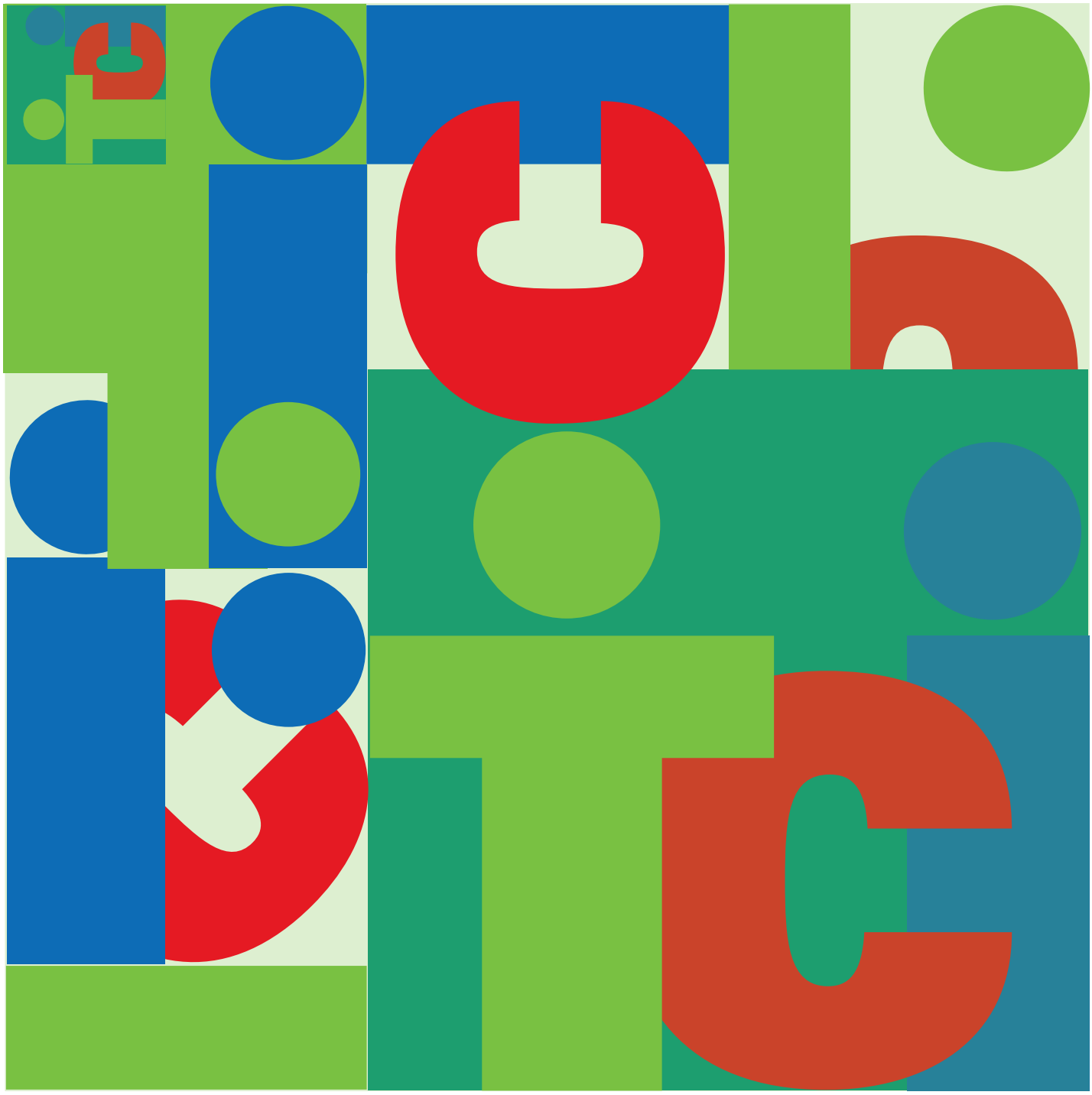
THE THERAPEUTIC CRISIS INTERVENTION SYSTEM, EDITION 7



RESIDENTIAL CHILD CARE PROJECT | BRONFENBRENNER CENTER FOR TRANSLATIONAL RESEARCH | CORNELL UNIVERSITY

Therapeutic Crisis Intervention System, Edition 7

Information Bulletin

Residential Child Care Project
Bronfenbrenner Center for Translational Research
College of Human Ecology
Cornell University, Ithaca, NY USA

Dear Colleague,

Enclosed you will find information about our Therapeutic Crisis Intervention (TCI) system. Our goal is to research, develop, disseminate, and evaluate model techniques to improve the quality of care for children in out-of-home care. In addition, the TCI system is designed to help organizations prevent child retraumatization and injury by reducing the need for physical restraint.

In 2020, we launched the 7th edition of our TCI system, celebrating 40 years of supporting residential organizations in their efforts to provide safe and quality care for children and young people. When implemented with fidelity, TCI has resulted in an increased ability on the part of staff to manage and prevent crises. Implementation studies have also shown an increased knowledge and skill on the part of all staff to handle crisis episodes effectively and a change in attitude regarding the use of physical restraint. If TCI is to be an effective crisis management system for your organization, you need to address six general criteria: (a) leadership and program support, (b) child and family inclusion, (c) clinical participation, (d) supervision and post crisis response, (e) training and competency standards, and (f) critical incident monitoring and feedback The description of these criteria and the TCI Theory of Change begins on page 17 of this brochure to help you decide whether TCI is right for your organization.

The Residential Child Care Project supports vigorous and ongoing in-house evaluation of TCI training and implementation efforts through testing participants' knowledge and skills, offering a trainer certification program, conducting agency TCI quality improvement and fidelity assessments, and establishing a TCI agency registration process designed to formally recognize organizations that have implemented the TCI system at the highest standard. The RCCP seeks to maintain a leadership role in discovering new knowledge, establishing new approaches to knowledge dissemination, and developing innovative programs to enable child caring agencies to serve children and families more effectively by building strong linkages among research, outreach activities, and evaluation efforts.

If you need any other additional information, please contact us at: Andrea Turnbull at ajt78@cornell.edu

Sincerely,

Martha J. Holden
Director, Residential Child Care Project

Contents

The Bronfenbrenner Center for Translational Research

The Bronfenbrenner Center for Translational Research, located within Cornell University's College of Human Ecology, administers the Residential Child Care Project (RCCP). The BCTR's origins date to 1974, when its parent organization, the Family Life Development Center (FLDC), was established by New York State legislation under the leadership of John Doris, professor of human development in the College of Human Ecology at Cornell. FLDC's mission was to study and develop programs to prevent child abuse.

On July 1, 2011, FLDC merged with the Bronfenbrenner Life Course Center to create the Bronfenbrenner Center for Translational Research (BCTR). The BCTR is named after Urie Bronfenbrenner, an American psychologist who is most known for his ecological systems theory that called attention to the large number of environmental and societal influences on child development. A Cornell alumnus and Cornell professor, Urie Bronfenbrenner helped form the Head Start Program in the United States in 1965.

The BCTR's mission is to improve professional and public efforts to understand and deal with risk and protective factors in the lives of children, youth, families, and communities that affect family strength, child wellbeing, and youth development. Translational research, as defined by the College and the BCTR, is the systematic application of research findings to the development of innovative interventions, practices, and policies that may ultimately improve health and wellbeing. Conversely, the use of knowledge derived from interventions, practices, and policies helps to inform future research.

Steve Hamilton, a faculty member of the BCTR, introduced a new model of translational research

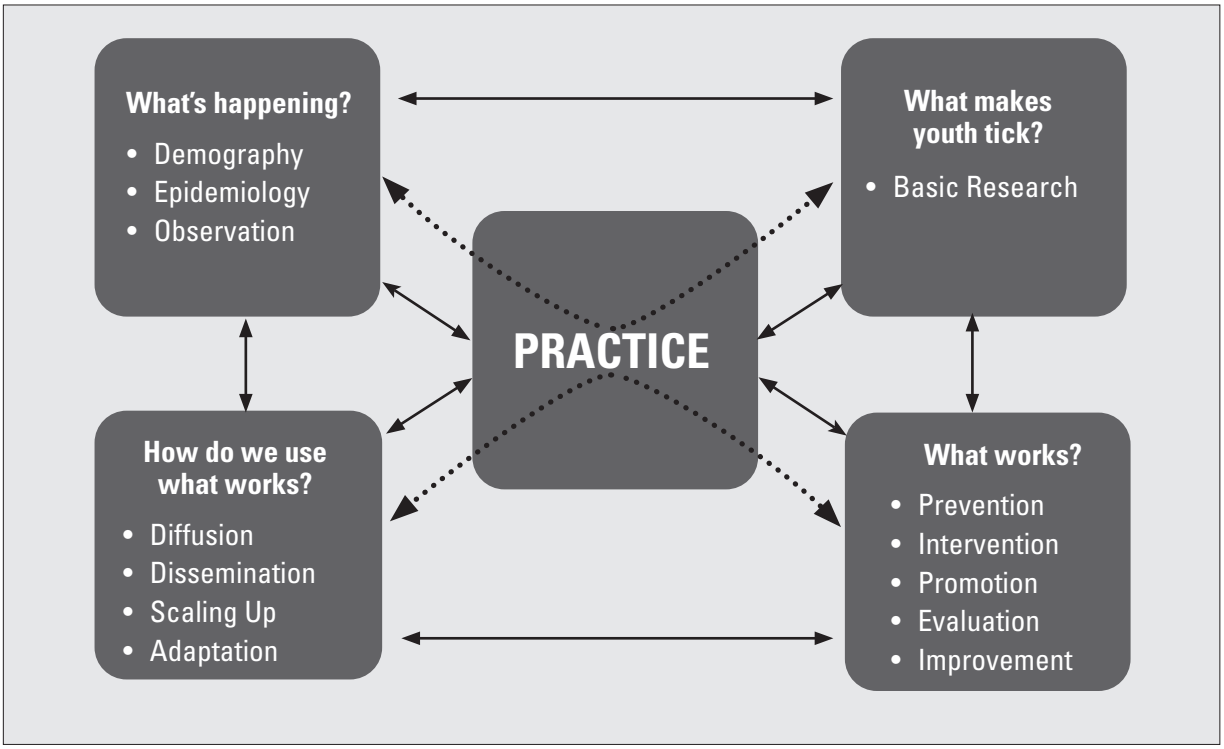


Figure 1. Hamilton Model of Translational Research for Youth Development

for his work in youth development. Hamilton's model of translational research (Figure 1)1 includes four quadrants, each with a different focus.2 Each quadrant is differentiated by the types of questions and the types of research methods most commonly employed. Most importantly, practice is deliberately placed in the center of the model with bi-directional arrows between practice and each quadrant. Practice can inform or inspire research and practice can benefit from research in any quadrant. The emphasis on evidence-based practices and translational research in human services, especially Hamilton's model, has the potential to have a significant and positive impact on therapeutic residential services and all the organizations that serve the best interests of children and their families.

Major Programs of The Residential Child Care Project

- Therapeutic Crisis Intervention (TCI) System
- Children and Residential Experiences (CARE): Creating Conditions for Change

The RCCP has delivered programs and consultation services throughout the United States, Canada, Puerto Rico, Russia, Israel, Australia, South Korea, Ireland, Bermuda, and the United Kingdom. Used in hundreds of residential child care agencies, TCI has also been adapted for other residential care settings (e.g., mental health, juvenile justice) as well as foster, kinship, and adoptive families (TCIF) and for schools (TCIS).

Since 1980 the Residential Child Care Project has developed, evaluated, and disseminated two major programs: Therapeutic Crisis Intervention (TCI) and Children and Residential Experiences: Creating Conditions for Change (CARE). Both programs have sought to translate the latest research into practice and to increase the knowledge and expertise of personnel at all levels of child serving organizations. The RCCP's intent for both programs is to promote more positive outcomes for children, families, and staff with a special emphasis on developing healthy relationships and safer environments.

A Center for Creating Trauma-Informed Residential Settings

In 2018, the Residential Child Care Project (RCCP) received a grant from the U.S. Department of Health and Human Services to establish the Center for Creating Trauma-Informed Residential Settings. The grant is part of the National Child Traumatic Stress Network, a federal effort to develop a national network of services for children and adolescents who have experienced trauma. The goal of the grant is to share research, strategies, and learning to assist residential settings to use trauma-informed and evidence-based models and to share the RCCP's Therapeutic Crisis Intervention (TCI) system and Children and Residential Experiences (CARE): Creating Conditions for Change program model with residential care centers across the USA.

Children and Residential Experiences (CARE): Creating Conditions for Change

CARE is a multi-level program model for improving services for children in out-of-home care. CARE is listed on the California Evidence Based Clearinghouse (CEBC) as of 2017 with a Scientific Rating of 3 (Promising Research Evidence) and a High Child Welfare System Relevance Rating.[3] The CARE program model is built on six principles that form the foundation for creating conditions for change in residential care. CARE is: (a) developmentally focused, (b) family involved, (c) relationship based, (d) competence centered, (e) trauma informed, and (f) ecologically oriented. These principles have a strong research and/or theoretical relationship to positive child outcomes, and can be incorporated into a wide variety of programs and treatment models. CARE enables child caring agencies to organize and deliver quality care of children according to research-informed principles based on the best interest of the child. The aim of CARE is to bring agencies' current practices closer to well-researched best practices in residential care and to help them achieve congruence among all levels of the organization in order to improve how the agency works as a whole.

The Therapeutic Crisis Intervention System

Therapeutic Crisis Intervention (TCI), a trauma-informed crisis prevention and management system first developed in the early 1980's for New York State's voluntary child care agencies, incorporates findings from the social science literature and is implemented through research informed strategies such as organizational assessment, active and targeted data analysis, training, and technical assistance. Also, in the 1980s, the RCCP, under a grant from the National Center on Child Abuse and Neglect, began disseminating TCI to residential child care organizations throughout the USA. The TCI system assists organizations in preventing crises from occurring, de-escalating potential crises, managing acute physical behavior, reducing potential and actual injury to children and staff, teaching children adaptive coping strategies, and developing a learning organization. This model gives organizations a framework for implementing a crisis prevention and management system that reduces the need to rely on high-risk interventions.

TCI addresses six general domains:

1. Leadership and program support
2. Child and family inclusion
3. Clinical participation
4. Supervision and post-crisis response
5. Training and competency standards
6. Documentation, incident monitoring, and feedback

These domains are required to establish effective crisis prevention and management in a residential setting. These six domains are congruent with the six core strategies outlined by the National Association of State Mental Health Program Directors[4] and the Child Welfare League of America.[5]

Many children who have experienced toxic stress and trauma have never learned effective emotional regulation skills and constructive ways of coping with or responding to internal or interpersonal stress, upset, or pain. The skills necessary to implement TCI are neither intuitive nor natural; staff must be fully trained and supervised in co-regulation skills and strategies that are based on self-awareness, active listening, behavior support techniques, emotional first aid, crisis co-regulation, and the Life Space Interview.

Since the curriculum's inception there have been

six major revisions. The revision process generally includes (a) examining the evaluation results and research conducted by the RCCP, (b) reviewing related literature and research, (c) conducting surveys of organizations using the TCI system, and (d) convening experts for consultation and review. TCI has been disseminated successfully for four decades and is now operating in more than 1,800 residential child care agencies, foster care settings, juvenile justice programs, hospitals, and schools across the U.S. and internationally.

The RCCP supports vigorous and ongoing in-house evaluation of TCI training and implementation efforts through testing participants' knowledge and skills, offering a trainer certification program, conducting agency TCI quality improvement and fidelity assessments, and establishing a TCI agency registration process designed to formally recognize organizations that have implemented the TCI system at the highest standard. The RCCP seeks to maintain a leadership role in discovering new knowledge, establishing new approaches to knowledge dissemination, and developing innovative programs to enable child caring agencies to serve children and families more effectively by building strong linkages among research, outreach activities, and evaluation efforts.

Past and Present Contributors

The TCI curriculum was first developed in 1980 by Michael J. Budlong and Andrea J. Mooney. Over the years, the TCI system and curriculum have been reviewed and revised with the assistance and support of many organizations and individuals. The Residential Child Care Project and the BCTR at Cornell University wish to thank the following people and organizations for their contributions, service, advice, and professional commitment to the project:

The Seventh Edition

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The Early Years

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Office of Children and Family Services, State of New York

Office of Mental Health, State of New York

Pressley Ridge School, Pittsburgh, PA

St. Vincent's Center and Villa Maria Continuum of Catholic Charities, MD

Tiesha D. Johnson, MS, NPP, RN, Rochester, NY

Preface Endnotes

1. Hamilton, 2015.
2. Nunno, Sellers, & Holden, M. J., 2014.
3. For additional information, please go to: http://www.cebc4cw.org/program/children-and-residential-experiences-care/detailed
4. National Association of State Mental Health Program Directors, 2013.
5. Bullard, Fulmore, & Johnson, K., 2003.

Notes

TCI Implementation Study

Project Overview

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

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

What Did Cornell Expect TCI To Accomplish?

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

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

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

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

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

What Was Cornell's Implementation and Evaluation Plan?

The implementation and evaluation project was designed to be completed in three phases over 18 months, from October 1994 to March 31, 1996 (See Figure 3 on page 10).

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

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

Overview of Evaluation Design and Timeline

Month: 1	6	12	18
• Incident baseline data (6 months before implementation and training) • Interviews with child care staff • Pre-implementation confidence data	Implementation and Training Pre-post to test mastery of crisis intervention training		• Incident post-data (6 months after full implementation) • Post-implementation confidence and knowledge data

Figure 2. Overview of Evaluation Design and Timeline

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

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

Integral to the implementation of this TCI methodology was a multi-method evaluation design which (a) provided baseline and follow-up data on crisis episodes within the residential care agency for an 18-month period; and (b) evaluated the effectiveness of both the crisis intervention methodology and the strategy for its implementation via training and technical assistance (See Figure 4). The evaluation design was a mix of qualitative and quantitative methods designed to discover current crisis intervention practices and to assess whether the project had reached its goals. This multi-method approach gave the implementation team methods to check and recheck the reliability of both qualitative and quantitative data gathered. It also offered the project team tools to study the phenomenon of crisis events within an organization.

Methodology: Evaluation of Outcomes

The incident reports, the pre- and post-implementation interviews with staff and supervisors, the confidence scale and the pre- and post-training knowledge tests were the principal data collection methods for evaluating the effectiveness of the crisis intervention methodology. The effectiveness of the project's implementation process was measured by positive changes in staff confidence levels, a decrease in the number of restraint episodes, and an increase in the knowledge and skill levels of staff (See Table 1 on page 12).

What Did Cornell Learn?

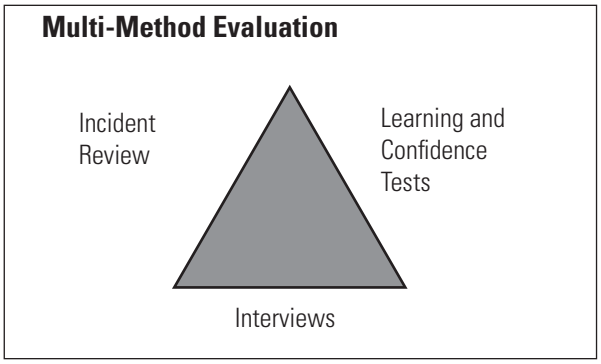

Figure 3. Multi-Method Evaluation

During the 18-month implementation period in which Cornell worked with the residential agency, the following results were evident: increased staff confidence, greater consistency in approaching children in crisis, documented reductions in incidents, increased staff knowledge of crisis dynamics, and an in-house training system (See Table 2 on page 13).

Confidence

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

Consistency in approaching children in crisis

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

Reductions in incidents

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

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

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

Study Limitations

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

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

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

Project Successes

Leadership. Despite the limitations of our evaluation methodology, the success of this project points to the necessary elements of leadership, cooperation, and collaboration among executive, clinical, and supervisory staff within an organization. Through the executive leadership the project gained remarkable access to the inner workings of a residential agency. The executive director clearly understood and supported the notion that any crisis prevention and management system needed to be consistent with the organization's

Overview of the Evaluation Design

Implementing, Monitoring, and Evaluating a Therapeutic Crisis Intervention Methodology in a Residential Child Care Facility

Information Domains	*Agency and Personnel Profile*	*Effective Management*	*Confidence*	*Teamwork*	*Restraint Episodes*	*Increased Knowledge and Skill*
Instrument	General Questionnaire	General Questionnaire and Interview Guide	General Questionnaire and Interview Guide	General Questionnaire and Interview Guide	Incident Report	Multiple Choice Pre-Post-test
Type of Data Gathered	Demographic Data	Qualitative & Quantitative (Likert scale)	Qualitative & Quantitative (Likert scale)	Qualitative & Quantitative (Likert scale)	Quantitative	Quantitative Number of Correct Responses
Type of Score Produced	Single Item Indicators	Total Score	Total Score	Total Score	Total Episodes	Item Analysis and Total Score Compared from Pre- to Post-testing

Data Synthesis and Findings Summary

1. Report findings which support or refute projected outcomes or hypotheses.
2. Report on questions raised that warrant further study.
3. Develop an information management system to assess incidents for a residential child care agency.

Table 1. Overview of the Evaluation Design

Results of Implementation and Evaluation Project

INTERVIEWS	*TESTS*	*INCIDENTS*
Supervisors report: • an increase in staff skills • a consistent strategy for intervention • higher level of practice standards	Confidence: Tests indicate significantly increased levels of confidence in: • managing crisis • working with co-workers to manage crisis • knowledge of agency policy and procedures • helping children learn to cope	Documented reductions over the 18 month study in: • fighting • serious verbal threats • physical assaults • runaways for the entire agency
Workers report: • more consistent incident reporting • consistency in follow-up	Training: Knowledge tests indicate: • a significant increase from pre- to post-test in learning scores • only a 5% drop in learning after 10 months • after training, 87% of participants plan to use the knowledge and skills • after training, 93% reported they were able to use the knowledge and skills	Statistically significant reductions in physical restraint reports in Unit B over the 18 month period
Supervisors and workers reported differing perceptions of whether a debriefing session occurred and how effective it was		Statistically significant increases in physical restraint reports occurred in Unit A (contrast group) over the 18 month period
• TCI was implemented in Units B, C, D • TCI was not implemented in Unit A		

Table 2. Results of Implementation and Evaluation Project

mission and philosophy of child care, and had to be supported through clear and well-known policies and procedures. Through the executive director's leadership, time and money were allocated to allow the entire residential services staff to attend TCI training delivered by agency TCI trainers. Supervisors supported the project by implementing the behavior management and intervention strategies on a unit basis. TCI trainers who were also agency supervisors then were able to monitoring their use on a day-to-day basis. The supervisor-trainer then was able to integrate what was learned on the unit into subsequent training and refresher courses offered to agency staff. Executive staff, supervisors, clinical staff, and direct care workers, as well as project implementation and evaluation staff shared leadership and learning throughout the organization.

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

Incident monitoring. Another significant outcome is the development of a monitoring and evaluation system to assess the impact and effectiveness of an agency's crisis prevention and management intervention system, and on quantifiable outcomes such as the frequency and kinds of incidents. This simple design can be used by clinical or administrative staff to assess the impact of their decisions, policies, or plans, on caregiver/child interactions. For example, this monitoring and evaluation design can offer administration the capacity to track periods of the day when children and staff may be more vulnerable.

Using this type of data in management decisions is not a new concept and has been in the human services literature during the past decade with the rise of computer-based information management and quality assurance systems. A crisis intervention strategy is a necessary and critical aspect of a residential child care agency's treatment and behavior management for children who have the potential for aggressive and self-destructive behavior.

Conclusions

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

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

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

Survey Methodology

In 1998 Cornell University's Family Life Development Center surveyed how children die in foster care, kinship care, group homes, residential care, and juvenile correction facilities. The survey had two distinct strategies: a mailed survey approach and an internet newspaper search. A 43-question survey was mailed to each of the 50 states, as well as the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands. The survey asked child welfare, youth correction, mental health, and developmental disability officials for child (age 18 or under) fatality information for the years 1996, 1997, and 1998 from their sponsored or licensed facilities. The survey resulted in a return of 71 surveys from 42 states and the District of Columbia. This represents a 39% return rate. This mail survey was augmented by a second strategy: an internet search for fatalities to children in out-of-home care due to restraint and isolation.

Survey Findings

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

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

- ***Age and gender.*** The overwhelming majority of the fatalities were males (n=14). Both males and females ranged from 6 to 17 years in age with a mean of 14 years.

- ***Immediate cause of death.*** Positional asphyxia was listed as the leading cause of death (n=8). Cardiac arrhythmia or cardiac arrest occurred in four cases, while the remaining causes were listed as strangulation (n=1), aspiration (n=1), unspecified or unknown (n=4). While psychotropic medication appeared to play a part in two fatalities, the psychotropic medication history was unknown in the vast majority of cases.

- ***Circumstances surrounding the fatalities.*** Four fatalities occurred in some form of mechanical restraint, while 14 fatalities were a result of physical intervention. In 7 of the 14 cases of physical restraint, there was only 1 staff worker involved. In three of the physical intervention fatalities,two staff workers were involved, and in the remaining four physical intervention fatalities, the number of staff workers involved was unknown. In two cases children were know to be on psychotropic medication. In one case the child was restrained over a lengthy period of time or multiple times.

Discussion

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

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

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

- Restraints are so commonplace within the organization that they are accepted as appropriate interventions to enforce program compliance and alleviate problems due to staff shortages, scheduling, and program deficits. Staff has little or no awareness of the potential dangers inherent in restraints, and feel that they are safe practice because "no one usually gets hurt."
- With a high frequency of use and a dependence on physical interventions, there is little or no monitoring or processing of the events to prevent future occurrence. Often there are so many interventions, they are perceived as a normal part of the job.
- "Home grown" training and crisis intervention packages without "expert" screening abound in the field, with in-house trainers and training further isolating the methods from review. A variation of this is when organizations at one time used an outside expert-based package, but did not keep the trainers and training resources current. The physical intervention methods are handed down with each generation of trainers who add their own spin or ideas. Eventually some of the physical techniques taught evolve into dangerous techniques.
- Little supervision and coaching occur with line staff, and new staff are often left to "figure it out themselves" and get trained by other staff "on-the-job" (often in questionable practices).
- There is no consistent monitoring by supervisors or colleagues. An attitude of professional "courtesy" develops that translates into, "You know what you are doing, and I won't question it." "I will not interrupt any intervention you make, even if I don't agree."
- There is little or no clinical oversight or medical screening, and what information is gleaned from screening is often not conveyed to line staff. For example, children are given a variety of medications and staff workers have no idea of the side effects of any individual medication, much less combinations of medicines. Staff is not routinely informed of medical conditions. If workers are told, they are not given alternative strategies to use if physical restraint is contraindicated.

Recommendations

1. ***Leadership:*** The level of effectiveness of a crisis management system to help staff members prevent and reduce potentially dangerous situations depends on leadership's commitment to its implementation. Leadership must provide adequate resources, including an adequate and qualified staff, support for regular external and internal monitoring, and clear rules and procedures that have safeguards against abusive practices. Leadership should promote an organizational culture that values developmentally appropriate interventions and therapeutic practice above control and expediency.

2. ***Clinical oversight:*** Clinical services play an important role in overseeing and monitoring clients' responses to crisis situations. Developing and implementing an individual crisis management

plan is critical to responding appropriately and therapeutically to each child in crisis.

3. ***Supervision:*** Frequent and ongoing supportive supervision should be built into the implementation and ongoing monitoring of the crisis management system. Supervisors should be fully trained in all of the prevention, de-escalation, and intervention techniques so that they can provide effective supervision, coaching, and monitoring. A post-crisis multilevel response should be built into the practice. The child and staff member should receive immediate support and debriefing following a crisis. Discussing crisis incidents should be built into team/unit meetings so that all staff members can learn from these situations.

4. ***Training:*** Crisis prevention and management training should be one part of a comprehensive staff development program that provides core training as well as specialized training based on the population served. Refreshers should be conducted with all direct care staff members as recommended and required. At the completion of the original training and refresher training, staff members can be expected to perform the skills at an acceptable standard of performance. This performance should be documented and the staff should be held to a certain competency level of performance in order to use high-risk interventions. Trainers should be required to attend refreshers in order to maintain their training status.

5. ***Documentation and critical incident monitoring:*** Documentation is critical, and includes the documentation of staff supervision and training, and the documentation and monitoring of critical incidents throughout the agency. This documentation and monitoring system allows the organization to review incidents and make decisions about individual and organizational practice.

Notes

Notes

The Therapeutic Crisis Intervention System: A Trauma-Informed Approach

The majority of children in out-of-home care have suffered much adversity and trauma in their lives. It is essential that the adults caring for these children understand the effects of trauma and adversity so they can respond in a way that decreases the child's stress. When adults understand how trauma effects children's ability to manage their emotions, the adults avoid confrontation. They respond to children with understanding and empathy when children are struggling to stay in control of their emotions. Adults who are trauma informed also know the importance of children's perception of safety within the context of trusting relationships.

The TCI System helps organizations

Prevent crises

De-escalate potential crises

Manage acute physical behavior

Reduce potential and actual injury to children and staff

Teach children adaptive coping skills

Develop a learning organization

The Therapeutic Crisis Intervention (TCI) system helps organizations create a trauma-sensitive environment where children and staff are safe and feel safe[1] and all staff, including leadership, clinical, supervisors, and direct caregivers, understand the effects of trauma and adversity.[2] The goal of the TCI system is to prevent and de-escalate potential crises, build the capacity of staff to manage aggressive and violent behaviors avoiding potential injuries, and to create a learning culture where everyone, children and adults, learn from experience.

Children whose lives are saturated with trauma and adversity (e.g., abuse, neglect, loss of a parent, witnessing violence) often develop problems managing their emotions and behaviors. They have developed patterns of pain-based behaviors (expressions of trauma and pain) and stress responses such as aggression, rigidity and inflexibility, withdrawal, impulsive outbursts, and self-injury.[3] A trauma-informed organization supports and facilitates trauma-informed care through its policies, procedures, and practices that recognize and respond to the traumatic events children have experienced.[4] Specifically, this involves ensuring that staff:

1. understand what trauma is and how it impacts all individuals within the system and the system itself (i.e., children, families, staff),
2. are able to recognize when behaviors and patterns reflect the children's and staff's past or present trauma experience,
3. know how to avoid re-traumatization by responding to and interacting with children and families in ways that convey safety, trust, support, collaboration, and autonomy, and
4. are sensitive to children's unique perspectives and circumstances.

Given the importance of establishing a safe environment and a sense of safety for children[5] who have experienced trauma, residential settings require a sound, well established agency-wide crisis prevention and management system to foster and maintain a physically and emotionally safe environment[6] for children and staff.

The premise underlying the TCI system is that

Agencies that have implemented TCI have reduced incidents of aggression and decreased use of high-risk interventions.[8]

- After the implementation of TCI, **the frequency of child restraints decreased** (Titus, 1989)[9]
- While TCI strategies were increasingly implemented over a six year span, **the use of restraints decreased by 75%** (Farragher, 2002)[10]
- Over an 18-month period from pre- to post-TCI implementation, aggressive and belligerent actions by children and young people that resulted in **physical interventions decreased by 66%** (Nunno et al., 2003)[11]
- TCI, in conjunction with Children and Residential Experiences (CARE), a trauma-sensitive therapeutic program model, reduced the rate of aggressive acts that resulted in a **decrease in physical interventions by more than 50%** (Nunno et al., 2017)[12]

pain-based and high-risk behaviors can often be prevented by creating a setting in which emotionally competent adults meet children's needs and allow children to heal and thrive through caring and developmental relationships. Developmental relationships are characterized by attachment, reciprocity, progressive complexity, and balance of power.[7] These four criteria work together to help children grow, develop, and thrive. When in a developmental relationship, the adult engages in reciprocal or "give and take" interactions with a child. For example, a child shows interest in learning to catch a ball. The adult tosses a ball to the child, who, in turn, tosses it back to the adult. Through this back and forth, reciprocal and fun activity, a relationship is developed. As the adult engages in on-going, non-coercive reciprocal interactions with a child, attachments are formed and enhanced. Attachment, in this context, is a positive emotional connection that provides a secure base for the child. The adult helps the child feel safe. Through sustained and shared activities with the child, the adult can assess the child's competence and adjust expectations, tasks, and their own level of support as the child successfully learns more and more complex skills. The adult tosses and catches the ball with the child, judges the child's skill level, and increases the distance or speed as the child becomes more competent. This is progressive complexity. As the child engages in more and more complex patterns of behavior and is able to exert more emotional and behavioral control, the balance of power shifts from the adult to the child. The child may begin setting the distance or the speed. The child starts playing catch with others independent of the adult.

Adults in the child's life space who have caring and developmental relationships with children can help children learn and practice more positive or adaptive responses to stressful situations. With support and practice, children are able to achieve a higher level of functioning and interpersonal maturity. This allows them to engage more fully

in their social networks and educational opportunities as well as negotiate everyday problems and stressful situations. The TCI system offers an organizational approach to creating a safe, calm, predictable environment and developmental relationships that help to prevent and de-escalate potential crisis situations as well as manage crises as they unfold.

TCI System Theory of Change

In order to implement and sustain TCI, organizations need to embed fully the TCI concepts and strategies within practice, as well as provide robust organizational support and accountability. Figure 4 summarizes the TCI System Theory of Change, including the pathways that lead to improved child outcomes. The TCI system identifies roles and tasks as well as desired practice at all levels of the organization that, when implemented, create a consistent approach to crisis prevention and management within a nurturing, safe, and predictable environment. Through TCI training and technical assistance, these tasks and practices are learned and applied by leadership, supervisors, and direct caregivers. The result is strong leadership creating a culture of high support and high accountability, supervisors providing supportive and reflective supervision, and staff with the knowledge, motivation, and practices necessary to prevent, de-escalate, and safely manage potential high-risk situations. Leadership provides the necessary infrastructure support and guidance so that supervisors are adequately prepared to mentor and coach staff as they learn and apply the TCI concepts and strategies. Organizational

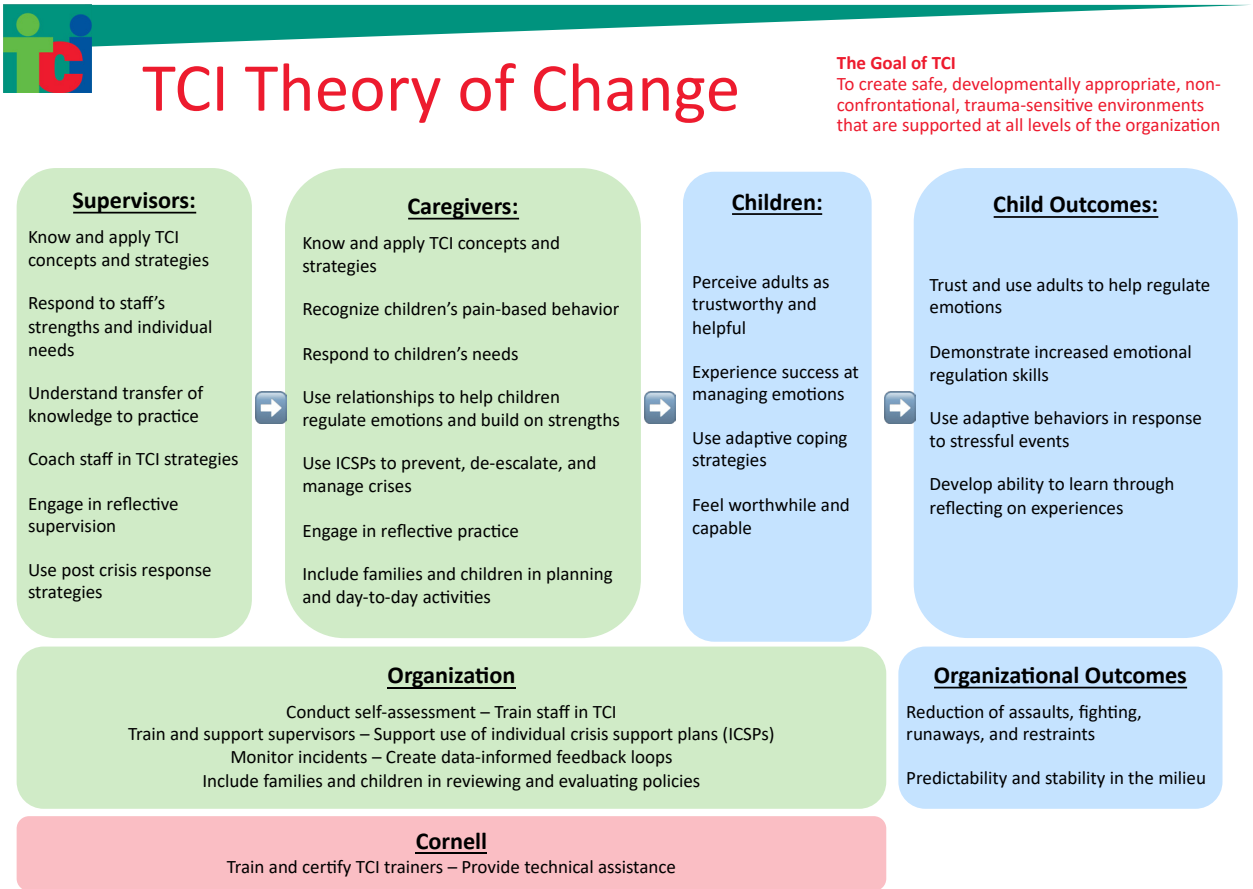

Figure 4. TCI Theory of Change

self-assessment, reflective practice, and continuous quality improvement help create a learning organization and a culture of collaboration and self-reflection.

As the staff adopt the TCI approach to preventing and managing children's stress responses and pain-based behaviors, they are better able to assess and intervene early in potential crisis events and help children manage stressful situations and regulate emotions. The TCI system includes a training component to teach staff how to interpret children's aggressive behaviors as pain-based and use strategies and skills that respond to the child's needs while reducing the potential for adult counter-aggression. Children feel safe and learn to regulate their emotions with help from caring adults (co-regulation). When the child is calm they can discuss the incident with a trustworthy adult and develop better ways to handle stressful situations in the future. Once children are able to manage their emotions they can negotiate potentially stressful situations occurring throughout the day on their own.

Agencies that have implemented TCI have documented benefits including reduced incidents of aggression and decreased use of high-risk interventions.[8] Titus (1989) documented a decrease in the frequency of child restraints after the implementation of TCI.[9] Farragher (2002) found a 75% decrease in the use of restraints over a six-year span while TCI strategies were increasingly implemented.[10] Nunno et al., (2003) discovered that over an 18-month period from pre- to post-TCI implementation, aggressive and belligerent actions by children that resulted in physical interventions decreased by 66%.[11] Using 13 years of administrative data, Nunno et al., (2017) demonstrated that TCI, in conjunction with Children and Residential Experiences (CARE), a trauma-sensitive therapeutic program model, reduced the rate of aggressive acts which resulted in a decrease in physical interventions by more than half.[12]

The TCI System: The Six Domains

In order for an organization to become a learning organization creating a culture of shared learning and reflection, leadership must foster openness, collaborative decision making, professional development, and a shared vision of how the organization should work. Leadership needs to set high expectations and goals for staff and children and provide the support and resources necessary to achieve the goals. Implementing TCI with the goal of reducing the need for high-risk intervention strategies and creating a safe place for children and staff to practice new skills requires that organizations put in place a system to promote learning and reflective practice. Reflective practice is the ability to reflect on one's actions and engage in a process of continuous learning. For TCI to be an effective crisis management system, the following six general domains need to be addressed as shown in Figure 5:

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

Leadership and program support. The TCI system is an organization-level intervention, requiring that staff develop new ways of understanding the children and families with whom they work and develop new skills for interacting therapeutically with them. Sustaining norms and practices that meet the relationship and developmental needs of children, requires organizational policies and procedures that provide ongoing expectations and support to personnel at all levels of the agency.

Achieving the level of effectiveness required to prevent and reduce the need for high-risk interventions begins with and depends on leadership's commitment to creating a culture that values developmental and therapeutic practice.[14]

When leadership is fully informed about the TCI system and understands its foundation, leaders can support the necessary components that are integral to its implementation and maintenance. Policies, procedures, and guidelines that are clearly written and communicated, assist staff in knowing what to do when confronted with potential crises. Staff throughout the organization should know how to prevent, de-escalate, and contain a child's aggressive and pain-based behavior in ways that are congruent with organizational guidelines.

A clear program philosophy and framework of care are essential for establishing an organizational culture that promotes the growth and development of children living with the effects of complex trauma. Establishing organizational practices that are in the best interests of the children[15] is paramount. Leaders can promote an organizational culture that establishes an environment where children can thrive by valuing developmentally appropriate and therapeutic practice above control and expediency. When leadership promotes and engages in reflective practice, it provides the safe space required for all staff members to openly self-assess their strengths as well as their challenges and improve their own practice. With a positive, trauma-informed program that is culturally sensitive in its approach to working with children and families, an organization can decrease its reliance on punitive and coercive practices as well as its use of restrictive interventions.[16] By providing sufficient resources including adequate and qualified staff, skilled and supportive supervisors, time for reflection and planning, support for regular external and internal monitoring, and clear rules and procedures that have safeguards against abusive practices, leadership promotes positive programming and an organizational culture to sustain the TCI system.

Child and family inclusion. Child and family inclusion means that both the child and the family are active and meaningful participants in making decisions regarding the child's care and treatment. Leadership and staff actively recruit and include children and families in all activities. Children and families have a role in reviewing and evaluating organizational policies and practices. This can make the organization more responsive to children and families and more respectful of their individuality. This move toward inclusiveness requires honest and open relationships underpinned by respect, trust, and cultural competence.

When implementing the TCI system, it is critical to promote the dignity and wellbeing of children. The Convention of the Rights of the Child adopted by the United Nations in 1989 ensures all children have the right to be heard and protected from harm. Very often in reviewing or making decisions about the use of restrictive practices, the focus can be on the intentions of staff instead of the impact on the child. It is important to not only protect the children's physical and emotional well-being but to respect their right to autonomy.[17] This means ensuring the child's participation and involvement, as much as possible, throughout their journey through placement.

There should be a focus on choice, participation, voice, and informed consent.[18]

As active participants, children have input into their own care plans, crisis plans, and treatment options. In addition, children have a voice in how policies, procedures, routines, and activities are designed and carried out. When plans and programs are written with the children, labeling and institutional jargon[19] are avoided.

Every child has a family. When and wherever possible, it is important to keep the family in the parenting role by seeking family input into planning and programming as well as helping the family stay active in daily activities (e.g., shopping, trips to appointments, meetings at school, meals, recreation). Families will need time, support, and information in order to have a meaningful role in the decisions made concerning their child. This requires a true partnership between staff, the organization, and the family.[20] Families need to be fully informed of the organization's policies, procedures, strategies, and interventions to prevent, de-escalate, contain, and manage aggressive, self-destructive, or violent behavior. The family can provide important cultural context when developing plans and designing activities and interventions for their child.

Clinical participation. Clinical and social work services play an important role in overseeing and monitoring children's responses to stressful events and helping staff to use trauma-informed intervention strategies. Developing and implementing an Individual Crisis Support Plan (ICSP) for children who exhibit high-risk behaviors is critical to responding appropriately and therapeutically to a child in crisis.[21] (See Figure 6.) These plans are most effective when they are written by clinical or social work staff with input from team members as well as the child and their family. Equally important is writing the ICSP in clear and concise language so that the care staff can implement the plan as intended. At intake, a risk assessment of the child's likelihood to exhibit high-risk behaviors and the conditions that have triggered these behaviors in the past can provide valuable information.

Rights of Children

The United Nations Convention on the Rights of the Child ensures all children have the right to be heard and protected from harm and provides guidance for serving children's best interests.

The child and family can contribute valuable information about what has worked (or not worked) in the past as well as give staff important cultural context. Families should be involved in developing the ICSPs as well as be informed when their child has had a crisis event.[22]

Well-developed ICSPs include strategies for preventing, de-escalating, and managing potential high-risk behavior specific to the child. Included in the plan are strategies to prevent undesirable setting conditions and possible triggers occurring simultaneously for each individual child. Specific techniques, to help de-escalate the child such as redirecting behaviors, prompting, offering to go for a walk, as well as techniques to avoid that might escalate the child, are included. And finally, specific physical interventions, if appropriate, or alternative strategies if physical intervention is not an option, are prescribed. For example, the provision of unobtrusive personal protective equipment where needed reduces the risk of injury and the need to respond with a physical intervention. It is important to screen all children for any pre-existing medical conditions that would be exacerbated if the child were involved in a physical

restraint. Any medications that the child may be taking that would affect the respiratory or cardiovascular system should also be noted. If there is a history of physical or sexual abuse that could contribute to the child experiencing emotional trauma during a physical restraint, it is equally important to document this in the plan. Ongoing reviews of the child's ICSP with revisions as the child's condition changes will help staff develop more effective ways to prevent and intervene with the child's high-risk behaviors. (See Figure 6).

Supervision and post-crisis response. Frequent and ongoing supportive supervision, mentoring, and coaching are essential for creating and sustaining an organization's ability to maintain good quality care and reduce the need for high-risk interventions.[23] Reflective practice and supportive supervision is built into the implementation and ongoing monitoring of the TCI system. Supervisors who are fully trained in all of the prevention, de-escalation, and intervention techniques can provide effective supervision, coaching, and monitoring of their staff members. Fully trained and effective supervisors hold reasonable expectations with realistic time frames and schedules for staff so that staff can accomplish tasks and respond to children's needs in a thoughtful and well planned manner. Supervisors play an important role in reinforcing the culture of high support and high accountability.

The integration of a well-developed post-crisis response system ensures that all children and adults receive immediate support and debriefing following a crisis as well as a brief medical assessment. When children return to normal functioning, staff conduct Life Space Interviews to look for strategies that can help the children calm themselves in the future when they are overwhelmed with stress and anxiety. Once things return to normal functioning, adults involved in the crisis event can deconstruct the incident to develop strategies for intervening in the future. It is important to document the incident and notify the family when these events occur. Building a discussion of crisis incidents into team/unit meetings helps everyone learn from these situations and provides accountability and support at the highest level.

Training and competency standards. Training and professional development are a cornerstone of any professional organization. Programs that keep emotionally competent staff informed and updated on the special needs of the children in their care can enhance treatment and child outcomes. A comprehensive training agenda includes prevention, de-escalation, and management of crises as well as child and adolescent development, trauma-informed interventions, cultural competence, and individual and group behavior support strategies.[24]

Children who have experienced complex trauma often have difficulty regulating emotions even in routine, everyday situations. Consequently, all staff need support, guidance, and training in using developmentally appropriate strategies to prevent, de-escalate, and manage a situation in which an upset child uses socially inappropriate or aggressive behavior. That is, staff need to understand that trauma often underlies challenging behaviors. Staff must have skills that facilitate the prevention and de-escalation of crisis situations.

TCI training can only be conducted by a certified TCI trainer. The TCI training should be 4 to 5 days in length with a minimum of 28 classroom hours. If the training is less than 28 hours, the physical restraint techniques should not be taught. TCI trainers are required to attend a Cornell University sponsored TCI Update and pass evaluation requirements at least every 2 years (1 year in New York State and in the United Kingdom and Ireland) in order to maintain their certification.

Training for direct care staff to refresh skills is required semiannually at a minimum. Refreshers are designed to give staff the opportunity to

INDIVIDUAL CRISIS SUPPORT PLAN TEMPLATE

Child's Name:_____Date:_____

Safety Concerns—Warnings (medical and physical concerns, medication, history of sexual abuse, etc.):

Current Issues—Potential Triggers (personal / family / social, etc.):

High-Risk Behaviors (hitting, biting, self-injury, etc.):

Intervention Strategies:
Baseline

Triggering Event

Escalation

Outburst

Recovery

Emergency Contacts (psychiatrist, psychologist, counselor, parents, etc.):

Review Date for ICSP: **By Whom?**

Figure 6. Individual Crisis Support Plan (ICSP) Template

practice de-escalation skills, Life Space Interviewing, and physical restraint skills as well as deepen their knowledge base and increase their skill level. At the completion of the original training and each refresher, staff are expected to perform the TCI skills at an acceptable standard of performance. These standards should be established by the agency and consider the abilities of staff to perform the skills in real-life situations. Documentation of these training events and staff's level of competency is critical in order to maintain the TCI system and ensure that staff can competently use high-risk physical interventions. In addition, the health and fitness level of all staff members trained in the use of physical interventions should be considered.

Direct Training Requirements

TCI training should be 4 to 5 days, with a minimum of 28 classroom hours.

The minimum requirement for TCI refreshers is 12 hours, annually, to be delivered a minimum of 6 hours every 6 months, and should include de-escalation skills, physical restraint skills, and Life Space Interview Skills.

TCI certification renewal is determined by semi-annual physical restraint testing, and annual knowledge testing.

TCI training can only be conducted by certified TCI trainers.

RCCP recommends quarterly TCI refreshers, based on best practice findings.

Documentation, incident monitoring and feedback. Documentation, data analysis, and feedback to all levels of staff teams are an important part of the TCI system.[25] Data management includes the documentation of staff supervision and training and the documentation and monitoring of behavioral incidents. An agency-wide committee appointed by leadership with the authority and responsibility to track the frequency, intensity, duration, location, and type of incidents as well as any injuries or medical complaints that occur, helps to monitor the effectiveness of the TCI system. This documentation and monitoring system allows the organization to review incidents, make decisions about individual and organizational practice, and recommend corrective actions that will improve practice.

In addition to an agency-wide incident review committee, a clinical review of incidents and a team or unit review can assist organizations in making changes to reduce the number of high-risk situations. These reviews focus on different aspects of the incident and provide feedback or suggestions to the team, clinician, or administration.

Some type of benchmarking or red flagging should call attention to any situation that exceeds the norm and requires a special review. For example, this red flag might appear when the number of incidents per month exceeds a set number, when restraints exceed a certain length of time, or when specific complaints or injuries that are unlikely to occur during a restraint are reported.

Organizations have been able to reduce aggressive

behavior and physical restraints by effectively implementing the TCI system. TCI implementation has resulted in an increased ability on the part of staff to manage and prevent crises. Implementation studies have also shown increased knowledge and skill on the part of all staff to handle crisis episodes effectively, and a change in staff attitude regarding the use of physical restraint when TCI is implemented as designed.[26]

TCI System Implementation Endnotes

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18. Gharabaghi, 2019; LeBel, J., Huckshorn & Cladwell, 2014.
20. Hust & Kuppinger, 2014.
21. CWLA, 2004; NASMHPD, 2013; Nunno, Holden, M. J., & Leidy, 2003; Paterson, Leadbetter, Miller, & Crichton, 2008; Ridley & Leitch, 2019.
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23. Blau, Caldwell, & Lieberman, 2014; CWLA, 2004; NASMHPD, 2013; Nunno, Holden, M. J., & Leidy, 2003; Ryan, Peterson, Tetreault, & van der Hagen, 2008; Thompson, Huefner, Vollmer, Davis, & Daly, 2008.

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24. Blau, Caldwell, & Lieberman, 2014; CWLA, 2004; Daly, Huefner, Bender, Davis, Whittaker, & Thompson, 2018; Farmer, Murray, Ballentine, Rauktis, & Burns, 2017; Holden, M. J. & Curry, 2008; NASMHPD, 2013; Nunno, Holden, M. J., & Leidy, 2003; Ridley & Leitch, 2019.

25. Blau, Caldwell, & Lieberman, 2014; CWLA, 2004; Daly, Huefner, Bender, Davis, Whittaker, & Thompson, 2018; NASMHPD, 2013; Nunno, Holden, M. J., & Leidy, 2003; Ridley & Leitch, 2019.

26. Nunno, Holden, M. J., & Leidy, 2003.

Notes

Questions for TCI Implementation Assessment

Leadership and Program Support

System consistent with mission

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

Administration

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

Policies, rules, and procedures

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

External and internal monitoring

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

Culture

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

Program appropriate to child's needs

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

Child and Family Inclusion

- ☐ Do children and families play a role in informing agency practice and policy?
- ☐ Do children have input in their Individual Crisis Support Plans?
- ☐ Do children have a voice in how routines and activities are designed and carried out?
- ☐ Do families have input into their child's plan and programs?
- ☐ Are families involved in debriefing after incidents?
- ☐ Are families active in their child's daily activities?

Clinical Participation

Individual Crisis Support Plans

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

Medical screening

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

Documented ongoing reviews

- ☐ Is the Individual Crisis Support Plan reviewed on a regular and frequent basis for progress or modification of intervention strategies?

Supervision and Post-Crisis Response

Supervisors fully trained in TCI

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

Types of supervision

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

Post-crisis multilevel response

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

Training and Competency Standards

Basic/core training

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

Crisis intervention training

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

Ongoing staff development

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

Refreshers

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

Credentialling based on achieving a level of competence

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

Documentation and Incident Monitoring and Feedback

Incident review committee

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

Peer review

☐ Is there clinical oversight of incidents and interventions?

Documentation and Incident Monitoring and Feedback, cont.

Team review

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

Data monitoring

☐ Are incidents documented in a timely and comprehensive manner?

☐ Is the following information collected: frequency, location/time, circumstances surrounding the event, child/staff frequency of events, child/staff injuries?

Feedback loop

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

Red flags/benchmarks

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

TCI Implementation: Leadership and Program Support

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

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

Services Offered

Assessment and Planning Meeting: Program Description

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

1. Leadership and program support
2. Child and family inclusion
3. Clinical participation
4. Supervision and post-crisis response
5. Training and competency standards
6. Documentation, incident monitoring, and feedback.

Agencies will also prioritize needs and develop an action plan to implement the TCI System fully.

Program Objectives

Participants will:

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

Intended Audience

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

Program Outline

9:00 a.m.

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

12:00 p.m. Lunch

1:00 p.m.
- Developing an Action Plan
- What to Expect When Implementation Begins
- Next Steps

4:00 p.m. Adjourn

Materials

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

Additional Technical Assistance Available

- Review crisis related policies and procedures
- Give feedback/review programmatic issues as they relate to TCI
- Do an assessment of organizational culture as it relates to crisis intervention
- Meet with administrators and leaders to discuss implementation of the TCI system
- Meet with the board of directors to present information about the TCI system
- Conduct a TCI fidelity assessment/review

Some technical assistance may be adapted for virtual delivery.

Model Policy on the Use of Physical Interventions

Definition

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

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

Risk and Safety Issues

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

Contraindications

Physical interventions must never be used as:

- punishments
- consequences, or
- to demonstrate "who is in charge"

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

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

Use

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

Necessary Requirements Prior to Use

- Physical interventions may only be undertaken by staff persons who have successfully completed a comprehensive crisis management course that covers: crisis definition and theory; the use of de-

escalation techniques; crisis communication; anger management; passive physical intervention techniques; the legal, ethical, and policy aspects of physical intervention use; decision-making related to physical interventions; and debriefing strategies. Staff members must also have demonstrated competency in performing the intervention techniques as measured and documented according to relevant professional and/or state regulatory guidelines.

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

Process for Use

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

Notes

Notes

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

Services Offered

Individual Crisis Support Planning Workshop: Program Description

One of the major responsibilities of clinical services in the TCI System is to assist direct care staff in preventing and monitoring a child's aggressive and inappropriate responses to crisis situations in residential care. This preventive and monitoring role is formalized through individual crisis management plans (ICSPs). These plans include a functional analysis of a child's high-risk behavior. The ICSPs include risk and safety screening, history of sexual abuse or trauma, pre-existing medical, psychological and emotional conditions, potential triggers to violence, and de-escalation strategies. The functional analysis of behavior and the safety screening help determine specific behavioral and physical interventions necessary to ensure safety for the child. These plans provide a road map for direct care staff workers when dealing with a potential crisis situation.

Program Objectives

Participants will be able to:
- differentiate between proactive and reactive aggression
- apply differential intervention strategies
- develop an ICSP that considers safety, risk, and effective intervention strategies
- involve direct care staff workers in developing and updating the ICSP
- develop an implementation plan incorporating ICSPs in their own agency

Intended Audience

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

Program Outline

9:00 a.m.
- Introductions
- Overview of the TCI System
- Role of Clinical Services
- High-Risk Behavior
- Individual Crisis Management Plans
- Types of Aggression

12:00 p.m. Lunch

1:00 p.m.
- Assessing Aggressive Behavior
- Developing ICSPs
- Implementation Planning

4:00 p.m. Adjourn

Materials

Participants receive a student workbook and an Individual Crisis Support Plan template.

Additional Technical Assistance Available

- Review ICSPs
- Conduct case reviews and assist in the development of ICSPs
- Observe units to monitor the use of ICSPs
- work with the team on developing a process for ICSPs
- Assist in the development of a system to involve children in developing de-escalation preference strategies
- Provide a review of models of trauma-informed care to enlighten practice

Some technical assistance may be adapted for virtual delivery.

Notes

TCI Implementation: Supervision and Post-Crisis Support

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

Services Offered

The Post-Crisis Multilevel Response Workshop: Program Description

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

Program Objectives

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

Intended Audience

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

Program Outline

9:00 a.m.
- The Role of Supervision in the TCI System
- Stress Model of Crisis: Staff/Agency Perspective
- Direct Supervision

12:00 p.m. Lunch

1:00 p.m.
- Immediate Response
- Incident Review with Staff
- Incident Review with Team
- Implementation Planning

4:00 p.m. Adjourn

Materials

Participants receive a student workbook.

Technical Assistance

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

Some technical assistance may be adapted for virtual delivery.

Notes

TCI Implementation: Training and Competency Standards

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

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

Services Offered

Therapeutic Crisis Intervention Training of Trainers: Program Description

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

Training of Trainers in TCI presents a crisis prevention and intervention model designed to help staff workers prevent potential crises, de-escalate crises when they occur, and assist children to learn constructive ways to handle feelings of frustration, failure, anger, and hurt. In addition, physical intervention techniques that respect the dignity of the worker and the child are practiced. The program also gives participants the tools to teach therapeutic crisis intervention techniques in their own agencies. There is an opportunity to practice and gain immediate training experience. The course stresses crisis prevention.

Program Objectives

Participants will be able to:

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

Intended Audience

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

Materials

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

Technical Assistance

- Conduct training skills seminars for TCI trainers
- Observe TCI training and give feedback
- Assess TCI trainers in delivering direct training
- Observe units to assess the transfer of learning
- Assist in implementing and testing an evaluation system

Some technical assistance may be adapted for virtual delivery.

TCI Certification Process

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

Associate Certification

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

Basic requirements for associate certification

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

Privileges associated with associate certification

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

Professional Certification

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

Basic requirements for professional certification

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

Privileges associated with professional certification

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

Agenda: TCI Training of Trainers

MONDAY
8:45 am
Introduction to Course
Implementation of the TCI System
Break
Therapeutic Milieu and Crisis Prevention
Intentional Use of Self
Lunch
Knowing the Child
Break
Stress Model of Crisis
Assessing the Situation
Assignments for Tuesday distributed to participants
5:00 pm Session adjourned

TUESDAY
8:45 am
Refocus
How do I Best Respond?
Crisis Communication and Active Listening
Break
Behavior Support Techniques
Emotional First Aid
Lunch
The Power Struggle
Nonverbal Communication in Crisis Situations
Break
Training assignments for Wednesday or Thursday
5:00 pm Session adjourned

WEDNESDAY
8:45 am
Refocus
Elements of a Potentially Violent Situation
Crisis Co-regulation
Break
Post Crisis Multi Level Response
Life Space interview
Lunch

WEDNESDAY, cont.
Reducing Risk of Harm
Protective Interventions
Standing Restraint
Seated Restraint
Small Child Restraint
Break
Supine Restraint and Transferring Control
Prone Restraint and Transferring Control
Training assignments for Thursday
5:00 pm Session adjourned

THURSDAY
8:45 am
Refocus
Crisis Intervention Role Plays
Break
Safety Intervention Considerations
Practicing Physical Interventions
Lunch
Practicing Physical Interventions
The Letting go Process
Practicing with Resistance
Break
Documentation
Certification Discussion
Criteria for Implementing TCI System and Action Planning
5:00 pm Session adjourned

FRIDAY
8:45 am
Life Space Interview After an Outburst
Break
Testing:
- Physical Intervention Techniques
- LSI
- Written Test

Close of Program
4:00 pm

Notes

TCI Implementation: Documentation, Incident Monitoring, and Feedback

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

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

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

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

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

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

Technical Assistance

- Attend incident review meetings and give feedback
- Review documentation and give feedback
- Conduct workshops on deconstructing incidents and assessing risk
- Assist clinical and supervisory staff in tying documentation into the individual crisis support plan debriefing

Some technical assistance may be adapted for virtual delivery.

Notes

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TCI Faculty, Instructors, and Staff

Project Director

Martha J. Holden, M.S., is a Senior Extension Associate with the BCTR, principal investigator and Director of the RCCP. Ms. Holden provides technical assistance and training to residential child caring agencies, schools, juvenile justice programs, and child welfare organizations throughout the United States, Canada, the United Kingdom, Ireland, Australia, and Israel. She is the author of Children and Residential Experiences (CARE): Creating Conditions for Change, a program model for residential care organizations and the lead developer of the TCI System. Ms. Holden has published in the Children's and Youth Services Review, Child Abuse and Neglect: An International Journal, Journal of Emotional and Behavioral Problems, Residential Treatment for Children & Youth, and The Journal of Child And Youth Care Work. She has co-authored chapters in the books, Therapeutic residential care for children and youth: Developing evidence-based international practice; For Your Own Safety: Examining the Safety of High-risk Interventions for Children and Young People; International Perspectives on Inclusive Education, Volume 2, Trans-forming Troubled Lives: Strategies and Interventions with Children and Young People with Social, Emotional, and Behavioural Difficulties; Understanding Abusive Families: An ecological approach to theory and practice. Previously Ms. Holden served as an administrator overseeing the day-to-day operations of a residential treatment agency for adolescents, including its education resources.

Extension Faculty

Zachary Barry, M.S.W., is an Extension Support Specialist at the Bronfenbrenner Center for Translational Research/Residential Child Care Project. A TCI trainer since 2013, Zac has trained school staff, residential workers, community-based workers and foster parents to prevent, manage and de-escalate crises. As a Social Worker, Zac has served youth and families through numerous roles within residential treatment centers and community-based services. Zac has developed agency policies, procedures and developed a nationally recognized model to provide youth and families meals over extended school breaks. Zac's research interests include resiliency and post traumatic growth.

Kelly Dempsey, B.S., is an extension associate with the BCTR. She has supported youth and their families living with complex trauma, intellectual and developmental diagnosis, and mental health conditions in residential care, school, and community settings since 2002. Kelly has held positions such as recreation worker, therapeutic foster parent, supervisor, and training coordinator while employed with Spurwink, an organization that provides behavioral health and education services for children, adults and families throughout Maine. Kelly has been a TCI trainer since 2007 and a CARE educator since 2013. Kelly became a professionally certified TCI trainer in 2012 and was a consultant with the Residential Child Care Project from 2013 until 2019, when she was hired as a full-time staff. Kelly provides training and technical assistance to agencies implementing TCI and CARE.

Thomas Endres, M.A., is an extension associate with the BCTR. Mr. Endres has worked in residential and child welfare settings for over 40 years. Mr. Endres has held various roles including direct care, supervisor, clinical and administrative positions. Mr. Endres provides training and technical assistance in TCI, TCIS and CARE. He is also involved in curriculum design and devel-opment. Research interests include implementation and evaluation of program models in human service organizations and facilitation of positive organizational change

Richard Heresniak has worked in school and residential care settings since 1985 in a variety of capacities including direct care, school support services, supervisor, and staff training/development coordinator. Richard was the first professionally certified TCI trainer and was a consultant with the Residential Child Care Project from 2003 until 2018, when he was hired as a full time staff with Cornell. He provides training and technical assistance in TCI, TCIS, and CARE. His work with the project also includes curriculum design and development, as well as providing written contributions to project communications.

Frank Kuhn, Ph.D., is a Senior Extension Associate with the BCTR. A clinical psychologist, Frank has worked in clinical, educational and administrative po-

sitions with child welfare organi-zations and universities for over 40 years. He has served as medical school faculty and has provided consultation and training to agencies across the U.S, Canada, Ireland and the United Kingdom. Dr. Kuhn coordinates CARE implementation throughout North America and Europe. He currently serves on the editorial board of the International Journal of Child, Youth and Family Services. Research interests include implementation and evaluation of program models in human service organizations and facilitation of positive organizational change.

Mary Ruberti, LMSW, is an extension associate with the BCTR. Ms. Ruberti has worked in child welfare and residential treatment for over 25 years in various roles including direct care worker, supervisor, social worker, training coordinator, and quality assurance manager. Ms. Ruberti has been affiliated with the Residential Child Care Project at Cornell since 1993. She has had the privilege of providing training and technical assistance to agencies implementing Therapeutic Crisis Intervention (TCI) and Children and Residential Experiences (CARE) in the USA, Canada, Australia, Bermuda, and South Korea.

Andrea Turnbull, LMHC, is an Extension Associate within the Bronfenbrenner Center for Translation Research at Cornell University. Ms. Turnbull is part of the Residential Child Care Project (RCCP) and serves as the Program Manager of Therapeutic Crisis Intervention (TCI). With over 25 years of experience working with young people and staff in out of home care settings, Ms. Turnbull provides training and technical assistance in a variety of residential, juvenile justice, foster, school and community programs across the United States, Canada, UK, Ireland, South Korea and Australia. She works closely with the RCCP team to support organizations with TCI implementation and fidelity.

Research Faculty

Charles Izzo, Ph.D., is a Research Associate at the Bronfenbrenner Center for Translational Research and a member of the research team in the Residential Child Care Project. He studied Clinical and Community Psychology with a specialty in the design and evaluation of community-based services to improve family functioning. His work has focused on applying social science research and methods to improve the quality of human service programs, particularly those that target caregiving. He has published in journals such as Prevention Science, The American Journal of Community Psychology, and the Journal of Prevention and Intervention in the Community.

Lisa McCabe, Ph.D., is a Research Associate at the Bronfenbrenner Center for Translational Re-search at Cornell University. Her research focuses on supporting high-quality services for children and families through program evaluations and policy studies in the areas of child welfare, early care and education, and home visiting. Dr. McCabe has published in scholarly journals such as Early Childhood Research Quarterly, Infant Mental Health Journal, Educational Policy, and the International Journal of Child and Family Welfare. Her work has also been shared through practitioner focused papers (e.g., Zero to Three) and research/policy briefs (e.g., QuickTRIP) designed to bridge the research to practice gap.

Michael Nunno, D.S.W., is a Senior Extension Associate with the Bronfenbrenner Center for Translational Research (BCTR). He has expertise in social policy, regulation, and legislation related child welfare issues as well as specific expertise in the identification, prevention, and etiology of child abuse and neglect in residential care. More recently Dr. Nunno has been working with ther-apeutic and residential child-care organizations to measure the impact of Cornell University's Therapeutic Crisis Intervention system and its Children and Residential Experiences program model on critical incidents.

Deborah E. Sellers, PhD, Director of Research and Evaluation for RCCP, is a sociologist with master's level preparation in biostatistics. Debbie coordinates research and evaluation activities as well as data collection and reporting activities required in the implementation of TCI and CARE. She has expertise in program and research administration, research and evaluation design, the design and implementation of survey research, and the analysis of quantitative data as well as data collection and processing. Debbie has managed multi-year, multi-site, multi-component studies for 25 years and has published in journals such

as the American Journal of Public Health, Preventive Medicine, Health Education and Behavior, Patient Education and Counseling, Social Science and Medicine, and Prevention Science.

Elliott G. Smith, Ph.D., is a developmental psychologist with methodological expertise in ex-perimental psychology and statistical analysis and content specialization in child maltreatment and child welfare. He is a Research Associate at Cornell University within the Bronfenbrenner Center for Translational Research where he serves as Statistician and CARE Data Specialist for the Residential Child Care Project. In his research, Smith evaluates the evidence for the effectiveness of the CARE program model. His implementation efforts center around providing quantitative data back to practice professionals in ways that is approachable, motivating, and actionable. His published research has appeared in numerous journals, including Child Welfare, Developmental Psychology, Journal of the American Medical Association, Pediatrics, and Prevention Science.

Support Staff

Kris Carlison (kmc16@cornell. edu): Handle financial, systems management and administrative operations for the RCCP. Responsible for NYS, National, International and non-sponsored accounts. NYS and Federal proposal and budget creation (NYS, NIJ, DOE, SAMHSA (USDHHS), modification and submission including reporting. Ensure reporting compliance to all funding sources. Supervision of all support staff and oversight of all positions' responsibilities. Data systems and evaluation management for TCI and CARE.

Kristie Lockwood, B.S. (kap9@cornell.edu): Packing and unpacking of evaluation/ test boxes for NYS, National, International and On-site classes, conference and event planning, update and modify database for research and evaluation projects, TCI Fidelity surveys and preparing reports (packing, maintaining, scanning, etc.), TCI-S-Syracuse City School district NIJ grant-surveys.

Kait Martin (kmm438@cornell. edu): Create and track all POs for RCCP. Maintain information about agency restraint policies/ behavior audits. Invoice and process all workbook/certificate orders and replacement material orders. Process consultant and casual employee payments. Review and approve hotel contracts and conduct hotel bill audits of the invoices for accuracy. Invoicing and deposits for on-site trainings and open TCI trainings and CARE. Conduct account reconciliation and monitor bills and payments for accuracy to accounts.

Alissa Medero (ab358@cornell. edu): TCI Class Registrations-National and On-site, processing payments for classes, coordinates and schedules On-site TCI classes-instructors, locations, etc. Initial On-site contact, provides information regarding TCI et al.

Debbie Mojica (dmh20@cornell.edu): Sends reference guide packets to all National, NYS, and on-site participants; coordinates and schedules date requests with hotels for annual trainings for National and NYS, as well as contacting sales office or catering representatives; processes NYS (STARS) TCI Class Registrations.

Trudy Radcliffe, B.A. (tr55@cornell.edu): CARE project – trainings and surveys (packing, maintaining, scanning, etc.) on-line and paper, certifications (assisting with grading and test creation), Management of agency information and status with CARE project, invoicing and deposits of contract payments, ordering CARE training materials, CARE agency report creation, travel reimbursements.

Eugene Saville, B.S. (eas20@cornell.edu): Handles administrative, contractual, and policy, and changes/ issues for the project. Plan for delivery of new training courses. Create online, in-service, and/or blended learning environments, activities, and RCCP training course content, including revisions of current programs. Provide general computer and RCCP database support and guidance to RCCP staff and faculty; develop new interactive learning capacities, and maintenance, for the project's web site. Provide program support for data management and instructional support.

Anna Shcherenkov (as2554@ cornell.edu): Coordinates shipment and packs training materials for NYS, National and On-site classes; orders training box materials, mats, cd's, and flash drives; scans class information into database; fills out and sends professional

development certificates; sends out weekly Status of Training emails to instructors/staff. Handles participant list corrections and revisions.

Holly Smith (hs226@cornell.edu): TCI Certifications including conditionals, class grading and test creation and modification (including STARS), certification renewals and expirations, NYS, National and International quarterly reports, Professional certification-sending letters and maintaining information, certification rules, Agency Injury Reporting-maintaining on-line reporting system and notification when an injury has been reported.

RCCP Consultants

Linda Avitan, M.S.W., has worked in Israel with youth at risk for over thirty years, including residential and foster care. She began work with TCI in 2006, and has instructed TCI/S in Israel and in the United States. Serving on the Israel TCI Steering Committee, she has coordinated the program and been involved in policy making and innovations such as trainer peer-group supervision. Linda is certified in Marital and Family Therapy and Mediation, as well as in Parental Consultation for Children with AD/HD, which she utilizes in her private practice.

Craig Bailey, B.S., has worked with youth in residential care and school settings since 1996. He has served youth and families through Hillside Children's Center, Monroe 2-Orleans BOCES, and Crestwood Children's Center. Craig is currently a Manager in Organization Development and Learning with Hillside Family of Agencies, located in Rochester, NY. He is a primary TCI Trainer and CARE Educator for new employees and helps coordinate the implementation of the TCI system and CARE program model throughout all of the service affiliates of Hillside Family of Agencies. Craig has worked as a consultant with the Residential Child Care Project since 2007 and facilitates TCI Train-the-Trainer and TCI Trainer Updates in the United States and internationally.

Shlomit Branski, M.S.W, has been working with residential care of youth at risk in Israel over 20 years. For the last 10 years, managing the social workers, psychologists and therapists team. Train-ing groups of staff members at residential care facilities and counseling social workers at various institutes. Studied TCI in 2004 and since then instructing TCI trainings and serving in the Israeli TCI steering committee as the liaison between the committee and the institutes that use TCI. Joined the TCI Instructor team in 2016.

Sharon Butcher, M.A., is the Director of Education at the Waterford Country School, a non-profit human service agency located in southeastern Connecticut. Her professional career began as a childcare worker in the residential treatment program at WCS before becoming a Special Education Teacher and advancing into her current role. Sharon became a professionally certified TCI trainer in 2004 and joined the RCCP in 2010 as a TCI and CARE Instructor. She implements both the TCI and CARE models with great success in her school programs and serves as a member of the Executive Leadership Team at Waterford Country School providing support and guidance in the implementation of TCI and CARE across all of the Agency programs.

Stacey Charchuk, B.A (Criminology); CYCW(cert) works at Oak Hill Boys Ranch, a campus based residential program for adolescent young people near Edmonton, Alberta, Canada. She began at Oak Hill in 1996 serving within the role of a Child & Youth Care Worker, Supervisor, and presently as the Executive Assistant Director. Stacey has been an associate Therapeutic Crisis Intervention trainer since 2007 and acquired her professional trainer status in the Fall of 2015. Sta-cey joined the RCCP team as a Casual Instructor in 2016. She has also been a CARE Educator (Children And Residential Experiences) at Oak Hill since 2010.

Ellysha Clark has worked in the out of home care sector in a range of capacities since 2008. With over 10 years of experience in the sector, Ellysha is passionate about the impact TCI can have on a young person. Ellysha is experienced using TCI in a range of programs including residential, disabilities, crisis response and family restoration work. In her current role as Training and Development Coordinator, Ellysha is passionate about upskilling staff to therapeutically manage crisis and ensuring they are supported to feel confident and competent to do so. Throughout her career, Ellysha has obtained qualifications in project management,

community services, mental health, training in assessing and is a registered foster carer.

Yeshaya Corrick, B.E.D., has 17 years of professional experience in various therapeutic settings as a child-care worker and coordinator. He is one of the leading team which brought the TCI system to Israel in 2003 and is a member of the national steering committee for TCI. He currently works as a supervisor, mentoring and training educational staff and families, mainly in schools and facilities, which specialize in emotional and behavioral disorders. (Israel)

John Gibson, Doc. P W., is owner of Secure Attachment Matters, Ireland. He is qualified in Social Work and worked in 4 different residential child care settings for a total of 25 years. He consults to residential child care organizations, principally in relation to development of models of care. He provides direct support to high risk foster placements. In 2015 he contributed a book chapter to the International Foster Care Organisation "Ensuring the Rights of the Child, and Family-Centred Services", Conference Proceedings publication. In 2016 he co-authored, with Colby Pearce, an article for 'Foster' the journal of the Irish Foster Care Association. The article reports on the Ireland based pilot of the Triple A Model of Therapeutic Care, developed and authored by Australian Clinical Psychologist, Colby Pearce. John was among the first workers to train in TCI in Ireland and Britain. He joined the RCCP as an Instructor in 2001. He holds post graduate qualifications in Social Learning Theory (Child Care) and in Social Work Management and Leadership. He is trained in the Child Attachment Interview at the Anna Freud Centre (London).

Jack C. Holden, Ph.D., has been an instructor and project consultant with Cornell University's RCCP for over 30 years. Dr. Holden earned a Ph.D. in Education, specializing in Adult Learning and has presented workshops and research nationally and internationally and has authored, Developing Competent Crisis Intervention Training, and co-authored a chapter, Preventive Responses to Disruptive and High-Risk Behaviours, in the book International Perspectives on Inclusive Education. Dr. Holden has co-authored several training manuals including Therapeutic Crisis Intervention for Schools, (TCIS) and published in the Journal of Child and Youth Care Work, and Journal of National Staff Development and Training Association.

Alexandria Horn MChild&AdolesWelf, has worked in the out of home care and disability sector since 2013. Alexandria has operated in roles including casework, case management and Human Resources including recruitment and training of staff. During her career Alexandria has experience in working with children and young people with complex mental health, physical disability and developmental disability needs and witnessed the positive and therapeutic benefits of implementing the TCI System in challenging environments. In her current role as Human Resources Officer with Allambi Care, Alexandria is passionate about using TCI to work with frontline staff in a supervision and post-crisis response capacity. Alexandria has qualifications in child and adolescent welfare, social welfare, community services, training and assessing, frontline management and business.

Ben Jones is a Training and Development Coordinator with TACT. Ben is the Central point of contact for the RCCP in Australia and Coordinates all TCI Train the Trainer courses. Ben has a passion and commitment for supporting youth, families, staff and carers. Ben has vast experience supporting a diverse range of needs, having worked in a variety of roles in the out-of-home-care sector including; direct residential care, disability care, supporting vulnerable families as well as case management roles. Since 2015, Ben's focus has been in Learning & Development; Ben became a TCI Instructor in 2017 and through TACT assists RCCP scheduling TCI throughout Australia. Outside of these roles, Ben is a dedicated foster carer.

Beth Laddin, L.M.S.W., has worked as a Social Worker in the area of Child Welfare for the past 40 years. Ms. Laddin worked for the RCCP at Cornell as a Program Manager and as a Field In-structor. Ms. Laddin became a TCI Instructor in 1994. She worked as a school social worker for 20 years in Albany, NY. Other child welfare experience includes positions in Child Protective Services, residential facilities, administrative state positions, quality assurance work, and program development.

Dalit Eshed Levy, M.A. is a clinical psychologist, life coach and private therapist. Works with children and staff in child and youth residential facilities. A TCI in-

structor since 2003. In charge of TCI implementation in the Youth Protection Authority. Senior consultant to the Israeli steering committee for TCI. Provides TxT courses and direct training. Mother of four, resides in (Israel).

William Martin, MHSA, has been working with children and families with special needs for over 30 years. He is the Executive Director of Waterford Country School, a nonprofit human service agency providing a multitude of services including residential treatment, emergency shelters, therapeutic boarding, foster care, special education, and outpatient services. Bill is also a CARE and TCI instructor and he and the staff of Waterford Country School are deeply involved in, and committed to TCI, TCIF, TCIS and the CARE and CARE for Foster Carers program models. Bill has a Master's degree in Human Service Administration and a Bachelor's Degree in Social Work.

Eddie Mendez has worked with children, young people and families since 1990 in both the gov-ernment and non-government sector. Over this time, Eddie has worked in a variety of settings including custodial roles, Residential program, Foster Care, Learning and Development and as a CARE & TCI Practitioner. Eddie's work has primarily been based in Western Sydney, Australia however now also provides support to programs at a national level. In addition to his direct work, Eddie has also been involved in the facilitation, design and development of many training work-shops for staff and carers. Eddie has been involved with the TCI program since 2000-2001 becom-ing a TCI Instructor in 2013 and delivers the TCI Train-the-trainer program across Australia.

Andrea J. Mooney, M.Ed., JD, is an original author of TCI. She has been involved with the program since its inception, and now teaches the one-day "Legal Issues" update. Andrea has been a special education teacher, an Attorney for the Child, and a trainer/consultant for various projects, including a school violence prevention project. She is now a clinical professor at Cornell University Law School, where she teaches legal writing, externships, and child advocacy. She also continues to represent children in family court at the trial and appellate levels.

Nick Pidgeon, is Director of NJP Consultancy and Training Ltd. based in Bridge of Allan, Scot-land. He has many years' experience in social work and over 20 years experience as an independent consultant. He has provided training and consultancy throughout Britain and Ireland and in the USA, Canada, Australia, and Russia. Since 1993 he has been a consultant to the RCCP.

Michele A. Pierro, M.S., holds an M.S. in Educational Psychology, Secondary Education, and certificate of Advanced Studies in Educational Administration. For the past 40+ years Michele has worked in a variety of educational settings, including Middle and High schools, programs for Gifted and Talented and in a maximum-security facility for juvenile offenders. She has been a fac-ulty member at Columbia Greene Community College, Supervisor of Teaching Fellows at Pace University, a Principal and Director of Special Education at a BOCES in upstate NY, Director of School Safety and Positive Behavior Supports in D75 in NYC and Director of Security Resources for the NYCDOE, providing technical assistance to schools on the NYS Persistently Dangerous List. She serves as a rating officer and consultant with the NYCDOE and UFT. Michele joined the RCCP in August 2012.

Marques Richardson has over twelve years of experience working with young people in resi-dential child care. He is a lead TCI trainer at Astor Services for Children and Families. In addition to this role, he also serves as the staff development coordinator and is a CARE educator. He has been training TCI since 2012. Marques became a Professional TCI Trainer December of 2016.

Anton Smith, Executive Director, MSW, RSW. Anton is currently the Executive Director for Oak Hill Boys Ranch, a campus based therapeutic residential program, located near Edmonton, Alberta, Canada. He has worked at Oak Hill for fifteen (15) years and in the area Child and Youth Care for over 30 years in variety children's services domains. In addition, he is a Children And Residential Care (CARE) Consultant and an Instructor for Therapeutic Crisis Intervention (TCI) with the Residential Child Care Project (RCCP) at Cornell University. Anton has completed a Masters in Social Work (2005) through Dalhousie University in Child and Family Practice and a Bachelor of Social Work from the University of Victoria.

Anton has presented at international, na-tional and regional conferences on topics related to Child and Youth Care. He has published two peer-reviewed articles in the areas of residential treatment and restraint reduction.

Zelma Smith-Pressley, LMSW, Child Welfare Consultant and Trainer, has over 45 years of ex-perience in the field of child welfare including training, consultation, curriculum development, supervision, and direct service delivery. Her work experience includes training in kinship care, re-cruitment, preparation and selection of foster and adoptive parents, residential treatment programs, child abuse and neglect and meeting planning. She is the principal developer of a national educational group support program for kinship families. Formerly, she was chairperson for the National Association of Black Social Workers' National Kinship Task Force Committee and a past member of the National Kinship Advisory Committee at the Child Welfare League of America. She is a TCI instructor on the Residential Child Care Project

Angela Stanton-Greenwood, MA, MEd, CQSW has worked with individuals with complex needs for over forty years as a practitioner with Barnardos in residential care and education and now as Director of Quality Assurance and Workforce Development in the Hesley Group England. She is a TCI and Proact SCIP R UK instructor and Positive Behaviour Support Coach. Angela is supporting CARE implementation and administers CARE and TCI through The Listening Post in Europe.

Laurence Stanton-Greenwood, BA hons in Education and Training, Qualified Social Worker with Qualified Teacher status has worked with a population of people with complex needs both in Social Care and Education for 40 years as a practitioner and manager. He now works as a training manager for the Hesley Group, England, coordinating and delivering a range of training programmes including TCI. He became a TCI Instructor in 2012.

Misha Thomas, M.Div., has been a TCI trainer since 1995; works internationally as an organi-zational training consultant, speaker, and group facilitator. Misha was a founding co-contributor and faculty/ consultant for The Sanctuary Institute between 2005-2015. Jobs throughout his tenure in residential care include teacher/counselor, child behavior specialist, program manager, training director, and textbook question writer for The Princeton Review. Publications include contributions in Therapeutic Communities and a textbook article in Danish professional development book, Engelsk: Paedogogisk Assistant, "Caring for Children with Special Needs," edited by Anne Brunstrom.

Fiona Waites, Dip CommServ(CaseMgmt), CertIV TrngAssmnt is a Learning and Development professional, specialising in supporting staff and carers engaging with traumatised young people, at risk families and mental health. She has worked with youth in a variety of out-of-home care and homeless shelter settings since early 2002. She has studied in the areas of psychology, adult learning and development with additional training in facilitation and community service management. Based in Brisbane, Australia, providing consultation and support across the country, however also working specifically within a leading provider of out of home care, housing services and aged care in Queensland. Fiona has particular interest in brain function, trauma, mental health and facilitation. She also has a passion for leadership, and is involved in running programs devel-oping this within staff and chaplains professionally, and with young adults and adolescents within the community.

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