. Although each had been given a specific question, it emerged from the feedback that many similar issues had arisen for each group. The presenter offered some comments that had been made by St. Joseph's staff in discussing the gender issues. The following is a far from exhaustive amalgamation of comments from workshop participants and St. Joseph's staff. Some views were widely endorsed; others reflect the view of only one individual.

- Some male staff feel that managers call on them to be available in situations that might require restraint.
- A female staff member felt constrained by the arrival at an incident of a male staff member. She felt she had been managing the situation well, but that she was now expected to step back and let the male take over.
- A male staff member cited his "envy" of some female colleagues' ability to take a gentle approach to agitated clients.
- Female staff might be more patient.
- Male staff member in a crisis situation: "someone's got to do something."
- Male staff sense of chivalry, to step in and protect females, which is culturally imbued.
- Older male staff watching young female staff in potential danger: "she could be my daughter."
- Male staff can take a child more quickly –this is safer.
- Female staff member: I feel safer when a male staff is present.

## RCCP To Initiate An Injury Database

Over the next few months the RCCP will be establishing an electronic and hardcopy survey capacity to monitor injuries incurred during the application of TCI physical interventions in direct care and in training. The survey will collect data about facility type, injuries, the level of medical attention due to the injury, type of physical intervention, and their duration. We will also ask for information about the young person involved in the physical intervention such as their age, gender, weight, medications, medical condition, and placement date. Staff information such as age, gender, weight, and hire date will also be asked.

In 2005 all the facilities in the UK that use TCI will be required to incorporate their injury data into the database on a quarterly basis. There will be several different options available to do this. Facilities will be able to mail, e-mail or fax their surveys to Cornell or they will be able to use the Residential Child Care Project website to directly input their data. The database will allow both the facilities participating and the Residential Child Care Project to chart and graph injuries in direct care and training via frequency, time of day, location, child placement date, staff hire date and other relevant areas. The Residential Child Care Project staff will provide technical assistance to any facility that wishes to examine in more detail their prevention initiative to reduce the potential for injury in direct practice with children and in staff training.

The database will provide a current measure of staff and child injuries to assist both the Residential Child Care Project and the TCI crisis prevention and management system to improve the overall safety of its methods and strategies. If you would like to be a part of this injury survey please contact Michael Nunno at [man2@cornell.edu](mailto:man2@cornell.edu)

- Male staff member: I feel safer when a female staff is present, as I believe a situation is less likely to escalate.
- Sometimes the presence of male staff can inflame a situation, giving a boy the message that trouble is expected.
- Sometimes the presence of male staff can avert an attack from a boy if aggression is proactive.
- Boys are less likely to hit a woman.
- Some boys have issues with women in authority and the presence of a woman can inflame the situation.
- The excessive use of particular male staff for restraint can impact upon

their subsequent relationships with the clients. A male staff member involved in a number of restraints stated: "boys then put it up to ...you're not going to restrain me!"

- The gender of the client group is also an issue. Boys might be less likely to hit a woman, but staff working with female clients are more likely to deploy male staff to de-escalate a situation, viewing them as being at less risk.
- Use of male staff for restraint could restimulate clients' past experiences of aggressive males in their lives, for example domestic violence.



Gender Issues, Cont. from p. 6.

- The same could be said vis-à-vis female staff restraining if a client has been physically abused by a woman.
- Use of male staff for restraint could reinforce clients' perceptions, based on life experience, of females as "weak" and males getting their own way through physical force.
- Male staff do not enjoy restraint. The excessive use of male staff can have mental health implications in terms of staff stress and distress.

The workshop presenter had also asked some of her clients about their experiences of staff intervention when angry or upset. The boys expressed no conscious preference in terms of gender of staff dealing with them when aroused. Preferences for them concerned the personality of the staff member(s), prior relationship, and the approaches that they took, namely being respectful, allowing them space and offering choices. Only one young boy stated that he preferred female staff to deal with him when agitated as "they roar at you less!"

The presenter concluded the workshop by reiterating her belief in the usefulness of the audit tool. One and half hours absorbing discussion had been generated simply from the record of who had been involved in each restraint. An equally interesting discussion could have stemmed from almost any subset of data from the audit. The audit provides a lasting record of a contentious area of practice; augments St. Joseph's child protection practice; offers impetus for change and allows staff to view their own experiences of restraint against the bigger picture. **V**

*Sophy Cawdry, C Psychol (Couns), is a chartered counselling psychologist at St. Joseph's School, Ferryhouse, Clonmel, Ireland.*

Reflections, Cont. from p. 2.

as wide as ever. Why, is the obvious question? It seems important and necessary to put all of this in context by stopping to consider the role of theory.

**What Can Theory Do for Us?**

Theories provide "workable definitions" of the world we live in (Howe, 1990, p. 10) they are not absolutes. And whether it is recognised or not, everyone is a theorist, we all hold ideas about how the "world" works. Fiona McDermott (2002, p 34-36) categorises how theory contributes to group work. Her ideas are just as relevant to residential child care. At a broad level of abstraction theory may:

- Provide a way of thinking about what we do or want to do
- Give coherence to complexity
- Help to locate what we are observing within a set of ideas that provides us with "meaning"
- Provide us with the conceptual means to go beyond what is self-evident
- Indicate causes for what we observe
- Indicate possible relationships among phenomena we observe or things we do
- Identify the "grammar" of the action we observe—those unnamed "rules" governing what is said or done
- Indicate for us what is important to note, observe, understand among the plethora of phenomena and experiences occurring as we interact with others
- Indicate those forces or factors that influence how we act even if we are not aware of them—for example, elements that are outside of consciousness as well as factors in wider economic and political world

Between the area of theoretical abstraction and the lived experience of residential child care in which we act and intervene theory may:

- Provide guidelines on how to act
- Provide a rationale for acting in a

particular way

- Provide a language for talking about what we do and what we understand with others who speak the same language
- Provide information upon which to reflect and critically appraise or evaluate what is going on and our actions in relation to this
- Connect with our lived experience as workers and participants or residents
- Give us choices about how to act and what to do

This is not a definitive list and more could be added, in fact much more, for as someone has said, "It all starts with what you believe," and although some child care workers may not value theory there is in fact no such thing as an atheoretical child care worker. Every intervention made is based on some notion, some belief, or some "theory" of what should happen. Some times these "personal theories" lead to effective interventions and some times not. The first of three theoretical frameworks or thinking tools presented at the workshop has the potential to help the child and youth care field identify some of these useful personal theories and more besides. It is an idea that is cited in work by Eisikovits and his colleagues (1991) and concerns the knowledge known and used in residential child care. For convenience I refer to it as the "Knowledge Utilization Matrix."

**The Knowledge Utilization Matrix**

I once watched a colleague who had little training interact with an adolescent girl who was defying his attempts to bring the night to a close and get everyone to bed. She told him, sure and certain that she was not going to go to bed, not now not ever. His reply was firm and done in an instant, he said, "Well you make sure you sit there the whole night then, I expect to see you sitting there in the morning." This was not sarcasm, he meant it. He turned and walked away



Reflections, Cont. from p. 7.

from her and went about this business. A few minutes later she went to bed without further exchange between them. When I asked him about it he replied, “It was just instinctive.” The Knowledge Utilization Matrix, (Table 1) by Zvi Eisikovits and two colleagues (1991, pp 1-23) provides a very useful tool that can plot intuitive knowledge as illustrated in the above example alongside more formal knowledge.

Where we need to be in work with troubled youth is in cell number one, knowledge known and used. When TCI as the agency crisis prevention and management system is successfully implemented, then agency and staff are in this cell. When things go awry and mistakes get made even after training and supervision, then they are in cell number two. When staff team norms prevent individuals from using knowledge, then they are also in this cell. When staff makes good interventions but cannot readily explain why the intervention works, then they are cell number three or are acting on intuition. Cell number four is the domain of research questions and the pursuit of new knowledge.

The matrix has multiple applications, for example, it could be used to determine staffs’ use of knowledge about an individual youth and her family in day to day care work. Another use is at the broad programme level. The questions in this instance may focus on transfer of learning from training to the workplace. Supervisors need to be considering their role in assisting staff to make the transition from cell number two to cell number one. When the oft heard cry goes up for “more research needed” cell one is a good place to start, well, what do we know on the subject already. It also has applications at team level and has the potential to challenge and replace unproductive team norms, like, “we are practical child care workers and theory has nothing to teach us,” with consciously selected norms

**Table 1. Knowledge Utilization Matrix**

	Known	Unknown
Used	1. Knowledge known and used	3. Knowledge unknown but used (Intuition)
Not Used	2. Knowledge known but not used	4. Knowledge unknown and not used

that are child focussed and professional, for example, “what knowledge can we draw on to help us give the best service to conduct disordered youth.”

The second thinking tool presented at the workshop is the one that gave the workshop its title and is outlined briefly in the next section of this article.

**The Therapeutic Diamond**

The originator of the Therapeutic Diamond, Steven Shindling (1995) defines it as a “model to help staff improve the effectiveness of their interventions and communication with children in residential treatment.” Effective communication is hereby defined as communication which either facilitates client behavioural change, enhances the therapeutic alliance (*the relationship—my italics and addition*), promotes insight, conveys necessary information, diminishes client distress, or enhances resident self esteem” (p.47).

The inner part of the diamond represents the life space, that place where young people and adults live, work, play; the place where crises occur and out of which we try to maximize learning for the youth and for staff. The heavy black arrows on the outside of the diamond opposite the letters C, TF, L and R&E represent points of entry and interventions for the worker. Picture the scene, a worker enters the dining room and finds fourteen year Tommy stomping on top of a chair. Using the Diamond the worker can enter and use Therapeutic Focus, which might sound like, “Hey, what’s up with you today, you seem upset,” or they might set Limits, “Hey down off the chair now,” or they might Re-direct & Encourage, “Hey why don’t we go outside and kick some ball.” Or, the worker might do

all three, “Hey let’s get you down off that chair, you’re looking a bit up-tight—what’s up, why don’t we go and kick the ball and talk a bit.”

When the interventions take place in the upper half of the diamond then the interventions are complimentary and reciprocal. There is space to move back and forth between the points. If the worker moves in from the lower half as the first point of entry and tries to use consequences to motivate behaviour then escalation and crisis cycle is likely. Not inevitable, but likely. That is not to say that there is no place for consequences. That is a discussion for another time. The author and creator of *The Therapeutic Diamond* (Shindling, 1995) claims that it helps staff emphasis positive interactions that can include the use of limit setting and authority as well as response that aim to process thinking and emotions. I agree.

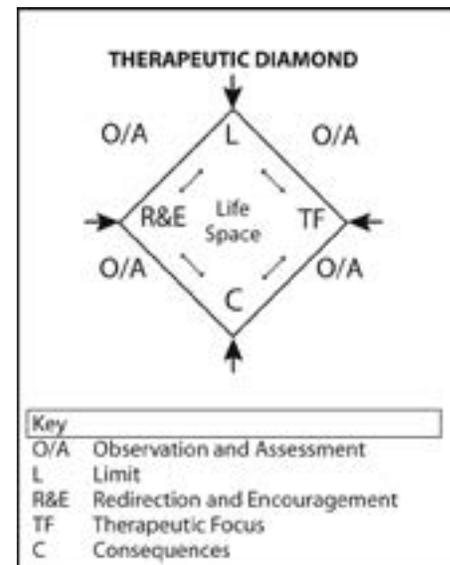


Figure 1. Therapeutic Diamond

Reflections, Cont. from p. 8.

In application with staff teams I have found that it has another powerful use. The model helps to draw out the sometimes overt but often covert beliefs about consequences and punishment as motivators to change behaviour. It is my experience, certainly in small group homes in Britain and Ireland, that staff teams get stuck in consequential thinking. The reasoning goes something like, "If only we had the right consequence or punishment then we could change this youth's behaviour." The Therapeutic Diamond has the potential to keep a staff team focused in the upper end of the diamond where relationships, activities, dealing with feelings, developing different ways of thinking, and achieving developmentally appropriate goals are the primary behavioural motivators. As for consequences, they need to be natural consequences and agreed as much as possible by the community of youth and staff who live, work, and play in the life space.

**A Model for Conceptualising Variation in Staff-Resident Behaviour**

Literature on residential child care recognises the multiplicity of groupings that occur in these settings (Brown and Clough, 1989). The two main groups though are the youth population and the staff population. Change in the one is reflected in the other. Uncertainty and confusion in the staff group affects the youth group. Duane Colyar (1992) has assembled a model that builds upon the idea of management styles. He makes an interesting link between these and patterns of youth group behaviour and staff group behaviour. The model assumes that staff behaviour is one of many influences on the behaviour of residents. Figures 2 and 3 illustrate the basic components of the model.

Colyar (1992) cross references the matching quadrants in the Staff Behaviour Grid and the Youth Behaviour Grid and

Staff Behaviour Grid	
SB3: Permissive High Empathy Low Expectation	SB2: Assertive High Empathy High Expectation
SB4: Passive Low Expectation Low Empathy	SB1: Aggressive High Expectation Low Empathy

Figure 2. Staff Behaviour Grid

Young People Behaviour Grid	
YB3: Cooperative High Compliance Low Disruption	YB2: Limit Testing High Compliance High Disruption
YB4: Passive Low Disruption Low Compliance	YB1: Rebellious High Disruption Low Compliance

Figure 3. Young People Behaviour Grid

argues for example, that in theoretical terms if the staff are on SB1, i.e., High Expectation and Low Empathy, then expect that the youth will be on YB1, i.e., High Disruption and Low Compliance. If the youth are on YB3, i.e., High on Compliance and Low on Disruption, then the staff could choose to be on SB 3, i.e., High on Empathy and Low on Expectation. Colyar provides examples of using the matrices to plot differences in youth behaviour evident when different combinations of staff are on shift.

The paper by Colyar is theoretical rather than empirical and in theoretical terms he conjectures that for youth in residential care the optimum position for staff to hold and demonstrate through their behaviour is about the mid-way point between SB 3 and SB 2, that is high empathy, high expectation with some scope for reducing expectations. There is now some empirical evidence to suggest that his position on this is more than conjecture. A study carried out by two Dutch researchers (Scholte and Van Der Ploeg, 2000) set out to explore residential treatment factors that had a favourable effect on the development of behaviourally difficult young people. They compared five climates in fifteen institutions for young people.

1. No structure—much support

- 2. Much structure—no support
- 3. No structure—no support
- 4. Much structure—much support
- 5. In between structure and support

These researchers conclude and provide some evidence to show that a "therapeutic climate in the living group of firm but not harsh control, and clear but not obtrusive emotional support is an important factor in the successful resocialisation of aggressive and anti-social youngsters in residential care" (p. 146).

**The Conference Workshop—A Reflective Comment**

My thoughts in anticipation of the workshop varied from, "I wonder who will come" to "I wonder will anybody come at all." Thirty five did come and all had impressive credentials. I enjoyed their company. They took some risks and entered into an event that required their participation. I have two abiding impressions. Firstly, they changed my mind and moved me from a pessimistic to more optimistic view on the extent to which, the child care community values theory. There were definite voices in the workshop saying that there is growing evidence of more theory in practice. Good. The second impression is that for ninety minutes thirty five people got excited

Reflections, Cont. from p. 9.

about “practical theories,” in symbolic interactionist terms the workshop group became like a reference group. Charon (2001, p.35) defines a reference group as “the group within which the individual communicates and whose perspective is applied to situations.” Now if that group of thirty-five represented an agency staff group in pursuit of “practical theories” to inform their work with youth—just think of the potential!

(1) Details on how to subscribe to this e-mail discussion group can be found at <http://www.cyc-net.org/index.html> click on the Network tab on the Homepage.

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**Johnnie Gibson**, MSc (Soc Wk); MSW: Dip App SLT (CC), is a TCI Instructor, Cornell University; and an Independent Social Work/Child Care Consultant, Ireland

More Images from the Second International TCI Conference....

“That which contributes toward the development of residential child care in Ireland is most welcome.” Noel Howard, Deputy Director St. Joseph’s Children Detention School in Clonmel, Ireland, and Michael Donnellan, Director of Trinity House School, Dublin, introduced Andrew Montague, Deputy Lord Mayor of Dublin who applauded the international group of practitioners in their efforts to research, develop and refine the real essentials of caring properly and professionally for the most vulnerable of children.



“TCI trainer certification represents a high standard of professional practice.” 156 TCI trainers from 10 countries take the written test to apply for TCI trainer recertification.



## ■ New Professional Certification Guidelines

We are pleased to announce new guidelines and standards for professional certification. The brochure explaining the guidelines in detail is posted on our website: [cornell.rccp.edu](http://cornell.rccp.edu). Below is a brief summary of the changes.

### Application Process

The applicant must complete the following items in the order they are listed:

1. The applicant must attend and successfully complete the TCI update: *Developing Professional Level TCI Training Skills*.
2. The applicant must send a letter of intention to apply for professional certification to the RCCP. This should include a copy of the applicant's latest certification letter and reasons for seeking professional certification. Upon receipt of the letter of intent, the RCCP will assign a mentor to assist the applicant during the application process.
3. The applicant will build a portfolio with guidance (telephone and email) from the mentor.
4. Before submitting the portfolio, the applicant will review the portfolio with the mentor.
5. Send the portfolio and \$100.00 application fee to the RCCP.

Applicants are notified of the results of their application in the mail after the certification committee review process is completed. There are four possible outcomes:

1. Professional certification
2. Professional certification with conditions (a six month period to respond to conditions)
3. No professional certification with recommendations for resubmission (\$100 application fee waived for second submission)
4. No professional certification

This process takes 10-12 weeks after the application and portfolio are received by the RCCP.

### Responsibilities of Professionally Certified Trainers

The professionally certified TCI trainer has all of the responsibilities of an associate certified trainer plus the following:

1. PCTs must practice in accordance with TCI principles.
2. All training delivered by a PCT must follow TCI training guidelines.
  - a. All training must meet the minimum of instructional hours and days as outlined in the activity manual. (The PCT does not have permission to revise or change the TCI training material.)
  - b. All TCI training must follow the TCI activity guide or if delivering refresher/update training, the TCI update activity guides.
  - c. When training TCI to participants employed by an organization other than the PCT's employer, the PCT must purchase from the RCCP a TCI student workbook or, if training an update, a TCI update student workbook for each participant.
  - d. The RCCP evaluation instruments must be used to evaluate participants in trainings.
3. PCTs must adhere to the TCI Trainer Code of Conduct as outlined in the TCI update: *Developing Professional Level TCI Training Skills Participant Guidebook*.
4. PCTs must maintain attendance and testing records for all training courses.
5. PCTs contracting with organizations to train TCI must follow the TCI implementation guidelines. Any agency using physical restraint techniques must have appropriate policies and procedures, regulatory and/or licensing authority, a system to provide clinical supervision and monitoring, direct supervision and monitoring, and proper documentation and oversight. Core training and refresher training standards must be met. PCTs should request documentation from the organization that these criteria are met.
6. PCTs must submit sample agendas, attendance records, and evaluation records of all training courses delivered outside of their organization when applying for recertification.
7. PCTs must submit evidence of compliance with implementation guidelines if training outside of their employing organization. This evidence may be a copy of an agreement between the PCT and organization or a copy of the documentation of compliance with implementation guidelines from the organization.

## RESULTS of Symposium Examining the Safety of High-Risk Interventions for Children and Young People NOW AVAILABLE ONLINE

On June 1-4, 2005 an international symposium entitled, *Examining the Safety of High-Risk Interventions for Children and Young People*, took place on the Cornell campus. Over 90 researchers, policy makers, advocates, and intervention system providers from throughout the United States, Canada, England, Wales, Scotland, Australia, and Ireland participated in this symposium that was sponsored by Cornell's Family Life Development Center in conjunction with Stirling University, Scotland and the Child Welfare League of America.



The papers presented represented topics such as the legal and ethical uses of physical and mechanical interventions, the safety of physical and mechanical interventions, the psychological and emotional impact of physical and mechanical interventions, guidelines for the development and use of high-risk physical and mechanical interventions, and clinical and organizational strategies likely to reduce high-risk physical and mechanical interventions. The papers and presentations for the entire symposium can be found on the symposium website: [rccp.cornell.edu/symposium.htm](http://rccp.cornell.edu/symposium.htm). A book with the symposium papers and discussion will be published in mid 2006.



Visit the symposium website:  
[rccp.cornell.edu/symposium.htm](http://rccp.cornell.edu/symposium.htm)

## Professional Certification Announcements



**Craig Bailey** is a Recreation Therapist at Crestwood Children's Center, an affiliate of the Hillside Family of Agencies, located in Rochester, NY. He has been working with young people in residential care since 1996, and has been with Crestwood since 2000. Craig has been the primary TCI trainer for new employees at Crestwood during this time, and currently works alongside the Learning Institute at the Hillside Family of Agencies to deliver TCI training to new employees from all of the service affiliates. He earned his professional certification in January of 2005.



**Julie Libby** has worked in social services for over 18 years and has been a TCI instructor since 1995. She has served in many capacities at The Children's Home Association of IL in Peoria, IL. Currently, as Director of Quality Improvement, she oversees the monitoring of all programs including Utilization Review, COA accreditation, outcomes measurement, consumer satisfaction, Medicaid compliance, and internal investigations. Julie has a BA in Psychology from the University of WI-Eau Claire and a MS in Psychology from Illinois State University.



**Elizabeth J. Brundige** has worked at St. Anne Institute, Albany, NY for the past 17 years. She has held various positions throughout the agency, including child care worker and manager/supervisor of the Alternate Living Arrangement (crisis) Unit. She has been a TCI trainer since 1993 and now works as a Crisis Intervention Worker in the Support and Coordination Office.

## RCCP Announces Three New One Day Updates

In our TCI Europe program and in our New York State voluntary agency OCFS training program, all TCI trainers are required to apply for recertification by successfully completing a TCI update annually. Beginning in 2006, we are offering one day TCI updates for TCI trainers who have successfully completed the *Post Crisis Response* and *Designing Refresher Training* updates. Three new one day updates will be offered at various locations throughout the year. All participants will be tested with written and competency based tests in order to be recertified. In 2007, we plan to offer these programs to eligible TCI trainers throughout North America.

### Adapting the Life Space Interview for Proactive Aggression

The LSI in the TCI core curriculum is designed to intervene with children and young people who are overwhelmed with emotions. By contrast, young people who display proactive aggression are thinking. Assessment skills to differentiate between proactive and reactive aggression and adjust the LSI accordingly are necessary to apply a modified LSI with youth who display proactive aggressive behavior.

This one day program examines in detail the behavioral and verbal manifestations of reactive and proactive aggression and the mechanisms by which proactive youth distance themselves from their emotions. The importance in having a program that reflects developmentally appropriate and value based expectations of pro-social behavior that guide youth and staff behavior is emphasized. A breakdown of the knowledge, skills, and attitudes required to conduct a LSI with youth who display proactive aggression is presented. Techniques include presenta-

tion, discussion, demonstration, role play, and practice.

### Conflict Resolution

Every conflict has at least two sides with differing viewpoints. Each side usually thinks their viewpoint is correct. It is impossible (and undesirable) to eliminate conflict from our lives so instead we can view it as an opportunity to work out individual differences without resorting to violent means. Direct care workers are in the unique position of modeling conflict resolution strategies and teaching children how to become effective conflict managers.

This update includes a set of conflict resolution steps to practice and an opportunity for participants to examine their own personal response to conflict. Techniques include a self-assessment survey, presentation, discussion, demonstration, role play, and practice.

### Legal Concepts Involved in Use of Physical Restraint

This update is an overview of the various legal concepts involved in using physical restraint which incorporate the practices and principles taught in TCI as they relate to best practices. Participants will be introduced to levels of oversight (professional conduct, agency policy, regulations, and laws) and the consequences for violating each level. An explanation of necessary components of negligence and how each is related to a failure to conduct a proper physical restraint will be outlined.

Participants will then be presented with a hypothetical situation in which a child was injured following an inappropriate, or at least questionable, incident of restraint. A mock civil trial will be conducted with the participants as the jury. Participants will have an opportunity to question witnesses after the “lawyers”

## Serious Fun and Games

by Jack Holden

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

### RED HANDED

*Have people form a circle and ask for a volunteer to get in the middle. Ask someone to show the volunteer*



*an object that will be passed around the group (it should not be too small but should fit inside someone's hand when the hand is closed).*

*Instruct the person in the middle to turn three times, eyes closed, and then open his/her eyes. Simultaneously, cue the people in the circle to begin passing the object around. The person in the middle has three chances to guess who has the object. (Sometimes the people passing the object become very tricky!)*

have done so. Participants will have “jury instructions” consisting of a synopsis of the relevant law, from which they will determine whether an individual or an agency has any liability for a child's injury, and, if so, to what extent. Techniques include presentation, discussion, case study, mock trial, and practice. ▽

## New Physical Guidelines for TCI Training

Our experiences, observations, and research over the past few years have resulted in a restructuring of our physical restraint training. The RCCP is committed to preventing institutional maltreatment of children by strengthening child caring organizations' capacities to provide quality care and treatment to children and to provide effective training and support to staff members. It is equally important for us to reduce risk of injury to our own training participants during the TCI training of trainers and update training.

### What We Have Learned

During our training events, we have observed participants coming to participate fully in the physical restraint training with a variety of conditions including extreme obesity, recent leg and foot injuries, pregnancy, recent surgeries, heart conditions, and poor fitness levels. They have signed a statement that they are capable of sustained, intense physical exertion but often struggle trying to properly execute the stretches before the practice session. In our review of the studies on physical activities and injuries, the one identified factor related to reduced injuries during physical activity was the participant's level of fitness. Overall fitness reduces injury occurrence during physical activity.

While providing technical assistance to organizations and observing direct training, we observe many child care staff members with body mass, girth, and weight problems participating in the physical restraint training because it is mandatory for their job. Trainers are put in the position of training people who are not physically fit or capable of conducting a physical restraint during training much less safely restraining a violent child with-

out placing themselves, their co-workers, and the children at risk.

Through telephone calls and email correspondence TCI trainers have shared their dilemmas and ethical concerns of being put in the position of training or certifying staff members who are not physically fit. Their organization and/or the staff member is pressuring them to do so because employment is dependent on successful completion of the physical restraint training.

In our ongoing study of child restraint/seclusion fatalities, we see that child obesity is a pre-existing risk factor for positional asphyxia for child. Staff obesity is also a concern in that some of the fatalities have occurred as a result of an obese staff placing their body weight on the back or chest of the child resulting in positional asphyxia.

### What We Are Doing

We are making changes in our physical restraint training requirements to:

- reduce the risk of injury to participants due to their own level of physical fitness when performing the physical techniques
- reduce the risk of injury to participants during physical restraint training due to other training participants' inability to perform techniques as a result of inadequate levels of fitness, and
- reduce the risk of injury to children and staff during high-risk situations that involve physical restraint as a safety intervention strategy

This means that participants' general level of fitness, cardiopulmonary health, body mass and distribution, and other temporary conditions such as pregnancy, recent injuries, or surgeries must be considered.

### Calculating One's Ability To Safely Participate In Physical Restraint Training

While formulating guidelines to assess people's ability to do TCI physical

techniques without putting themselves or the person in the role of the child at undue risk, body mass index (BMI) was identified as a possible measure. During selected TxT weeks and Updates, we have been discussing the issue of BMI with participants and TCI trainers focusing on who might be at risk for injuring themselves, others, or putting weight on the young person's back due to physical size and fitness. These informal surveys were conducted to collect information about participant's BMI and observe their ability to perform TCI physical techniques. With BMI numbers above 30 we observed that BMI alone as a measure to determine a participant's ability to perform techniques was not enough. The structure of participant's bodies and their levels of fitness influenced their ability to perform the techniques.

### New Guidelines

Our aim is to develop a process that will assist people in making an informed decision about the level at which they can safely participate in the physical restraint training. We want to reduce the risk of injury for participants during our training as well as model reasonable guidelines for trainers to use in their own agencies in order to reduce the risk of injury for staff members and children. The following risk factors should be considered before deciding at what level to participate in the TCI training. The following web site can be used to estimate BMI: <http://nhlbisupport.com/bmi/bminojs.htm>

#### ***Limited or no physical restraint training***

If you have one of the following conditions, you should not participate in any physical activity that requires maneuvering to the floor or extreme exertion. Depending on your own unique characteristics, you may participate in Level 1 physical activities (protective interventions, breaking up a fight, and standing hold) if you and your physician feel that you are not putting yourself or others at risk. You



## TCI Bookshelf

### **Making Residential Care Work: Structure and Culture in Children's Homes**

*Written by Elizabeth Brown, Roger Bullock, Caroline Hobson, Michael Little*

*Published by Ashgate Publishing Limited (1998)*

*Reviewed by Martha J. Holden*

This book was written by members of the Dartington Social Research Unit and is one study out of a series of studies dealing with personal social services. *Making Residential Care Work* concentrates on aspects of children's homes and explores the links between structure, staff and child cultures, and outcomes.

The authors write the introduction to this book while sitting in a hotel lobby making observations about the "culture" of a hotel, a place where adults and children understand the rules, boundaries, and relationships, and ponder what makes it a good hotel. Is it the furnishings, the technology, the hotel manager, the mini-bar? What makes good residential care? Is it the building, the leadership, the resources? The authors conclude that it is much deeper than that. All aspects of the residential care must be complementary, congruent, balanced, and the program must be based on the best interests of the child and sound child welfare practice.

Nine homes were studied over a period of a calendar year. Site visits as well as telephone calls and letters were made to and from staff and children. Data was drawn from files, interview with managers, professionals, children and families inside and outside of the homes. Researchers made "non-participant observations" throughout the study. Information was collected on the structure of the homes, the staff culture of the homes, the child culture of the homes, the outcome for the homes, and the outcome for children living in the homes.

The link between structure and culture is an important relationship for managers and professionals to understand if they are to provide quality residential care and meet the needs of vulnerable children. This structure can be understood by examining the congruence between societal goals (shared principles and ideas about the way children are raised), formal goals, (the aims and objectives of each children's home) and the belief goals (what a manager fundamentally believes about what the home can do for its children and the capability of staff). The goal is for the three structural goals to be concordant which leads to healthy culture. The authors establish, through their research, that a good structure leads to a concordant staff culture which leads to a concordant child culture. This results in a good home and leads to better outcomes for children. Another valuable contribution of this study is the focus on the way homes change and suggestions about how to manage change.

This book provides a conceptual framework that can help residential leadership plan and manage their programs to provide better outcomes for the homes and the children. It describes useful methods to identify the levels of structure and help to establish congruency between societal, formal, and belief goals. Methods to identify and understand staff and child culture are presented. Once leadership better understands the complex processes within their residences, a series of interventions to improve their practice can be applied.

*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. She 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.*

Physical Guidelines, cont. from page 14.

and your physician may decide that you should not participate in the physical training at any level.

- Pregnant
- Back or knee problems
- Cardiopulmonary conditions
- Recent surgery
- Osteoarthritis
- Osteoporosis
- BMI over 35
- BMI 30-35 If your BMI is between 30-35 and you wish to participate in the full physical restraint training, all of the following conditions need to be met:
  - Your waist size is under 40 inches or 102 centimeters (males), under 35 inches or 89 centimeters (females)
  - You adhere to a regular fitness/work out routine
  - Your blood pressure is within normal range (with or without medication)

**Certification Levels**

When applying for TCI trainer certification or recertification, we have the following levels of certification.

**Associate Levels**

- Associate: certified to train TCI and all physical restraint techniques in his/her employing agency
- Associate, level 1: certified to train TCI and the protective interventions, the standing hold, and breaking up a fight technique in his/her employing agency;

cannot train team or small child restraint techniques

- Associate without physical techniques: certified to train TCI without any physical techniques in his/her employing agency
- Conditional certification: has a six-month period to meet certain conditions and send in documentation

**Professional Certification Levels**

- Professional: certified to train TCI and all physical restraint techniques
- Professional, level 1: certified to train TCI and the protective interventions, the standing hold and breaking up a fight technique; cannot train team or small child restraint techniques
- Professional without physical techniques: certified to train TCI without any physical techniques
- Professional certification with conditions: the associate TCI trainer has a six-month period to meet certain conditions and send in documentation to receive full professional certification at the level requested

These new guidelines will impact child caring organizations as well as individual trainers and staff members in various ways depending on an organization's present hiring procedures, policies, and procedures. Our goal is to make training and caring for children and young people as safe and risk free as possible for everyone involved.

**TCI EUROPE NEWS**

On April 27th 2005, the TCI programme received accreditation to the British Institute of Learning Disabilities Code of Practice. This means that TCI Europe is a government approved training provider in physical interventions in the UK. It also gives agencies working with us accredited status within the Inspection framework.

Trainers now have to be accredited annually, keep particular records of the people they train, and only train to an appropriate level of physical interventions for their agency. TCI Instructors in the UK are now involved in several working parties particularly in relation to the prone restraint and the development of a Code of Practice for agencies working with emotional and behaviourally disturbed children and young people.

The details of TCI Europe can be found on the bild website. If you need particular information about TCI Europe, please email [tc\\_europe@freeserve.co.uk](mailto:tc_europe@freeserve.co.uk).



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

*“Age is foolish and forgetful when it underestimates youth.”*

—J. K. Rowling, *Harry Potter and the Half-Blood Prince*, 2005

## Reducing Restraints Some Suggestions from Current Best Practice

by Glenn Johnson

After attending the conference, *Achieving the Balance: Best Practice for Managing Challenging Behavior*, in Dublin and the symposium, *Examining the Safety of High-Risk Interventions with Children and Young People*, in Ithaca, I have compiled some information to assist an agency in its efforts to reduce restraints.

One issue that repeatedly is revealed in reviews of literature on restraints is that terms and definitions vary greatly. As Jerome (1998) concluded, “there is no clear agreement regarding the definitions of ... restraint.” As an example, we here at Green Chimneys, have in the past, referred to restraints as therapeutic holds. This confusing term is most readily associated with therapies developed to treat RAD (Reactive Attachment Disorder), where children were held in prone positions, sometimes wrapped in blankets etc. for hours (Welsh, 1988). This is a controversial practice, resulting in death and criminal charges in some states. We use what are commonly referred to as physical restraints, although this term sometimes includes mechanical devices, which we do not use (Brendtro and Ness, 1991). Staff use the terms restraints and holds interchangeably even today. This needs to be clarified. We use restraints as a safety intervention; not in therapy. Some writers have also referred to restraints as a treatment failure, however, I feel this is inadequate also. Young people come to treatment with many aggressive and destructive behaviors. Any therapy will take time to have effect. If safety interventions occur along this continuum, it does not necessarily reflect a failure of the treatment process or technique. Using the term treatment failure may also, inadvertently, cause staff to feel they are being blamed for failing in their actions.

In fact, treatment centers with programs for severely symptomatic individuals, have a responsibility to address the aggression and violence in their population. To be unresponsive may allow injury and distress for which an institution may be liable (Fisher, 1994). In fact, the literature reviews conclude that restraint works as an effective means for preventing injury, reducing agitation (Fisher, 1994), and as a prudent remedy to address harm to self and others (Busch & Shore, 2000). Focusing on restraints as safety interventions will place them in focus in terms of need, purpose, and evaluation.

I believe Incident Reports should employ common terminology to assist in data collection, analysis, and comparison. CWLA’s National Definitions and Data Collection for Residential Care Facilities Restraint and Seclusion Use (CWLA, 2003) would probably be a good standard to adopt in residential agencies. With the advent of computerized records, it is wise to use definitions and terms, which are established and accepted within the industry, to facilitate benchmarking efforts.

Adopting the Public Health Model in planning strategies is a universal theme for an approach towards aggression and violence in the institutional setting. This model has three levels that focus on prevention.

**The Primary Level:** Is action taken to prevent violence before it occurs, which would include, assessment of triggers, and sources of challenging behavior. It deals with the whole population.

**The Secondary Level:** Is action taken to prevent violence when it is imminent. This would include, de-escalation and behavior management techniques and would be more specific to an individual.

**The Tertiary Level:** Is action taken when violence occurs. This would include the use of restraint and programmatic consequences.

We train staff in techniques for the secondary and tertiary levels, but do not spend much time focusing on the primary level of prevention. Even on the second-

ary level, more supervision is needed to increase skill development and knowledge. When the greatest effort is placed on tertiary responses, the majority of our resources will be used in “putting out fires.” An analogy would be, dealing with an outbreak of Cholera by giving antibiotics to those who got sick, but not treating the source of the bacteria, i.e., chlorinating the water supply.

A number of core strategies have been identified in those programs that have been successful in reducing the number of restraints (National Technical Assistance Center, Revised 2005).

### **Leadership Toward Organizational Change**

- Define and articulate a vision, values, and philosophy
- Develop and implement a performance improvement action plan
- Hold people accountable for that plan
- Elevate oversight of every restraint event by management

#### *Notes:*

- *Leaders should expect resistance to change both overtly and covertly. Involvement of staff in the process may minimize this.*
- *This is a multi-year effort and requires determination and perseverance.*
- *Facilities should do a value exercise to ensure actual clinical and administrative practices are congruent with stated missions and values.*
- *Policy statements should include beliefs to guide in use of restraints and reveal its commitment to reduce them.*
- *The performance improvement plan should include the creation of goals, objectives, and steps assigned to responsible individuals with noted due dates.*
- *Make sure all staff are aware of the CEO’s role in the reduction initiative (may include financial commitment).*

### **Use of Data to Inform Practice**

- Identify baseline use
- Gather data on usage by Unit, shift, day, staff member, young person’s characteristics, diagnosis etc.

Reducing Restraint, continues on page 18.

*“It is our choices...that show what we truly are, far more than our abilities.”*

—J. K. Rowling, *Harry Potter and The Chamber of Secrets*, 1999

Reducing Restraint, cont. from page 17.

- Give feedback to staff
- Note: CWLA's definitions include appropriate data for collection.*

**Workforce Development**

- Create a treatment environment with policy, procedures, and practices based on principles of recovery and trauma informed care
- Communicate to staff expected knowledge, skills, and abilities with regards to restraint reduction through:
  - new hire interview questions
  - job descriptions
  - performance evaluations
  - new employee orientation

*Notes:*

- *Staff development goes beyond training situations. Supervision should assist growth and development and ensure appropriate actions.*
- *Encourage staff to explore unit rules, with an eye to analyzing these for logic and necessity.*
- *Allow staff to suspend “rules” within defined limits to avoid incidents.*

**Use of Restraint Prevention Tools**

- Use existing models, i.e., Collaborative Problem Solving (Greene, 1998); Sanctuary Model (Bloom, 1997)
- Use strength based programming
- Use assessment tools to identify risk for violence, trauma, and restraint history
- Use person-first language
- Provide comfort and sensory rooms

**Consumer Roles in Inpatient Settings**

- Have full and formal inclusion of consumers, families, and advocates in various roles and at all levels
- Use consumers in monitoring, debriefing interviews, peer support, and roles in key facility committees

*Notes:*

- *Encourage staff to include consumers at all operational levels*
- *Communicate the importance of co-opting this resource.*
- *Use consumer satisfaction surveys.*

- *Include consumer involvement in new employee interviews where appropriate.*

**Post Crisis Follow-up**

- Analyze every restraint event
- Use knowledge gained from this analysis to inform policy, procedures, and practices

*Notes:*

- *Multi-level post crisis response programs should be implemented.*
- *Administration needs to be involved in this and in ensuring it is completed.*

As a way to get started a tool is available for assessing the organization’s readiness for reducing restraint (Colton, 2004). It is valuable in pointing to gaps, which need to be addressed to successfully reduce restraints. Proper administration requires the following:

- The checklist should be completed by people from multiple perspectives to ensure a comprehensive assessment. This includes line-staff, which may help engage them in the process.
- The instrument must be completed individually, and then people should come together to discuss their ratings. It should take about thirty to forty-five minutes to complete. Allocate sufficient time to complete this task.
- The entire checklist should be completed by the facility administrator and the major department heads.
- Differences between management and those involved in service provision should be examined.
- The checklist can be administered to all members or the organization in the form of a survey. The advantage of this approach is that it provides a wide scale assessment of staff perceptions and it helps introduce staff to the concepts that will be addressed in a restraint reduction effort.

The checklist serves as a diagnostic instrument and points to a performance improvement plan. In the discussion and review phase, users should attempt

to develop a consensus for each item. In situations where differences become polarized, it may be best to defer that element until staff has had the time to assimilate the information and weigh the different positions.

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**Glenn Johnson, MS**, HR Training Associate, has worked for Green Chimneys Children’s Service for 25 years. He has been a TCI Trainer since 1986. He is an adjunct professor at Dutchess Community College.

## Ask Eugene

**Q: Is the training I want to register for still open? If it is, can you sign me up?**

A: Please remember that all of our TCI training of trainers (TxT) and Update courses are available on a first-paid, first-served basis. They fill up very quickly. Even though the training you want to attend is open when you call, it could fill up at any time after you ask about it. We are not able to reserve space for you in any TCI training without completed applications and either a check or a purchase order for the proper tuition amount. Our recommendation is that you routinely check the training schedule and plan to register for the training you wish to attend as early as possible.

**Q: Why was I never notified of any changes in the TCI curriculum, training schedule, or certification process?**

A: We understand that due to changes in your own schedule, work load, and even location that you may not receive correspondence from RCCP on a regular basis. Here are some things you can do to help ensure that you are up to date on all things TCI, as well as new things the RCCP at Cornell might be doing:

1. Please read your certification letters that you receive when you have completed any TCI training. There may be changes that we are telling trainers about via their certification letters.
2. Check our website periodically. Changes to anything TCI will be on our website, as well as new projects/training that may be of interest to you.
3. Please read our Refocus newsletter carefully. If there are any changes, or new things going on, it will be in Refocus.
4. Please notify RCCP with any changes in your contact information. This is very important. If your address, phone number, and/or email address changes, please let us know as soon as possible. We cannot maintain contact with you without it.

Our website is <http://rccp.cornell.edu>

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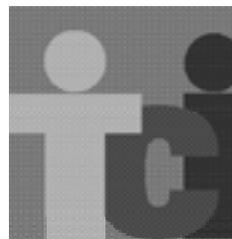
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## 2006 COURSE OFFERINGS

### TCI: TRAINING OF TRAINERS

January 30 - February 3, 2006 ..... Auburn, NY  
 January 30 - February 3, 2006 ..... Leeds, England  
 February 6-10, 2006 ..... San Diego, CA  
 February 13-17, 2006 ..... Pittsburgh, PA  
 February 13-17, 2006 ..... Sydney, Australia  
 March 6-10, 2006 ..... Colorado Springs, CO  
 March 20-24, 2006 ..... Peoria, IL  
 March 20-24, 2006 ..... Myrtle Beach, SC  
 April 3-7, 2006 ..... Cincinnati, OH  
 April 24-28, 2006 ..... Warwick, RI  
 May 15-19, 2006 ..... Glasgow, Scotland  
 May 22-26, 2006 ..... Dublin, Ireland  
 June 5-9, 2006 ..... Atlantic Beach, NC  
 June 26-30, 2006 ..... Auburn, NY  
 July 10-14, 2006 ..... Pittsburgh, PA  
 July 24-28, 2006 ..... Auburn, NY  
 August, 14-18, 2006 ..... Auburn, NY  
 September 11-15, 2006 ..... Sacramento, CA  
 September 18-22, 2006 ..... Peoria, IL  
 September 18-22, 2006 ..... Penrith, England  
 October 16-20, 2006 ..... Myrtle Beach, SC  
 October 23-27, 2006 ..... Mesa, AZ  
 November 13-17, 2006 ..... Warwick, RI  
 November 13-17, 2006 ..... Dublin, Ireland  
 December 11-15, 2006 ..... Ithaca, NY

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

February 27 - March 3, 2006 ..... Penrith, England  
 June 5-9, 2006 ..... Ithaca, NY

### TCI UPDATES

#### DEVELOPING PROFESSIONAL LEVEL TCI TRAINING

March 2-3, 2006 ..... Colorado Springs, CO  
 July 6-7, 2006 ..... Pittsburgh, PA  
 September 14-15, 2006 ..... Peoria, IL  
 October 3-4, 2006 ..... Glasgow, Scotland  
 November 9-10, 2006 ..... Warwick, RI

#### TCI FOR FAMILY CARE PROVIDERS

April 27-28, 2006 ..... Cardiff, Wales  
 August 21-22, 2006 ..... Ithaca, NY  
 October 19-20, 2006 ..... Mesa, AZ

### TCI FOR DEVELOPMENTAL DISABILITIES

January 19-20, 2006 ..... Ithaca, NY  
 March 20-21, 2006 ..... Bournemouth, England  
 April 20-21, 2006 ..... Warwick, RI  
 June 1-2, 2006 ..... Atlantic Beach, NC  
 July 17-18, 2006 ..... Ithaca, NY  
 November 9-10, 2006 ..... Warwick, RI

### DESIGNING REFRESHER TRAINING

February 2-3, 2006 ..... San Diego, CA  
 February 9-10, 2006 ..... Belfast, N. Ireland  
 February 20-21, 2006 ..... Glasgow, Scotland  
 March 27-28, 2006 ..... Myrtle Beach, SC  
 March 30-31, 2006 ..... Cincinnati, OH  
 April 3-4, 2006 ..... Dublin, Ireland  
 May 10-11, 2006 ..... Dublin, Ireland  
 May 11-12, 2006 ..... Glasgow, Scotland  
 June 8-9, 2006 ..... Penrith, England  
 June 20-21, 2006 ..... Dublin, Ireland  
 September 7-8, 2006 ..... Sacramento, CA  
 October 12-13, 2006 ..... Myrtle Beach, SC  
 November 22-23, 2006 ..... Dublin, Ireland

### POST CRISIS RESPONSE

February 9-10, 2006 ..... Pittsburgh, PA  
 February 23-24, 2006 ..... Hertfordshire, England  
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 April 25-26, 2006 ..... Liverpool, England  
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 June 26-27, 2006 ..... Belfast, N. Ireland  
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*Note: The following NEW 1 day updates are ONLY available to TCI trainers in Europe who have successfully completed BOTH Designing Refresher Training AND Post Crisis Response.*

### ADAPTING THE LIFE SPACE INTERVIEW FOR PROACTIVE AGGRESSION

October 5, 2006 ..... Glasgow, Scotland  
 November 24, 2006 ..... Dublin, Ireland

### CONFLICT RESOLUTION

May 10, 2006 ..... Glasgow, Scotland  
 June 19, 2006 ..... Dublin, Ireland  
 September 12, 2006 ..... Wheathampstead, England