The Therapeutic Crisis Intervention System for Schools

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Therapeutic Crisis Intervention System For Schools

Information Bulletin

The Residential Child Care Project
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Preface

The Bronfenbrenner Center for Translational Research (BCTR), formerly the Family Life Development Center (FLDC), was established by New York State legislation in 1974. The center's mission is to improve professional and public efforts to understand and deal with risk and protective factors in the lives of students, youth, families, and communities that affect family strength, student wellbeing, and youth development. The Therapeutic Crisis Intervention System is one of several programs delivered by the BCTR relevant to the lives of students, families, and care agencies.

In the early 1980s, under a grant from the National Center on Child Abuse and Neglect, Cornell University developed the Therapeutic Crisis Intervention (TCI) crisis prevention and intervention model for residential child care organizations as part of the Residential Child Care Project (RCCP). Since the curriculum's inception there have been five major revisions. The revision process has generally included (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, (d) talking to other crisis management training providers, and (e) convening experts for consultation and review. Although TCI was originally developed to provide children's residential centers with an effective crisis management system, many of the centers had on-grounds schools for the children in their care. Because of the initial success of TCI in the residential programs, residential centers began teaching their on-grounds school staff the TCI curriculum. Over time, some of the New York States Boards of Cooperative Educational Services (BOCES) began training their staff in TCI to help their staff manage crisis more effectively with the special education population.

During the past 10 years the number of schools implementing TCI as their crisis management system has increased dramatically. Additionally, federal and state school guidelines regulating the use of physical restraints are being developed. Although TCI has been successful in helping school staff better manage students in crisis in schools, the TCI curriculum is geared towards residential care workers.

The decision was made by Cornell University's RCCP to explore the possibility of adapting TCI for schools. During a RCCP TCI retreat held in Ithaca, NY, 2007, a group of school experts came together to discuss the crisis intervention needs for schools, how TCI could met those needs, and what changes needed to be made to adapt TCI for schools. It was in that spirit that TCI for Schools (TCIS) has been adapted and developed. The TCIS system assists public and private schools in preventing crises from occurring, de-escalating potential crises, managing disruptive and acute physical behavior, reducing potential and actual injury to students and staff, teaching students adaptive coping skills, 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 and complements the Response to Intervention (RTI) approach used in the United States.

The RCCP supports vigorous and ongoing in-school evaluation of TCIS training and implementation efforts through testing participants' knowledge and skills, a certification program, formal assessment, and direct monitoring of agencies' use of high-risk interventions. The RCCP seeks to maintain a leadership role in discovering new knowledge, establishing new approaches to knowledge dissemination, and developing innovative programs to enable schools to serve students, youth, and families more effectively by building strong linkages among research, outreach activities, and evaluation efforts. These relationships are viewed as cyclical: research leads to the development of innovative and effective outreach programs, which are carefully evaluated. Evaluation activities contribute directly to the adaptation and improvement of outreach programs and may also contribute to new research. In-house and external evaluations have been essential in modifying intervention strategies and protocols to improve the TCI system's effectiveness for a wide range of organizations (see Figure 1).

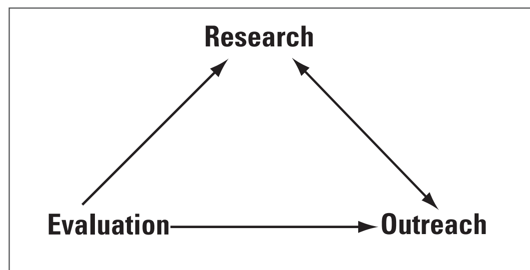

Figure 1. Research, Practice, and Evaluation Cycle

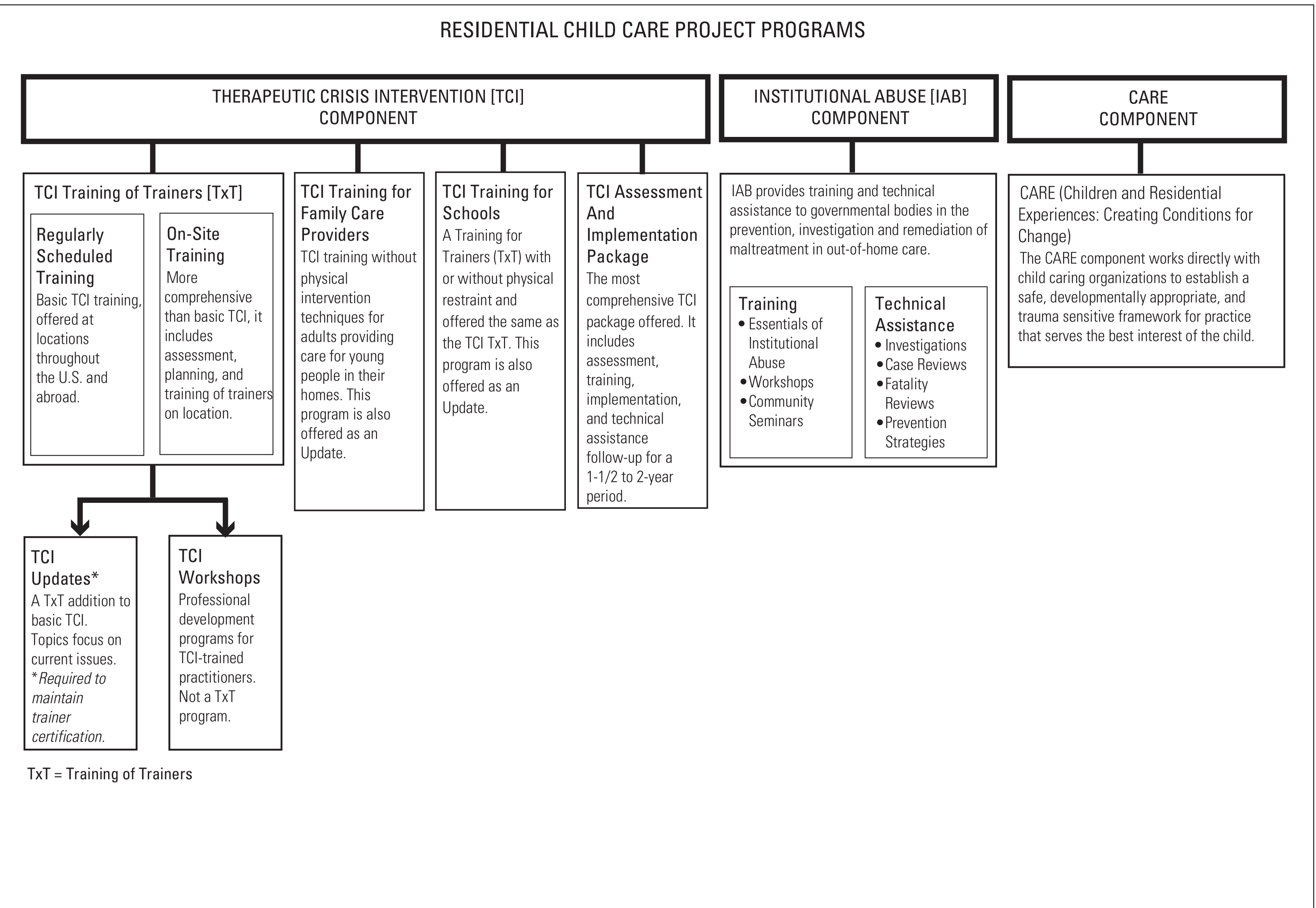

Figure 2. RCCP Programs

Criteria for an Effective Crisis Prevention and Management System

In his book, *The Fifth Discipline, The Art and Practice of the Learning Organization* (1990, p. 3), Peter Senge defines learning organizations as:

> *…organizations where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning to see the whole together.*

Organizations can only learn when the people who make up the organization learn. Leadership must foster openness, collaborative decision-making, professional development, and a shared vision of how the organization should work. Leadership needs to set bold goals and high expectations for staff and students and provide the support and resources necessary to achieve the goals. Implementing TCIS with the goal of reducing the need for high-risk management strategies requires that schools put in place a system to promote learning and reflective practice.

For TCIS to be an effective crisis management system, the following five general domains need to be addressed: (a) leadership and administrative support, (b) social work and clinical services participation, (c) supervision and post crisis response, (d) training and competency standards, and (e) data-driven incident monitoring and feedback (Nunno et al., 2006). (See Figure 2).

Leadership and administrative support. The level of effectiveness to prevent and reduce the need for high-risk interventions depends on and begins with leadership's commitment to TCIS (Bullard, Fulmore, & Johnson, 2003; Carter, Jones, & Stevens, 2008; Child Welfare League of America Best Practice Guidelines, 2004; Colton, 2008; Donat, 1998, 2005; Farragher, 2002; Hellerstein et al., 2007; Huckshorn, 2006; Miller et al., 2006; Murphy & Bennington-Davis, 2005; National Association of State Mental Health Program Directors (NASMHPD), 2003; Nunno et al., 2003; Paterson, Leadbetter, Miller, & Chrichton, 2008; Petti et al., 2003; Ryan, Peterson, Tetrault, & Van der Hagen, 2007; Stefan & Phil, 2006; Thompson, Huefner, Vollmer, Davis, & Daly, 2008).

For schools, the leadership commitment begins with the district leadership or local educational agencies who in turn provide the school leadership with guidance and support to fully implement the crisis management system. When leadership is fully informed about the TCIS crisis prevention and management system and understands its foundation, it is more likely that leaders will be able to support the necessary components that are integral to its implementation and maintenance. This means that school leadership can clearly communicate the crisis procedures, policies, and guidelines to everyone in the organization so that all staff members know what to do when confronted with potential crises. It also means that staff members throughout the building know how to prevent, de-escalate, and contain a student's aggressive and acting out behavior consistent with school guidelines.

A clear school and school district philosophy and framework are essential for establishing a school culture that promotes the academic and social growth and development of students with emotional and behavioral difficulties and for establishing practices

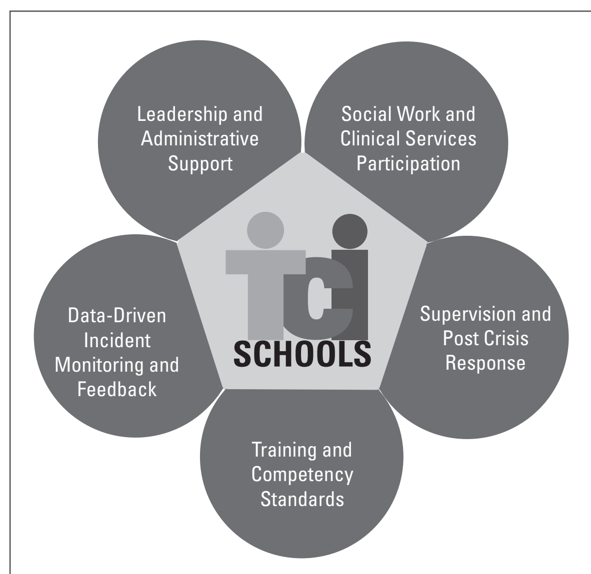

Figure 3. Implementation Criteria: Organizational Cornerstones of the TCIS System

that are in the best interests of the students (Anglin, 2002). Leaders can promote a school culture that establishes an environment where students can learn by valuing developmentally appropriate practice above control and expediency. With a positive, trauma sensitive, and strength based culture and climate, and appropriate teaching and support based on the needs of individual students, schools can decrease their reliance on punitive and coercive interventions and restraints (Bullard et al., 2003; Colton, 2008; Farragher, 2002; Hellerstein et al., 2007; Huckshorn, 2006; McAfee, 2006; Miller et al., 2006; Murphy & Bennington-Davis, 2005; NASMHPD, 2003; Paterson et al., 2008; Petti et al., 2003; Stefan & Phil, 2006).

By providing sufficient resources including adequate and qualified staff, 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 a safe and caring community within the school and reduce the need for use of restraints in school (McAfee, 2006; Ryan et al., 2007).

Social work and clinical services participation. Social work and clinical services play an important role in overseeing and monitoring staff's responses to students in crisis. Developing and implementing an individual crisis management plan (ICMP) or some form of emergency restraint plan is critical to responding appropriately and in the best interest of a student in crisis (Bullard et al., 2003; Carter et al., 2008; CWLA Best Practice Guidelines, 2004; Donat, 1998, 2005; Farragher, 2002; Hellerstein et al., 2007; Huckshorn, 2006; Murphy & Bennington-Davis, 2005; NASMHPD, 2003; Nunno et al., 2003; Paterson et al., 2008; Salias & Wahlbeck, 2005; Stefan & Phil, 2006).

The United States Federal Law, Individuals with Developmental Education Improvement Act (IDEA), governs how states provide early intervention and educational services to children with disabilities. IDEA stresses the importance of Individual Education Plan (IEP) teams developing behavioral and educational plans to minimize the need for physical restraints. An individual crisis management plan (ICMP) or emergency safety plan should be developed and in place for any student who is likely to be restrained.

The ICMPs are more effective when developed with input from classroom team members, the student, and the student's family, and are written in clear and concise language so that the classroom staff can implement the plan. All students with IEPs should have a risk assessment of the student's propensity to engage in high-risk behaviors. The conditions that have provoked these behaviors in the past can provide valuable information. Key questions to address are: (a) How can high-risk behaviors be prevented? (b) Is there a need for an ICMP? (c) What intervention strategies should be used if an ICMP is necessary?

Well developed ICMPs include strategies for preventing, de-escalating, and managing potential high-risk behavior specific to the student. Included in the plan are specific physical interventions, if appropriate, or alternative strategies if physical intervention is not an option. It is important to screen all students in schools for any pre-existing medical conditions that would be exacerbated if the student were involved in a physical restraint. Any medications that the student may be taking which 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 student experiencing emotional trauma during a physical restraint, it is equally important to consider this but care should be taken for confidentiality reasons not to write this in the plan. Confidentiality can be maintained by focusing on strategies to help the child in crisis that have the least risk for re-traumatizing that child. Ongoing reviews of the student's ICMP with revisions as the student's condition changes will help staff develop more effective ways to prevent and intervene with the student's high-risk behaviors. This process should be data-driven. These decisions should be informed by the data generated from incident reports.

Supervision and post crisis response. Frequent and ongoing supportive staff supervision, mentoring, and coaching are essential for creating and sustaining a school's ability to reduce the need for restraint and to serve the best interests of the student (Bullard

et al., 2003; Colton, 2008; CWLA Best Practice Guidelines, 2004; Donat, 1998, 2005; Farragher, 2002; Huckshorn, 2006; Miller et al., 2006; Murphy & Bennington-Davis, 2005; NASMHPD, 2003; Nunno et al., 2003; Petti et al., 2003; Ryan, Peterson, Tetreault & van der Hagen, 2008; Thompson et al., 2008). Reflective and supportive supervision is built into the implementation and ongoing monitoring of the TCIS crisis management system. Building administrators 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 building administrators should have reasonable expectations with realistic time frames and schedules for staff so that staff members can accomplish tasks and respond to students' needs in a thoughtful and well-planned manner.

A post crisis response system ensures that all students and staff members receive immediate support and debriefing following a crisis as well as a brief medical assessment (Bullard et al., 2003; CWLA Best Practice Guidelines, 2004; Farragher, 2002; Huckshorn, 2006; Miller et al., 2006; Murphy & Bennington-Davis, 2005; NASMHPD, 2003; Nunno et al., 2003; Petti et al., 2003, Ryan et al., 2009). Once things are back to normal, all staff members involved in the restraint can deconstruct the incident to develop strategies for intervening in the future. It is important to notify families when their child has been involved in a physical intervention (Ryan et al., 2009). Building a discussion of student crisis incidents into team meetings helps staff learn from these situations and provides accountability and support at the highest level.

Training and competency standards. Training and professional development are cornerstones of any professional organization. Schools that keep staff informed and updated on the special needs of the students in their classrooms can enhance academic success and improve student outcomes. A comprehensive training agenda includes prevention, de-escalation, and management of crises as well as child and adolescent development, trauma sensitive interventions, and individual and classroom behavior support strategies (Bullard et al., 2003; CWLA Best Practice Guidelines, 2004; Donat, 2005; Farragher, 2002; M. J. Holden & Curry, 2008; Huckshorn, 2006; Murphy & Bennington-Davis, 2005; NASMHPD, 2003; Nunno et al., 2003; Paterson et al., 2008; Petti et al., 2003; Ryan et al., 2008; Thompson et al., 2008).

TCIS training is only one part of a comprehensive staff development program that provides core training and specialized training based on the population served. TCIS training is only to be conducted by a certified TCIS trainer. The TCIS training should be 4-5 days in length with a minimum of 28 classroom hours if physical restraint is taught, 3.5 days with a minimum of 24 hours if protective interventions are taught, and 3 days with a minimum 21 hours without physical interventions. TCIS trainers are required to attend a Cornell University sponsored TCIS Update and pass testing requirements at least every 2 years in order to maintain their certification.

Training for staff to refresh TCIS skills is required semi-annually at a minimum. Refreshers are designed to give staff the opportunity to practice de-escalation skills, Life Space Interviewing, emotional first aid, crisis co-regulation, and physical restraint skills, if trained. At the completion of the initial training and each refresher, staff are expected to perform the skills at an acceptable standard of performance. Documentation of these training events and staff's level of competency is critical in order to maintain the TCIS system and ensure that staff can competently use the skills and interventions.

Data-driven incident monitoring and feedback. Documentation, data analysis, and feedback to all levels of staff teams are an important part of restraint reduction efforts (Bullard et al., 2003; Carter et al., 2008; CWLA Best Practice Guidelines, 2004; Donat, 2005; Farragher, 2002; H.R. 4247, 2010; Huckshorn, 2006; Miller et al., 2006; Murphy & Bennington-Davis, 2005; NASMHPD, 2003; Nunno et al., 2003; Petti et al., 2003; Ryan & Peterson, 2004; Stefan & Phil, 2006; Thompson et al., 2008). Data management includes the documentation of staff supervision and training and the documentation and monitoring of incidents throughout the school. A school-wide restraint committee appointed by

leadership with the authority and responsibility to enforce documentation requirements and track the frequency, location, and type of incidents as well as any injuries or medical complaints that occur in the school helps to monitor the effectiveness of the TCIS system. This documentation and monitoring system allows the school to review incidents and make decisions about individual and organizational practice and recommend corrective actions.

In addition to a school-wide restraint review committee, a clinical review of incidents, and a team review can assist schools in making changes to help reduce high-risk situations. These reviews focus on different aspects of the incident and provide feedback on any information or suggestions to a team, clinical services, 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, a 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.

Schools have been able to reduce physical restraint episodes and aggressive behavior by following these guidelines and effectively implementing the TCIS system. Implementation of TCIS 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 staff attitude regarding the use of physical restraint when TCIS is implemented as designed (Nunno et al., 2003).

Questions For Implementation Assessment

Leadership and Administrative Support

System consistent with district and State regulations

- ☐ Is TCIS approved by the school district or local educational authorities?
- ☐ Does the school have a well thought out crisis response plan based on the population?
- ☐ Does the school have ongoing in-services based on the population served?

Administration

- ☐ Does the leadership of the school district/building understand and support TCIS as the crisis prevention and management system?
- ☐ Are there adequate resources at the school to support the TCIS system, i.e., training hours, adequate staffing in classrooms, monitoring and coaching of classrooms, post crisis response, Individual Crisis Management Plans (ICMPs), and first responders/crisis staff?

Policies, rules, and procedures

- ☐ Do the policies and procedures clearly describe intervention strategies taught in the TCIS training?
- ☐ Are the procedures understandable and communicated to all staff?
- ☐ Are there clear guidelines against abusive practice?
- ☐ Is there an informed consent process in place for family or caretakers?

External and internal monitoring

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

Culture

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

Program appropriate to student's needs

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

Social Work and Clinical Services Participation

Individual Crisis Management Plans (ICMP)

- ☐ Is there an ICMP identifying the students high risk behavior, medical, physical and emotional condition with individualized strategies to prevent and de-escalate potential crises?
- ☐ Has a functional analysis of each student's individual high-risk behavior been completed?
- ☐ Are there specific intervention strategies tailored to the needs of the student?
- ☐ Is the student involved in identifying de-escalation preferences and triggers?
- ☐ If physical restraint may be necessary based on high risk behaviors of the student, are specific restraints indicated and prescribed?
- ☐ If physical restraint is inappropriate based on the special needs or situation of the student, are there alternative interventions described?

Medical Screening

- ☐ Has each student 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 student?

Documented Ongoing Reviews

- ☐ Is the ICMP reviewed on a regular and frequent basis for progress or modification of intervention strategies?

Supervision and Post Crisis Response

Administrators Fully Trained in TCIS

- ☐ Have the building administrators been trained in TCIS so they can coach, support, and have reasonable expectations of teachers and staff members?

Types of Supervision

- ☐ Do administrators provide on-the-job training in the form of coaching staff in early intervention and LSI skills?
- ☐ Is supervision supportive, frequent, and ongoing?

Post-Crisis Multilevel Response

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

Training and Competency Standards

Basic / Core Training

- ☐ Do teachers and staff members receive training in skills necessary to competently manage and teach children with special needs, i.e., child development, transition planning, group processing, communication skills, relationship building, trauma assessment, and re-traumatization in addition to quality instruction training?

Crisis Intervention Training

- ☐ Do all teachers and staff members receive a minimum of 20 hours of TCIS training (28 hours if physical restraint training is included)?
- ☐ Is the training delivered by certified trainers?

Ongoing Staff Development

- ☐ Do teachers and staff members attend additional, ongoing training that is relevant to the students and program, such as developing appropriate lessons and instruction and effective instructional strategies?

Refreshers

- ☐ Do teachers and staff members attend TCIS refreshers at annually (preferably every 3-6 months), 6 hours without physical restraint and 12 hours with physical restraint?
- ☐ Do staff members practice and receive corrective feedback on the main skills, i.e., LSI, behavior support skills, co-regulation strategies during these refreshers (physical interventions if taught)?

Credentialling Based on Achieving a Level of Competence

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

Data-Driven Incident Monitoring and Feedback

Critical Incident Review Committee

- ☐ Is there a school-wide committee that reviews incidents? Does that committee have some authority to recommend and implement policy and changes? Are advocates and/or students involved in review of incidents?

Clinical Review

- ☐ Is there a clinical review of incidents and interventions?

Data Monitoring

- ☐ Are incidents documented in a timely and comprehensive manner?
- ☐ Is the following information collected: frequency, location/time, circumstances surrounding the event, student/staff frequency of events, student/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?

Developing School Policies and Procedures on the Use of Physical Restraint

The use of physical restraint is a complex issue and has been part of the human services field of practice for centuries. Restraints pose a number of risks to children including trauma, injury, humiliation, suffering, and death. Due to the inherent risk involved in the use of restraints, there are state and federal regulations and guidelines that govern the use of restraints in human service organizations. The following material includes suggestions for drafting school policies and procedures on the use of physical restraint. Additional tips and suggestions are written in italics.

Purpose

The purpose of these policies and procedures is to insure the safety of students and staff, inform parents of the possibility of children being restrained, specify under what circumstances restraints would be conducted, and provide guidance to educators and staff about the purpose, training, and expectations for how physical restraints could be used.

Definitions

Definitions should include a list of terms used in the policies and procedures including, but not limited to:

Physical restraint – one or more individuals using physical force to reduce, restrict, or immobilize the ability of an individual to move his/her arms, legs, or head fully.

Physical escort – the temporary touching or holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a student who is acting out to walk to a safe location.

Individual crisis management plan (ICMP) – a plan developed and documented for an individual student that includes an assessment of the student's medical, physical, and emotional status that would contraindicate the use of physical interventions, the student's potential triggers to violence, and prevention, de-escalation and crisis management strategies tailored specifically for that individual student.

High-risk behavior – behavior that places the student or others at imminent risk of bodily harm.

Crisis Prevention

One of the most important aspects of crisis prevention is the culture of the organization. A clear and unambiguous statement supporting crisis prevention over high-risk interventions sets the tone for the organization.

The school will promote students' emotional well-being, improving their ability to achieve their full academic potential. It is the policy that the school provides a range of positive interventions to support adaptive and pro-social behavior and foster dignity.

Use of Physical Restraint

- Physical restraint is appropriate only when a student is acting in a way that presents imminent risk of physical harm to the student or others. The student is demonstrating the intent and ability to cause injury within a matter of minutes.
- Staff must always weigh the risk of physical intervention against the risk of not intervening. Physical restraint should never create more risk that the behavior it is trying to contain.
- Where possible, staff members must consult with peers and administrators before initiating any physical intervention.
- Any student identified as demonstrating high-risk behavior should have an individual crisis management plan (ICMP) developed, which is communicated to all relevant staff members.
- Staff should use the de-escalation and intervention strategies indicated on the student's ICMP.
- Physical restraints should only be employed after other less intrusive approaches (such as behavior support techniques or verbal interventions) have been attempted unsuccessfully, or where there is no time to try such alternatives.
- Physical restraints must never be used as (a) punishments, (b) consequences, (c) for demonstrating "who is in charge", or (d) classroom maintenance (such as enforcing compliance with directions or rules for preventing the student from leaving the classroom)
- Staff must stop the restraint as soon as they judge

that the student is safe and is no longer a risk to self or others.

- Two or more trained staff members should be involved in any physical restraint and a nurse or medically trained person should be in attendance during any physical restraint to observe and monitor the student and staff for physical indicators of distress.
- Students are never permitted to restrain or assist in the restraint of other students.

Informing Parents and Guardians

The school will provide parents and guardians with a description of the school's safety strategies and interventions to prevent, de-escalate, contain, and manage students' aggressive self-destructive or violent behavior that presents an imminent risk to self or others. Schools should receive an informed consent agreement from the parents. The schools should also discuss with the parents the ICMPs, what the restraints look like, how the student can remove themselves from the restraint, potential risks and side effects, and treatment or safety options (Mohr & Nunno, 2011). After any incident in which safety interventions (e.g., restraint, seclusion, calling police) have been employed, parents and/or guardians will be informed as soon as possible.

Staff Training Requirements

- Only staff who have successfully completed approved crisis management training may conduct physical restraints. This training must include:
  1. crisis definition and theory
  2. the use of de-escalation techniques
  3. crisis communication
  4. anger management
  5. physical intervention techniques
  6. the legal, ethical, and policy aspects of the use of physical restraints
  7. decision making related to physical restraints
  8. debriefing strategies
  9. signs of distress and effect on the student and how to monitor restraints
  10. identification of events and environmental factors that may trigger an emergency safety situation
  11. instruction on the State Board of Education policy on physical restraints
  12. the effects of restraint on ALL students, and
  13. the developmental and emotional needs and behaviors of the population being served.
- All staff involved in an incident of physical restraint must have successfully completed the training program which has been fully endorsed and implemented in the School District, been assessed as competent in the use of physical restraints, and have successfully completed a skills review within the previous six months.
- Staff who are not trained to perform physical restraints must still receive training on crisis prevention, de-escalation, as well as safety concerns and documentation related to physical restraints.
- Staff who have not been trained to perform physical restraints must never restrain students.
- Trained staff may only use physical restraint techniques that are taught in the appropriate crisis management training and as demonstrated in training.

Post Crisis Response

- Following any physical restraint, there must be a medical and follow-up evaluation of the student and staff members who took part in the restraint.
- Staff members involved in the restraint should provide the student with an explanation for the intervention and offer the student an opportunity to express his or her views. Staff will help the student understand the event and identify ways to handle similar situations better in the future.
- Parents of the student should be notified following any use of restraint.
- Each staff member involved in the incident will receive a supportive and process debriefing session conducted by a staff member trained in debriefing

strategies. This debriefing session will examine the de-escalation and intervention strategies used during the incident and develop a plan to prevent the need for restraint in the future.

- The school must have a human rights committee review process and a formal grievance policy for anyone who wants to challenge a restraint. This procedure should be easy to understand, readily accessible, and confidential.

Documentation

- Any use of physical restraint should be reported to the appropriate statutory authority and (if not already in place) an ICMP should be developed with input from the student and parents or care taker. The plan should define what types of intervention techniques may be used in the future. This could include physical restraint.
- Staff must record all instances of physical restraint on an Incident Report Form, including: details of the incident, the people involved, the prevention strategies that were employed, actual techniques used, any injuries sustained by the student or staff, and debriefing that was provided for the student. In additional, all debriefing that was provided to the staff should be recorded.
- School administrators reviewing these forms should take any required immediate action (e.g., counseling for the student, and/or staff members, critical incident review, skills, update, notification to external authorities, notification of the family) and modify any school policies as needed.
- School administrators must report any physical injuries that occurred during the restraint, conduct a formal review of the incident, and adjust the student's ICMP.

MODEL POLICY FOR USE OF PHYSICAL RESTRAINTS IN SCHOOLS

- ***Physical restraints to contain and/or control the behavior of students should only be used to ensure safety and protection.*** Except where otherwise specified as part of an approved individual crisis management plan or emergency intervention plan, ***physical restraints should only be employed as a safety response to acute physical behavior and their use is restricted to the following circumstance: The student, other students, staff members or others are at imminent risk of physical harm***.

- ***An informed consent process for the family or caretaker of the student should be in place prior to the use of any physical restraint with a student.***

- ***Physical intervention should never increase (or create more) risk than the behavior it is trying to contain.*** As any physical restraint involves some risk of injury to the student or staff, staff must weigh this risk against the risks involved in failing to physically intervene when it may be warranted.

- ***Physical restraints must never be used as (1) punishments, (2) consequences, (3) for "demonstrating who is in charge", or (4) for classroom maintenance*** (such as enforcing compliance with directions or rules or for preventing the student from leaving the classroom). Additionally, restraints must not be used for the convenience of staff, as a substitute for an educational program, as a substitute for less restrictive alternatives, or as a substitute for adequate staffing patterns.

- ***Physical restraints should only be employed after other less intrusive approaches (such as behavior support techniques or verbal interventions) have been attempted unsuccessfully, or where there is no time to try such alternatives.***

- ***Physical restraints must only be employed for the minimum time necessary.*** They must cease when the student is judged to be safe and no longer at risk of self-injury or harming others.

- ***Physical restraints may only be undertaken by staff who have successfully completed a comprehensive crisis management course*** that covers: (1) crisis definition and theory, (2) the use of de-escalation techniques, (3) crisis communication, (4) anger management, (5) physical restraint techniques, (6) the legal, ethical, and policy aspects of their use, (7) decision-making related to physical restraints, (8) debriefing strategies, (9) signs of distress and effect on the student and how to monitor, (10) identification of events and environmental factors that may trigger an emergency safety situation, (11) instruction on the State Board of Education policy on physical restraints, (12) the effects of restraint on ALL students, and (13) the needs and behaviors of the population being served. They must also have demonstrated competency in performing the intervention techniques, which is measured and documented according to relevant professional and/or state regulatory guidelines and the guidelines of the crisis management course.

- ***All staff involved in an incident of physical restraint must have successfully completed the same training program which has been fully endorsed and implemented in the School District, been assessed as competent in the use of physical restraints, and have successfully completed a skills review within the previous six months.*** Although all staff will not be trained in physical restraints, all staff should be trained in safety concerns and documentation during orientation training. The school policy on physical restraint should be reviewed with all staff during orientation at the beginning of each school year and immediately with any newly hired staff. Untrained staff may not restrain children and must refer to the School District's policy about options available to untrained staff.

Figure 4. Model Policy for Use of Physical Restraints in Schools

- ***Only physical restraint skills and decision-making processes that are taught in the comprehensive crisis management course and approved by the School District (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.

- ***Where possible, staff members must consult with peers and supervisors prior to initiating any physical restraint.***

- ***Two or more staff members should be involved in any physical restraint*** to help ensure safety and accountability. A nurse or medically trained person should be in attendance during any physical restraint to observe and monitor the student and staff for physical indicators of distress.

- ***Students may not be permitted to restrain or to assist in the restraint of other students.***

- ***Following any incident involving physical restraint, the school must ensure that post-incident medical and follow-up evaluation,*** debriefing and support is offered to the student, the staff members, and any other people involved in or witnesses of the episode. Staff members should provide the student with an explanation for the intervention and offer the student an opportunity to express his or her views on what transpired.

- ***The school must have a human rights committee review process for concerns that arise regarding humaneness or social acceptability.*** Further school must have a formal grievance procedure in place for students (or their advocates), that is easy to understand, assures confidentiality, and is readily accessible. The grievance procedure should include how to contact the school human rights committee and relevant external authorities.

- ***Any initial use of physical restraint should be reported to the appropriate statutory authority or school governing authority and an agreed individual crisis management plan or emergency intervention plan should be developed and implemented*** by the concerned parties, including making informed decision-making with parents and/or guardian. Use of restraint should be discussed with the student and under what circumstances restraint would be used and what kind. The plan should cover the use of positive and less intrusive intervention techniques and specify the circumstances under which physical restraint may or may not be an appropriate response in the future.

- ***All incidents of physical intervention must be recorded on incident report forms*** that reflect the stated policy and include (at least) details of the incident, the people involved, the preventive strategies that were employed, actual techniques used, any injuries sustained by the student or staff, and debriefing that was provided for the student. School administrators should review all such reports and appropriate action should be taken (for example, counseling for the student and/or staff members, critical incident review, skills update, notification to external authorities, notification of the family). The data collection system should be used for a data-driven decision making process that concentrates on adjusting the system to support the student.

  If any injuries to students result from the use of physical restraints, the details must be reported to the appropriate statutory authority or school governing authority. A formal review of the incident and the individual crisis management plan or emergency intervention plan should be implemented and/or adjusted.

Figure 4. Model Policy for Use of Physical Restraints in Schools

Research Foundations of TCI

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 young people 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 and young people 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 5 on page 22).

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 5.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 6). 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

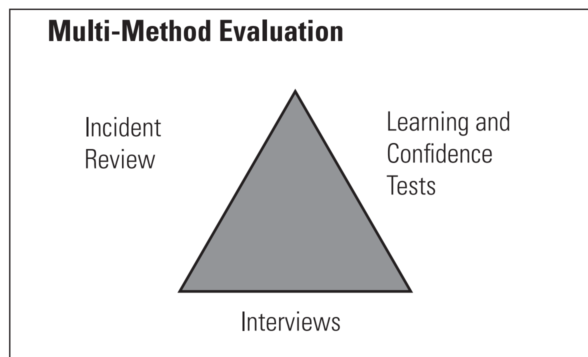

Figure 6.Multi-Method Evaluation

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 24).

What Did Cornell Learn?

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 25).

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.

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 Workers report: • more consistent incident reporting • consistency in follow-up Supervisors and workers reported differing perceptions of whether a debriefing session occurred and how effective it was • TCI was implemented in Units B, C, D • TCI was not implemented in Unit A	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 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	Documented reductions over the 18 month study in: • fighting • serious verbal threats • physical assaults • runaways for the entire agency Statistically significant reductions in physical restraint reports in Unit B over the 18 month period Statistically significant increases in physical restraint reports occurred in Unit A (contrast group) over the 18 month period

Table 2.Results of Implmentation and Evaluation Project

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 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 af Fatalities in Out-of-Home Care

Introduction

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.

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Greg Wise, M.A., who formerly worked as a residential child care supervisor and with the developmentally disadvantaged and mentally ill, is an extension associate with the BCTR. He delivers TCI training and updates nationally and internationally.

Thomas J. Endres, M.A., is an extension associate with the BCTR. Mr. Endres has over 20 years of experience in residential and group care and has worked as a coordinator of group care, a therapist in residential treatment facilities, and an educateur. He provides TCI and CARE training, TCI updates, and technical assistance for the RCCP.

Andrea Turnbull, M.A., LMHC, QS, has 15 years experience working with young people in residential treatment settings in positions such as direct care worker, milieu coordinator, program director and ultimately training director. Ms. Turnbull, a licensed mental health counselor, provides TCI and CARE training, updates, and technical assistance for the RCCP.

I. Franklin Kuhn, Jr., Ph.D, is a senior extension associate with the BCTR, a clinical psychologist, has worked in clinical and administrative positions with child welfare organizations for over 20 years. He has served as medical school faculty and has provided consultation and training to agencies across the U.S. Dr. Kuhn provides training and technical assistance to agencies implementing CARE and TCI throughout North America.

Joanna F. Garbarino, B.S., graduated with distinction from Cornell University's School of Human Ecology in 2004. Since that time she has worked with the RCCP as a research assistant and been involved in many facets of development for the CARE and TCI curricula.

Eugene Saville, A.As., is the administrative assistant for the Residential Child Care Project. He is responsible for scheduling training programs, handling registration, and coordinating materials for all of the RCCP training programs. In addition, he oversees the web site and data base and provides information and assistance to the public in regard to the many programs of the RCCP.

Kristen Carlison supports the data management needs of the RCCP. Within these duties she manages the data needs of TCI's certification and testing system, as well as TCI and CARE implementation projects. She also has responsibilities for the project's quarterly reports, budget proposal, and proposal development.

Holly Smith handles the processing of testing materials for the RCCP training. Her responsibilities include scanning test information, mailing individual's test results, and maintaining the database. She also assists in preparing the quarterly reports.

Alissa Medero handles the training registrations for the RCCP. She sends out confirmation letters, training materials and corresponds with participants to ensure a productive training for all.

Trudy Radcliffe is the primary contact person for CARE, a program model for residential services. She coordinates CARE training, registration, evaluation, and logistics.

Deborah M. Hover manages logistics for hotel sites for RCCP training programs. She packs and ships training materials for over 200 training programs conducted by the RCCP annually.

TCI Instructors

Andrea Mooney, M.Ed., JD, is an original author of TCI and has been involved with the program since its inception. She has been a Special Education teacher, a law guardian, and a consultant. She is now a clinical professor at the Cornell University Law School and an attorney/trainer in private practice, specializing in child advocacy and family law.

Jack C. Holden, Ph.D., an independent trainer and consultant working with residential care, foster care, and public schools has been an instructor and project consultant with Cornell University's RCCP for nearly 25 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 several training manuals. Dr. Holden has published in the *Journal of Child and Youth Care Work*, and *Journal of National Staff Development and Training Association*.

Carla Sockwell Morgan, M.Ed., NCC, currently employed by NC Mentor, has been in the human service field for over 25 years. She has worked in both public and private agencies as a foster care social worker, group home director, clinical coordinator, and trainer. She has worked with Cornell University since 1984 and has also presented at many state and national conferences. In 1978, she earned an M.Ed. in Guidance and Counseling and is a nationally certified counselor. In 1998, she was nominated for the *International Who's Who of Professionals*.

Raymond Taylor, Msc., has extensive experience in social work education, research, and training. He holds degrees in Social Administration, Social Work and Research from the University of Stirling, an Advanced Diploma in Child Protection Studies from the University of Dundee and a Master's Degree in Public Sector Management from the University of Strathclyde. He has been a TCI consultant since the introduction of TCI into Britain and the Republic of Ireland in 1992.

Doug Bidleman, B.A., is the Senior Learning Coach for the Learning Institute at Hillside Family of Agencies in Rochester, NY. He has over 30 years of experience providing service to children and families in a residential treatment environment. He is responsible for overseeing Hillside Children's Center Behavior Management System which addresses all aspects of crisis intervention in an effort to ensure the best practice and client and staff safety.

Nick Pidgeon, BSc, is Director of NJP Consultancy and Training Ltd. based in Bridge of Allan, Scotland. He has many years experience in social work and over 10 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.

Mary Ruberti, M.S.W., is a private consultant specializing in teaching and technical assistance to residential programs. She has many years of experience working with emotionally disabled and mentally ill children and youth in both residential and community-based settings. This work has included the utilization of adventure-based counseling in this population in a variety of settings. Ms. Ruberti has received training from Project Adventure, Inc., a nationally recognized ABC training provider.

Beth Laddin, M.S.W., works as an elementary school social worker in Albany, NY. Previously, Ms. Laddin worked for the BCTR at Cornell as a Program Manager and as a Field Instructor. As a Field Instructor, Ms. Laddin trained child service providers in the TCI program. Other child welfare experience includes positions in Child Protective Services, Residential Facilities, administrative state positions, Facility Quality Assurance work, and program development.

Angela Stanton-Greenwood, M.A., M.Ed., has worked with a learning disabled population for 30 years as a practitioner with Barnardos, and now as a training manager for the Helsey Group, England. Ms. Stanton-Greenwood coordinates the TCI program in Europe. She is a TCI and SCIP Instructor and was staff supervisor in the program that piloted TCI in England.

John Gibson, M.S.W., MSSc, CQSW, is owner of Gibson-Cathcart Social Work Consultancy (Ireland). He is qualified in Social Work and has worked in 4 different residential child care settings for a total of 21 years. He was among the first workers to train in TCI in Ireland and Britain. He joined RCCP as in Instructor in 2001. John has an interest in practical theology and the role of spirituality in the lives of children and families.

Zelma Smith, LMSW, Child Welfare Consultant and Trainer, has over 35 years of experience in the field of child welfare including training, consultation, curriculum development, supervision, and direct service delivery. Her work experience includes training in kinship care, recruitment and preparation and selection of foster and adoptive parents, residential treatment, child abuse and neglect and meeting planning. Formerly, she was chairperson for the National Association of Black Social Workers' National Kinship Task Force Committee. She is a current member of the National Kinship Advisory Committee at the Child Welfare League of America.

Rich Heresniak is the Training director at the Astor Home for Children, a 75-bed residential facility for severely emotionally disturbed children, ages 5-13, located in Rhinebeck, NY. He handles crisis intervention work and is the primary TCI trainer for the facility. Mr. Heresniak worked his way up to this position, starting out as a Teacher Assistant in the Astor Learning Center, followed by Crisis Intervention and childcare worker in the RTC and RTF units.

Craig Bailey, B.S., is the Crisis Prevention Specialist at Crestwood Children's Center, an affiliate of the Hillside Family of Agencies, located in Rochester, NY. He has been working with young people in residential care since 1996, and has been with Crestwood since 2000. Craig has been the primary TCI trainer for new employees at Crestwood during this time, and currently works alongside the Learning Institute at the Hillside Family of Agencies to deliver TCI training to new employees from all of the service affiliates.

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

Diana Boswell M.A., Ph.D., obtained her masters and doctoral degrees in school psychology from the University of Toronto, Canada. Diana has worked as a clinician, manager and director in the areas of autism and child and adolescent out of home care programs. She has been involved in presenting TCI training since its inception in Australia, as Director of the Thomas Wright Institute. She provides specialist psychological services for young people with complex and challenging behaviours, and their families. Diana teaches graduate courses at the University of Canberra in the areas of managing complex behaviours and autism spectrum disorders.

William Martin, MHSA, has been working all of his professional life with children and families with special needs. He has been a program administrator at Waterford Country School for 30 years, providing a multitude of services including residential treatment, emergency shelters, safe homes, group homes, foster care, education, and in-home 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 and the CARE program. Bill has a Master's degree in Human Service Administration and a Bachelors Degree in Social Work.

Sharon Butcher, M.A., began as a child care worker in residential treatment working full time as she obtained her bachelor's degree about 3 decades ago.

She went on to become a special education teacher, then an instructional leader, then vice principal and now principal, all at Waterford Country School. Sharon is also a TCI and CARE instructor and has been an active advocate for CARE implementation at Waterford Country School and in other agencies.

For more information about the Residential Child Care Project, please visit our web site at http://rccp.cornell.edu