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TCI **S**tudy **A**bout **F**idelity and **E**ffectiveness (TCI: SAFE)

by Jack C. Holden, PhD, Joanna Garbarino Novakovic, BA, Martha Holden, MS, and Lisa McCabe, PhD

Introduction

Is TCI working at your agency? If so, is it as effective as it could be? If TCI is not working, why not? There is an increasing demand to provide evidence for outcomes of behavioral interventions (Bellg, Borrelli, Resnick, Hecht, Minicucci, Orwig et al., 2004; Frank, Coviak, Healy, Belza & Casado, 2008; Mowbray, Holter, Teague, & Bybee, 2003; Paulsen, Post, Heronckx & Risser, 2002; Teague, Bond & Drake, 1998). Fidelity refers to the "methodological strategies used to monitor and enhance the reliability and validity of behavioral interventions" (Bellg et al., 2004), "the extent to which delivery of an intervention adheres to the protocol or program model originally developed" (Mowbray et al., 2003), and "the match between an intervention as it was intended to be delivered and the intervention as it is actually delivered in real world circumstances" (Hill, Maucione & Hood, 2006). The Residential Child Care Project (RCCP) is in the process of developing a fidelity tool to assist agencies in their efforts to successfully implement the Therapeutic Crisis Intervention (TCI) System.

The TCI fidelity tool will be developed as part of a larger TCI Study About Fidelity and Effectiveness (TCI: SAFE). For this work, we are going to examine the process of TCI implementation in various agencies to discover what aspects

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Holy Cross Children's Services and TCI: A Partnership for Success

by Loren P. Brown and Gary Tester

Background

Holy Cross Children's Services (HCCS) began providing residential services to Michigan youth at its inception as Boysville of Michigan in 1948. The agency changed its business name to Holy Cross Children's Services in 1998 to more appropriately reflect services to males, females, families and communities. HCCS is a Catholic-oriented, nonprofit child care and family preservation agency headquartered in Clinton, Michigan. The agency now conducts residential and community-based programs throughout the state of Michigan and is one of the largest private providers of services to children and families in the state. HCCS seeks to provide for the social, emotional, educational, economic and spiritual needs of its clients and staff with the goal of empowering children and families to function effectively in their community. HCCS provides a community-oriented living and working environment and seeks to be an effective advocate on issues which affect children and families. The agency maintains programs which incorporate personal development, individual attention, family involvement, life skills, formal education and staff team work.

From its humble beginnings as a boarding school with 16 original students in 1948, HCCS is now an agency serving approximately 2,600 males, females and families from 78 of Michigan's 83 counties in over 20 residential and community-based programs. Approximately 30 percent of all children served are females. The agency operates four campuses, three serving males and one serving females, and six group homes across the state. Beginning in the 1970s the agency employed a concept termed positive peer culture (PPC) that drew upon the power and intensity of the group to help members come to terms with the various issues that they faced. Consistent with this approach was the utilization of peer restraint, an approach using peer group members to restrain an individual who presented a danger to self or others. Staff members were not considered part of the restraint process as the organization felt it would destroy the trust between staff members and youth. For years this was considered a model approach to working with youth experiencing behavioral issues.

HCCS' national accrediting agency, the Commission on Accreditation of Rehabilitation Facilities (CARF), in 2006 qualified its accreditation of the agency with an understanding

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It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change.

—Charles Darwin (1809 --1882)

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that peer restraint would not be acceptable. A review of data in 2006 disclosed a high frequency of incidents, including restraints, with an increasing trend especially in campus based residential programs. Correlating with these trends included an increase in coworker turnover, property damage by clients and an increase in client and coworker dissatisfaction among various survey elements.

In 2007, CARF issued a three-year accreditation renewal with the understanding that future renewals would be contingent upon the elimination of the peer restraint practice by the agency. No other national accreditation bodies allowed the practice of peer restraint in meeting standards.

Consumer feedback in 2007 indicated an increasing dissatisfaction with the agency's practice of peer restraint. State licensing and contract consultants increasingly expressed their concern about the practice as well, indicating the probability it would not be acceptable in the near future.

Leading up to 2007 we received continuous insurance reports about increased in claims pertaining to property damage, workers compensation and other liability settlements as a result of client behaviors. Although no particular claim resulted from the practice of peer restraint, it was obvious that insurance underwriters were growing uneasy about continued coverage for child welfare and foster care programs. The agency's insurance company expressed the possibility of dropping coverage if the increased frequency of claims was not addressed and pushed for evidence of reduced incidents.

In early 2007, we surveyed numerous staff around the agency from long-term clinical managers to new direct care coworkers, were surveyed regarding their understanding of what the agency's fundamental treatment and behavior management model was. There was significant inconsistency between regions and sites, clearly indicating that the agency had drifted in its practices from the beliefs that drove implementation of PPC and peer restraint many years ago. As a result, we challenged agency's leadership and coworkers to design a new approach to behavior management.

An internal working committee called the Behavioral Management Task Force (BMTF) was formed, comprised of coworkers from all levels of direct care. Monthly meetings began with the intent of determining if a new approach was warranted or if the model employed by the agency was actually the best available. The working group identified a number of models and programs across the United States with a strong reputation for quality care and proven behavioral management approaches. The work group then divided into teams and, through phone calls and personal visits, over a dozen agencies were investigated to determine what the constructs of a model therapeutic milieu were and to learn the best approach to manage behaviors. We were determined to take the best ideas we could find in order to insure that the therapeutic approach at Holy Cross Children's Services was the best it could be.

The Problem

In 2007 Holy Cross Children's Services averaged over 250 peer restraints per month. The internal work group agreed that the new approach at Holy Cross Children's Services needed to be based on the concept that each youth should be treated as if he/she were your own; if you wouldn't want your child to be restrained by his peers, then no child should be restrained by his/her peers. The group examined all types of model programs and considered numerous options regarding behavior management.

As this process was under way an examination of the type of youth being served in residential programs also took place. The conclusion was that most youth being referred for residential treatment seemed to be more traumatized than those in the past. Youth now generally had been placed in more foster settings and other residential programs before being referred to HCCS. They appeared to be "more damaged" and in greater need of treatment services than ever before. Peer restraint was viewed as a conflict with the safety of youth who themselves were more challenging, traumatized, and aggressive. The increased practice of peer restraint was reducing trust between youth and staff as part of the group model. In addition, we were concerned about the trauma a youth might experience if another youth would purposely cause harm, retaliate, or inadvertently hurt another youth.

Finally, because of Michigan's desperate economy, all levels of municipal government were struggling with adequate revenues to provide needed services, including children's services. As a result, the push for shorter lengths of stay and more community-based services in lieu of residential programs became more intense.

In summary, at the same time HCCS determined to create a different treatment milieu and move away from its long-practiced peer restraint approach, the youth being referred to residential treatment had more intensive needs and the paying consumer required less time to meet those needs. Many thought this marked the beginning of the end of residential services for HCCS. A major concern of coworkers who had lovingly served youth at HCCS for more than 15 years was how to provide care and manage behaviors without the use of peer restraint.

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of TCI are consistently implemented or omitted, what adaptations agencies have made and what aspects of TCI are challenging for agencies to implement. We will also examine how particular features of TCI implementation relate to programmatic practices (e.g., number of restraints used; critical incidents of fighting or verbal threats). Finally, based on these examinations and field test, we will create a "Fidelity" tool to be used in on-going TCI evaluation and Technical Assistance (TA).

The TCI System, developed by Cornell University's RCCP, has been available for children's residential centers since 1981. There is some evidence from the field that TCI has been successful in assisting agencies in their efforts to reduce crisis events, physical restraints, and child and staff injuries. Concurrent studies were conducted in the mid 1990s with agencies both in the US and the UK (Nunno, Holden & Leidy, 2003) and findings indicated that successful implementation of TCI was related to five domains; Leadership, Clinical Oversight, Supervision, Training, and Critical Incident Monitoring and Feedback.

Although the RCCP has never formally assessed the fidelity for implementation of TCI, the RCCP has worked with over 25 agencies in a contracted implementation process (an 18-month implementation package) over the past 15 years using the five domains. Many of the contracted agencies claimed to have reduced crises, restraints, and injuries to staff and youth. In addition, many other agencies that have used the recommended TCI implementation process have reported reductions in the use of restraints.

In order to assess the success of the TCI model, there must be evidence of what criteria contributes to successful implementation. If TCI is not working, there must also be a way to discover if it is a failure of the TCI model or a failure to implement the TCI model as intended. Mowbray et al. (2003) suggest that failed implementation is the most common grounds for failed outcomes and that programs with failed outcomes had not used the strategies, techniques, and protocols for the particular interventions. Reasons such as "running out of time, disagreeing with the content, forgot, and this won't work with our populations" were typical reasons for not following protocol. Part of this fidelity study will work to identify what adaptations can be made without losing the effectiveness of the TCI System.

Development, Measurement, and Validation

The following description is based on the Mowbray et al. (2003) study and includes a three-step process to establish fidelity criteria, 1) identify and specify fidelity criteria, 2) measure fidelity, and 3) assess reliability and validity of fidelity criteria. The RCCP is using this model in the development of fidelity criteria for TCI implementation.

Step One: Identify and Specify Fidelity Criteria. In this step specific fidelity criteria based on a) proven success or general acceptance, b) expert opinions and/or literature reviews and, c) qualitative research (i.e., opinions of users and advocates about what works) will be selected.

TCI Fidelity Study: The specific fidelity criteria are contained within the five domains, leadership, clinical, supervision, training, and critical incident monitoring and feedback. The five criteria are based on proven success as well as expert opinion as to what makes TCI effective.

Step Two: Measuring Fidelity. This step includes measuring adherence to the fidelity criteria. The most common methods are: a) ratings by experts considering documentation, on-site observations, and/or interviews and b) surveys or interviews by individuals delivering or receiving the services. Since research suggests that service users are either generally overly positive or overly negative in their reporting, it is important to consider other evaluative methods as well as to support any findings.

TCI Fidelity Study: The RCCP evaluators will examine agencies' implementation of TCI through review of agency documents, conducting interview and surveys, and reading critical incidents. Data collected from critical incident reviews will serve as a quantitative representation for numbers of crisis, restraints, and injuries to youth and staff. Additionally, the significance of any adaptations will be considered through discussion in agency interviews with the intent of determining the significance of the adaptation.

Step Three: Assessing The Reliability and Validity of Fidelity Criteria. The five main approaches used by respondents in the Mowbray (2003) study to assess reliability and validity were:

1. Examining reliability across respondents—calculating the extent of inter-rater agreement (coefficient kappa, intra-class correlations [ICC], percent agreement, or Pearson correlations).
2. Examining the internal structure of the data empirically and in relationship to expected results, such as through confirmatory factor analysis (CFA), internal consistency reliability (Cronbach's coefficient alpha), or cluster analysis.
3. The method of known groups—examining differences in fidelity scores across types of programs expected to be different.
4. Convergent validity—examining the agreement between two different sources of information about the program and its operations.

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The Solution

The HCCS work group concluded that the key to any successful treatment effort was the relationship that existed between treatment staff and the youth. Further, the key to success in living in society was also relationship-oriented. With that in mind, Relationship Based Treatment (RBT) was born. Using model constructs from numerous programs around the country and drawing upon HCCS' own 60 years of quality services, RBT was created, refined and introduced across the agency in a period of approximately nine months. It was clear that the need for an internally developed model would result in greater initial acceptance and investment by coworkers than would the introduction of another agency's approach. Restructuring of supervisory positions took place in order to provide for more on-the-job training and support.

The work group also concluded that HCCS needed to establish an expectation that there would be no restraints, and that only properly trained coworkers would address behavior management if a restraint was indicated. Realistically, knowing that restraint by trained professional staff was the only way to address youth who will not stop from harming themselves or others, the goal was to create a culture of restraint being unacceptable as a treatment tool and only practiced by professional staff trained in a credible model.

To accomplish this, we needed to add a lot of tools to the therapeutic tool belt the direct care coworker had available. The focus shifted from peer restraint and group management to individual relationships within a group, recognition of signs of escalating emotion/behavior and de-escalation of spiraling emotions in order to prevent a physical outburst.

A major emphasis on Therapeutic Crisis Intervention (TCI), an evidence-based model developed at Cornell University, was introduced. While HCCS had long employed the TCI model in certain sites, it had really served as a guide to peer restraint. Now, the focus was on insuring that **every** direct care coworker, supervisor and manager was completely immersed in TCI. The agency invested resources to have a number of coworkers complete the TCI "Training of Trainers" so that, regardless of tenure with the agency, every coworker who interacted with youth underwent a rigorous training including frequent practice and demonstration of technique and the passing of a test demonstrating understanding and competence. The agency's approach was simple—demonstrate competence in TCI or don't work with the youth. This approach was so important that the agency's new CFO went through TCI training as well in order to understand the importance of quality care on the agency's business operations. It was important for him to understand why investment in TCI at such a significant level was so important.

At the same time, RBT was integrated with TCI in the treatment programs. The reasons for the fast pace of introducing the new model and approach to behavior management were clear—youth needed to be treated differently and the agency's leadership was determined to be free of peer restraint by July of 2009, in advance of the next CARF accreditation survey.

The Result

RBT has been fully introduced into all HCCS residential and educational programs and is now being introduced into community-based programs. TCI training and utilization remains front and center for all initial and ongoing coworker training efforts in the area of behavior management. Holy Cross Children's Services became completely free of peer restraints in June, 2009.

The agency's senior leadership team now monitors on a monthly basis 34 incident indicators including verbal aggression, physical aggression, property destruction, restraint, etc. The results are dramatic. The occurrence of restraints declined over **70%** in **12 months**! The average monthly figure of over 250 restraints agency wide has now dropped to between 25 and 30 each month and the plan is to drop that figure further. Additionally, incidents overall are down over **50%** in the same **12 month** period! The results suggest that the RBT model and emphasis on therapeutic relationships has greatly enhanced the success of youth in care in identifying problems and managing their emotions appropriately. They also clearly demonstrate the value of TCI as a behavior management tool to the direct care coworker. Now, the agency can focus on education, treatment planning, permanency and service continuums for serving more challenging youth in shorter periods of time and not on reducing incidents and restraints. A quality baseline has now been clearly established.

Our coworkers have a lot to be proud of. They accepted a challenge that not too long ago would have been dismissed outright and committed to making an absolute change in how we work with youth. The results speak for themselves. Outcomes now include a safer atmosphere for youth in care, significantly less liability exposure for the agency, a greater focus on all aspects of treatment, an improved agency image and a sense across the agency that Holy Cross Children's Services has what it takes to make significant changes on behalf of children, youth, families and its coworkers.

It seems there are 600+ coworkers and 2,600 youth who agree. ✷

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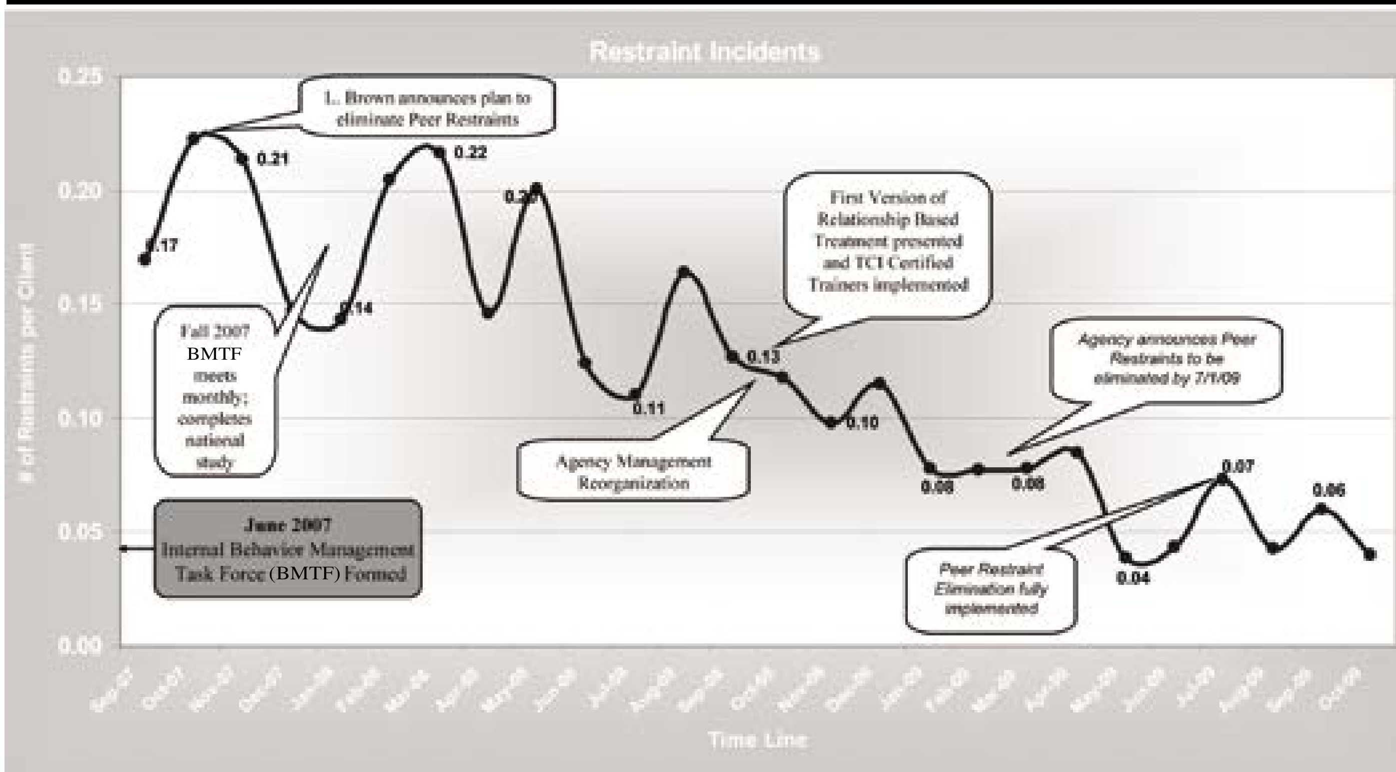
Holy Cross Children's Services: Restraint Incidents

Actual Client Restraint Numbers:

High = 326 January 2007

Low = 31 October 2008



***Loren P. Brown** was appointed Executive Director of Holy Cross Children's Services in January 2007. He was the agency's Chief Financial Officer between 1994 and 2006. Mr. Brown worked in government and non-profit social services before coming to Holy Cross. He holds a BBA from the University of Toledo and an MBA from the University of Notre Dame. The parent of a teenage daughter and a son in college, he brought a perspective of critical analysis and parenting to the position. He did not personally agree with the philosophy and practice of peer restraint and its use as a tool for peer culture and group work.*

***Gary Tester** is the Director of Advocacy and Government Relations at Holy Cross.*

The Two Crabs

One fine day two Crabs came out from their home to take a stroll on the sand. "Child," said the mother, "you are walking very ungracefully. You should accustom yourself to walking straight forward without twisting from side to side."

"Please, mother," said the young one, "do but set the example yourself, and I will follow you."

Example is the best precept.

—AESOP's Fables

Finding Direction Through CARE

by Bill Martin

Alice came to a fork in the road.
"Which way do I take?" She asked.
"Where do you want to go?" responded the Cheshire cat.
"I don't know," Alice answered.
"Then," said the cat, "it doesn't matter."
—Lewis Carroll, *Alice in Wonderland*

This quote sums up where our agency was a year ago, and is the opening thought in the presentation of the CARE (Children and Residential Experiences: Creating Conditions for Change) principles in the new curriculum by Cornell University.

Although you might not think it from our name, Waterford Country School offers many levels of congregate care including residential treatment, emergency shelters, group homes, and therapeutic foster care. With a staff of 300, we provide a dozen different programs in five sites across Eastern Connecticut. Over the years we put together a strong staff team, with most of the managers having worked together for more than ten years. In the mid 90's we discovered and embraced the principles of the TCI curriculum across all programs. It helped us reconcile our crisis/safety interventions with the children with our focus on the importance of a supportive, relational approach.

What we still lacked, however, was a milieu model that would pull all things together. We studied trauma programs, looked at many evidenced-based models, looked at many promising therapeutic approaches and were still unsettled in an overall approach.

Then came CARE. This was the first thoughtful collection of the best research available on what makes children in placement successful. It is packaged in the same training-friendly style as TCI and, when we got a look at a draft, seemed to be what we were looking for.

As fate would have it, we received an opportunity to bring CARE to Waterford Country School and, in January of 2009, 25 of our leadership staff were trained by Martha Holden, Tom Endres, and Jack Holden from Cornell University. Although committed to the concepts and to the Cornell team, we were not an "easy sell" in the new model. With each unit, we had to work through some old paradigms that had served as our guide for years. Martha was tenacious in her commitment to the material and worked us through it until we emerged, after five days, equally committed to the material.

We learned about the importance of shifting rules to expectations, moving from control to order, being flexible in our expectations, and shifting from consistency across children to consistency within children…and that was only day one. The material was very thought provoking and the discussions lively, but at no time were we able to contest the merit of the material. Over the five days, we started to change the way we looked at things with some new vocabulary and lots of new information, nicely pulling together what we already knew and were committed to. What we got was the framework we were looking for. CARE nicely organized all that we felt was important in our work and added lots for us to think about.

Three months later the Cornell team trained 19 of the original group to be trainers who then divided into three training teams and have, to date, trained almost 200 staff. We expect all staff to be trained by early 2010. Concurrent to this training is the release of the new "CARE-infused" TCI-6th Edition. We plan to roll this out in the first quarter of 2010 which should be a great complement to the CARE material, nicely pulling it all together.

We recognize that training is only the first step in the theory of change related to CARE. In October of this year, we convened a retreat with 70 of our key program staff to kick off the implementation phase. Each program met independently and crafted their initial approaches to how they will bring the CARE principles into their programs. The presentations by each program at the end of the retreat were inspiring in the level of commitment to the material and the scope of changes planned. Each of the dozens of ideas presented all made perfect sense and would serve to make our programs better for the youth we serve. I think that is the beauty of CARE—it just makes sense.

Through the thoughtful work of Martha Holden and her staff, our agency now has the direction that it has sought for so long. CARE is our framework for treatment and our guide for providing the highest level of services for our youth and their families. We are looking forward to the next few years and the promise that this curriculum brings. ✷

Bill Martin, MS, is the Assistant Executive Director at Waterford Country School, a Professional TCI Trainer, and a CARE Trainer.

CARE (Children and Residential Experiences: Creating Conditions for Change) *written by Martha J. Holden, published by the Child Welfare League of America, Washington, DC, will be released in January 2010.*

A Supervisory Component to CARE

by Floyd Alwon, EdD

The task of ensuring staff consistency was seen by several agency managers to be an important responsibility of the home supervisor and a pronounced lack of consistency between a manager and a supervisor in one setting was seen to result in negative attitudes and a lowered quality of work of the supervisor and also the staff members.

—Jim Anglin, *Pain, Normality and the Struggle for Congruence: Reinterpreting Residential Care of Children and Youth, page 64.*

Supervisors play a critical role in maintaining organizational stability especially given the high turnover rates among direct care staff in most agencies. It is also understood that supervisors and other middle managers do not typically receive adequate, if any, preparation or training for their stressful roles.

From the early stages of the development of CARE, it became clear that special efforts would be needed to support supervisors in their implementation of the CARE principles. This need is even more heightened in agencies that experience CARE as a significant change from their prior treatment philosophy, for example, those that had previously relied on a complex point and level system as the primary basis for behavioral management.

The RCCP has begun to develop better ways to support supervisors. At one large agency in New York State, all the supervisors and assistant supervisors participated in a six-hour curriculum designed to enhance their skills in implementing CARE. These supervisors had already participated in the five-day basic CARE training. They also had several months experience wrestling with the issues that accompany organizational transformation.

The curriculum for the supervisors consisted of several activities designed to encourage participants to explore optimal ways to utilize the CARE principles within their individual and group supervisory sessions. A trainer-facilitated case simulation was especially well received. In these case analyses, a participant volunteered to "present" to the class, one student who has created substantial challenges to those who worked with him/her. The facilitator prompted the fish-bowl dialogue by asking a series of questions that addressed the CARE principles.

Jack Holden and Mary Ruberti have been working with me to develop the supervisory initiative. Current plans include field testing this one-day curriculum at several other sites and also offering it to smaller agencies that do not have sufficient numbers of participants to host an internal course. In addition, a group of agency executives recommended bringing together supervisors for periodic meetings to share successes and ongoing challenges. ✷

Floyd Alwon, *EdD, is a RCCP faculty member, a trainer, writer, consultant and avid fly fisher. Dr. Alwon, author of Effective Supervisory Practice, has extensive experience with training supervisors and other middle managers.*

From The Serious Fun Corner by Jack C. Holden

GROUP JUGGLE

This activity involves using some kind of ball to toss (I prefer a koosh ball because it's easy to catch and basically harmless) while participants are in a circle.

Give the following instruction:

1. I will start by gently tossing the ball to someone and saying their name as I toss the ball.
2. The person receiving the ball then tosses to someone else who hasn't received the ball yet, saying the recipient's name as the ball is tossed. (It is important to instruct participants to remember who threw the ball to them and whom in turn they are throwing it to, as well as saying the name of the person each time they are throwing the ball.)
3. The ball continues to be thrown around the group using step 2 until everyone in the group has received and thrown the ball once.
4. Once everyone in the group has received and thrown the ball, repeat the rotation exactly the same way it was done the first time making sure participants call out the name of the person they are throwing to each time. You can speed it up and then try adding more balls to the game (even some fun things like rubber chickens and pigs), always following the same order.

It's a good warm up for fun and learning people's names. ✷

SO: Kerr T. & Straughan (1988). *T.E.A.M. challenge; Facilitator training manual.* Ithaca, NY: Cayuga Nature Center.

Jack Holden is a TCI Instructor from Ithaca, NY and has a PhD in Education, specializing in Adult Learning.

"What If..."

By Rich Heresniak

Over the course of my career, I have had the opportunity to train TCI countless times and to hundreds, if not thousands of people. I have come to many different conclusions about training over the years and chief among them is this: If I had a nickel for every time someone asked a question that began with the words "what if…" or "what do you do when…" I would indeed be a very rich man! With the current trends of increased standards for mandated reporting and more focused scrutiny of the use of high-risk physical interventions, these sorts of questions seem to be increasing in frequency.

As a trainer, my position on such questions has varied over the years. At times, I have struggled to offer very specific and concrete answers to situations about which I had not nearly enough detailed information upon which to make a sound decision. Other times I have simply become annoyed about such "what if" questions—passing them off as nothing more than the musings of a "difficult" trainee. For a variety of reasons, neither tactic is a very sound one.

Fortunately, there is a third option regarding a trainer's response to those difficult and challenging questions that arise in training. It is a response that takes into account the fact that, like the children and young people we work with, our trainees have feelings, needs, and wants that drive and motivate their behavior (and the difficult questions they ask us in training!). Additionally, it is a response that does not give an answer to "what if" questions, but rather promotes a systematic process through which participants can discover possible answers for themselves. It is, in essence, teaching someone to fish, rather than simply handing them a single fish directly.

When someone asks me a "what if" or "what do you do when" question, my first course of action as a trainer is to try to sort out where the question is coming from—in other words, asking myself "What does this participant feel, need, or want?". Are they anxious about how they will handle "real world" situations once they leave the training? Are they one of those experienced staff members who feel uncomfortable with learning new skills that do not fit with their customary ways of thinking? Does this participant feel nervous about the evaluation process at the end of training? Or, are they simply seeking clarification? The possibilities are endless—and I may not even be able to put my finger on the exact answer. And yet the mere act of contemplating the motivations for the "what if" questions accomplishes two important goals. First, it helps to ground my thinking as a trainer and avoid simply getting annoyed with the question. Second, it allows me to make a thoughtful and measured response—one that will hopefully meet the needs of the participant as well as the group as a whole. Once I, as the trainer, am in the correct mindset, I can then begin the next phase—actually responding to the question.

As previously mentioned, it is rare for me to respond with a direct and specific answer to a "what if" question and in many cases I will directly state this to the group. Unless it involves an obvious safety situation (e.g., Q: What if a child starts to turn a dusky purple color during a restraint? A: End the restraint immediately and seek emergency medical attention!), this is almost always impossible to do. Instead, I employ the following "model" which helps me to guide participants toward the discovery of possible answers. Due to the often highly charged nature of crisis events, I use the acronym "ACDC" as a memory aid.

1. Assess—*The situation.* In any crisis situation this is the first task to be accomplished.

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5. Examining the relationship between fidelity measures and expected outcomes for participants—examining scores as they relate to client outcomes.

TCI Approach: *The RCCP evaluators will select the method that appears to most accurately reflect reliability and validity for fidelity of the TCI model. This work is underway and will likely involve a combination of approaches as outlined by Mowbray and colleagues.*

Conclusion

The RCCP is interested in providing a rigorous evaluation of the fidelity for TCI implementation. It is the belief and hypothesis that effective implementation of TCI can reduce numbers of crises, restraints, and injuries to youth and staff provided TCI has been implemented according to the five domains. Once the criteria are established, tested, and piloted, the TCI Fidelity Instrument as well as technical assistance to conduct TCI Fidelity assessments will be available to TCI agencies.

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TCI SAFE continues on page 9.

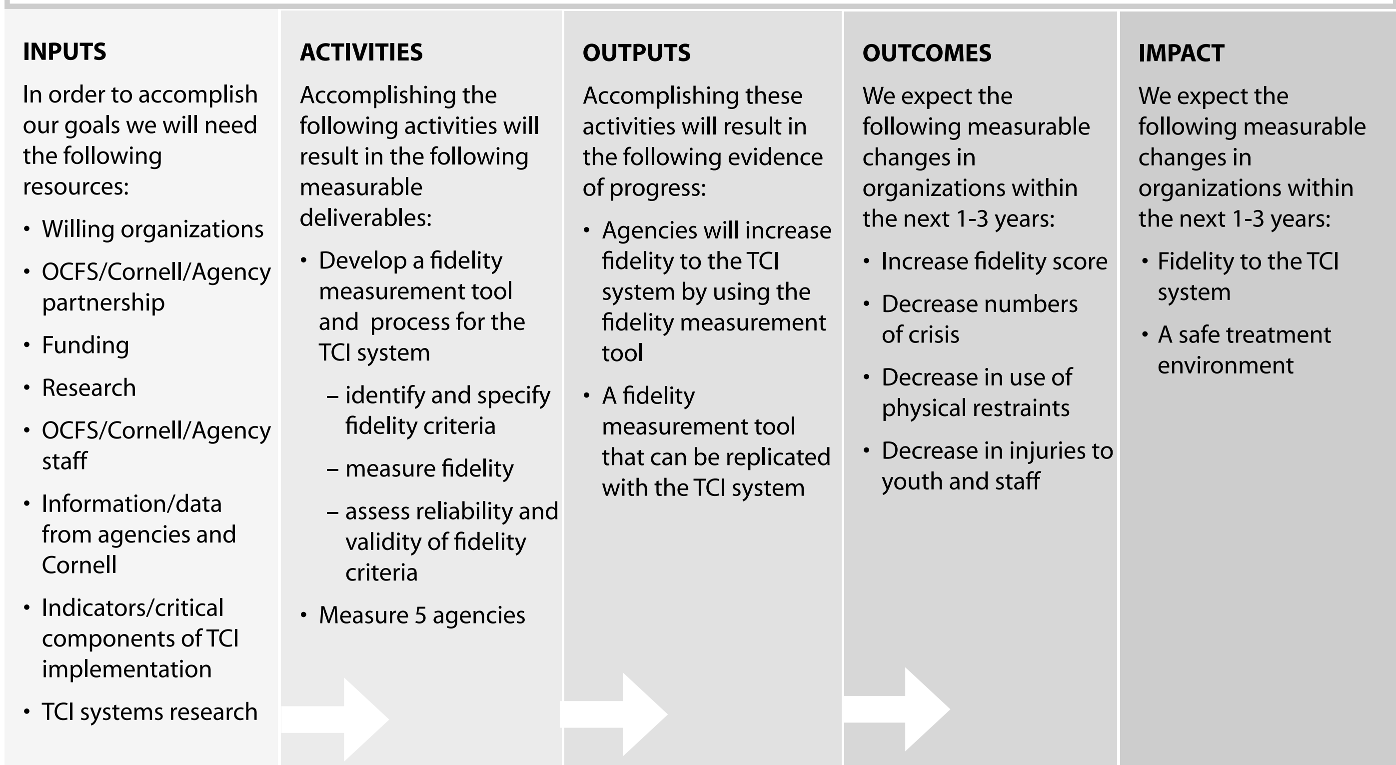
Truth is eternal, knowledge is changeable.
It is disastrous to confuse them.

—Madeleine L'Engle (1918 –)
An Acceptable Time

TCI SAFE: TCI Fidelity Logic Model

Assumptions: If the TCI System is implemented in children's residential centers according to the Cornell University's RCCP "TCI System Implementation Criteria" (Holden et. al, 2009), the results for children's residential centers will include fewer crises, physical restraints, injuries to children and staff, and safer environments in which to provide treatment to youth in care.

Goal(s): To provide children's residential centers, Cornell University's RCCP, and the field with "a structure and process to measure the fidelity" (Mowbray et al., 2003) to the TCI System implementation.



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***Jack C. Holden**, PhD, is a TCI Instructor from Ithaca, NY and specializes in adult learning.*

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

***Joanna Garbarino Novakovic**, BS, is a Research Assistant with the RCCP.*

***Lisa McCabe**, PhD, is a Research Associate in the FLDC at Cornell University.*

Change happens by listening and then starting a dialogue with the people who are doing something you don't believe is right.

—Jane Goodall (1934 –)

What If..., continued from p. 8.

– Risk: What is the level of risk in this situation? Is the child or someone else at any risk of harm? If so, to what degree? How imminent is the risk? Is there a high likelihood of serious injury that can be predicted from the child's history (frequency, patterns of behavior)?

– Other Factors: What am I feeling now? What does the child feel, need, or want? How is the environment affecting the situation? Do I have a relationship with this child? What other resources are available?

***2. Consider**—Any factors that will help guide our decision making.*

– Are there any agency policies that direct a specific course of action under the circumstances?

– What knowledge and skills have I learned in training and through my experiences?

– What does the child's ICMP say? Does it offer guidance as to how I should respond?

***3. Develop**—A list of possible options and gauge the potential ramifications of each.*

– What are my options? Have I considered all of the possibilities? Am I missing anything as far as potential choices in this situation?

***4. Choose**—A strategy and respond.*

– What is the safest and most effective strategy I could use to intervene? Would it increase or decrease the child's level of arousal? Would it decrease the risk in this situation? Are there any other strategies that might be more effective?

Of obvious importance is the fact that the process I have outlined is a continual cycle that does not end until the crisis has been de-escalated. After choosing a strategy and responding, the effectiveness of the response must be evaluated through another assessment, consideration of decision-making aids, development of further options, followed by the choosing of an appropriate response. And so on…

Though this can be a useful tool, I would offer just a couple of cautions. First, I would hesitate to spend a great deal of time "teaching" this process as an actual training activity—particularly in an initial TCI training that involves so many other learning objectives that need to be met. Second, you will certainly need to be cautious with time management. I usually find it helpful to use this strategy for a few of those "what if" questions, and then as others arise, I will simply refer to the process previously used.

Based on my own experiences, I have found this to be a consistent and helpful way to deal with those "what if" questions that inevitably come up in TCI training. No, it does not always give the black and white answers that our participants sometimes desire, but minimally it offers guidelines that our trainees can possibly employ in difficult situations, as well as a framework around which we, as trainers, can mold our responses to "What do you do when…" ✷

***Rich Heresniak** is a Crisis Prevention and Management Specialist at Astor Home in New York and a TCI instructor.*

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

Ask Eugene

Q. *I am calling because I received a letter from Martha Holden saying I need to get re-certified. Can you tell me when and where the re-certification trainings are?*

A. Please go to our web site at http://rccp.cornell.edu. There are too many offerings for RCCP staff to be able to go over the entire schedule with everyone who calls asking about updates. Everything you need is available on the site, including schedules and applications for training. Remember, to get re-certified you must successfully complete a TCI update.

Q. *I am a TCI trainer and I have to do refreshers for our staff. How many hours are refresher trainings?*

A. Staff who are trained in TCI are required to complete a minimum of 12 hours of TCI refreshers per year. We recommend that refreshers be delivered quarterly, but staff must attend refreshers at least every six months and be retested in the physical skills, and be re-tested annually with a written test.

Q. *I need a copy of the TCI student workbook electronically. Can you email that to me?*

A. We are unable to provide any written TCI materials, such as the activity guide, reference guide, and student workbook in any kind of electronic form. If you need copies of the student workbook, they are available to purchase. The order form is in the back of your trainer's binder and on our website. TCI trainers can also make photocopies of the student workbooks as needed. ✷

From the Instructor's Booth

The RCCP is pleased to announce our newest TCI Instructors:

Floyd Alwon, EdD, has worked as a direct care worker and supervisor, a live-in house parent and director of child care and associate executive director under his mentor, Dr. Albert E. Trieschman, founder of the Walker Home and School in Needham, Massachusetts. In 1986, Dr. Alwon was the first director of the Albert E. Trieschman Center. In 1998, the Trieschman Center became a division of the Child Welfare League of America (CWLA). At CWLA, Dr. Alwon was responsible for professional development and field consultation activities, and developed CWLA's workforce initiative, helping public and private organizations enhance the competence of their workforce and supporting communities and systems in their efforts to improve practice. In April 2009, Alwon launched a consultation and training service professionally affiliated with nationally renowned individuals and organizations. Dr. Alwon has substantial experience as a trainer, consultant, administrator, writer, and teacher. Dr. Alwon and his wife have been married for more than 35 years and have two daughters who teach special education. Dr. Alwon is an avid fly fisher and a mediocre tenor saxophone player.

Marty Mineroff, MS, has an extensive background in education. He retired from the New York City Department of Education in June 2008, after 29 years working with special needs students in Brooklyn, NY. He began his career as a special education teacher, became a unit coordinator, an assistant principal, and finally spent 14 years as principal of a special education school. His school in Brooklyn, NY, provided educational services for 300 students in three community schools, grades K-8. Marty became a certified TCI Instructor in May 2009 and is assisting the RCCP in implementing TCI in schools as well as training TCI. Marty still resides in Brooklyn, NY.

Professional Certification Announcements

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

Stephanie Guthman, PhD. Dr. Guthman was born and raised on Long Island, NY. Her professional experience has included clinical interventions with children and families, the administration of psycho-educational and systemic assessments in diverse settings, and work as a consulting school psychologist. Since 1999, the island of Bermuda has been her home. She currently serves as the Director of Specialized Training and Assessment at The Family Centre in Bermuda and for three years prior served as their Director of Clinical Services. Stephanie works collaboratively with local organizations and government agencies on community projects to create systemic change and is committed to making a difference in the lives of at-risk children and families. She views change as a positive opportunity for growth and along with her co-workers has successfully provided specialized programs and prevention initiatives resulting in increased family stability and improved family functioning for hundreds of families. Stephanie also holds a Master's Degree in Human and Organizational Systems and has been a TCI trainer since 2006. She attained her professional Trainer certification in the Fall of 2009.

Siobhan Henry, BSW. In 2001 after receiving a BSW from Saint Anselm College in Manchester, NH, Siobhan supervised a group home in Texas for children age birth to six with serious medical and emotional problems. Since returning to Massachusetts, she has been at The Home for Little Wanderers, a social service agency serving children and families in and around Boston. She has served as a direct care counselor for latency age children with severe behavioral problems and mental illnesses and as the Activities Coordinator providing a full range of activities including art, music, dance, recreation, leisure-time, and community trips. She developed

Professional Certification Announcements, continued

and implemented weekly curriculum for the clients in Life Skills, Teamwork, Social Skills, Self Expression, and Emotion Regulation. In June 2006, Siobhan began working as the Training Specialist for the agency, conducting New Employee Orientations and initial and refresher trainings for all agency employees in Therapeutic Crisis Intervention, CPR, First Aid, and Boundaries. She has been a TCI trainer since November 2005 and received her Professional Certification in October 2009. Siobhan can be contacted at shenry@thehome.org.

Steve Jeffers. Steve graduated from Ball State University, Muncie, IN, with a bachelor's degree in psychology. He has worked with youth for over 26 years in a variety of different settings. Steve has been employed by the Youth Opportunity Center, a Residential Treatment facility in Muncie, IN, since March of 1999. For the past 10 years Steve has worked as a Childcare Specialist in a boy's Translife Cottage, was a Team Leader in a secure unit, and currently serves as the Training Coordinator. Steve has been training TCI since October of 2002 and is very passionate about sharing the skills and knowledge of TCI with others. Steve is also a CPR/First Aid instructor with the Red Cross, a Certified Training Consultant, and a Foster, Adoption, and Kinship Care trainer for the State of Indiana.

Mary M. Roach has over 30 years experience working in out-of-home care settings for children and adolescents in a variety of roles that include direct care, supervisory, and training positions. Mary has been at The Buckeye Ranch, in Grove City, OH for the last 26 years and in her current role as Staff Development Coordinator since 1987. She is responsible for the coordination and delivery of initial and on-going training for professional, paraprofessional, and support staff in the areas of Orientation, Therapeutic Crisis Intervention, Trauma Sensitive Care, Behavior Support, Post Crisis Response/Debriefing processes, Client's Rights, and Relationship Boundaries. Mary has been a certified trainer in Therapeutic Crisis Intervention and TCI for Family Care Providers for over 20 years. In addition to her work at The Buckeye Ranch, she provides training on a contract basis for community based, residential, and family care providers through the Ohio Child Welfare Training Program and has presented workshops at local, state and national conferences. Mary can be contacted at: mmroach11@aol.com or Mary.Roach@buckeyeranch.org or by phone at (614)539-6494.

Laurence Stanton-Greenwood PGCE, CSS, BA Hons, CIPD, has worked in special education and care for 29 years with a range of young people and adults with complex needs including autism, communication difficulties and severe challenging behaviours. His roles have ranged from Residential Social Worker to Team Manager to Unit Coordinator. He has developed Post 16 vocational education to provide educational and vocational experiences including work, life, social, and occupational skills. Laurence was also an inclusion manager and learning consultant at a mainstream UK college enhancing teaching skills for more successful learning for students. Presently, Laurence is working in a specialist education and care provision, coordinating, providing, and developing learning activities and competency assessment for staff. His interest areas include the use of Augmentative Communication systems supporting those who are limited or cannot communicate vocally/verbally; support and management of challenging behaviours; individual and person centred planning; and development of staff skills, knowledge, attitudes and values to meet the needs of those with special needs. Laurence has been involved with TCI since 1996 and can be contacted at +447910962581 or laurencesg@msn.com ✷

Frequently Asked Questions

By Martha Holden

In the last few years, there have been many changes in national policy, state and licensing regulations, accreditation guidelines and funding requirements that regulate residential care for children. As a result, 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 systems. 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 certifying staff members, recertification, testing, 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 the TCI System, a crisis prevention and management 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 and procedures on training and certifying staff, as well as 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 individual staff members are qualified to apply restrictive interventions and when these 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 adopt 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.

Our agency has a policy that all staff must be fully certified in TCI. What happens if a staff member has a BMI over 35? Can they participate in the training?

Our physical fitness guidelines include BMI but we list several other contributing factors that make up someone's fitness level. Essentially what we are doing is asking people registering for training to follow our fitness guidelines which include considering their BMI when they decide at what level (Certification 1, 2, or 3) they wish to participate. There is a list on our application of different physical factors to consider including waist size, medical and physical conditions, level of physical activity, etc., to determine overall fitness. BMI is only one factor to be used to determine physical fitness.

We are suggesting that there are limits to what people who are grossly unfit (including obesity) can do without increasing the risk of injury to themselves, other participants, as well as the child. In order to be certified for all the restraint techniques, they must be able to do a restraint without putting weight on the "child" and they must be agile and enough in control of their own body mass to not drop or fall on the child during the takedown. If someone is physically fit, can perform the restraints without placing weight on the child, especially during resistance, and is flexible and agile, they will most likely be able to perform the physical test without safety violations and therefore, be certified.

We are hoping that people can self-select the level of participation that is right for them and will not place others at risk. If we have concerns at the training, we will speak to the person in private at some point to discuss options. If they are obviously injured, unfit, or pregnant and are insisting on participating, we can request a doctor's release. Essentially the final decision if they are certified at level 3 is made during testing—can they demonstrate the restraints properly, safely and precisely? So, we will allow people to practice and test out if we do not see any immediate safety issues. If they cannot meet our standard during the testing process, they will not be certified in the physical component.

At an agency level, the guidelines may need to more restrictive since people will need to be able to conduct restraints in a violent situation. BMI is important, but there are many equally important factors to consider. Agility and balance

FAQ, continues on page 15.

Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have the potential to turn a life around.
—Leo Buscaglia

TCI Bookshelf

A Review of *Children and Residential Experiences: Creating Conditions for Change*
by Martha J. Holden

Reviewed By Jim Anglin, PhD

Welcome to the CARE program model.

The CARE program model represents a new approach and a new generation of training for residential child and youth care work. The Residential Child Care Project at Cornell University has long been a leader in child and youth care training, and in this model, the Project has brought together in a unified manner the best practices derived from the work and wisdom of the field's top practitioners with the latest knowledge and frameworks derived from residential care research.

Initial feedback from agencies utilizing this approach indicates that it is both challenging and liberating. It is challenging because it places prime importance on the practitioner's ability to be self-aware, reflective, and truly responsive—not just reactive. It is liberating as it frees the worker to help to heal the pain and trauma at the heart of young peoples' experiences, rather than directing them to focus on controlling behavior.

The sub-title of this text, "creating the conditions for change" emphasizes both the need for enhancing young people's development and the fact that young people are always "in charge" of their own behavior. Our job as child and youth care practitioners in residential care is to create an environment conducive to growth and to respond therapeutically to the situations and struggles of the residents and their families.

But make no mistake—this is tough work that requires rigorous training and ongoing supervision of the highest order; thus the need for a powerful, integrated and well-grounded model for understanding and addressing residential life and residential child and youth care practice. But the lives of the young people, and their futures, are worth the struggle and they deserve our very best efforts.

Finally, research has demonstrated that effective residential care practice requires the commitment and active participation of the entire residential agency and system. It must be a system that is congruent with the responsive carework needed by the young people themselves. At each level of the organization, and across all levels of the system, the core principles and effective interactional dynamics that comprise the foundation of this approach need to be modeled and practiced. Any agency taking on a commitment to implement this CARE program model is to be applauded and encouraged.

I am confident that this book will prove to be a rich resource for managers, trainers and workers alike, and that the quality of residential care in agencies utilizing this material in a conscious and disciplined way will be significantly enhanced. ✷

Jim Anglin, PhD, is a Professor at the School of Child and Youth Care in the University of Victoria, BC, Canada.

Holden, M. (2010) Children and Residential Experiences [CARE]: Creating Conditions for Change. Washington, DC: CWLA.

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, PhD 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/

New RCCP Staff

Debra M. Hover manages the logistics for hotels/sites for our training programs. She packs and ships training materials for the 200+ training programs conducted annually.

Debra M. Hover

Trudy Radcliffe, B.A., is the primary contact person for CARE and coordinates CARE training, registration, evaluation, and logistics. She also assists with the processing of testing materials for TCI trainings. She has worked in the human service field for over 25 years. Before coming to RCCP she worked with children, families and educators in the early childhood education field teaching, mentoring, and consulting. She has presented at both state and national conferences on program and curriculum development, and is delighted to continue advocating for children and families with RCCP. ✷

Trudy Radcliffe

The Lion and The Mouse

Once when a Lion was asleep a little Mouse began running up and down upon him; this soon wakened the Lion, who placed his huge paw upon him, and opened his big jaws to swallow him. "Pardon, O King," cried the little Mouse: "forgive me this time, I shall never forget it: who knows but what I may be able to do you a turn some of these days?" The Lion was so tickled at the idea of the Mouse being able to help him, that he lifted up his paw and let him go. Some time after the Lion was caught in a trap, and the hunters who desired to carry him alive to the King, tied him to a tree while they went in search of a wagon to carry him on. Just then the little Mouse happened to pass by, and seeing the sad plight in which the Lion was, went up to him and soon gnawed away the ropes that bound the King of the Beasts. "Was I not right?" said the little Mouse.
Little friends may prove great friends.

—AESOP's Fables

FAQ, continued from p. 13.

would be two as well as capability to sustain a high level of physical exertion. Heart and joint conditions would be extremely important physical and medical criteria. We are certifying adults to train adults, agencies are certifying people to restrain children; agencies have a higher level of risk.

Once agencies take the position that all direct care staff must be certified to apply physical restraints, TCI trainers find themselves in very difficult positions as they might be under pressure to certify people they would not certify without that policy. Since people's jobs are at stake, trainers will need a lot of support from administration to adhere to the policy. It becomes an ethical and liability question for the trainers. It is unfortunate that agencies are in a position where they can only hire people who can restrain children. It is just as important, if not more important, to hire people who are able to build relationships and use good verbal skills.

Before agencies adopt these types of policies, there needs to be clear job descriptions and guidelines for hiring staff in regard to their physical and medical condition. If an agency has employed staff previously that cannot complete the physical portion of TCI, it might be worth looking at how necessary it is to have everyone certified at level 3.

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

We recommend quarterly refreshers of about 3-4 hours but the minimum requirement to maintain the TCI system is 6 hours every 6 months. There is an entire TCI update, *Designing Refresher Training*, devoted to delivering effective and agency relevant refresher courses. In addition, there are suggestions for refresher trainings in the core *TCI Activity Guide* in the Introduction section. Agencies should develop policies that mandate how many hours of training staff must receive annually in order to maintain employment. This should include specific requirements for TCI refresher training. Staff should also be tested at each refresher in the physical techniques (if they are certified at level 2 or 3) and at least annually with a written test for recertification purposes. If staff members do not successfully complete refreshers, they should not maintain their certification in TCI. ✷

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

RESIDENTIAL CHILD CARE PROJECT
FLDC • Cornell University
Beebe Hall
Ithaca, New York 14853

TCI USA 2010 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT)

Feb. 8-12/10 .... San Diego, CA
Feb. 22-26/10 .... Pittsburgh, PA
Mar. 8-12/10 .... Denver, CO
Mar. 22-26/10 .... Peoria, IL
Apr. 19-23/10 .... Cincinnati, OH
May 17-21/10 .... Warwick, RI
Jun. 7-11/10 .... Atlantic Beach, NC
Jul. 21-25/10 .... Ithaca, NY
Jul. 12-16/10 .... Baltimore, MD
Jul. 26-30/10 .... Pittsburgh, PA
Aug. 9-13/10 .... Ithaca, NY
Sep. 20-24/10 .... Sacramento, CA
Sep. 27-Oct. 10/10 .... Peoria, IL
Oct. 18-22/10 .... Atlantic Beach, NC
Nov. 1-5/10 .... Mesa, AZ
Nov. 15-19/10 .... Warwick, RI
Dec. 6-10/10 .... Ithaca, NY

TCI UPDATES

Developing Professional Level TCI Training Skills
Aug. 4-5/10 .... Ithaca, NY

TCI Curriculum Revisions, Edt. 6
Mar. 1-2/10 .... Pittsburgh, PA
Mar. 4-5/10 .... Denver, CO
Mar. 18-19/10 .... Peoria, IL
Apr. 15-16/10 .... Cincinnati, OH
May 13-14/10 .... Warwick, RI
Jul. 3-4/10 .... Atlantic Beach, NC
Jul. 22-23/10 .... Pittsburgh, PA
Aug. 2-3/10 .... Ithaca, NY
Aug. 25-26/10 .... Ithaca, NY
Sep. 16-17/10 .... Sacramento, CA
Sep. 23-24/10 .... Peoria, IL
Oct. 14-15/10 .... Atlantic Beach, NC
Oct. 28-29/10 .... Mesa, AZ
Nov. 9-10/10 .... Warwick, RI
Dec. 2-3/10 .... Ithaca, NY

TCI CANADA 2010 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT)

Jan. 25-29/10 .... Toronto, Canada
Jun. 7-11/10 .... Toronto, Canada

TCI UPDATES

TCI Curriculum Revisions, Edt. 6
Nov. 9-10/10 .... Toronto, Canada

TCI EUROPE 2010 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT)

Mar. 1-5/10 .... Glasgow, Scotland
May 17-21/10 .... Glasgow, Scotland
Jul. 5-9/10 .... Dublin, Ireland
Sep. 27-Oct. 1/10 .... Doncaster, UK
Dec. 6-10/10 .... Dublin, Ireland

TCI FOR FAMILY CARE PROVIDERS TRAINING OF TRAINERS (TXT)

Oct. 4-8/10 .... Dublin, Ireland

TCI UPDATES

Developing Professional Level Training Skills
Apr. 19-20/10 .... Glasgow, Scotland

TCI for Developmental Disabilities
Apr. 22-23/10 .... Penrith, UK

TCI For Family Care Providers
Apr. 27-28/10 .... Bournemouth, UK

Designing Refresher Training
Mar. 10-11/10 .... Dublin, Ireland
May 24-25/10 .... Glasgow, Scotland
Jun. 28-29/10 .... Dublin, Ireland
Sep. 14-15/10 .... Stevenage, UK
Oct. 27-28/10 .... Glasgow, Scotland
Dec. 2-3/10 .... Dublin, Ireland

Post Crisis Response
Mar. 8-9/10 .... Dublin, Ireland
May 26-27/10 .... Glasgow, Scotland
Sep. 21-22/10 .... Dublin, Ireland
Oct. 11-12/10 .... Doncaster, UK
Oct. 25-26/10 .... Glasgow, Scotland

TCI Curriculum Revisions, Edt. 6
Feb. 3-4/10 .... Glasgow, Scotland
Feb. 16-17/10 .... Dublin, Ireland
Jun. 21-22/10 .... Glasgow, Scotland

ONE DAY UPDATES*

One Day: Life Space Interview for Proactive Aggression
May 11/10 .... Dublin, Ireland
Sep. 13/10 .... Stevenage, UK
Nov. 15/10 .... Dublin, Ireland

One Day: Conflict Resolution
Mar. 19/10 .... Dublin, Ireland
Sep. 9/10 .... Penrith, UK

One Day: Testing, Evaluation, and the Transfer of Learning
Apr. 21/10 .... Glasgow, Scotland
Apr 29/10 .... Bournemouth, UK
May 10/10 .... Dublin, Ireland
May 28/10 .... Glasgow, Scotland
Jun. 7/10 .... Belfast, N. Ireland
Jun. 23/10 .... Glasgow, Scotland
Jun. 30/10 .... Dublin, Ireland
Sep. 10/10 .... Penrith, UK
Nov. 16/10 .... Dublin, Ireland
Dec. 1/10 .... Belfast, N. Ireland

***Note:** ONE-day updates are ONLY available to TCI trainers who have successfully completed TWO, two-day updates, preferably Designing Refresher Training and Post Crisis Response.*

PLEASE CONSULT THE RCCP WEBSITE FOR UPDATES TO THIS SCHEDULE: rccp.cornell.edu