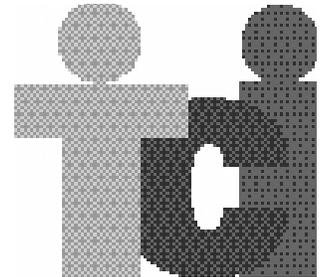


# REFOCUS

CORNELL UNIVERSITY'S RESIDENTIAL CHILD CARE PROJECT NEWSLETTER • VOL. 7, 2002

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## TCI Revision: Frequenty Asked Questions

by Martha Holden, MS

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In April of 2001, the Residential Child Care Project introduced its 5<sup>th</sup> edition of the Therapeutic Crisis Intervention curriculum. This latest revision of TCI, a crisis prevention and management system, was the result of more than two years of research and evaluation, field surveys, implementation studies, trainer and agency input, and focus groups. This information was elicited from child caring organizations and professionals from around the world. Concurrently, there have been many changes in national policy, state and licensing regulations, accreditation guidelines and funding requirements. These new requirements were also taken into consideration during the revision process.

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Since April of 2001, we have had in excess of 1500 participants attend TCI updates and training of trainers courses. We are also providing our full implementation program and technical assistance to over 30 agencies and/or organizations throughout North America, the United Kingdom and Ireland. During our training programs and delivery of technical assistance, many participants and organizations have asked similar questions. The following is a brief discussion of the most commonly asked questions with our response.

### Policy vs. Best Practice?

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Most of the questions we are asked center around what TCI is recommending and what is policy. These questions are often about certifying agency staff, use of Individual Crisis Management Plans (ICMP's), use of physical restraints, etc. The most important issue here is to understand the difference between regulation, policy and best practice guidelines.

### State or Licensing Regulations?

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Regulations are rules set down by licensing or governing agencies and funding agencies, such as Departments of Social Services, Mental Health, Education and Medicaid. These agencies license facilities or reimburse agencies for services and require them to follow their regulations in order to maintain their license or continue receiving reimbursement.

### Agency Policy and Procedures?

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Policies are developed by agencies and reflect the specific rules and procedures that the agency must follow to meet their own practice standards.

### Accreditation Standards?

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Accrediting organizations such as the Commission on Accreditation and Joint Commission on Accreditation of Health Care Organizations also have sets of standards that agencies must meet if they wish to receive accreditation by that organization.

### Best Practice Guidelines?

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Best practice guidelines are recommendations for agencies to follow in order to provide the best services to their clients.

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TCI has been developed to promote the best practice guidelines that we know to date. We are recommending a system and training that adheres to what we feel (and have some evidence to back up) is best practice. We cannot set policy for agencies. Agencies are required to follow the regulations that govern their operation. They must develop their own policies and procedures on crisis management, training, testing and certifying staff.

### Physical Management

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The latest revision of TCI has resulted in many questions about the use of physical management. TCI does not promote the use of physical management for program compliance or for expediency and control. In the TCI system, physical intervention techniques are used only when there is a safety concern and the physical techniques have been assessed

"The universe is change; our life is what our thoughts make it."

Marcus Aurelius Antonius (Roman Emperor  
(121 AD - 180 AD) in *Meditations*)

TCI Revision, Cont. from page 1.

to be the least risky intervention at that moment. This safety assessment is made based on agency policy and state regulation, previous assessment of the client and what is the most appropriate and safest intervention, and the professional judgment of the trained staff member intervening.

### Escorts

----- Frequently asked questions about physical management include use of escorting techniques. In 1991, TCI discontinued teaching a specific physical technique for escorting clients. This was based on surveys and analysis of crisis events which showed that the vast majority of escorts resulted in physical restraint. A noncompliant client would have a choice to leave the area or be escorted. Once in an escort the client would escalate to physically aggressive behavior and be restrained. Instead of de-escalating the client by removing them from the area, the escort would escalate the client. Having the opposite of the intended effect, escorts were dropped as a physical management technique.

----- "The Children's Health Act 2000 (United States) defines physical restraint as: *The application of physical force by one or more individuals that reduces, restricts or immobilizes the ability of an individual to move his/her arms, legs, or head fully.* The Children's Health Act 2000 (United States) defines physical escort as: *The temporary touching or holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a resident who is acting out to walk to a safe location.*

----- These definitions can be interpreted to mean that once the individual is restricted from freedom of movement, the action falls under the definition of physical restraint. In our opinion, the use of escorting, i.e., temporarily touching or holding, as a supportive intervention strategy does not require restrictive physical techniques. A touch on the arm or hand to encourage a

young person to leave an area can be effective if the young person is still responsive and has a relationship with the adult. This does not require special physical techniques but training in assessing the emotional status of the young person, an understanding of the use of behavior management techniques and a good relationship with the young person.

----- The issue of touching in order to manage behavior is addressed in the TCI material covering behavior management techniques and in the material addressing the management of noncompliant behavior. Basically, when we discuss the use of touch in the training, we speak of it in terms of placing a hand on someone's arm or, particularly with small children or developmentally delayed children, holding their hand. There is no physical technique to be taught here.

----- During role plays on behavior management techniques, many people use a hand on the arm or shoulder to encourage or induce a young person to head off for bed or to school, etc. This could be seen as the TCI technique of escorting but is not identified as such because of the confusion in the field over the use of escorting techniques, many of which are restrictive and coercive.

### Removals

----- In the 1991 revised edition of TCI, we included techniques called removals. Based on our surveys prior to this revision, practitioners identified situations in which a young person was presenting a safety risk and required a safety intervention but was in an area that was hazardous, i.e., stones on the ground, broken glass, too much furniture. To address that situation, we developed a technique called a removal that allowed staff to initiate a secure hold, move that young person a few feet and then continue into a physical restraint technique. The removal was essentially the first step of the physical restraint.

----- In our surveys

and critical incident analysis for the 2001 revision, it was discovered that removals were being used to force compliance with staff directives such as "Leave this area" or "Go to time out" and not for safety reasons. To address this misuse of the technique, these techniques are now included in the physical restraint training activities as part of the physical restraint.

### Single Person Restraint

----- There are many concerns and questions about the discontinued training of the single person restraint techniques. The rationale for this change is discussed in a separate article on page 5 of the Refocus.

### Training and Practicing the Physical Techniques with Resistance

While working with agencies involved in our implementation program, we heard several times how uncomfortable staff members are initially with the physical techniques when they are in the milieu. When we asked how the staff members were doing in the training when they practiced with resistance we were informed they were not doing resistance in their training. In some agencies this is because of an agency policy, in others it was due to a shortage of time or the TCI trainers reluctance to monitor this practice. This presents a problem for staff members being able to correctly apply the techniques in a real situation.

We strongly recommend that the participants practice with resistance during the training. Practicing with resistance is outlined in the Activity Guide in Activity 30, page A150, Step 7. Throughout the Activity Guide it is mentioned to tell participants not to offer resistance until the trainer decides it is time. The trainer must wait until participants can conduct the steps correctly and quickly. At that time the trainer should introduce the practice with resistance and follow the guidelines outlined in the Activity Guide. Without a realistic picture of what restraint is really



TCI Revision, Cont. from page 2.

like, people are more likely to get hurt and/or be unsuccessful. If your agency allows it, conduct a practice session with planned and reasonable resistance.

### Testing and Certifying Agency Staff Members

This is an important area for agency implementation and we discuss it at length in a separate article on page 10 in the Refocus. Although we make recommendations about testing and certifying staff, your agency should decide what the standards are and should develop policies reflecting those standards.

### Transitioning to the Revised TCI Model

We recommend that the agency develop a plan to transition into the revised TCI system. Previously trained TCI trainers who have not yet been certified in the revised course cannot present the revised course. TCI agencies need to plan how to get their TCI trainers through the Update for the revised course as well as how to retrain their staff. Very large agencies may want to retrain staff and implement the changes unit by unit. Smaller agencies may be able to transition quickly and all at once. We do not have a deadline for this transition although we recommend that once the TCI trainers have been certified, they begin training as soon as possible so that they do not have to relearn the changes months later.

There is a grandfather period until April 2003 for TCI trainers registered prior to 2001 to attend an update and apply for certification in the revised TCI. After April 2003, they will have to attend a full Training of Trainers to receive the revision and apply for certification.

### Assessing the Agency's Current Implementation of TCI

If an agency or organization is interested in assistance in implementing the changes

## Professional Certification

As of April 2001, the Residential Child Care Project implemented a 2-tier TCI trainer certification program. This program is designed to develop, maintain and strengthen the standards of performance for individuals who have successfully completed the requirements of the 5-day Therapeutic Crisis Intervention (TCI) Training of Trainers Program. This process affirms our commitment to ensure that TCI is implemented in child caring facilities in a manner that meets the developmental needs of children, and the safety of both children and staff. In order to be eligible to deliver TCI training at their agency, a participant in the 5-day TCI training of trainers must successfully complete the

week, pass written and skills tests and be certified at the first level or associate TCI trainer. As of November 2001 there are approximately 1500 TCI trainers that have received full associate certification status. Since we initiated the certification process there have been many enquiries about applying for the second level, professional certification.

### Eligibility for Professional Certification

After a minimum of one year as an associate TCI trainer (this requirement is waived for TCI trainers who were registered prior to 2001), applicants for professional certification can submit portfolios of their work and attend and successfully complete a TCI update designed for professional certification applicants. As an associate TCI trainer, you must have completed a

## Meet Rich Heresniak: RCCP's First Professionally Certified TCI Trainer

I work at the Astor Home for Children, a 75-bed residential facility for severely emotionally disturbed children, ages 5-13, located in Rhinebeck, NY. I began my career in residential care in 1985 at the ripe old age of 21. After attending St. Lawrence University, I "wandered" into the field, not really certain of what I wanted to do as a career. I began as a Teacher Assistant in the Astor Learning Center. After 2 years, I moved out of the classroom and took on the position of Crisis Intervention Worker for the Learning Center. In addition to that, I also began to work on a part-time basis as a childcare worker in the RTC and RTF units. In 1989, I attended my first 5-day TCI training, and began training for the agency shortly after that. I have been the agency's primary TCI trainer since that time. Currently, I am the Lead Crisis Counselor for the residence, and continue to handle the crisis intervention work for the Learning Center, as well as doing TCI training. Since April of 2001, I along with other TCI trainers, have been busy with a much more active training schedule. The administration has been more than supportive of the new TCI material and training mandates. Since April of 2001, we have held 10 full 5-day TCI trainings. Our goal is to have all staff, both old and new, go through a full 5-day training. So far, we are on schedule to have everyone up to speed on the new material by the early spring of 2002. It's been a difficult task, to encompass all of the changes, but I'm proud of what the agency has been able to achieve in a relatively short period of time. 🍀



"They always say that time changes things, but you actually have to change them yourself."

Andy Warhol, American Artist and Film Maker  
(1928-1987)

Professional Certification, Cont.  
from page 3.

minimum of four direct training programs of a minimum of 24 hours each with the prescribed evaluation instruments, written test, skills checklists that include the LSI and Physical intervention techniques, if applicable. If you are not certified to teach the physical intervention skills, or your organization does not require you to teach them, the direct training programs must be a minimum of 18 hours each.

### Applying for Professional Certification

If you are an Associate TCI trainer and wish to apply for the professional level of certification, two tasks must be completed. 1) You must attend and successfully complete a two day TCI Update program identified as a requirement for professional certification. Successful completion is defined as complete attendance, a passing score on a written test and on skill demonstrations in key TCI competency areas. 2) You must submit a portfolio to the RCCP. It is important to be thorough in the building of your portfolio and exact in your training demonstrations, carefully following the training tips that are included in the reference guide. Mail your portfolio to the Residential Child Care Project after successfully completing your Update training.

### Building a Portfolio

Please see boxed information (opposite column) for instructions.

### The Review Process

Selected members of the certification committee meet quarterly to review portfolios and recommend professional certification. This certification committee is composed of RCCP staff, TCI instructors, and professionally certified TCI trainers. Video tape demonstrations are reviewed using the following criteria:

**Setting the Stage:** establishes the context of

the presentation, states goals and objectives, reviews previous points, if applicable.

**Presentation Skills:** is organized, uses a variety of methods and materials, uses open questions to stimulate discussion, encourages active participation from group, uses appropriate language, highlights key points, segues to co-trainer.

**Group Process and Communication Skills:** remains focused on group and training process, paces material to the group, handles group process demonstrating good listening skills, encourages questions, manages tension and balances group participation.

**Knowledge of Subject Matter:** reflects a depth of understanding of the concepts, makes connections between activities, places material in context of practice, builds on knowledge of participants, effectively uses co-trainer.

**Demonstrations:** demonstrates skills clearly and appropriately, follows protocol outlined in reference guide.

**Coaching:** builds rapport, listens actively, provides encouragement, cues participants by using questions, makes suggestions, gives feedback, follows protocol outlined in reference guide.

**Management of training:** stays within time frames, has necessary materials, sets room up appropriately, uses audio visuals effectively.

Applicants are notified of the results of their application in the mail after the quarterly certification committee meeting.

### Privileges of Professional Certification

In addition to all of the privileges of the Associate level certified TCI trainer, the professional certified TCI trainer can provide direct training outside of their organization/agency and is eligible to sit on a certification committee. Agencies requesting direct TCI training would be referred to professionally certified TCI trainers by the RCCP. To maintain professional level certification, certified trainers

### Portfolio Requirements: You Must Include

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

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

## Single Person Restraint

by Michael Nunno, DSW; Martha Holden, MS

### Introduction

Although there are various definitions of physical interventions or physical restraints with a young person in care, most childcare professionals would agree that any definition includes limiting, restricting, or controlling the dangerous behavior of a young person by physical holding. Unsafe or dangerous behavior is defined as behavior that presents an imminent safety risk to the young person or others.

Physical interventions to contain and/or control the behavior of young people in care, should only be used to ensure safety and protection, *and* when specified as part of an approved individual crisis management plan. Physical interventions are limited to safety responses with behavior likely to result in physical injury since any physical intervention involves risk of injury to the young person or staff. The risk of injury can range from the physical (cuts, bruises, fractures, and asphyxia leading to fatalities) to the emotional/psychological (apprehension, mistrust, fear, trauma). The risks of physical and emotional injury apply to the young persons and the staff members involved in the intervention. When deciding to employ a physical intervention in a safety situation, these injury risks must be weighed against the risks involved in using alternative nonphysical techniques, such as verbal de-escalation techniques, removing others from the area, or other behavior management techniques. When intervening in any situation in which there are safety concerns, it is not a choice between physical intervention and doing nothing. It is a choice among a range of intervention strategies with differing risks and consequences for the young person, the

staff and the unit or the facility.

### History of the Use of the Single Person Restraint

When TCI was developed in the early 80's, the child care field requested a restraint technique that allowed one staff person to restrain a young person when other staff were not available but when help was on the way. The restrictions on its use were that it would be undertaken with young people no larger than the staff person, and that immediate help would be on the way. It was considered a high-risk intervention for both the young person and the staff and to be used temporarily until help arrived.

### An Evaluation of the Use of the Single Person Restraint

Throughout this period, the Residential Child Care Project evaluated the use of the single-person restraint through its critical incident reviews during Therapeutic Crisis Intervention implementation in facilities, fatality reviews, and institutional abuse reports and investigations. The project staff also reviewed accreditation standards for the use of all physical interventions from standard setting groups such as the Council on Accreditation, the Joint Commission on Accreditation of Healthcare Organizations, and Health Care Financing Agency.

### Field Surveys and Critical Incident Reviews

Over the past few years upon examination of critical incidents and field surveys by the staff of the Residential Child Care Project, the extent of misuse of the single person restraint became apparent. Common misuses were:

- single person restraints are used to accommodate staffing shortages on units;
- staff engage in power struggles (counter aggression) with children and enforce the struggle through use of the single person restraint;
- single person restraints are initiated

without any backup summoned or even available; and,

- staff initiate single person restraints on young people too large to safely control with one person.

---- Single person restraints result in more frequent injuries to staff and children, and the use of dangerous practices such as applying additional pressure to a young person's upper torso and neck to gain control thereby increasing the risk of serious injury or death. The use of single-person restraints also increases the likelihood that the incident is inadequately documented and witnessed. There is some evidence that single person restraints make up the majority of restraint related reports of child abuse and neglect.

---- The *1999 TCI Implementation Survey and TCI trainer updates* gave facility representatives and TCI trainers an opportunity to talk about the use of single person restraints. Respondents discussed the difficulty of one staff restraining younger, larger children from a size-weight-age perspective, while other respondents mentioned the difficulty in single person prone restraints from a support and assistance perspective. Trainers had difficulties training staff in the proper use of single person restraints, and could not verify that staff persons were competent in using the technique, and understanding its risks and limitations.

### Fatality Reviews

---- There is no single reason why young people die in restraints. To address fatalities from a single-factor perspective is to miss the complex dynamics of the incident. Fatalities happen in facilities because of multiple causes. These causes include:

- use of physical force for program compliance;
- lack of training as evidenced by an ignorance of the consequences and risks of certain medical conditions, physiological phenomena, and biomechanical movements;

### Single Person Restraint, Cont. from page 5.

- overconfidence of staff;
- lack of monitoring by colleagues and supervisors;
- inadequate or nonexistent feedback from other staff prior to and during a restraint;
- inadequate or nonexistent information about the young person's medical conditions and medications; and, the
- use of sanctioned but dangerous techniques which are accepted agency practice.

Many of the above-mentioned causes are inherent in a single person restraint technique. Of the 28 fatalities reviewed from 1996-2001, information on numbers of staff involved in the restraint was available for 20 cases. Fifteen of these restraints were restraints conducted by one staff member without assistance or monitoring by other staff members. A gruesome but graphic detail of inadequate monitoring appears in fatalities when the single staff person

discovers that the young person in the restraint has been dead for up to 30 minutes. The staff person involved in the restraint was not able (for emotional reasons perhaps) to recognize the signs of distress from the young person. A more objective witness is needed—hence two people.

### Recommendations

Conducting a physical intervention or restraint without the direct assistance of another professional, or at least another professional monitoring the restraint puts both the young person and the staff at increased risk. For example, very often the staff person present is the target of the young person's aggression. The potential for the target staff becoming counteraggressive during the struggle is high. If a single staff alone conducts the restraint that person will exacerbate the situation and elevate the aggression and violence. If they are alone they are in the impossible situation of self-monitoring their counteraggression, as well as the young person's physical and emotional wellbeing. If the young person

or staff is injured or is overpowered by the young person there is no back up, or no immediate assistance. From a civil protection standpoint, the staff person performing a single-person restraint has no witnesses to the event. It remains the young person's word against the staff member's word.

Even with the small child restraint (which is essentially a single person restraint), another person should be present, monitoring and witnessing the event. The decision to use the small child restraint instead of a team restraint is based on the assessment that it is not wise or in the young person's best interests to place himself or herself over the young person, or place the young person in a prone position. It is *never used* because there is only one staff person available with no assistance summoned.

The Residential Child Care Project recommends the attached model policy on the use of physical interventions in residential child care facilities. The policy articulates a practice standards of two or more trained staff involved in every physical intervention, and the development and design of Individual Crisis Management Plans to guide their use (or nonuse) in potential safety situations.

Our experience is that agencies that rely heavily on the use of single person restraints have inadequate staffing levels, poor program structure and program schedules, and organizational cultures that lead to control and expediency. We recommend that these agencies should engage in a thoughtful assessment of their entire organization's crisis prevention and management system and engage in a planning process to cease using single person restraints in a timely manner.

In order to reduce the potential for further tragedies in residential care, multiple solutions have to be integrated into a package addressing agency leadership, staff knowledge and skill-building, supervision, clinical oversight, critical incident monitoring and agency policy and practice. One basic and fundamental structural and

## Serious Fun and Games

### Warm-Up: Bumpity Bump-Bump



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

Participants should stand in a circle fairly close to each other, with the leader standing in the middle. The leader should turn around in the middle of the circle with his/her hands pressed together in front of him/her, stopping and pointing to one participant and calling out as quickly as possible, "Bumpity Bump-Bump." If the person being pointing to can say the person's name on his/her right before the leader completes saying "Bumpity Bump-Bump," then the participant wins and the leader stays in the middle. If the participant cannot say the name or says the wrong name before the leader says "Bumpity Bump-Bump," then the participant must step into the middle of the circle and be the new leader. After awhile, the game can be made more complicated by having the leader say "Left Bumpity Bump-Bump" or "Right Bumpity Bump-Bump" and having the participant identify either the person on his/her right or left. 🎲 [This game adapted from: "Quick Silver", Karl

## Model Policy On the Use of Physical Interventions In Residential Child Care Facilities

### Definition

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

### Standard for Use

The child/young person, other clients, staff members or others are at imminent risk of physical harm.

### Risk and Safety Issues

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

### Contraindications

Physical interventions must never be used as 1) punishments, 2) consequences, or 3) for "demonstrating who is in charge." Unless approved by the relevant statutory authorities and specified in an Individual Crisis Management Plan, physical interventions must never be used for 1) Program Maintenance (such as enforcing compliance with directions or rules or for preventing the young person from leaving the premises) or 2) for therapeutic purposes (such as forming attachment as promoted by "holding" therapy advocates or inducing regressive states).

### Use

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

### Necessary Requirements Prior to Use

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

guidelines.

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

### Process for use

- Where possible, staff members must consult with peers and supervisors prior to initiating any physical intervention.
- Two or more staff members should be involved in any physical intervention to help ensure safety and accountability.
- Clients may not be permitted to restrain or to assist in the restraint of other clients.
- Following any incident involving physical restraint, the agency must ensure that debriefing and support is offered to the client, the staff members and any other people involved in the episode. Staff members should provide the client an explanation for the intervention and offer the client an opportunity to express his/her views on what transpired.
- The agency must have a formal grievance procedure in place for the children/young people in its care (or their advocates), which is easy to understand, assures confidentiality and is readily accessible. The grievance procedure should include the contact details of senior Agency management and relevant external authorities.
- Any initial use of physical restraint should be reported to the appropriate statutory authority, and an agreed Individual Crisis Management Plan (ICMP) developed and implemented by the concerned parties. The plan should cover the use of positive and less intrusive intervention techniques and specify the circumstances under which physical restraint may or may not be an appropriate response in the future.
- All incidents of physical intervention must be recorded on incident report forms which reflect stated policy and include (at least) details of the incident, the people involved, the preventive strategies that were employed, actual techniques used, any injuries sustained by client or staff, and debriefing that was provided for the client. All such reports should be reviewed by senior agency personnel and appropriate action taken (for example, counseling for client and/or staff members, critical incident review, skills update, notification to external authorities). Any deviation to the ICMP must be fully documented and reviewed by facility clinical staff.

If any injuries to clients result from the use of physical interventions, the details must be reported to the appropriate statutory authority.

## Individual Crisis Management Plan (ICMP) Workshop

An important element of the TCI system is developing and maintaining individual crisis management plans for young people in care. This tool is discussed frequently in the TCI training curriculum. Many organizations are eager to implement this part of the system and have requested assistance in developing this process. In response to these requests we are offering a series of one day workshops discussing the process for developing ICMP's and presenting a template for the documentation of these plans. These workshops are designed for staff in facilities who have clinical responsibilities for treating and documenting treatment for the young people, i.e. therapists, social workers, nurses. A prerequisite for attending the workshop is having attended direct TCI training within an agency or having attended a Cornell University TCI training of trainers course.

### Background

Clinical services play an important role in preventing and monitoring a young person's aggressive and inappropriate responses to crisis situations in residential care. This preventive and monitoring role is formalized through individual crisis management plans (ICMPs). These plans include a functional analysis of a young person's crisis response and behavior, an outline of individually specific, developmentally appropriate, and medically safe controls, a strategy that eliminates the need for these external controls, and a plan for the young person to develop more appropriate coping skills. The ICMPs include risk and safety screening, history of sexual abuse or trauma, pre-existing medical, psychological and emotional conditions. The functional analysis of behavior and the safety screening help determine specific behavioral and physical interventions

### ICMP Workshop

**Program Outline**

9:00 - 12:00	Overview of TCI System, clinical oversight Types of crisis behavior for ICMP's Types of aggression Crisis response and long term response
12:00 - 1:00	Lunch (on your own)
1:00 - 4:00	Overview of ICMP process for clinicians Process for ICMP planning with staff (aggressive and non-aggressive behaviors) Use of ICMP form Implementation plan

**Schedule of Offerings**

March 20	Colorado Springs, CO
April 24	Cincinnati, OH
May 22	Raleigh, NC
July 9	Ithaca, NY
September 18	Peoria, IL
October 30	Mesa, AZ

See our website for applications and information: <http://rccp.cornell.edu>

necessary to ensure safety and learning for the young person.

### Program Description

This one-day workshop will outline the process and steps in developing individual crisis management plans. At the end of training participants will be able to:

- differentiate between proactive and reactive aggression,
- apply differential intervention strategies,
- develop an ICMP that considers safety and risk issues and effective intervention strategies,
- involve direct care staff in developing and updating the ICMP; and
- develop an implementation plan incor-

porating ICMPs in their own agency's clinical services.

### Intended Audience

TCI trainers, clinical staff and social workers, nurses and medical staff. Participants are required to have clinical responsibilities within an agency and to have attended a TCI training in an agency or a TCI training of trainers.

### Materials

Participants receive handouts and a template for Individual Crisis Management Plans

"Our deeds determine us, as much as we determine our deeds"

George Eliot (1819 - 1880), English novelist.

## A Special Remembrance: Dr. Alan Keith-Lucas

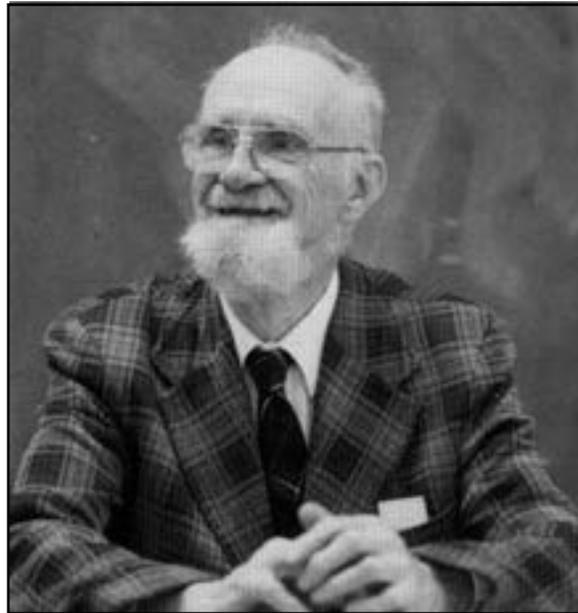
by Frank Kuhn, Ph.D.

"Friend of Children..." is the moving tribute that is paid to Dr. Alan Keith-Lucas every year by the Child and Family Services Association of North Carolina when it presents the Alan Keith-Lucas Friend of Children Award. "Keith," as he was known to friends, was a compassionate and caring scholar who made significant contributions to the field. But I remember him sitting under a tree, wearing his customary plaid jacket, smoking a pipe, surrounded by child care staff who relished an opportunity to share experiences with him and learn from him. The twinkle in his eye, and his slight smile communicated his interest in listening as well as teaching. And, throughout the conversation, Keith never allowed us to lose sight of the needs and feelings of those we intended to help.

Dr. Keith-Lucas's writing addressed fundamentals on the helping relationship in books including *Decisions About People in Need*, *This Difficult Business of Helping*, and one of his most well known, *Giving and Receiving Help*. He led the field toward addressing the needs of families of youth in care with his book *Group Child Care as a Family Service*, which he coauthored. In addition to these works, he published more than 100 professional articles, chapters and monographs. A final collection of his work, *Essays From More Than Fifty Years in Social Work*, was published as a tribute by the North Carolina Association.

Dr. Keith-Lucas adopted the Carolinas, and particularly the University of North Carolina in Chapel Hill as his home, and he loved to tell stories of the South – particularly "Uncle Remus" and "Tar Baby" stories – to children as

he visited residential programs. He was born in Cambridge, England, in 1910. He attended Trinity College there, and earned



a B.A. Degree with First Class Honours and an M.A. Degree in English. He immigrated to the United States in 1942, served in the U.S. Army, and became a U.S. citizen. Continuing his education, he earned an M.S. Degree in Social Administration from Western Reserve University, and a Ph.D. Degree in Public Administration from Duke University. After working as a district supervisor for the Cleveland Humane Society, a case supervisor for the New Orleans Children's Bureau, and as state supervisor of children's services for the Louisiana Department of Public Welfare, Dr. Keith-Lucas began his career in the School of Social Work at the University of North Carolina. He was honored by being named Alumni Distinguished Professor

in 1961.

Responding to the need for consultation and training for residential programs, Group Child Care Consulting Services, a unit of the UNC School of Social Work was born. Through his leadership in this organization Dr. Keith-Lucas and colleagues published training curricula and provided consultation and assistance to residential programs. Dr. Keith-Lucas personally visited more than 115 agencies, addressing the needs of each in a very personal way, and telling the "Tar Baby" story more than one thousand times. Each year residential staff flocked to the Chapel Hill Workshops, held at the university, which brought together professionals and leaders in the field from across the United States and a number of foreign countries for training and discussion. The Keith-Lucas home was the "open house" where participants gathered for informal discussions, and all were welcome.

A true hero in the field, Dr. Larry Brendtro referred to Dr. Keith-Lucas as a "powerful pioneer" in residential group care. Brendtro said, "Keith-Lucas saw love, acceptance, and understanding as prerequisites to positive behavior." Keith will be remembered for his contributions to the understanding of the importance of the helping relationship, for extending our focus of helping to families of children in care, and for his emphasis on the importance of professionalism and training for our field. He'll also be remembered for telling a great story with a Southern-English accent, for listening, for that twinkle in his eye, and for the pipe that never went



## Direct TCI Training Protocol

by Michael Nunno, DSW

### Overview

In order for you and your agency to assess whether participants in your direct training understand and can demonstrate the principles and skills inherent in Therapeutic Crisis Intervention (TCI), it is important that a TCI trainer evaluates participants' knowledge and skills. There are three tools for conducting this evaluation. The RCCP provides certified trainers with knowledge- and skills-based instruments to use in direct training.

The **knowledge-based** instrument is designed to demonstrate a participant's understanding and knowledge of the basic principles and concepts of TCI. The **skills-based** instrument is designed to demonstrate verbal and physical skills such as the LSI and the physical interventions. The participant's **trainer-supervisor** appraisal allows the TCI trainer to evaluate the strengths and needs of the participant in the areas of overall performance, participation in training activities, and general understanding of the TCI principles, skills and material, and communicate this performance to their supervisor. The use of this appraisal form is optional.

You can expect that participants will demonstrate competence in all three sections of this evaluation after training. If your agency does not use physical interventions such as the **small child** or the **team restraint**, and you do not train staff in those skills, they can be omitted from the evaluation. Your agency should maintain copies of the results for each employee throughout their employment history.

### The Testing Principles and Goals

TCI testing is a work-related corrective feedback process whose goal is maximum learning, skill acquisition, and improved job performance. The testing system is

## TCI Bookshelf

Aggression and Violence: Approaches to Effective Management.

Edited by John Turnbull and Brodie Paterson

MacMillan, 1999.

ISBN: 0-333-62251-0.

Reviewed by Raymond Taylor, Msc

I warmed to this book upon reading the first paragraph. The reason for this was the very simple aim which is to explore ways in which violence and aggression towards staff in public services can be managed more successfully. The editors also draw the reader's attention to the fact that all of the contributors have themselves been victims of violence during their careers.

This is not, however, a simple book. The editors have done sterling work in inviting a range of contributors to prepare articles which identify which staff are at risk and explore contemporary theoretical approaches to violence and aggression. Contributors also examine legal and ethical issues in the management of aggression and violence. The damage of verbal abuse is clearly recognised, in so far as a chapter is devoted to this issue. This form of abuse, which is often taken for granted, merits a chapter in its own right. Rob Wondrak examines the research in relation to the effect of verbal abuse and provides the reader with a range of techniques to reduce verbal abuse. The book also contains useful chapters on the de-escalation of management and aggression in the workplace and identifies the role the manager has in assessing risk, and supporting staff after an incident.

The vast majority of contributors to the text come from the nursing profession and I think that this is a strength, given the emphasis that, certainly in the U.K., the nursing profession places on research evidence. Readers, however, will have no difficulty in applying lessons to their own organisational context.

One minor criticism is that the chapter on "Managing Physical Violence" provides an overview of different systems of managing aggression and violent behaviour which is over simplistic. In so far as some of the programmes that are examined focus exclusively on physical restraint, whilst others have a much heavier emphasis on prevention and de-escalation. Nevertheless this chapter is well researched, clearly written and provides a much needed overview, and analysis of some of the main programmes which are currently available to agencies.

Each of the chapters is written in a lucid, accessible style. Similarly, every chapter is well researched, contains useful tables and very practical guidance. Each of the authors have a concern not only with effective management, but also with practice which is informed by legal responsibilities and ethics. I would recommend this book to anyone who wishes to develop a full understanding of violence in the workplace. 🐾

Raymond Taylor, Msc, is a social worker and service manager at Falkirk Council Social Work Service in Scotland. He has extensive experience in social work training, and working with children and families in residential and fieldwork settings. He has been



Direct TCI Training Protocol, Cont.  
from page 10.

designed to comply with agency standards, and to maintain your own TCI certification standards. The protocol favors the training of new workers, but it can be used in all agency refreshers. Further, it gives the TCI trainer a means to evaluate and monitor whether a participant 1) knows and can recall fundamental TCI concepts, 2) can apply them in simple ways, 3) can perform verbal skills and strategies, and 4) can perform physical interventions with no safety violations. The protocol supports trainer-participant corrective feedback, and supports participant-trainer-supervisor communication and corrective feedback prior to and after workers start on the job.

#### Maintain the Integrity of the Testing Process

The TCI trainer has to assure that the testing process is fair and consistent, and that there is an equal opportunity for practice, coaching and study for all participants. You should also maintain an adequate level of test security while being open to participants about what knowledge and skill areas they are going to be tested on.

- Trainers should maintain a presence in the testing evaluation room.
- Keep the room free from unnecessary distractions. Remember this testing process may impact a person's job responsibilities and career.
- Keep the conversation in the room on testing only.

#### Maintain a Fair and Consistent Scoring System

Use the **knowledge test** with the answers that have been provided as the basis for your "correct or acceptable" answers. Keep the passing grade consistent from training program to training program. If you are going to raise or lower the passing grade, please let participants know in advance.

Your agency administration and/or the human resources or personnel office determines the acceptable standard of performance for your agency. You may also supplement or modify this test with items that are agency-specific, or with items that highlight or reinforce knowledge or skills tailored to your agency needs or circumstances. You may also wish to develop additional items specific to agency refreshers or updates.

When scoring the **skills checklist**, please keep in mind that *an acceptable level of performance means that the participant was able to perform the skills in sequence and without violating any safety issues or concerns. Achieving an acceptable level of performance in a training arena does not ensure that the participant can perform the skill on-the-job. That task must be determined by the participant's supervisor.*

When filling out the **trainer-supervisor appraisal** the trainer should comment so that the participant's supervisor may be able to use the information to address strengths, qualities and needs in supervision and coaching.

#### Maintain a Fair and Consistent Test Retaking System

Some participants will not meet the standards that your agency sets, so it is essential to determine a fair and consistent procedure for retesting participants. Remember the testing may have an impact on employment or advancement in the agency. Opportunities for retaking the test should be consistent from one participant to another, and from one training program to another. If there are going to be changes in the retesting procedure they should be announced in advance and in writing. Opportunities for retest training, practice, coaching, and supervision should meet the standards of fairness and consistency.

Please remember that under the current Federal, state, and accreditation regulatory requirements, it is essential that your agency's administration, its human

resource or personnel office support and approve the TCI testing and appraisal system. They should be mindful of and active in designing the TCI training schedule, appraisals, reappraisals, evaluation and corrective feedback methods, grading, record-keeping, and any other pertinent topics that arise within your agency. If you or your agency has any questions, please feel free to call or e-mail the Residential Child Care Project.

#### Trainer Tips

##### Knowledge Appraisal

Keep in sight the participants who are taking the written test to ensure that the answers are the participant's own knowledge.

##### Physical Skill Appraisal

- Place the participants at ease. We suggest having them stretch prior to the appraisal. This has the dual effect of putting them at ease and limbering them up.
- Tell the participants that you may not be able to see everything that they do so you may ask them to perform the steps again. Tell them that when you ask them to perform something twice it is because you did not see a step, it will not affect their performance.
- Tell participants that if they find themselves doing something wrong, they should stop the steps when safe and begin again.
- When evaluating and testing the physical interventions, stand and walk around for a better view of the participant's performance.

##### Verbal Skill Appraisal

When testing for the LSI, sit at 45 degrees to the role play participants but pay attention to not get too close or get into their space.

##### Trainer/Supervisor Appraisals

- Keep your appraisal simple and to the point.
- Anchor your comments to your observations of the individual's participation in



## Implementation Project: A Case Study

by Brian Leidy, Ph.D.

In January of 2000, the Residential Child Care Project and a Residential Child Caring Agency entered into an agreement to work together to reduce physical restraints in two of the agency's units. The services provided by the RCCP is part of our TCI implementation package which consists of assessment of the current crisis management system, working with an agency work group to assess and make a plan to improve implementation and provide ongoing training and consultation to fully implement the plan. The following information is the results of the evaluation component of the implementation package.

We received data on the critical

incidents that occurred in Cottages A and B from July 1, 1999 through June 30, 2001. This corresponds with the six month period prior to implementing a Therapeutic Crisis Intervention system, the six month period during implementation of TCI, and two six month periods after implementation. During this two year period, there were 855 critical incidents at Cottage A and 830 critical incidents at Cottage B. Most incidents involved some form of physical restraint, 78.9%, if escorts and removals are counted as restraints. (See Table One.) Most of incidents involved more than one staff person, 58.5% of all incidents and 67.2% of incidents involving restraint. Most incidents occurred in the cottage, 72.9%, while the remainder occurred on grounds. Only 1.8% of incidents involved staff injury, while 5.2% of incidents involved client injury. Most injuries were minor cuts

and abrasion or soreness; however, there were three trips to the emergency room for injuries during the two year period. The largest group of incidents not involving restraint was runaways, 7.7% of all incidents. Typically these clients were gone for less than two days and returned on their own.

There were changes over time in the rate at which critical incidents occurred. The most abrupt change occurred between the first and second quarters of 2000, which was the middle of the implementation phase. There had been a steady increase in the numbers of critical incidents during the last half of 1999, peaking in the first quarter of 2000. At the end of this nine month period, the number of critical incidents dropped to less than half the previous rate and fluctuated at the new level throughout the next fifteen months.

This change was most dramatic at

Table One. TYPE of INCIDENT

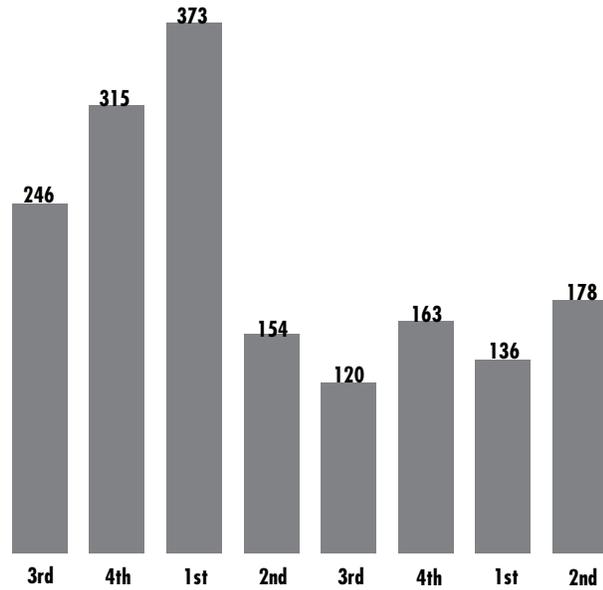
	Frequency	Percent	Valid Percent	Cumulative Percent
Runaway	129	7.7	7.7	7.7
Assaultiveness by Client (injury &/or police)	21	1.2	1.2	8.9
Property Damage by Client (willful)	5	.3	.3	9.2
Arrest of Client (Criminal or Mental Health)	6	.4	.4	9.6
Suspension from Ongrounds School Program	23	1.4	1.4	10.9
Restraint: Alternate Method	464	27.5	27.5	38.5
Restraint: Cornell Method (or unspecified)	679	40.3	40.3	78.8
Suicide Alert Procedure Initiated	58	3.4	3.4	82.2
Self injury (no suicide alert procedure)	74	4.4	4.4	86.6
Possession of a Weapon	2	.1	.1	86.7
Allegation of Abuse/Neglect Toward Agency	1	.1	.1	86.8
Other: Due to Client Acting Out	36	2.1	2.1	88.9
Restraint: Escort	104	6.2	6.2	95.1
Restraint: Removal	83	4.9	4.9	
Total	100.0	100.0	100.0	100.0

Implementation Project, Cont.  
from page 12.

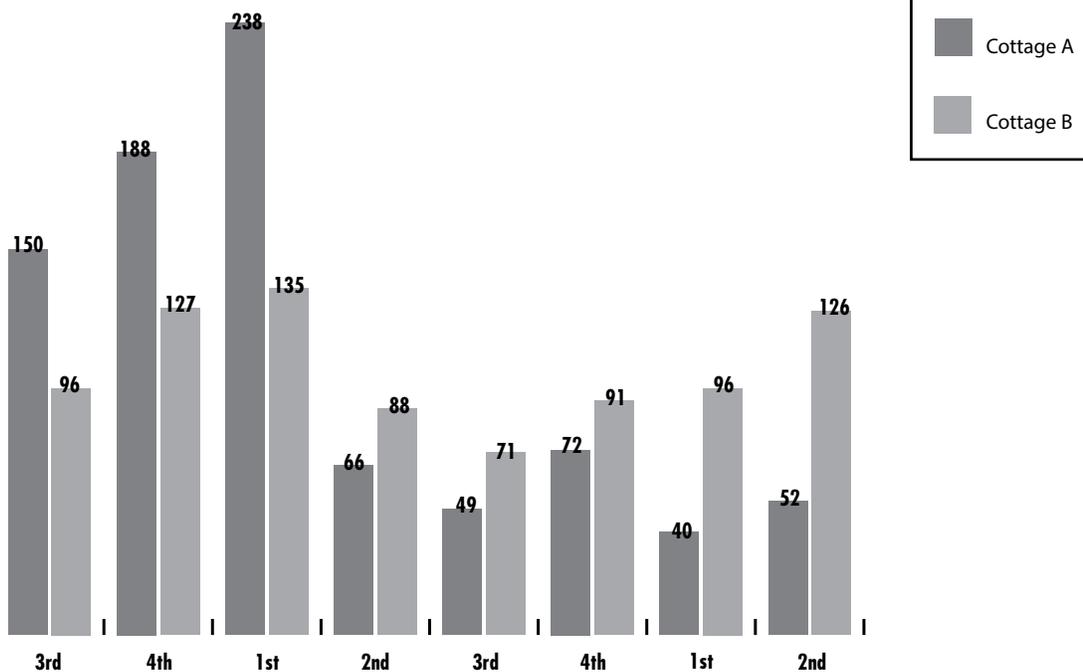
Cottage A where there was more than a 70% reduction between the first and second quarters of 2000. Not only was the drop less dramatic at Cottage B, only about 20%, but the last quarter for which data is available, the second quarter of 2001, saw a return to pre-TCI levels at Cottage B. When data from the cottages are grouped into pre/implementation/post periods, the differences between cottages become more apparent. The two highest rates of critical incidents occurred at Cottage A during the pre and implementation phases, and the two lowest rates of critical incident also occurred at Cottage A during the two post periods.

The populations in the two cottages appear to be very different. While clients

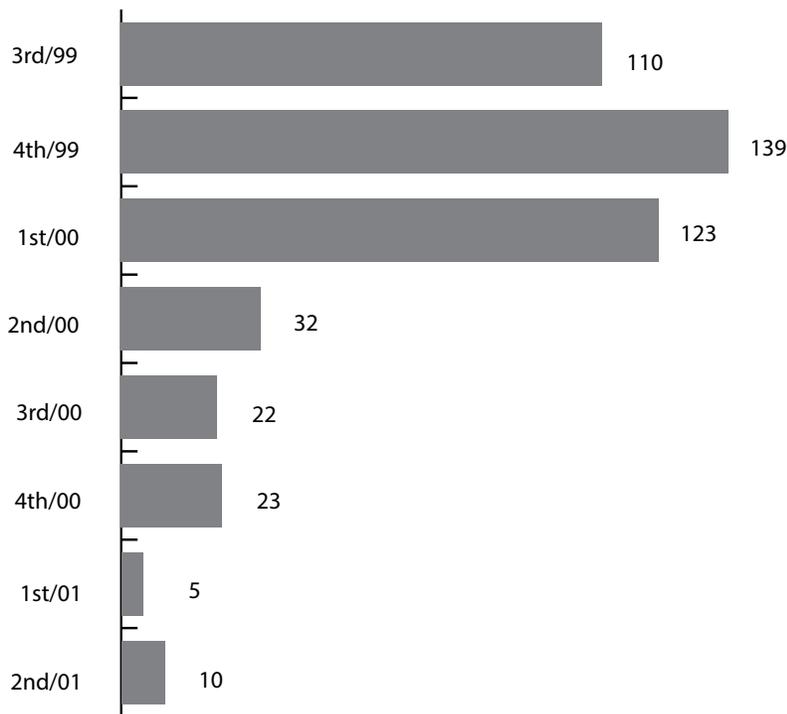
Graph One. INCIDENTS by QUARTER at TCI COTTAGES



Graph Two. INCIDENTS by COTTAGE per QUARTER



Graph Three. RESTRAINTS per QUARTER



Implementation Project, Cont.  
from page 13.

at Cottage A are female with an average age at the time of the incident of 15.8 years, clients at Cottage B were male with an average at the time of the incident of 11.5 years. Incidents at Cottage A were much more likely to involve additional staff. Incidents at Cottage A were more likely to occur in the bedroom, playroom, hallway, grounds, and special services. Incidents at Cottage B were more likely to occur in the living room, timeout room, basement, dining room, school area, and classroom. The type of incident was very different in the two cottages. The restraint method at Cottage A was more likely to be Handle with Care®, while at Cottage B the Cornell method was more typically used. Most restraint/escorts occurred at Cottage A while most restraint/removals occurred at Cottage B. Almost all the self-injury incidents occurred at Cottage A as well as the majority of incidents involving initiation of suicide alert procedures. Incidents at Cottage B were more likely to be runaways, assaultiveness, and suspension from school. Incidents at Cottage A were more likely to happen in the evening or at night, and incidents at Cottage B were more likely to occur during the day.

Table Two. INCIDENT COUNT by STUDY PERIOD

	Cottage A	Cottage B	Total
Pre TCI	338	223	561
Implementation Period	304	223	527
First 6 Months Post	121	162	283
Second 6 Months Post	92	222	314
Total	855	830	1685

**Restraints**

Although all critical incidents are important, restraints are of special interest when introducing a Therapeutic Crisis Intervention System. When restraints were looked at separately, we found even more dramatic declines in the rate at which they were occurring. Once again, the biggest change came between the first and second quarters of 2000. This was the middle of the implementation period and restraints dropped from 124 per quarter to 18 per quarter, or an 85% reduction. Even more importantly, restraints as percent of

all incidents occurring in these cottages declined dramatically as well. During the first three quarters 40% of all incidents were restraints. During the last five quarters only 12% of all incidents were restraints.

When the two cottages were looked at separately, changes in the number of restraints appeared very similar. In Cottage A, the number of restraints dropped from an average of 86 per quarter during the first three quarters to an average of 10 during the last five quarters. This was an 88% reduction in the number of restraints. In Cottage B, the number of restraints dropped from an average of 38 per quarter during the first three quarters to an average of

Brian D. Leidy, Ph.D., is a Senior Research Associate in the Family Life Development Center at Cornell University. He provides program evaluation, consultation, and training to a variety of projects and programs within and outside the Center, including the Residential Child Care Project. He has worked extensively in public child welfare and mental health programs. His current areas of interest include family and community violence prevention programs and program evaluation.

## Ask Eugene



I am leaving my agency and they are keeping my TCI training manuals. Can they do that?

If your agency sponsored your participation at the TCI training, it was part of your job responsibility, and the agency covered the cost of the training, they can keep the materials. Only a certified TCI trainer can use them, but the agency does own them. If you are a certified TCI trainer you may purchase a replacement set from us. To order them, call Eugene Saville at 607 254-5210 or e-mail him at [eas20@cornell.edu](mailto:eas20@cornell.edu) and request which of the materials you wish to replace. Eugene will let you know the cost and where to send the check. 📧

## From the Instructor's Booth



The Residential Child Care Project is pleased to introduce the newest member of our training staff:

Thomas Endres, MA, is an extension associate with the FLDC. Mr. Endres has twenty five years of experience in residential and group care. He previously worked as a coordinator of group care for a South Florida agency. Mr. Endres began his career as a child care worker, then as a program therapist, moving into management and finally serving as a facility safety officer. Mr. Endres received his BSSW from Ohio State University and later received his MA as an educator. He has extensive knowledge and experience in program development. Mr. Endres provides TCI training and technical assistance for the residential child

## Got Questions?

You're likely to find the answer on our website:  
<http://rccp.cornell.edu>

## 2002 COURSE OFFERINGS

### Therapeutic Crisis Intervention: Train the Trainer

- January 7 - 11 .....Auburn, NY
- February 11 - 15 .....San Diego, CA
- February 18 - 22 .....Glasgow, Scotland
- March 11 - 15.....Colorado Springs, CO
- April 15 - 19.....Cincinnati, OH
- April 15 - 19.....Dublin, Ireland
- May 13 - 17 .....Atlantic Beach, NC
- May 13 - 17 .....Glasgow, Scotland
- July 22 - 26.....Auburn, NY
- August 12 - 16.....Auburn, NY
- September 9 - 13.....Peoria, IL
- October 21 - 25.....Mesa, AZ
- November 18 -22.....Worcester, MA

### TCI Update: Revisions to the Curricula and Certification Process

- January 14 - 15.....Auburn, NY
- February 13 - 14 .....Glasgow, Scotland
- February 18 - 19 .....San Diego, CA
- March 18 - 19.....Colorado Springs, CO
- April 22 - 23.....Cincinnati, OH
- May 8 - 9.....Glasgow, Scotland
- May 20 - 21 .....Raleigh, NC
- July 11 - 12.....Ithaca, NY
- August 22 -23 .....Ithaca, NY
- September 16 - 17 .....Peoria, IL
- October 28 -29.....Mesa, AZ
- November 14 - 15 .....Worcester, MA

### TCI Update for Developmentally Disabled

- June 10 - 11 .....Penrith Cumbria, UK
- June 20 - 21 .....Ithaca, NY

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

### TCI for Family Care Providers: Train the Trainer

- March 12 - 15 .....Glasgow, Scotland
- April 4 - 7 .....Dublin, Ireland

### TCI Update for Family Care Providers

- June 10 - 11 .....Ithaca, NY

### Individual Crisis Management Plan Work shop

- March 20 .....Colorado Springs, CO
- April 24 .....Cincinnati, OH
- May 22 .....Raleigh, NC
- July 9 .....Ithaca, NY
- September 18.....Peoria, IL
- October 30 .....Mesa, AZ