MONITORING AND EVALUATING A THERAPEUTIC CRISIS INTERVENTION METHODOLOGY IN A RESIDENTIAL CHILD CARE FACILITY

by

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Introduction

The purpose of this project is to implement, monitor and evaluate a crisis prevention and crisis management program in a residential treatment setting. The primary goals of the crisis prevention and management program, known as the Cornell University's *Therapeutic Crisis Intervention (TCI)* project, are to:

- provide the direct care worker with skills and knowledge to help children change maladaptive patterns of behavior;
- de-escalate crises and to present strategies for dealing with upset children;
- use crisis as an opportunity for children to learn new coping skills;
- teach safe, appropriate physical restraint and self-protection techniques.

The residential child care facility, known here as the Children's Home[1] is located in the Northeastern United States and serves children ages 5 through 18 in a variety of residential care settings. Throughout the life of this 18 month project, interviews were conducted, questionnaires were distributed, and critical incident reports were collected. An advisory group selected by the Children's Home and comprised of supervisors and administrative staff met periodically with the implementation and evaluation staff from Cornell University to facilitate the project.

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[1] The facility in this project will remain anonymous to the reader to maintain the confidentiality of the of the children and the staff. All names and locations have been modified to ensure this confidentiality.

Phase One:

During the first phase of this project (October 1994 to March 1995) prior to implementation of *TCI*, project staff collected critical incident reports for baseline data, and developed a computer based data collection instrument to input the present critical incidents, and to assist in monitoring, measuring and analysis. Implementation staff administered a confidence questionnaire, conducted interviews (all tests and interviews were confidential and anonymous) to assess current practice and staff attitudes.

Phase Two

During the second phase of this project (April 1995 - September 1995), Four trainers from the Children's Home attended a *Training of Trainers in Therapeutic Crisis Intervention* training program in Providence, RI and Cincinnati, OH sponsored by the Residential Child Care Project at Cornell University. Upon their return, all levels of the Children's Home child care staff attended *TCI* training from May through September. In addition, supervisors attended a special session to learn specific implementation, monitoring and supervisory methods which supported implementation.

Phase Three

During the third phase of the project (October 1995 - March 1996) Cornell staff conducted interviews, administered confidence and knowledge based tests to monitor implementation. Critical incident monitoring continued through this phase, and technical assistance was available throughout the period. Critical incident data was collected from October 1995 to March 1996 and contrasted to critical incident data collected during the baseline period.

Chapter One - A Review of the Literature

Foreseeing and meeting the developmental needs of children in out-of-home care is the business of our professional child welfare system. Professional standards of child care and their subsequent tests of adequacy exceed those applied to families. When standards are met we assume quality care; when standards are breached rules of liability based on foreseeability apply with culpability extending to all professionals assigned to the child (Nunno & Motz, 1988; Nunno & Rindfleisch, 1991; Rindfleisch & Nunno, 1992; Thomas, 1980; Thomas, 1990).

Even under the best of circumstances the provision of quality care to meet a child's developmental needs and society's expectations for care can be extremely difficult and stressful. Youth in residential care often emerge from aggressive, hostile, or disorganized communities, neighborhoods and families (Garbarino, Dubrow, Kostelny, & Pardo, 1992). Stories of physical and sexual abuse, and exposure to and the participation in violence dominate the conversations of the youth treated in group care. Without intervention, patterns of aggressive and antisocial behaviors become stable by age 8 and can predict later adult violence (National Research Council, 1993). Treatment is difficult and multi-faceted, and children especially adolescents, are often slow to respond and to change.

Youth exposed to community and family violence are at risk for a series of related behavioral and psychological problems. Garbarino (1994) in his review of childhood violence prevention programs and the supporting

literature reports that children who experience violence in their families both as victims and witnesses are at increased risk for disturbances and delays in their social, emotional, cognitive and academic performance. He cites a developmental consequence of children adapting to violence through "identification with the aggressor" and emulating those powerful and aggressive figures in their environment. These children often engage in a "cycle of violence" by responding to aggression with aggression thereby increasing the probability of a pattern of violence in their lives. The behavioral cycles of violence and maltreatment in these children's lives may also be complicated by the lack of consistent caring and support by adults, the loss of or rejection by significant people in their lives, and serious drug or alcohol problems. Garbarino points to considerable research that supports the view that children exposed to violence have attitudes and beliefs that legitimize violence and aggressive behavior and may develop "truncated" moral development, and that truncated moral development is a risk factor for subsequent violent delinquency.

These children are often cared for by staff who are poorly qualified, untrained, and inadequately supervised in residential facilities that place a premium on control and enforcement. What can result are high levels of violence against children by other children, by staff against children or by children against staff. At the extreme end of the spectrum some facilities develop institutional

control procedures such as "beatdown"[2] (Seely & Craig, 1993) and "pindown"[3] (Bell, 1993; Levy & Kahan, 1991) whose sole purpose is to counter this aggression with counter aggression. These continued conditions and practices have called into question the effectiveness, safety and risk of residential care to children (Miller, 1987; Schwartz, 1991; Thomas, 1990). Yet, most child welfare professionals see residential care as the last best hope for adolescents who are products of high-risk families living in high risk neighborhoods. Properly selected and trained child care workers can provide the emotional context for the necessary "processing" to make positive moral sense of stressful and traumatic events in their lives.

Working with adolescents in out-of-home settings is a task which requires sophisticated residential assessment tools and protocols, organizational programming and treatment models, as well as experienced and accomplished practitioners. The research points to multiple causes and patterns of aggressive behavior in children which require a variety of interventions and treatment. Again, Garbarino (1994) cites the literature on the treatment of aggressive, violent behavior which indicates that it is not a matter of simply providing discipline and/or nurturance within the confines of a residential setting. The proper mix of treatments such as those that combines "cognitive restructuring" with "behavioral rehearsal" (Tolan &

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[2] Beatdown is described as a process of encircling a youth with staff in an isolated area of the facility and yelling at him, listing all the things that he had done wrong. After the list of wrongs is exhausted, a staff person begins to push the youth from one person to another. The pushing escalates to punching and kicking.

[3]Pindown has four basic features; 1) isolation in a special unit, 2) removal of ordinary clothing and enforced wearing of shorts or night clothing, 3) earning privileges, and 4) allowing attendance in the facility school in ordinary clothing but returning to night clothes upon return to isolation.

Guerra, 1993) and "aggression replacement" (Goldstein & Glick, 1987) with moral leadership (Goldstein & Glick, 1987; Tolan & Guerra, 1993) in a controlled therapeutic environment may greatly facilitate improvement and break the cycle of aggression. Incorporating these treatment methodologies into the everyday life of the facility requires extensive screening, assessment, evaluation and planning, and some environmental and organizational modifications. For example, a complication in residential care facilities is the ability of the older, more aggressive youth to create subcultures or "gangs" that can sabotage the treatment process, and perhaps place younger, weaker children at risk. Aggression, and its consequences, challenges the skills and abilities of staff to remain objective and focused on the needs of youth in care. The verbally and physically assaultive youth frequently elicits counter-aggressive responses from adults which feeds the "cycle of violence", and to some degree, legitimizes children's notions of aggression. Bath (1994) points to the need of developing specialized verbal and physical intervention techniques with aggressive children that adhere to strict legal, ethical and developmentally sound methods of treatment. Without adequate training and programming, staff are at risk for re-enforcing violence with counter-violence that characterized the youth's family, neighborhood and community life.

What Affects the Interaction of Adults and Children in Residential Child Care?

Reasons having to do with the environment

Even under the best of circumstances, working conditions in residential facilities can be extremely difficult and stressful. Structural supports for direct care staff are essential if the facility is to provide quality of care. Donabedian (1980) characterizes structural components as the facility's organizational culture, its human resources, and its technology and treatment methodologies. It also includes the quality and quantity of staff, staff supervision, education levels, qualifications and appropriateness of staff, and services for the children in care. The literature identifies a number of structural variables that can be associated with poor quality of care, in particular the management of aggressive children.

Organizational Culture established by the Administration

Krantz & Frank (1990) view organizational and structural factors, such as the facility's mission, organizational and operative goals, the director's leadership style, the program's technological development, as well as staffing patterns, as affecting the potential for crisis management in a particular facility. These features have a profound effect on child care workers and how they handle their role induced anxiety. Kranz & Frank (1990) point out that child care workers with high role-induced anxiety are likely to be harsh and punitive in response to children's acting out and aggression.

Sundram (1986) holds that facility leadership is responsible for placing children in high regard, and setting clear expectations for staff behavior. Jones (1994) shows clearly that the facility director's influence extends even to issues of domination and power over children in her review of the Castle Hill School scandal.

This theme of the organization's top administrative officer setting the tone for the facility and, accepting responsibility for the environmental factors, condition and actions of subordinates is reinforced by Thomas (1980). Further, in a survey by Dodge-Reyome (1990) of executive directors' perceptions of maltreatment within their facilities, directors identified organizational issues (such as the lack of clear policy and procedures on the interaction between caretaker and child) as one of the most important factors affecting staff-child interactions resulting in physical maltreatment of children within their facilities.

Supervision Patterns

Supervisors can mediate the stresses and pressures that child care worker feel on the job, set clear expectations of how children in care should be treated, and be responsive to the needs of care givers. The supervisor is also the linchpin between the direct care workers and the administration, and has a role in identifying any environmental factors which may place children in the facility at risk (Blatt, 1990). The supervisor may also be able to mediate the life stress felt by staff which is associated with serious adverse events with children in residential facilities (Rindfleisch & Foulk, 1992).

Staffing patterns

Blatt & Brown (1986) documented an increase of critical incidents as measured by child abuse reports when admissions to mental health facilities increased dramatically enough to affect staff-child ratios. In a more recent study of similar facilities, 57% of the reported critical incidents occurred while the children were engaged in free time or activities of daily living like eating, bathing or dressing. These "free time" incidents were associated with physical abuse (39%), and inappropriate restraint or seclusion (45%). New York State Commission on Quality of Care (1992) speculated that "the most vulnerable times for institutional child abuse and neglect allegations are when direct care staff are left unsupervised, without planned activities". Rosenthal, Motz, Edmonson, & Groze (1991) found that 39% of all incidents reported occurred during the evening hours when staffing patterns are light, and children are without planned activities.

Program issues

Kennedy (1988) found physical restraint and seclusion episodes were used to promote: physical safety of the child, physical safety of adults and other children, prevention or termination of the destruction of property, a positive group mood, and to channel emotional discharge safely. Others see the employment of safe and effective management strategies for aggressive children to be severely affected by staff-child ratios, poor training, long hours and the advent of increasingly difficult children (Bath, 1994).

Reasons having to do with the workforce

The literature provides ample anecdotal information which paints a picture of facilities where direct line staff who have the most contact with children have the least training and experience, and where newly hired staff are often immersed in the work and directed to carry out the duties of full-time staff without adequate training, orientation and supervision. This leaves new workers, who lack experience and training, not knowing how to handle the difficult and explosive situations with provocative youth they are likely to encounter (Powers, Mooney, & Nunno, 1990). Garbarino, Guttman, and Seely (1986) characterize staff whose interactions with children are maltreating as working under inappropriate conditions, having unhealthy relationships with their administrators, and working under continuos stress. Long (1995) suggests seven reasons why adults who work with children become counter aggressive; being caught in student's conflict cycle, the violation of our personal and cherished beliefs, being in a bad mood, not meeting professional expectations, feelings of rejection and helplessness, prejudging a problem student, and exposing our unfinished psychological business.

The literature identifies a number of staff variables which have an impact on the use of force or counter aggression by staff in their interactions with children.

Gender

Rosenthal et al. (1991) found that the majority (64%) of perpetrators were male in all three types of maltreatment incidents - physical abuse (62%),

neglect (56%) and sexual abuse (77%). Other studies do not document gender difference in perpetrators populations as an important variable but Rindfleisch & Baros-Van Hull (1982) have found that women may be less likely to use force in their role as child care worker in a residential facility.

Age

Rindfleisch & Baros-Van Hull (1982) cite the age of the caretaker as being strongly associated with the use of force in simulated child care situations. They found that the older caregiver tended to justify higher levels of force with children in the simulations. McGrath (1985/86) describes the older worker who is impervious to change adhering to outdated and outlawed interactional practices that are now considered abusive. In a later study Rindfleisch & Foulke (1992) find the age of the child care worker as a significant factor in harmful treatment of resident children.

Education, Background and Training

No studies associate a lack of education with use of force, although Rindfleisch & Baros-Van Hull (1982) report that child care workers who were reared in a smaller community justified higher levels of force in simulations. A number of studies focused on the lack of training of child care workers. Rosenthal, et al. (1991) notes that direct care staff "frequently lack skills in preventing crisis from occurring and in de-escalating crises without resorting to physical force." This lack of training in crisis management and other child

care skills is cited as a risk factor for maltreatment (Blatt, 1990; Daly & Dowd, 1992; Dodge-Reyome, 1990; New York State Commission on Quality of Care, 1992; Pisani, 1983).

Status in the Facility

Krause (1974) studying role and status differentials within facilities found that caseworkers were the least authoritarian, the most open minded, and favored the least coercive control methods; supervisors and administration were more authoritarian, less open minded and favored more coercive methods; and finally child care workers were the least open minded, the most authoritarian, and favored the most coercive control methods. The literature shows that there is some association with seldom or never participating in the decisions of the facility and the increased use of force with children (Rindfleisch & Baros-Van Hull, 1982). Blatt (1990) describes child care workers who are powerless, isolated from other professionals, told what to do with little training or incomplete knowledge of the total treatment philosophy or program. Sundram (1986) concurs with this illustration and indicates that children in care become the targets and outlets for this powerlessness.

Attitudes

Krause (1974) measured the child care staff attitudes in relation to the type of institution in which they worked. He found that direct care workers selected alternatives for handling problems on the basis of the type of institution in

which they were employed. Rindfleisch & Baros-Van Hull (1982) associate the amount of a child care worker's resentment toward children with an increased use of force. McGrath (1985/86) connects the interaction between the alienated child care worker and the new youth care worker to the depersonalization of children that results in maltreating behavior. Dodge-Reyome (1995) found that child care workers who had high job satisfaction levels scored significantly lower on an abuse inventory scale.

Job stress

Studies cite the relationship between job stress and burnout behavior on the part of staff (Freudenberger, 1977; Mattingly, 1977; McClelland, 1986) with the corresponding influence on the interaction with and depersonalization of children (McGrath, 1985/86).

Reasons having to do with the children

Child residents of institutions are not a random sample of the general child population. They are a subset of children who are placed because of mental retardation, emotional problems, substance abuse, and/or previous familial maltreatment. Garbarino et al. (1986) characterizes children in residential care as fearful, mistrusting adults and their environment. He describes adolescents in care as often in open rebellion and destructive to themselves, others or property, or they may turn their anger inward and develop

symptoms such as somatic, sleeping or eating disorders. Depression and suicide may also be a "strategy" for coping with painful life experiences.

Condition of the Child

Blatt & Brown (1986) found that youngsters who were subjects of institutional maltreatment reports were perceived as more difficult for facility staff to work with, that is, more likely to be assaultive, suicidal, violent and dangerous, and in greater need of one-on-one supervision in comparison to the other children in care. They were also more likely to have run away from the facility, destroyed property, or set a fire.

The profile above contrasts with the description of the "repeat" victims who were represented in 47% of the total cases reviewed by the New York State Commission on Quality of Care (1992). "Repeat" victims showed no significant gender difference. However, they were more likely to be older children, non-white, to come from mental health facilities rather than facilities for the mentally retarded, and have less serious or no injury in the report. The study further described these "repeat" children as being more likely than single incident children to be involved in allegations of staff neglect, and thereby contributing to child-to-child sexual activity (21% versus 7%). They were also more likely to be cited in reports referencing no injury (73% compared to 64%) or less serious injury (5% compared to 8%). "Repeat" children were less likely to be involved in physical abuse (49% compared to 61%) and adult to child sexual activity (11% versus 18%) (New York State Commission on Quality of Care, 1992).

Gender

Two single state data surveys reveal that different patterns of maltreatment occur for male children than for female children. Groze (1990) using reports from a midwestern state show that males are over represented in abuse and inappropriate treatment allegations, and girls are over represented in neglect and sexual abuse. Rosenthal et al. (1991) reports that males were predominantly reported for physical abuse (71%) and neglect (76%), while females were predominantly reported for sexual abuse (60%).

Age

The vast majority of children (75.5%) reported in Groze's (1990) four categories - inappropriate treatment, physical abuse, neglect and sexual abuse were over 14 years old with a mean age of 14.6 years. Rosenthal et al. (1991) contrasts this age profile with the mean age for victims in his Colorado study being 11.8 years with females averaging 11.6 years, and males averaging 12.1 years.

Discussion and summary

The environment of the facility, and its leadership, the behavior and conditions of the children, and the characteristics, training, and age of the workforce are essential ingredients in judging whether critical incidents will be resolved therapeutically. The literature reviewed under the environment section cites numerous variables which make strong association with adverse

outcomes of critical incidents for children in care. The Pisani Report (1983) offers strong support for testing a variety of facility leadership styles which open lines of communication among staff, and offer strong centralized leadership in order to enhance the quality of interactions among staff, and therefore children. The literature also alerts executive staff to the impact of their decisions on caregiver-child interactions. This review also offers facility administration insight into periods of the day which children and staff may be more vulnerable to crisis and conflict because of light staffing patterns, free time enjoyed by children, or a combination of both. Studying the incidence of child-to-child sexual activity or adult-to-child sexual exploitation within the variable of supervision patterns might be fruitful. On a more global level, evaluation and research designs can be drawn which compare and contrast various systems of care to objective standards of quality, including outcome measures. A number of potential hypotheses come to mind that would test the impact of positive, supportive child-centered leadership and supervision styles on the rate of adverse incidents within a facility.

The new care giver hired with little training and background and not knowing how to handle difficult and explosive situations is a powerful reality in contemporary residential child care. This literature review points out how little we know about the workforce employed to care for our youth. One study design has been suggested by Pillemer (1988) in his review of elderly abuse. He suggests that a set of hypotheses could be designed which relate staff characteristics to adverse incidents or even maltreatment. Taking Rindfleisch's (1992) data from this review we might suggest that older, less educated staff are more likely to use force or counter aggressive behavior with children.

Of interest to administrative staff in this literature review, is the notion of adult caretakers who repeatedly engage in counter aggressive behavior with children in their care. Further descriptive studies are necessary so that we can develop a more complete profile of this type of caretaker and offer more rapid and effective remedial action. The existing staff attitudinal variables discussed in Rindfleisch & Baros-Van Hull (1982) might be a starting point in this effort. A careful examination of this phenomenon is essential to ensure harm free environments for children in our care, and a risk profile for child care workers might be possible.

This literature review found that training child care workers in approved crisis intervention and crisis management strategies was cited as essential. Further, others speculate that it played a part in lowering reporting and confirmation rates of adverse events defined as maltreatment (Pisani, 1983; Rosenthal, et al., 1991). It seems evident in light of the literature presented that workshops on anger management, behavior control and conflict or crisis resolution are essential, and empower both the child and the child care worker if presented in the context of responding to the children's developmental needs.

It is this aspect of the literature that this evaluation project will address. Specifically, *what impact will the introduction of a crisis intervention methodology have on a facility's child care staff and its rate of reported physical restraint episodes?*

Chapter Two - Crisis as an Opportunity for Growth

In the daily life of any facility, aggressive behavior between children, and between children and adults can escalate to dangerous proportions. Acute acting out behavior, in which it is foreseeable that children will injure themselves or others, often results in the child care worker using physical restraint to help the child regain self-control (Russo & Shyne, 1980). In residential child care, physical restraint is the safe and therapeutic holding of a child in order to contain acute acting out behavior (Budlong, Holden, & Mooney, 1991). The only containment and resolution strategies that are ultimately effective are strategies which are consistent with the facility's therapeutic environment, contribute to a safe and timely resolution, and most importantly, address the child's developmental needs (Drisko, 1981; Garrison, 1984a; Garrison, 1984b; Holden & Levine-Powers, 1993).

Studies indicate that the adoption of a crisis intervention model may lower the reporting and confirmation rates of maltreatment, and therefore lower the potential for injuries to children within facilities (Miller, Walker, & Freidman, 1989; Pisani, 1983; Rosenthal, et al., 1991; Titus, 1989). A review of the literature has not uncovered any empirical evaluation designed to study the effectiveness of specific crisis intervention methodologies although some qualitative studies exist (Bell, 1993; Bell & Mollison, 1995; Titus, 1989). Despite of the lack of empirical data to support specific crisis intervention methods, it is reasonable to expect that any residential child care facility should employ a crisis intervention strategy that provides therapeutic options

available to staff as a basic standard of residential child care (Holden & Levine-Powers, 1993).

Crisis Theory - A theoretical basis for crisis intervention

Crisis theory is based in psycho dynamic ego psychology. It has at its roots the theories of Freud, Erikson, and others in the fields of psychology who define the origins of personality development as the individual's struggle with life's basic circumstances and difficulties (Golan, 1986). Over the past 30 years, crisis theory has gained a foothold in social work, community psychiatry and psychology, and child care work. It is used as the theoretical basis for individual, family and community intervention to ameliorate mental suffering in the aftermath of a wide range of natural and man-made disasters, or more personal mental anguish after unexpected death, divorce, or separation (Hendricks, 1985; Parad, 1965; Parad & Parad, 1990; Slaikeu, 1984). As Caplan (1961) writes in an early work:

> "During the period of upset of a crisis, a person is more susceptible to being influenced by others than at times of relative psychological equilibrium...this is a matter of supreme importance, because by deploying helping services to deal with individuals in crisis, a small amount of effort leads to a maximum amount of lasting response."

Crisis theorists define life's stages as "hazards" due to either situational (unanticipated or accidental) or maturational (anticipated or predictable) events. Situational events can be death, divorce, or accidental occurrences, while maturational events are closely associated with normal life stages such as adolescence. These events, in effect upset an individual's equilibrium, and either help or hinder growth and learning depending on whether the

individual has the requisite coping mechanisms, cognitive skills, and developmental maturity. Hill (1965) outlines four component parts to the adjustment profile of individuals in crisis (See Figure 2.1).

Figure 2.1: Components of a Crisis

crisis > disorganization > recovery > re-organization

Within this framework, an ordinary or accidental life event is perceived as a crisis by an individual. Perception of an event as a crisis occurs when an event conflicts with an individual's culture, relationships, desires, values or needs. The person's usual coping skills or resources are taxed beyond their usual limits and a four to six week period of disorganization ensues. The recovery process begins as the person re-builds internal strengths or finds new resources. Recovery and eventual reorganization of the individual's internal and external resources often depends on individual strengths, family support or close personal friends. It is often anticipated that in reorganization, an individual can learn new ways of coping, although crisis theorists also consider that the crisis process may leave an individual more vulnerable. Since Hill first described the crisis state in the 1960s there have been refinements to his schematic, but his four basic components remain consistent through much of the crisis theory of others who have written since his early publications.

Crisis assessment and intervention

In order to assess the situation properly it is imperative that the social worker determine the nature and extent of the crisis from the perception of the individual. In effect the therapists must assess the meaning of the hazardous event to the client, the resulting vulnerable state, the precipitating factor that set off the crisis, the depth of the active state of crisis, and the capacity for re-integration (Golan, 1986). Intervention within this model is based on a planned therapeutic action to interrupt a series of events which leads to a larger disruption of normal functioning (Payne, 1991). Rapoport (1970) discusses two levels of crisis intervention. At the *initial level* of intervention, the therapist tends to the clients distress symptoms, and attempts to get the client back to a previous level of functioning, or if can be, to improve the client's level of functioning. Within this first level the therapist can mobilize both the natural support systems present in the individual's life, and the client own cognitive skills to gain a perspective and an understanding of the event which may have led up to the crisis. Rapoport also includes a second and more complex level of intervention. Assuming adequate client developmental maturation and resources, she advocates the therapist assist clients to understand connections between present and past crisis and conflicts, and to start the client on new ways of thinking and coping.

In summary, crisis intervention or treatment provides practical tasks or tools to help an individual to cope or to re-adjust. Integral in this approach is the emotional response to crisis events and assisting the individual in longer term change, and the capacity to manage future events (Payne, 1991). When the individual has re-integrated they achieve the correct cognitive

perceptions, manage feelings more effectively and develop new and stronger coping mechanisms (Golan, 1986).

Crisis theory in child welfare

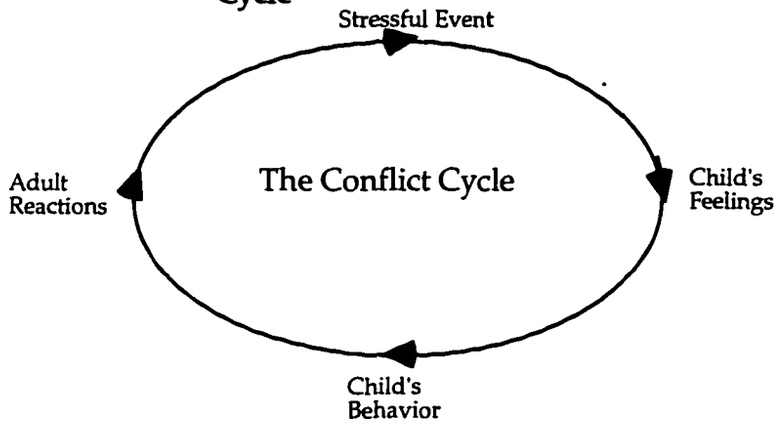
Crisis theory has been used as a basis for child welfare and residential child care practice for a number of years (Cumming & Cumming, 1962; Daly & Dowd, 1992; Maier, 1988; Maier, 1989; Maluccio, 1983; Maluccio, 1974; Maluccio, 1979; Maluccio, 1981; Redl, 1959; Small & Alwon, 1988). Crisis theory finds particular comfort in child and youth care's long tradition of teaching competence and life-skills (Brendtro, 1988), as well as its more recent developments in the youth care field which include short term treatment efforts (Durkin, 1988).

Perhaps the most popular adaptation of crisis theory to residential care is the stress or conflict model of crisis. Described by Wood and Long (1991), the conflict cycle (See Figure 2.2) arises out of a stressful event that may seem like a minor incident to some but to the child evokes feelings that drive behavior fueled by strong emotional processes which in turn triggers adult caretaker reactions that may create additional and more complex stresses on the child. Unless the conflict cycle is broken, it continues into ever increasing spirals of conflict and eventual crisis. This model provides four optimal points of intervention: modifying the stresses on the child, alleviating the child's distressed feelings, changing the child's behavior, and changing the behavior of others.

Modifying stresses on the child

Research shows that children can cope with high levels of major life stress, but when stresses multiply beyond two children's intellectual, emotional and

Figure 2.2: The Conflict Cycle



developmental capacities to cope suffer greatly (Garbarino, 1995). Children who enter residential care are a subset of the child population who have experienced multiple stresses or risks factors. These children can respond to common interactions with adult residential caretakers or teachers as threats, infringements or deprivations. Interactions and expectations that are considered developmentally appropriate for children living in low-risk environments, may trigger feelings and behavior which escalate events into major conflict for children living in high-risk environments. Adults maintaining a supportive and controlled residential environment are critical to mediating the stress events in children's lives, and teaching children new ways of coping that are positive and growth enhancing.

Alleviating distressed feelings

Wood and Long (1991) illustrate a point common to all crisis assessment: that all public events witnessed and shared by individuals have a private reality for each of those individuals. Our perception of events is often based, not solely on the circumstances of the events themselves, but on how those events impact our lives, and our perceptions of ourselves. Often those perceptions include joy and satisfaction, but often those perceptions trigger feelings of rejection, despair anger, boredom and threats. These feelings can become antecedents to and motivation for behavior that is either productive and growth enhancing, or defensive and self-limiting. Intervention in residential facilities which recognizes and considers these feelings and anxieties is essential to breaking the conflict cycle.

Changing behavior

Clearly addressing its psycho dynamic and ego psychology roots, the conflict cycle interprets a child's behavior as an indication of self-protection and defense. Changing behavior within the conflict cycle has to do with examining the defense mechanisms utilized to protect the child from the anxiety produced by the event. Although defense mechanisms can be seen as necessary and as adaptations to a hostile environment, they can also be employed too frequently and in a manner that restricts or prevents growth and learning. Within the conflict cycle defense mechanisms are grouped into three categories: denial, escape and substitution. Adult intervention supports

the constructive use of defenses when they assist in growth and learning, and seeks to re-shape and modify defenses when they obstruct.

Others reaction

Children's behavior can trigger counter-aggressive behavior in the adults who care for them. Counter-aggression feeds the crisis cycle with a rich source of energy and allows the cycle to spiral through time with ever increasing levels of anger and destructive behavior. Counter-aggression from adults becomes the predictable response, the expected norm from an environment of hostile or rejecting adults. Counter-aggression becomes a self-fulfilling prophesy for the child. Adult intervention in this stage demands tolerance and self-control. A mature, objective, and dispassionate view or a "dispassionate compassion" is essential to successful intervention.

Like all crisis intervention strategies, this model of intervention demands that the child has basic cognitive and communication skills in at least six developmental areas: 1) an attention span that allows for listening and retaining, 2) verbal skills to use language spontaneously, 3) an ability for sequential thought processes, 4) an understanding of basic vocabulary, 5) reasoning capacity to understand the incident and the problem that it produced, 6) trust in the adults. The adults and the environment of the facility in turn must be able to project qualities of 1) protection and emotional support, 2) gratification and hope that things will get better, 3) an active and trusting relationship and an unwavering connection to the child's welfare, and 4) responsibility for both their own personal behavior but also for projecting the sense of responsibility for one's behavior as an ethic of all

relationships and interactions with others and the environment (Wood & Long, 1991).

These adult qualities of trust, support and personal commitment to an individual child are the same qualities and basis for all successful parental relationships.

Cornell University's Therapeutic Crisis Intervention

The resolution of the typical critical incident within residential care requires great skill and caring on the part of the child care professional. Only intervention strategies that are consistent with the facility's therapeutic environment, contribute to a safe and timely resolution and, most importantly, address the child's developmental needs are ultimately effective and should be considered (Drisko, 1981; Garrison, 1984a; Garrison, 1984b; Holden & Levine-Powers, 1993). It is reasonable to expect that any residential child care facility should employ a crisis intervention strategy that provides therapeutic options available to staff as a basic standard of residential child care. These crisis intervention strategies are: integrated into a safe and orderly residential care environment; a structured treatment approach geared to child oriented developmental outcomes; an active leadership style; and, a reflective practice approach. All successful crisis management strategies are collaborative and problem-solving, and support or are used to improve the context and the quality of the relationship between the adult care taker and the child.

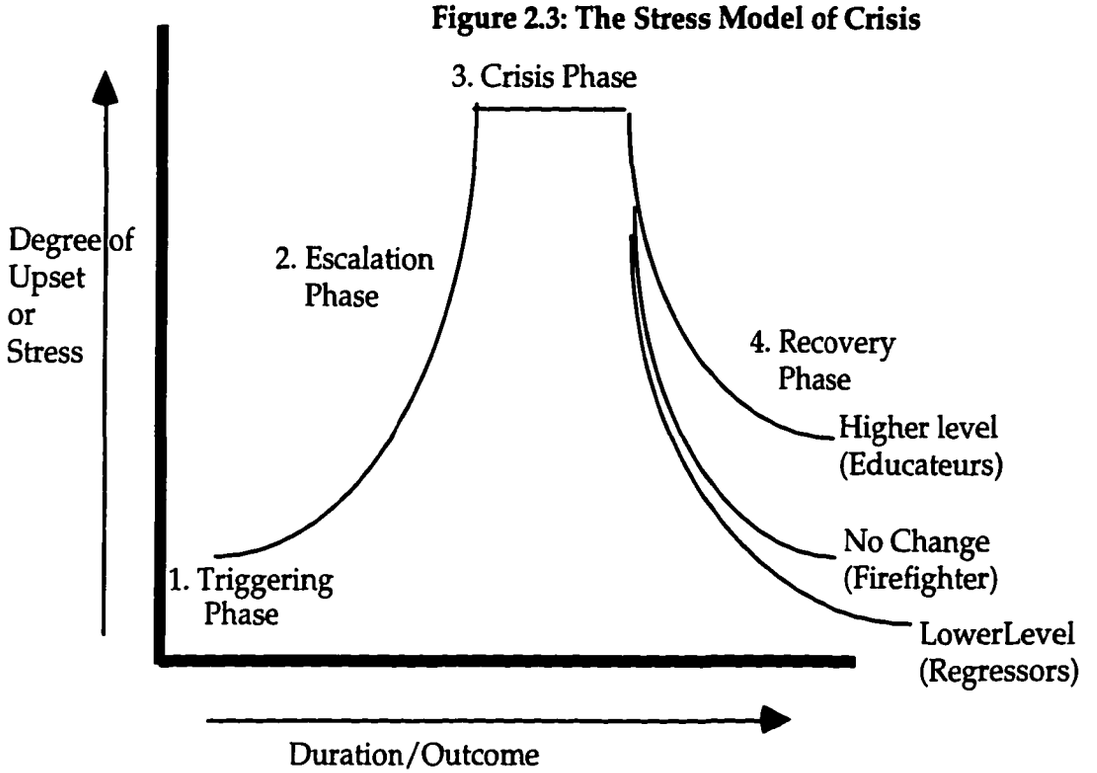
Cornell University's *Therapeutic Crisis Intervention* curriculum and methodology is a cognitive / behavioral approach to crisis prevention, de-

escalation and resolution. It is geared to the pre-adolescent and adolescent children with adequate verbal and cognitive skills described within this chapter's conflict cycle section. In all phases of crisis intervention; from prevention to de-escalation, to therapeutic management, the program is oriented to residential child care personnel helping the child learn developmentally appropriate and constructive ways to deal with feelings of frustration, failure, anger and pain. Essential aspects of this program are self-awareness, the use of prevention and de-escalation techniques, and the use of the Life Space Interview (LSI) (Redl, 1959) (Wood & Long, 1991) between the child and the care worker, and between the worker and the supervisor after an physical restraint incident or a crisis episode. Based on strategies to break the crisis cycle that feeds counter aggressive reactions on the part of adults to children (Long, 1995) (See Figure 2.2), the *Therapeutic Crisis Intervention* program teaches child care workers self-awareness, crisis as opportunity, prevention and de-escalation techniques such as active listening, hurdle help, bridging, hypodermic affection, etc. A key component of this process is that crisis events produce learning for the child, the child care worker, the supervisor and therefore the entire organization.

The stress model of crisis is used in this therapeutic crisis intervention methodology and illustrated in Figure 2.3 below is seen in four phases: 1) triggering; 2) escalation; 3) crisis and 4) recovery (Budlong, et al., 1991). The child, the caretaker and the facility engage throughout all four phases with successful resolution of the event measured by the child, the adult and facility's higher level of functioning. Supporting this aspect of interpersonal crisis and conflict prevention, de-escalation skills are taught to youth care staff such as accounting, reflecting, structuring, teaching and relating. Physical

restraint methods skills that are not pain compliant are practiced and integrated into the crisis methodology. A life space interview (Redl, 1959) as well as a critical incident review procedure is an essential component of all crisis episodes.

Figure 2.3: The Stress Model of Crisis



When the *Therapeutic Crisis Intervention* management strategy is implemented by a residential facility all levels of residential child care personnel are mandated to attend workshops and seminars on the nature and stages of crisis, underlying contributions to crisis situations, de-escalation and prevention strategies, causes of aggressive behavior, philosophy and principles of therapeutic physical intervention, and the dynamics of crisis in group child care situations. Participants gain insight and awareness of

personal values including how personal bias, attitude and professional style affect children in crisis. Specifically, the importance of avoiding power struggles, using personal and professional authority appropriately, children's perceptions of adults, the key role an adult plays in crisis intervention, and team work are discussed. After training, each participant will have functional skills to prevent, de-escalate and therapeutically manage crisis situations. The participant will be able to use intervention techniques which minimize power struggles, behavioral management skills which help the child learn new ways of coping, and physical intervention skills to contain acute physical behavior.

The *Therapeutic Crisis Intervention* model acknowledges crisis theory's short term goal when it uses practical tasks to help children readjust their feelings and behavior. It also stresses the longer term goal of modifying a child's emotional response to crises, and changing their capacity to manage everyday problems feelings and anxieties more productively. Achieving long term behavioral change through successful conflict and crisis resolution within a residential youth population is difficult to achieve and to measure. The number of variables having an impact on long term behavioral change are infinite while measuring change is complex and uncertain.

Discussion and Summary

Children require adults who are tied to the child through strong emotional bonds (Bronfenbrenner, 1979). These bonds form the roots of attachment, and facilitate the child's social, intellectual, moral and emotional development.

Maier (1988) calls this attachment "a nurturing, liberating force" "fundamental to healthy human care and development" fostering a "rootedness" "basic for creating sound affect experience" in both the child and the adult caretaker. What are the implications for residential child care? First, all children in care, either temporary or permanent, must know they will be cared for, accepted, and loved. Second, the adults who are in charge of the facility need knowledge and skill in child care practices that are developmentally based. More simply, adult behavior and expectations should match a child's potential and readiness. Third, adult/child relationship that produces healthy and competent children needs an organizational environment that supports and gives status to this interaction. The task for the residential child care profession is to blend science with humanism; to develop organizational commitments which encourage interpersonal intervention strategies. These strategies based on a life-span perspective where the child and adult are given the time, space and the environment "where youthful, spontaneous life can evolve" (Maier, 1988, p 7).

Within this developmental context, professional caretaker actions and organizational responses to children's behavior strongly shape and influence a child's subsequent behavior and ultimately growth. In few other areas is an adult's actions and reactions more important and critical than when a child is in crisis. The child care professional skills, knowledge and judgment are critical in helping children learn constructive and adaptive ways to deal with frustration, failure, anger, rejection, hurt and depression. Society's standards for residential, supervised 24 hour care and crisis theory demands that adult caretaker and organizational responses to children in crisis assist in the

resolution of the child's interpersonal conflicts and teach behavior responses that bring children to a higher level of functioning. *Crisis is, therefore, a learning, growing experience for the child, the adult caretaker and the organization.* Without this triadic growth and learning, crisis management is in danger of becoming a strategy for adult control over children, enforcement of rules and regulations, and self-defense.

Chapter Three - Evaluation Design and Methodology

Overview of the project

The purpose of this project was to implement, evaluate and monitor a crisis intervention methodology for residential child care facilities. The primary goals of this crisis intervention methodology were to:

- prevent crisis from occurring;
- de-escalate occurring conflicts;
- manage acute crisis phases.

In all phases of this process from prevention, de-escalation to management, the crisis intervention strategy was oriented to residential child care personnel helping the child learn developmentally appropriate and constructive ways to deal with feelings of frustration, failure, anger and pain.

As a result of using the crisis intervention methods outlined in Cornell University's Therapeutic Crisis Intervention curriculum, participants were able to prevent, de-escalate and effectively manage crisis situations with children in residential care. Throughout the initial implementation and training phases, all levels of residential child care personnel were mandated to attend workshops and seminars on the nature and stages of crisis, underlying contributions to crisis situations, multi-cultural dimensions of crisis, de-escalation and prevention strategies, causes of aggressive behavior, philosophy and principles of therapeutic physical intervention, and the

dynamics of crisis in group child care situations. Participants gained insight and awareness of personal values including how personal bias, attitude and professional style affect children in care. Specifically they learned, teamwork, the importance of avoiding power struggles, using personal and professional authority appropriately, children's perceptions of adult behavior, and the key role an adult plays in crisis intervention. At a minimum, each participant has functional skills in techniques for the prevention, de-escalation and management of crisis situations, conflict resolution techniques which minimize power struggles, behavioral management skills, and physical intervention skills to control acute behavior.

Over the eighteen month implementation period, the project introduced and evaluated:

- a therapeutic crisis intervention methodology in preventing, de-escalating and managing crisis situations between children and staff and between children;

- a curriculum for residential child care which teaches and supports the skills necessary for the prevention, de-escalation and management of crisis.

Implementation staff worked closely with the residential facility to adapt the project's existing evaluation methodologies, curricula and protocol developed from previous implementation strategies with other child care agencies. As a result participating in this program it was anticipated that all levels of Children's Home staff:

- more effectively managed and prevented crisis situations with children;

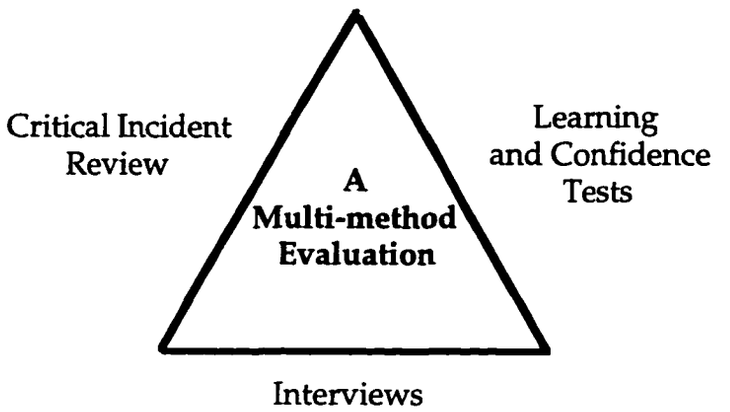
- felt more confident in their ability to manage crisis situations, and;
- worked as a team in prevention, de-escalation and acute crisis management.

Using a train-the-trainer approach, project staff trained selected supervisory staff in the project's Crisis Intervention methodology to deliver the Therapeutic Crisis Intervention curriculum to all levels of a residential child care staff. A pre/post evaluation was conducted to analyze the effectiveness of this approach in transmitting knowledge and skills and whether the knowledge and skills support the staff development functions of residential child care personnel.

Evaluation Design

Integral to the implementation of this Therapeutic Crisis Intervention methodology was an multi-method or triangulated evaluation design which 1) provided baseline and follow-up data on crisis episodes within a residential care facility for an 18 month period of time; and, 2) evaluated the effectiveness of both the crisis intervention methodology and the strategy for its implementation via training and technical assistance. The evaluation design was a mix of qualitative and quantitative methods appropriate to discover current crisis intervention practices and to assess whether the project had reached its goals outlined above. This multi-method or triangulated design allowed the implementation team a method to check and re-check the reliability of both qualitative and quantitative data gathered. It also offers the project team holistic analysis tools to study the phenomenon of crisis events within a facility.

Figure 3.1: A Triangulated Evaluation Approach



With these advantages this type of methodology can offer the evaluator more confidence in their results and assistance in uncovering "deviant" dimensions of a problem (Jick, 1983). It also prevented the evaluation team from relying too heavily on any one finding to influence the implementation, or to measure the effectiveness of the implementation.

Components of the Design

Consistent with this triangulation, the evaluation plan consisted of qualitative and quantitative methods within both the formative and summative phases of this project (See Table 3.1).

Formative component

The formative evaluation component was implemented throughout the life of the project. The goals of the formative evaluation activities were to:

- determine the perceived needs of residential child care staff in relationship to crisis intervention skills;
- assess the current institutional structure and programs in the facility with regard to the prevention, de-escalation and management of crisis incidents;
- define the underlying environmental, personnel and child oriented factors that contribute to crisis situations;
- assess current behavioral techniques utilized by staff in crisis situations; and,
- provide useful, reliable and valid indices and measures in which to assess the efficacy of particular strategies or combinations of strategies to enhance the prevention, de-escalation and acute management of crisis situation, including training.

Table 3.1: Outline of the Evaluation Design

Formative Phase - Crisis Intervention methodology	**Summative Phase** - Crisis Intervention methodology and curriculum implementation
Goals: • determine perceived needs • assess institutional structures • define factors that contribute to crisis • assess current practices	**Goals:** • assess the efficacy of the crisis intervention methodology • assess confidence staff levels • assess learning within the crisis intervention training
Data Gathering Methods: • personal interviews • literature review • record reviews • observation	**Data Gathering Methods:** • Critical Incident Report (CIR) • Questionnaire - Likert scale • Pre- post criterion-referenced multiple choice test

This formative component of the evaluation involved:

- personal interviews with child care personnel;
- review and synthesis of relevant research and clinical literature;
- record reviews at the facility, disciplinary or incident reports, policy and procedure manuals.

These methods were utilized throughout the project in the pre-implementation phase as a way to provide information to project staff concerning implementation strategies, training needs and current practices.

Data gathering

The primary data gathering methodology in this formative stage were interviews with child care workers and supervisors using an interview guide developed for the project. The purpose of the personal interviews were to discover how child care personnel at the Children's Home *managed aggressive and acting out behavior prior to and after the implementation* of Cornell's Therapeutic Crisis Intervention methodology. Another equally important purpose was to illustrate the quantitative critical incident data gathered prior to and after implementation. Child care personnel were interviewed with an interview guide (See Appendix) modified from a previous qualitative research project in another agency. Staff were asked to respond to questions based on six domains (See Table 3.2) and to articulate their perception of an incident where they intervened with a child who was

exhibiting aggressive behavior. All interviews were be held confidential, and according to the appropriate state laws and Federal Research Guideline. No attempt was made to pre-determine or select the outcome of the incidents for these pre implementation interviews. The post-implementation interviews focused on physical restraint incidents and the events were selected for review within a set of criteria.

Table 3.2: Domains covered in the pre and post implementation interviews
Domain 1: Description of the incident
Domain 2: Precipitating factors surrounding the event
Domain 3: De-escalation / behavior management techniques used prior to the incident.
Domain 4: Was physical restraint used?
Domain 5: Effect of this experience on the relationship to the child
Domain 6: Assessment of worries and fears about this aspect of their work

Every effort was made to ensure that the events described occurred within two week of the interview, although this was not always successful.

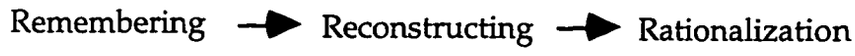
Supervisors were interviewed at intervals one month after training was completed and then again four months after training was completed. The purpose of these interviews was to assess from the perspective of the supervisor the progress of the implementation, and to assess whether any change could be measured or articulated. The supervisors will be asked their perceptions of how acting out and aggressive behavior is handled in the Children's Home, whether anything has changed since implementation, and how they have changed.

Specific details of the pre and post implementation interviews with the child care workers and the supervisors will be reported with the results.

Reliability and validity issues

Qualitative research is limited by the process of memory, perception and cognitive bias. (Carroll & Johnson, 1990) warns the researcher to distinguish between the explicit theories that individuals claim as the basis of their decisions and the theories-in-use. Factors such as time between the event and the time that the individual reported on the event are critical to overall accuracy. In general, the greater the time lapse between the event and recall; the greater the chance of inaccuracy. The memory process appears to follow a path from remembering to reconstruction to rationalization with bias introduced at each point in this process (See Figure 3.2). Individuals may remember certain aspects of an event and fill in the remainder, or they may be motivated to put a favorable spin on the decision to meet expectations, lifestyle changes, subtle pressure or inability to justify their actual decision with their stated value system. As early as 1916, social workers have known that memory and its reconstruction, plays a complex and dynamic part of an individual's social, moral and emotional life (Addams, 1916).

Figure 3.2: Process of recalling events and decisions related to events over time



The limitation of decision-making research referenced earlier in this paper were used to inform this methodology. As was said above, the research found child care worker's access to detail, and memory retrieval to be confounded by time, and the impact of the event itself. As a general impression, the longer the span of time between the event and the interview the fewer details are available to the child care worker and the interviewer, and the more reconstruction and rationalization were present in the story. Examining an event and the decisions made during that event one to ten weeks after it occurred opens the researcher to an examination of the bias and the value system of the child care worker, as well as a modification of the details of the event. If the researcher wishes to study the process of decision making for a physical restraint event, then my earlier study indicates that the research will have to interview the child care worker within hours of the event, even before they discuss the event with their supervisors, administration, the child, or family. On the other hand the purpose of this methodology is not to study the decision making to use physical restraint but to examine the perception of learning that went on during and after the event. It would seem likely that if the interview occurred too soon after the event, an assessment of learning by any participant would be limited or unable to be made at all.

There are ways of improving the accuracy of recall to events, decisions and perceptions of learning, and this proposal will take them into consideration. The researcher will:

1) interview as close as possible to the event - as a criteria for selection the event will have to have occurred between five and fourteen days of the

interview. This time frame allows the individuals to have settled down and assessed the events and their impact, and their personal learning from them.

2) develop a simple and clear procedure for eliciting the information - the interview guides will be designed and tested for simplicity, and for ease of use by the interviewer and ease of understanding by the child, the child care worker and the supervisor;

3) research events that are strong so that it is remembered - physical restraint episodes are generally filled with emotion and turmoil. This researcher's experience in interviewing over twenty child care workers is that little forgetting takes place within this two week period;

4) sequence questions to promotes recall - Questions will be sequenced to promote the recall of events and perceptions. The researcher will use Critical Incident Reports which are completed by the child care worker immediately after the incident for verification and confirmation of details if the span of time between the event and the interview exceeds more than a few days.

Finally this researcher will follow the advice provided by (Carroll & Johnson, 1990): he will use diligence, follow written or accepted procedures, maintain complete field notes, be up front about preconceptions and hypotheses, present confirming and disconfirming evidence; and, keep faithful to the research question but open to other opportunities.

Therefore within the limited parameters of this study design and the limited parameters of the sample size the potential to generalize from the study to a larger population of child care workers may seem to some to be limited. Yet,

there are insights and discoveries made that will inform the field, and perhaps guide the development of a larger more representative study.

The other limitation encountered is connected to the notion of expectations. All the child care workers interviewed will be trained in the Cornell University Therapeutic Crisis Intervention methodology. The facility invested enormous resources and time to provide training and technical assistance to staff. As a representative from Cornell and specifically this training program, there may be bias introduced which will tailor some of the child care worker and supervisor responses to conform to what they learned in training. In short, there is some speculation that their responses will be designed to please the interviewer. In past interviews the researcher was aware that some respondents were "reading from a script" when discussing their decisions to use physical restraint. Some of the incident descriptions initially sounded wooden and rehearsed until, the researcher realized that what many child care workers were describing were physical restraint episodes that "went just like training". A deeper probing of the incidents generally solved the problem.

Summative component

This summative component provided quantitative baseline information for a research effort aimed at assessing the efficacy of the crisis intervention program. The **summative** evaluation component of the project began in the first month of the project. The essential data collection tools in this regard

were the 1) Critical incident reports (CIR), 2) the confidence scales, and 3) the pre and post knowledge and skills tests.

Critical incident reports

In order to test evaluation project met its stated goals and objectives (See Table 3.4), the project designed a system to measure the impact of the implementation of TCI on overall critical incidents, in particular physical restraint reports over an 18 month period of time. The project utilized an off-the-shelf database software package *Filemaker Pro* where the facility's Critical Incident reports were complied and inputted for later analysis. This summative evaluation component of the project began in the first months of the project with the collection of critical incident data through the Children's Home's own Critical Incident Report system. The Critical Incident Report system (See Figure 3.3) is designed to document the experience of residential child care personnel each time they encounter a situation defined as a critical incident. These critical incidents can include such diverse events as missed medications, accidental injury to staff or child, physical restraint, serious verbal threats, temper tantrums, destruction of physical property, and lack of supervision. The Critical Incident Report (CIR) contains information on the date, time, location, circumstances, and the initial outcome of the incident. The CIR is filled out by the staff directly involved in the incident. It is reviewed by their immediate supervisor, the director of treatment and then signed off by the executive director of the facility. The facility then stores the reports, or places copies of the reports in the child's records if it is deemed to be appropriate to the child's history, assessment or treatment plans. The CIR

Figure 3.3: CRITICAL INCIDENT REPORT (SAMPLE FORM)

NAME OF CLIENT _____ AGE _____

LIVING UNIT _____ DATE AND TIME OF INCIDENT _____

LOCATION OF INCIDENT _____

WITNESSES _____

TYPE OF INCIDENT (Check all that apply)

_____Injury to child	_____Suicide Attempt	_____Runaway
_____Injury to staff	_____Physical Aggression	_____Fire-setting
_____Physical Restraint	_____Verbal Aggression	_____Fight
_____Abuse allegation	_____Substance Abuse	_____Accident
_____Missed Medication	_____Property Damage	_____Self Abuse

Describe the Incident and circumstances surrounding the incident. Include a detailed description of precipitating factors, supervision being provided, precautions being taken, early warning signals, specific client behaviors and early crisis intervention techniques applied: (Use additional pages if necessary)

What action was taken? How did staff intervene? Name the staff who intervened. If restraint was used, describe the technique used and how it was implemented. Include who initiated the restraint, who assisted, who held which body parts, length of time, letting go process, etc. If there were any injuries, include first aid applied.
Describe follow up. Specify any special precautions, supervision, or disciplinary restrictions. Note the time of the Life Space Interview and the plan developed. Include recommendations for further follow-up.

List persons notified	**Time**	**Person who notified**

Signatures

Person completing this report	Supervisor
Social Worker	Administrator

baseline data collection period was for a 6 month period prior to implementation - October 94 to March 95, during training and

implementation - April 95 to September 95 - and after training and implementation - October 95 to March 96 (See Figure 3.1). Since the four separate units of the Children's Home serve children with varying ages and needs, the data analysis strategy to measure the impact of TCI is dependent on an examination of the effect of TCI within each unit. Data from these four units cannot be aggregated and reported since there is a heterogeneity among the units, especially in treatment philosophy, and populations of children served. Although this might be seen as an disadvantage because it reduces the total numbers of episodes to be analyzed, it provided the project with a strategy where we assessed the impact of TCI on various units within the facility in relationship to the rise or fall of reported physical restraint rates.

Confidence scales

A major desired outcome of this implementation strategy is to increase child care staff confidence in crisis prevention, de-escalation and management. An additional measure, beyond the child care interviews, of how crises events within the facility are perceived and managed is necessary. In order to establish a quantifiable baseline for measuring child care worker confidence the project developed a 10 question six point Likert scale. The scale was based on four perceptual domains: personal knowledge and skill, co-worker knowledge and skill, organizational support, and crisis as an opportunity for learning. These domains with corresponding questions are listed in Chapter Seven (Table 7.1). The domains are linked to the project's goals, the theoretical constructs present in the TCI crisis intervention training and discussed in the literature review, and the implementation staff's need to

learn more about present practice in the facility. This initial information was used to inform and shape the implementation strategy.

The development of a new test instrument was not taken lightly by project staff. Other tests for confidence were examined and rejected because they did not examine the confidence domains that the project wished to examine. In order to ensure the validity of the instrument, the confidence domains together with the questions developed were examined by child care colleagues for face validity. After modifications to the domains and the questions, the Likert scale questionnaire was initially tested on colleagues with child care experience for face validity. It was modified after this validity test, and later given to 32 child care supervisors and trainers who were participants in three separate Therapeutic Crisis Intervention training program unrelated to this evaluation project. After each round of testing there was some modifications in language and question order until the current test version was accepted. A Cronbach Alpha test for internal reliability would be done after the test was distributed in the pre and post implementation phases.

Pre - post test of knowledge and skills

In addition to assessing the impact of the crisis intervention methodology and the training on the ways in which residential care workers handle critical events involving children, assessments will be made during and after the training sessions themselves. The Crisis Intervention training has a pre-post criterion referenced knowledge based test comprised of thirty multiple choice questions. Pre and post tests have identical items. The first eight questions of

the test require participants to watch a video before answering while the remaining twenty-two test questions are written. Each test item is linked to specific training objectives, and has been validated by a group of national experts who ranked the objectives and the test items as key knowledge and skills necessary for assisting children to resolve crisis. The test has been modified periodically, and used for over 15 years and has achieved a high degree of reliability.

In this way, knowledge of specific crisis intervention techniques and learning points can be assessed before and immediately after the training to ensure that participants demonstrate sufficient knowledge gain, and have mastered the behavioral approaches they have practiced in the training sessions. These data provided aggregate level data which can be used to assess the success of the program in increasing the knowledge and skill level of the staff of the Children's Home.

How did the project evaluate outcomes

The critical incident reports, the pre and post implementation interviews with staff and supervisors, the confidence scale and the pre and post training based knowledge and skill tests remained 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, number of restraint episodes, and knowledge and skill levels (See Tables 3.3 & 3.4). In order to

Table 3.3: 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	Critical Incident Report	40 item multiple choice pre - post test
Type of Data Gathered	Demographic data	Qualitative and Quantitative (Likert scale)	Qualitative and Quantitative (Likert scale)	Qualitative and 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

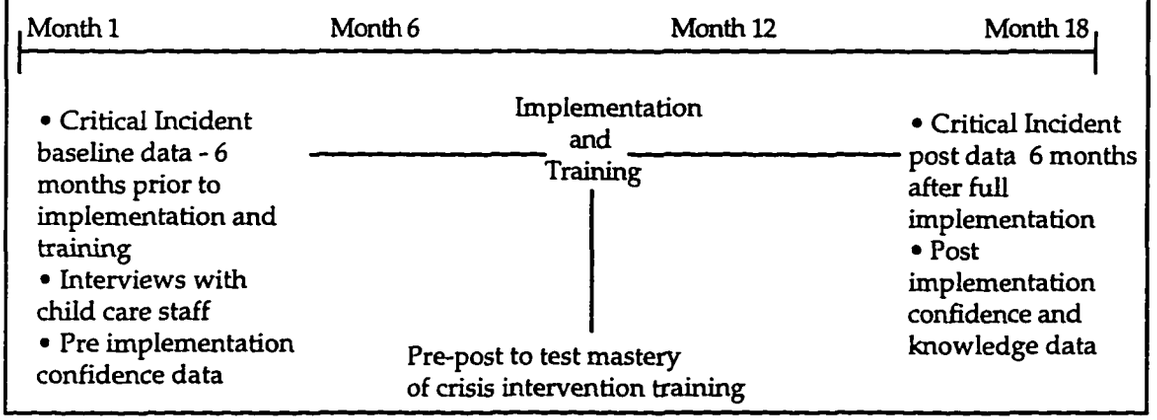
1. Report findings which support or refute projected outcomes or hypotheses.
2. Report on questions raised which warrant further study.
3. Develop an information management system to assess critical incidents for a residential child care facility.

measure these outcomes a quasi-experimental pre-post design was used with data gathered throughout the three phases of the project: pre-implementation, implementation and post-implementation (See Figure 3.4). Baseline interviews were performed with residential personnel regarding training history, current practices of crisis prevention and management, levels of perceived competence and skill in handling crisis situations. Baseline interviews were supplemented with a review of critical incident

records as they relate to crisis reports and disciplinary actions. The baseline data collection period for all data was 6 months prior to implementation. Following participation in the training by residential care personnel, and full implementation of the crisis intervention methodology, critical incident reports were monitored for an additional 6 months. The post-intervention data was used to document the impact of the crisis intervention methodologies and training on changes in the number and type of incidents in each unit of the facility.

The Critical incident report data was supplemented with follow-up interviews of the training participants and other individuals who participated in the initial baseline interviews. These data was useful in documenting changes in the institutional climate regarding crisis prevention and intervention.

Figure 3.4: Overview of the evaluation design and timeline



The project staff initially developed a basic pre-post design which followed a staggered schedule of training for units within a facility but for our study this design was found to be unworkable. Campbell and Stanley (1963) refer to this

as the "recurrent institutional cycle design" and Epstein and Tripodi (1977) describe the evaluation design as an "Interrupted Time Series Design". Implementing this design would have assisted the project and residential care staff to maintain the internal validity of the project and its evaluation and monitoring strategies. According to Epstein and Tripodi this design demands that the project: identify program objectives clearly; operationally define program objectives; specify the intervention strategy; take baseline measures; graph the baseline data; implement the program; take post-implementation measurements; collect the supportive data; and, compare pre- post intervention patterns. In graphic form below, such a design within a residential facility with multiple residential units may look as follows:

Unit A:	Baseline	Training	Follow-Up	
Unit B:		Baseline	Training	Follow-up
Time:	Month 1——>Month 6——>Month 9——>Month 12——>Month 18			

Our current evaluation design without the staggered approach to training meets all of the Epstein and Tripodi criteria. A staggered approach to training is often problematic in smaller facilities such as the Children's Home. Implementation and training at the Children's Home had to be initiated over a three months period of time because of institutional constraints such as the size of the facility, staff schedules and deployment and training. Granted the strength of this staggered design is superior to our current design since it compares baseline data with follow-up data within each group, and adds a meaningful comparison between the follow-up data in Unit A with the baseline data in Unit B. For example, 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. Still, the 18 month period of time in our present study design allows one to compare the same calendar periods. For example, the pre - implementation period of October 94 through March 95 will be compared to the same calendar period October 95 through March 96. This comparison of calendar periods minimize the critical incident variables associated with vacations, holidays, and seasons.

Data Analysis

The data analysis strategy resulted in data being available at the following units of analysis:

- the critical incident;
- the residential staff, and;
- the residential living unit

The data analysis strategies are designed with these different levels of aggregation in mind. Yet, no aggregation of data occurred prior to testing the homogeneity of effects across the group (units) being aggregated. For example, data from various residential units was tested separately before any attempt to perform a combined analysis would be attempted. And even when data was combined, a control variable representing the individual units will be included in the models. For example, " residential unit" would be retained as a control variable in models testing the effectiveness of the training program. The basic approach for assessing program and training impact was to test for differences between baseline data on incidents and

follow-up data on the same incident characteristics during the same calendar period.

Critical incident reports, restraint data and training test results during the three major phases of the project were subjected to parametric statistical analysis such as Chi square and t-tests, where appropriate, using a standard *SPSS* statistical package for *Windows* or *Microsoft Excel* for the Macintosh (See Table 3.4).

Table 3.4: Outcomes, Hypotheses, Instruments, Variables and Statistical Tests

	Pre-post Knowledge	*Pre-post Confidence*	*Pre - Post Interviews*	*Pre - Post Critical Incident Review*	*Variables*	*Statistical Tests- Possible Measures*
Outcome • all levels of residential care staff will more effectively manage and prevent crisis situations with children			all levels of staff	Review pre and post implementation	**IND** = Implementation **DEP** = Decrease in total Incidents, Decrease in types of incidents.	Mean, Standard Deviation, t-test
• staff will feel more confident in their ability to manage crisis situations		all facility staff who attend training	direct child care workers and supervisors		**IND** = Implementation **DEP** = Confidence	Mean, Standard Deviation, Pearson's *r* t-test
• all levels of facility personnel will work as a team in prevention, de-escalation and acute crisis management		all facility staff who attend training	all levels of staff		**IND** = Implementation **DEP** = Team work	Mean, Standard Deviation, Pearson's *r* t-test

Hypotheses As a result of the crisis intervention methodology being introduced a facility will see						
• Fewer overall physical restraint episodes after implementation and training;				Review pre and post implementation	**IND** = Implementation **DEP** = Number of Physical Restraint Episodes	Mean, Standard Deviation, t-test
• Increased knowledge and skill on the part of the facility personnel to handle effectively crisis episodes.	all facility staff who attend training				**IND**=Implementation and Training **DEP** = Increased knowledge and skill level	Mean, Standard Deviation, t-test
• Immediately after training and implementation, an increase in the numbers of critical incidents will be reported.				Review pre and post implementation	**IND** = Implementation and training **DEP** = Increase in the number of critical incident reports	Mean

How will this project impact this facility?

The literature and the experience of the project staff indicates that a well defined and approved crisis intervention methodology, together with training and education in preventing, de-escalating and managing crisis

situation will result in an overall improvement of a facility's ability to handle incidents (Holden & Levine-Powers, 1993; Miller, et al., 1989; Titus, 1989). Therefore, as a result of the Therapeutic Crisis Intervention methodology it is hypothesized that:

- staff will more effectively manage and prevent crisis situations with children;
- staff will feel more confident in their ability to manage crisis situations, and;
- staff will work more as a team in handling crisis situations.

Improvement in employee cooperation, a focus on crisis as a learning opportunity for children, designing residential environments which prevent crisis from occurring, designing conflict resolution strategies which assist children to learn alternative strategies for coping with frustration, anger and pain lead to a reduction in the incidence of, and frequency of developmentally harmful crisis events.

Through its train-the-trainer program, project staff provided the facility's supervisory and training staff with the knowledge and skills to deliver the Therapeutic Crisis Intervention curriculum. A pre - post evaluation was conducted to analyze the effectiveness of this approach in transmitting the knowledge and skills and whether the knowledge and skills support the staff development functions of residential care personnel.

Chapter Four - The Agency

In 1994 the Children's Home and Cornell University's Residential Child Care Project entered into an agreement to implement and evaluate Cornell's *Therapeutic Crisis Intervention* program. The Children's Home was reviewing its crisis intervention procedures, and sought to implement consistent strategies throughout its five programmatic areas. The executive director of the Children's Home had previously worked with Cornell staff when he was the executive director of a New York State facility in the Ithaca, New York area. The *Therapeutic Crisis Intervention (TCI)* program was implemented in this New York State facility, and the executive director was knowledgeable about its ideology, purpose, and goals. Cornell University staff agreed to implement its *Therapeutic Crisis Intervention* program in the Children's Home in return for it agreeing to be a site for an in-depth evaluation and monitoring project.

Agency Description

The Children's Home is located in the Northeastern United States. Originally built in 1865 to house the orphaned children of civil war dead, the facility now operates four types of residential facilities for children ranging from 5 to 18 years who have been neglected and abused, abandoned by their families, exhausted the resources of their families and communities, or who have been

placed by the courts for truancy, delinquency or drug use. The Children's Home published statement of purpose or mission

> "is to promote the social, emotional, spiritual, and physical well-being of children and youth; and to assist them in developing their capacity to lead productive, satisfying lives" (Children's Home, 1995).

The facility is accredited by the Council on Accreditation of Services for Families and Children, Inc. and its programs are funded through placement arrangements with State Department of Social Services, and local departments of social services, and their state's Children and Family Court system.

Programs and residential units

The Children's Home provides residential services to children in settings from foster and community group care, and diagnostic assessment and temporary shelter services. An **Emergency Shelter** and a **Diagnostic Center** (for the purposes of this paper these two residential services will be called Unit B) are located at the Children's Home main campus while the three other community based group homes are located throughout the greater metropolitan area that the facility serves. These residential units hold 45 beds and cares for approximately 350 children per twelve month period. The overwhelming majority of the population is male.

The **Emergency Shelter** program accounts for over 250 of these children by providing emergency shelter 24 hours a day, 365 days a year. The purpose of the shelter is to provide temporary living for children between the ages of 12

and 18 years for up to 30 days until more long term arrangements can be made. The **Diagnostic** program offers 45 day assessment for troubled children from 5 to 18 years. Children are generally referred by county child welfare authorities or the courts. These Unit B programs accounts for 83% of the children served by the Children's Home's four residential group facilities.

The three remaining group homes - Unit A, Unit C and Unit D all serve varied youth populations, and have different treatment - oriented approaches.

The **Unit C Program** is designed for 14 to 18 year old youths who have been placed by the courts for neglect or delinquency. Residents all have emotional or behavioral problems that warrant therapeutic attention but they are not judged severe enough to require psychiatric hospitalization or a secure facility. All youths are integrated into the community public schools, and are expected to graduate. The treatment approach is focused on anger management, and learning acceptable social skills. This program cares for approximately 8% of all children served by the facility.

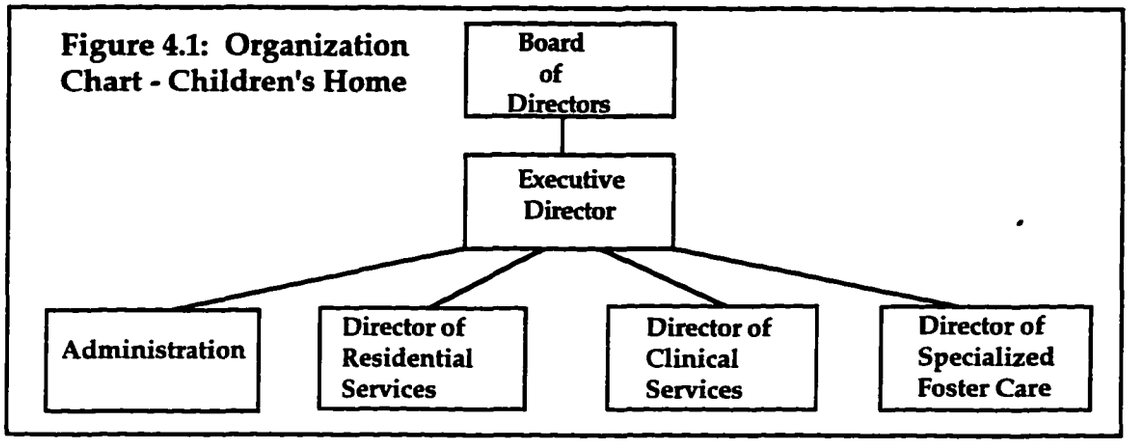
Unit D - is a group home for youths ranging from 14 to 18 years who have alcohol and substance addictions. The population limit is nine. The program is designed in six parts with a minimum stay of one month in each part. As a short-term placement, the program is geared to teaching youths how to control their dependency and learn the causes of their addiction. Each resident continues his education and schooling. The Unit D program serves 5% of the total child population at the Children's Home's residential programs.

Unit A is one of the few licensed Community Residential Rehabilitation Service programs for young children in their state. The program serves younger children ages 6 through 12 and offers child welfare authorities with alternatives to psychiatric hospitalization for children with serious emotional disturbances. Close cooperation between staff and parents is a hallmark of the program. It serves approximately 3% of all children in the Children's Home's residential programs.

The Children's Home has a **Specialized Foster Care** and **Host Home** component with approximately 40 foster families caring for over 180 children ranging in ages from birth to 18 years over a twelve month period. The Specialized Foster Care program meets the needs of the County child welfare services, while Host Homes offers the state's mental health authorities alternatives to institutional or group home placement. For the purposes of this study the project will not monitor critical incidents in its Host or Specialized Foster Care projects.

Agency structure

The agency is headed by a Board of Directors and administered by an Executive Director who oversees the Administration, Directors of Residential Services, Clinical Services, and Specialized Foster Care (See Figure 4.1). The Board of Directors take an active part in the fund raising, capital improvement and overall goal setting and direction of the facility. In recent years they have overseen the Children's Home's "dramatic growth and enhancement" of services to children and youth. This growth and



enhancement is encompassed in immediate plans for capital improvements, movement towards Medicaid reimbursement of treatment services (specifically Unit A), and expansion of a more community based foster care service. The capital improvement program is based on contributions from community fundraising campaigns, and trust and investment income. Approximately 96% of the facilities income for services to children and families stems from local, state and federal support with the remaining from trust and endowment income.

Agency workforce

The agency workforce during this study period was comprised of approximately 120 employees, of whom 70 are full-time, and 50 are part time. Both part time and full time staff work on weekends, nights and holidays, although there were indications that part time staff worked these periods almost exclusively. Sixty-two direct care staff work with children in the four

Table 4.1: Children's Home - Employee Status According to Program						
	Full-time		Part-time		Total	
	N	%	N	%	N	%
Central Administration					**16**	
Directors	9	100				
Support Staff	4	56	3	44		
Residential Programs						
Unit B					**30**	
• Administration and Support	3	50	3	50		
• Youth Counselors	10	42	14	58		
Unit C					**14**	
• Administration and Support	2	100			2	
• Youth Counselors	7	58	5	42	12	
Unit D					**21**	
• Administration and Support	3	60	2	40		
• Youth Counselors	8	50	8	50		
Unit A					**17**	
• Administration and Support	2	100				
• Youth Counselors	7	46	8	54		
Other Services						
Unit B	4	57	3	43	**7**	
Independent Living	1	100	0		**1**	
Specialized Foster Homes	8	80	2	20	**10**	100
Brick House	1	50	1	50	**2**	100
Host Homes	1	50	1	50	**2**	100
Total	**70**	**58**	**50**	**42**	**120**	

residential units - Unit A, Unit B, Unit C, and Unit D. Twenty-seven are full time staff (44%) while the remaining 35 (56%) are part time staff (see Table 4.1). These staff represent the bulk of the direct care staff of the four residential units in the Children's Home. The remainder of the staff are either clinical, supervisory or administrative personnel or support staff such as secretaries, cooks, janitors or grounds keepers, or staff who work in the foster care or independent living units.

Although there are no overall staffing patterns recommended by any national accrediting organization, project staff have reviewed these staffing patterns and find that there is a higher level of part time personnel than usually found in residential care facilities of this type.

An additional snapshot of the Children's Home workforce emerged from the ten demographic questions given prior to the direct TCI training (See Appendix). Sixteen administrative and support employees did not take part in the training leaving 104 full and part time direct care, supervisory, and clinical employees responding to the demographic questionnaire. The results of these demographic questions on the pre test portion of the training evaluation provided the project with an excellent breakdown of the Children's Home staff.

Staff are almost equally divided according to gender - 52% are female and 48% are male. Almost half of the staff have worked at the Children's Home for less than one year while at the other end of the spectrum only 3% of the staff have worked at the facility for 11 years or over.

Table 4.2: Length of Time at Children's Home		
	Number	Percent
1 year or under	52	49
1 to 5 years	36	34
6 to 10 years	13	13
11 years and over	3	3
Total	104	99

The picture portrayed (See Table 4.2) is a relatively new staff, although it is not necessarily a staff that is inexperienced in the child care profession since there are other indicators that this staff had prior experience in other agencies. The demographic question on length of time in child care revealed a child care staff with one quarter of the staff having under 1 year of experience, with the majority of staff having between 1 and 5 years of child care experience (See Table 4.3).

Table 4.3: Length of time in child care		
	Number	Percent
1 year or under	26	25
1 to 5 years	41	39
6 to 10 years	22	21
11 years and over	15	15
Total	104	100

Education levels of staff range in categories from "some high school" to "master's degree" and are outlined in Table 4.4. Clearly the largest percentage

of staff have a Bachelor's degree (36%), while a surprising 19% have a master's degree.

Table 4.4: Education levels of the Children's Home staff

	Number	Percentage
Some High School	2	2
High School	17	16
Some college	27	26
Bachelor Degree	37	36
Master's degree	20	19
Total	**103**	**99**

missing cases = 1

Participants categorized their area of study as social work (12%), psychology (25%), sociology (5%), education (13%) and other social sciences (12%). The remaining listed "other" as their area of study. Clearly then the majority of staff at the facility are educated beyond high school, and they have considerable specialized knowledge in areas pertinent to residential child care.

Why would an agency open itself to scrutiny and review?

Child caring agencies depend on the personal and professional commitment of its staff to care for children who are often aggressive, emotionally draining, and manipulative. Children's aggressive behavior can have both a physical and emotional consequence for the caretaker, often beyond mere injury or upset to the caring worker (Snow, 1994). Ideally, even under the difficult circumstances, child care workers like any other professional caregiver must

be assessable emotionally, physically, and intellectually, and create meaningful relationships with children (Kahn, 1993) in safe environments (Peter & Daly, 1988). Day & Dowd (1992) characterize a safe environment as beyond "doing no harm" to providing a highly organized, coordinated system of care that can be measured as effective, as the only way that one can justify removing a child from the community and placing him in the restricted environment of residential care. It is within these safe environments and relationships that children learn and grow, and in fact facilities meets their professional, moral, ethical and contractual obligations to the community for which it serves. It is in the best interest for any child caring agency to encourage and support an environment in which a caring and compassionate relationship between the care giving adults and the care seeking children can grow and thrive. For many of these children this caring and compassionate relationship may be the basis for realizing their last, best hope for normalcy. It is within this context that Cornell University's *Therapeutic Crisis Intervention* project was invited into the company of the Children's Home.

As was stated earlier in this chapter, the executive director of the Children's Home knew about the Cornell's *Therapeutic Crisis Intervention* project through its work in New York State. When the executive director moved from a facility in Central New York to the directorship of the Children's Home, he discovered that he was taking over a facility with no overall crisis management philosophy, policy, procedure or training. In this director's eyes, the absence of a crisis management strategy was a recipe for a future disaster in a facility that prided itself on "constantly working to improve its methods of treatment to help children" (Children's Home, 1995).

In the meanwhile, the project staff at Cornell wanted to initiate a comprehensive implementation and evaluation study of its therapeutic crisis intervention program in a child care facility with no formal crisis program. The project staff were feeling some pressure from their university colleagues to legitimate its training and technical assistance projects with more research and evaluation. In effect, all projects were being asked to develop more substantial evaluation programs, to publish the results of their research, and to show more of a research based practice model. Also, since the project has been offering training and technical assistance in therapeutic crisis intervention since 1982 throughout North America and the United Kingdom with much anecdotal success, only a handful of evaluation or research designs have studied the effects of the strategy on facilities, their staff or the children served. Potential customers have been demanding more and more empirical evidence that the training and technical assistance they were purchasing from the project would result in an improved service to staff and children, and perhaps even reduce the potential for injury to children and staff. Past evaluations had established that the program reduced the number of child maltreatment reports (Pisani, 1983), and increased the staff skills in handling crisis events (Titus, 1989). No evaluation had been designed to follow the impact of *TCI*'s implementation on the critical incident reports in the facility. In order to do this a facility would have to open its doors to an intrusive research methodology that would last for a minimum of 18 months, and perhaps longer. The research methodology would entail intrusive interviews with care staff, supervisors, and administration, filling out questionnaires, training commitments, overtime expenditures, and above all a self-examination of practice.

Dimensions of the exchange

Levine & White (1960) define organizational exchange as "any voluntary activity between two organizations which has consequences, actual or anticipated, for the realization of their respective goals" (p. 586). Initially the concept of exchange was limited to or bound by economics, but since the late 1950s organizational theorists have used the concept to explain why and how organizations work together to meet their needs, and to fulfill their organizational goals (March & Simon, 1958). The key concept in exchange or equilibrium is that of interrelationship; interrelationship within organizational structures, and for the purposes of our study here the interrelationship between two organizations needing to fulfill their respective missions and goals. Therefore, in the simplest terms, the *TCI* project needed to develop a research component that legitimated its programs for its own organizational sponsor (the College), and the Children's Home needed a crisis intervention strategy implemented immediately to fulfill its mandate to the community. It is important to examine the key dimensions of the exchange between these two organizations within Levine & White (1960) four dimensions of any exchange situation. They are: the parties to the exchange, the kinds and quantities exchanged, the agreement underlying the exchange, and the direction of the exchange.

The parties to the exchange

The Children's Home is a direct service provider of a relatively moderate size, with a population of children suited to Cornell University's *Therapeutic*

Crisis Intervention program. It had an excellent reputation for service to children for many decades, and was now poising itself to expand its child welfare services in the community to include community based foster care, and independent living services to children. In addition to these overt organizational characteristics and aspirations, the executive director had a previous trusting relationship with Cornell staff in his prior directorship in a Central New York facility close to Ithaca, New York. Cornell staff had assisted this executive director with training and technical assistance programs during a particularly intense and troubled period in this Central New York facility's history. Throughout many organizational hardships and crises, this director and the Cornell staff person maintained a close and professional relationship. This executive director often equates that relationship, and the training and technical assistance, with helping him through his most difficult professional period.

The kind and quantities of the services exchanged

In order for the Children's Home to continue to expand its resources and programs it needed to incorporate a crisis intervention methodology into its entire residential program. The financial expenditures for this type of project were considerable. The *TCI* project needed to legitimates its programs through research and evaluation and in order to accomplish that end it needed access to a facility with no consistent crisis intervention strategy, its program records, its staff and its training system. Through a continuing relationship with the executive director after his move from Central New York, Cornell staff knew that this director was moving to a facility with

limited resources, almost no crisis intervention strategy and high aspirations to expand services. A call was made and Cornell staff offered to exchange training and technical assistance for access and opportunity for evaluation research. An initial agreement was made before that phone call ended. The only stipulation was that the Children's Home Board of Directors would have to approve the arrangements, and the *TCI'* project's sponsoring organization at the College of Human Ecology would have to approve the relationship and the exchange agreements. A letter of agreement was written by Cornell staff and sent to the Children's Home in December 1994.

The agreement underlying the exchange

The letter from Cornell summarized the proposal to: review all of facility critical incident reports for a 24 month period starting in October 1994, review and offer suggestions for modification of the facility's crisis management procedures, implement Cornell's Therapeutic Crisis Intervention program through direct training, offer follow-up technical assistance to ensure implementation, and for a period of six months after implementation review the facility's critical incidents, and at periodic intervals. The total project time frame is 24 months, from October 1, 1994 to September 30, 1996. A six page document was attached giving the facility an overview of the project's implementation schedule, monitoring and evaluation process, and the projected outcomes. It was agreed that all records would remain confidential, especially the critical incident reports.

In order to implement and train the Therapeutic Crisis Intervention program correctly, the project would sponsor up to four staff in its national TCI train-the-trainer programs in various offerings throughout the northeastern United States. Their registration fees would be waived but staff travel and per diem would be the responsibility of the Children's Home. Complimenting this train-the-trainer program, the project would supply at no cost one of its own staff or consultants to assist the facility trainers in a minimum of four direct training necessary to implement the program. The specific staff or consultant would be at our discretion, and logistical expenses for the program will be borne by the facility.

Further complimenting the training would be on-going technical assistance provided by project staff on the implementation of the training, modification of facility procedures, and any other technical assistance that is deemed necessary to ensure implementation. This technical assistance would be at no cost to the facility.

The Cornell University's Residential Child Care Project retained the right to publish the results of this implementation, monitoring and evaluation program. If at any time the Children's Home did not want its name mentioned in any publication, the project would comply. Of course, confidentiality protecting the identities of the children will be maintained in all publications.

Direction of the Exchange

The overall direction of the exchange within this agreement was reciprocal. In exchange for access to the Children's Home and an opportunity for implementation, Cornell University would supply all the necessary training and technical assistance to implement its *Therapeutic Crisis Intervention* program. An additional reward is that the Executive Director and the President of the Board of Directors can proudly state in its 1995 Annual Report that they had entered into an agreement with Cornell University, a relatively prestigious research university, to improve its therapeutic treatment of children in crisis.

In summary, the elements of the organizational exchange are evident. The organizational goals and objectives of the Children's Home to provide a safe and effective therapeutic environment within its mandate and resources prompted the facility to accept the offer and invitation of Cornell University to engage in an implementation project. Cornell's *TCI* program need access to a direct care residential facility to evaluate and research its *Therapeutic Crisis Intervention* program to gain additional legitimacy within its own organization, and to gain additional credibility with its potential customers throughout North America and the United Kingdom.

Chapter Five - Interviews with Child Care Staff

Personal narrative is a necessary component to study perceptions of crisis events, effects on relationships and learning. Interviews with the child care workers before and after implementation on their experiences with acting out and aggressive children is the qualitative leg of this project's triangulated evaluation methodology. This qualitative aspect of the research design has the potential to elicit data and suggest implications and consequences to our implementation strategy that reviewing the critical incident or the training data alone would not give. Clearly through qualitative research methods, events in context are illuminated and new and deeper dimensions emerge from empirical data (Jick, 1983).

There were two strategies using qualitative methods that were employed in this study that met with varying degrees of success. The first strategy's purpose was to discover how child care personnel at the Children's Home *managed aggressive and acting out behavior prior to the implementation* of Cornell's Therapeutic Crisis Intervention methodology. Beyond illustrating the quantitative critical incident data gathered in the six months prior to implementation, the researcher wanted to assess how child care workers, their supervisors and the facility were responding to aggressive and acting out behavior. It was hoped that these pre-implementation interviews would inform the implementation and establish a baseline for judging the impact of implementation. The second qualitative strategy after the post-implementation period examined how child care workers, children and

supervisors perceived physical restraint episodes that they encountered. This strategy was less successful, yet it revealed the power and impact of both the research method and *TCI's* implementation.

Interviews with residential child care personnel prior to implementation

Fifteen child care personnel and one supervisor were interviewed within the six month period prior to implementation with an interview guide (See Appendix) modified from a previous qualitative research project in another agency. Staff were asked to respond to questions based on six domains (See Table 5.1) and to articulate their perception of an incident where they intervened with a child who was exhibiting aggressive behavior. No attempt was made to note the child care worker's names or identities. All interviews were confidential according to the laws of the State and Federal Research Guideline. No attempt was made to pre-determine or select the outcome of the incidents for these pre-implementation interviews.

Table 5.1: Domains covered in the pre - and post implementation interviews

Domain 1: Description of the incident
Domain 2: Precipitating factors surrounding the event
Domain 3: De-escalation / behavior management techniques used prior to the incident.
Domain 4: Was physical restraint used?
Domain 5: Effect of this experience on the relationship to the child
Domain 6: Assessment of worries and fears about this aspect of their work

Every effort was made to ensure that the event described occurred within a two week period. The interviews were conducted over a three day period at

the convenience of staff. All interviews took place at their specific worksite during their workday with four staff representing each of the four residential units at the Children's Home. The interviews were tabulated (See Appendix for Tables 2 - 8) for reference during the implementation period and are summarized below.

Who are the adult caretakers and their supervisors?

Every effort was made to obtain a representative sample for the interviews. Four staff from each of the four major units were interviewed. One supervisor was interviewed within one unit. The interviewers did not make an attempt to interview supervisors from the other units since project staff met regularly with supervisors who served on the implementation advisory committee. Of the 16 staff interviewed, 9 were male and 7 were female ranging in ages from 23 to 53 years with a mean age of 32 years. Staff experience ranged from 1 year to 22 years with a mean of 6 years. Of the 16 child care staff interviewed 11 were full-time and 5 were part-time. Education levels of staff interviewed ranged from some high school to individuals with master's degrees. The experience, gender and employment status of these 16 individuals compared favorably to the demographic data obtained prior to training (See Chapter 4), so that one could assume we had a fairly representative sample. Fifteen out of 16 staff reported that they received some form of crisis intervention training, although it was not often clear whether the training received was an agency approved program (See Table 5.2).

What types of incidents were described by child care staff?

It is not known whether any one incident described by a child care worker is described by another child care worker. The 16 incidents were distributed throughout the day with 4 incidents occurring in the morning hours (6 am to 12 noon), 4 incidents in the afternoon hours (12 noon to 6 PM) and 8 incidents in the evening hours (6 PM to midnight) (See Table 5.3). The duration of the incidents reported ranged from 2 minutes to 120 minutes with a mean of 42 minutes. The location of the incidents included bedrooms, outside the facility, recreation rooms, living rooms and staff offices. Staff reported physical threat to self or others as high in 9 incidents, medium in 3 incidents, and low in 4 incidents, although only 1 staff member reported an injury to themselves (kicked in the head), and only 2 reported injuries to the children (an eye and lip injury and bleeding knuckles) involved. Property damage occurred in only 2 incidents. A significant finding was that in only 7 incidents was it determined that a critical incident report was filed with the agency. In only 7 out of 16 episodes described did the child care worker have a formal discussion of the episode with the supervisor, colleagues, or the treatment team.

Factors related to incidents which resulted in physical restraint

Twelve of the 16 incidents described involved physical restraints (See Table 5.4). Of those 12 physical restraints, 3 restraints occurred during an attempted escort. In 5 out of 12 restraints, the child took a swing or lunged at the child care worker prompting the decision to restrain. In 3 out of 12, the child care

worker attempted to prevent the child from injuring another child. In 1 of the 12 incidents the child was refusing program rules.

One area that we examined with the 16 child care workers was their perception of factors that precipitated the incidents. In 5 of the 16 incidents child careworkers discussed events which occurred external to the facility such as telephone calls from parents, weekend visits that went poorly, changes in family functioning that affected the child's life. In the remaining 11 incidents, the precipitating factors discussed are internal to the facility such as arguments with other children, on-going conflicts with staff or inability to adjust to program structure.

What was learned during these interviews which is relevant to implementation?

Although it is difficult to generalize from a small sample of child care worker and incidents, the incidents described were consistent with the authors experience (Nunno, 1994) and the limited literature on physical restraints in residential child care (Bell, 1996; Bell & Mollison, 1995). The interviews did offer valuable information necessary for successful implementation of the Therapeutic Crisis Intervention methodology in the Children's Home. A review of the total numbers are relevant to the learning during this pre-implementation phase, but further analysis of practice reveals major differences among the units within the Children's Home on the decision to use restraint, recording and follow-up of critical incidents. Most of these differences can be explained by the population of the children served in terms

of their age and developmental needs, the structure and philosophy of the program. Yet, the interviews also uncovered some practice differences such as the use of time out in Unit A. The major learning points are detailed below in four categories: critical incident reports, injuries to staff and children, critical incident follow-up, and consistency of training.

Critical Incident reports

A major learning point was that critical incident reports were filed in less than 50% of the 16 incidents described in these interviews. Even more important was that of the 12 physical restraint episodes only 5 were reported as critical incidents according to agency policy. Further, this non-reporting of critical incidents was most evident in Unit A since no reports were filed in the four events described. Unit A staff indicated that reports were not filed because the child did not resist strongly enough, or that these incidents happened too frequently to take time to report them. The incidents were however generally written into the daily log for review by a supervisor or colleagues coming in to their shift. The potential impact on our study though was to skew the quantitative pre and post critical incident data which was being collected. This skew would be especially evident for Unit A which reported no physical restraints as critical incidents. The researchers speculated that both the process of interviews within this pre-implementation phase and the implementation phase itself would increase the *reported* but not the *actual* number of restraints occurring in Unit A. This concern was verified when you review the critical incident data. During the period prior to the interviews (October 94 - December 94) when the

researchers and the executive director of the facility were negotiating the terms of the study and only he knew of the study, only 2 restraints were reported as critical incidents in Unit A. During the next quarter (January 95 - March 95) when the study was announced to staff and supervisors In Unit A in January, and the interviews began in early February reported restraints increased to 19 - an over 900% increase.

Injuries to staff and children

Another point learned was that few of these episodes resulted in injury to children or staff, although over 50% were regarded as having high threat associated with them (See Table 5.3). The low level of injury to staff and children in this facility was good news, especially when contrasted to other facilities that this author has studied where the injury rate was considerably higher. The very low injury rate has the potential to make it difficult to document a decrease in injuries to staff and children since the facility is starting with such a low base rate.

Consistency of follow-up

Consistent with the author's experience, in only 50% of these incidents was there a formal discussion with the child or the staff after the incident. The concept of de-briefing the child care worker or engaging the child in a Life Space Interview after a critical incident is a relatively unpracticed standard.

The concept of talking to both the child and the child care worker after an incident in a formal de-briefing and a Life Space Interview is a chief component of the *TCI* methodology. One marker indicating change in practice in the facility is to measure an increase in de-briefings and Life Space Interviews after implementation. This practice assessment will be vital to documenting whether practice changes were made as a result of implementation.

Consistency in policy and training

There was a noted lack of consistency in training and understanding as to what is appropriate practice and policy in the agency. Practice and policy varied among units and although 15 out of 16 participants reported receiving training in crisis intervention, the training received may not have been sponsored by the Children's Home or the methodology may have been learned during previous employment with a population of children whose needs are significantly different than the children of the Children's Home. Another example of this differentiation among units within the facility are the physical restraint episodes in Unit A compared to Unit D All of the incidents that led to physical restraint in Unit A resulted from the child care workers escorting the child to time out rooms. Attempting to move children physically from one location to another seemed to be a signature of the physical restraint episodes at Unit A, and this physical interaction has been found to be a trigger to physical restraints in the literature (Bell, 1996; Bell & Mollison, 1995; Nunno, 1994). This dynamic was not evident in the physical restraints described in the other three units.

Worries or fears of the child care staff

One of the major purposes of the interviews was to gauge the concerns of the child care staff in relationship to dealing with aggressive and acting out behavior (See Table 5.6). The concerns voiced by staff can be grouped into three categories: the safety of the children, personal physical or emotional safety, and lack of support or teamwork.

- *Safety of the children*

One staff was concerned that placing a child in a prone position might lead to death. The staff said directly *"that I am afraid to put a child in the prone position because of an article that I read about a child who died when he was placed in a prone position"*. Another staff member said *"I'm afraid of hurting the kids inadvertently"* while another commented that he thought *"staff over-reacts and is overly aggressive with children who act out"*. Regardless of the personal concerns of the child care worker, their primary concern seemed to be whether the children would be injured by their own aggressive and acting out behavior.

- *Personal safety*

Child care workers did, however, voice concerns over their own personal safety. A few discussed the size of the children in relation to their own size,

and one talked about getting *"whacked around"* by the children. The issue of children's size came up over and over - *"The kids are real big"* was a typical comment. One discussed his reaction to getting hurt - *' I am concerned about a reaction to getting hurt, maybe I'd lose control and perhaps use too much force."* One care worker feared getting bit and getting diseases such as AIDS and Hepatitis. Safety was not limited to personal safety. Some child care workers discussed fear of liability suits, and of being accused of using excessive force.

- *Lack of support or teamwork*

Lack of support or teamwork was an important and almost universal concern or fear. In one or two interviews participants commented that they thought colleagues over-reacted and are overly aggressive to children who act out. One female participant felt that male staff want more discipline and are harder on kids when they are aggressive than they need to be. She states that *"they get the kids all hyped up."* One child care worker saw a problem in there being more part-time rather than full-time staff. Some participants considered lack of training and teamwork as a major concern, while another thought that there was not enough immediate and periodic supervision.

Summary

The interviews were a rich source of information prior to implementation and training. The implementation and evaluation strategy was modified to

take into account the under-reporting of critical incidents in Unit A, the low injury rate to children and staff, the inconsistency of follow-up after physical restraints or other critical incidents, the inconsistency of policy and training in the facility, and the concerns of the child care staff.

Table 5.2: Demographics - Supervisor and Child Careworkers

	Age	Gender	Experience (years)	Position Status	Education	Training in Crisis Intervention
Unit A						
Supervisor #1	43	Male	11	Full-time	MA	Yes
CCW#2	24	Female	2	Part-time	MA	Yes
CCW#3	53	Female	22	Full-time	HS	Yes
CCW#4	26	Male	5	Full-time	BA	Yes
Unit B						
CCW#5	31	Male	8	Full-time	HS	Yes
CCW #6	32	Male	7	Full-time	HS	Yes
CCW#7	45	Female	11	Full-time	HS	Yes
CCW #8	23	Male	1	Part-time	BA	Yes
Unit C						
CCW#9	24	Female	7	Full-time	BA	Yes
CCW #10	24	Female	7	Full-time	BA	Yes
CCW #11	30	Male	2	Full-time	HS	Yes
CCW#12	24	Male	2	Full-time	HS	Yes
Unit D						
CCW #13	44	Male	2	Part-time	Some HS	Yes
CCW #14	26	Female	1	Part-time	BA	No
CCW#15	31	Female	4	Part-time	AS	Yes
CCW#16	30	Male	2	Full-time	HS	Yes

Table 5.3: Child Careworker - Perception of Incidents

	TOD + DOW	Duration (Minutes)	Location	Threat	Frequency	Injury to self - Description	Property Damage	Child's Age Gender	Injury to Child Description
Unit A									
Supervisor #1	2:00 PM W	15		High	Never		No	9 Male	No
CCW#2	7:30 AM Sun	30	Staff Office	Medium	Never	No	Yes	7 Male	No
CCW #3	AM before school Th or Fr	60		Low	Sometimes	No	No	8 Male	No
CCW#4	9:30 PM Weekday	75	Stairway	High	Sometimes	No	No	11 Male	Yes, Eye injury and bloody lip
Unit B									
CCW#5	1 PM W	30	Bedroom	Low	Often	No	No	15 Male	No
CCW#6	7 PM F	40	Bedroom	Medium	Never	No	No	15 Male	No
CCW#7	3:30 PM Weekday	5		High	Sometimes	No	No	17 Male	No

Table 5.3 continued: Child Careworker - Perception of Incidents

CCW#8	9 AM F	30	Bed-room	High	Some-times	No	No	16 Male	No
Unit C									
CCW#9	9:30 AM F	60		Low	Some-times	No	No	17 Male	Yes Bloody Knuck-les
CCW#10	8:30 PM Tu	120	Outside	High	Some-times	No	No	18 Male	No
CCW#11	9:00 PM Tu	30		High	Some-times	No	No	17 Male	No
CCW#12	8:30 PM Tu	60	Living Room	High	Often	No	No	18 Male	No
Unit D									
CCW#13	6 PM Tu or Th	1 - 2	Living Room	Medium	Never	No	No	17 Male	No
CCW#14	4 PM W	5-6	Recrea-tion Room	Low	Never	No	Yes	16 Male	No
CCW#15	10 PM M	90	Bed-room	High	Some-times	No	No	18 Male	No
CCW#16	Eveni ng Week - day	20 -25		High	Some-times	Yes, Kicked in the head	No	17 Male	No

Table 5.4: Circumstances surrounding the event

Circumstances surrounding the incident	Physical Restraint	Incident Report Filed	Decision criteria for using intervention strategy
Unit A			
Sup #1: Child was kicking the banister and slamming the door during a staff meeting.	Yes	No	Child escorted to the time out room and started with verbal abuse.
CCW #2: Child was throwing things at another child.	Yes	No	During an escort child took a swing at the CCW.
CC W #3: Child was throwing things, swearing and hitting other kids.	Yes	No	Child was threatening, refusing program rules, refused to go to time out.
CCW #4: Child was kicking the railing of the stairs, swinging at CCW, attempted escort but fell with the child on stairs.	Yes	Yes	Child was swinging at CCW.
Unit B			
CCW #5: Child was asked to engage in a behavioral contract when he became upset.	No	No	Child was not hurting himself, property or others.
CCW #6: Child attacked another child in the Shelter. CCW used a modified basket hold	Yes	Yes	He was hitting another child.
CCW #7: The child went after another child who was taunting him. The child let us restrain him.	Yes	No	There was no other choice he was going to hurt another child.
CCW#8: Two kids were calling each other names, and the child was going after the other child.	Yes	No	The child pulled the door open while the CCW was pulling it shut.
Unit C			
CCW #9: Child was upset over breaking up with his girlfriend. He was hitting the wall.	No	Yes	I let the child talk.

Table 5.4 continued: Circumstances surrounding the event			
CCW #10: CCW told the child to leave the recreation room and that hit his button. Child began to swear and run through the house. He had to be restrained outside.	Yes	Yes	He took a swing at another staff person during his swearing and run through the house.
CCW #11: The child was confronted by staff for lying and he became angry.	Yes	Yes	He lunged at a staff member.
CCW #12: The child wanted to use the phone 3 minutes early. He was refused permission. He became more agitated and began swearing.	Yes	Yes	He touched the CCW. He pushed the CCWs chest with both of his hands.
Unit D			
CCW#13: Child started to yell and punch the chalk board and toss books around.	Yes	Yes	The child was loud, knocked the chalk off the board and pushed the books to the floor.
CCW #14: Child got angry after a meeting and flipped over the pool table.	No	Unk	I knew to stay calm and speak calmly.
CCW #15: Child was very angry, another staff confronted him and he ran upstairs and ran into the door head first. He fell down and later started to cry.	No	Unk	I gave him alternatives
CCW #16: A child wanted to get out of the program. He could only get out by acting out. He was refusing everything and was in my face trying to get me to react.	Yes	Unk	When he would not take time out. We wanted to get him away from the group. There was a chance of getting hit.

Table 5.5: Effect on the Relationship			
Circumstances surrounding the incident	**Physical Restraint**	**Decision criteria for using intervention strategy**	**Effect on Relationship**
Unit A			
Sup #1: Child was kicking the banister and slamming the door during a staff meeting.	Yes	Child escorted to the time out room and started with verbal abuse.	Crisis enhances the relationship between the child and the careworker
CCW #2: Child was throwing things at another child.	Yes	During an escort child took a swing at the CCW.	Incidents gives you a more accurate picture of what is happening to a child
CC W #3: Child was throwing things, swearing and hitting other kids.	Yes	Child was threatening, refusing program rules, refused to go to time out.	It had no effect
CCW #4: Child was kicking the railing of the stairs, swinging at CCW, attempted escort but fell with the child on stairs.	Yes	Child was swinging at CCW.	It hampered it for a while but it basically had no effect
Unit B			
CCW #5: Child was asked to engage in a behavioral contract when he became upset.	No	Child was not hurting himself, property or others.	The incident made my relationship with the child stronger. I learned the source of the child's conflict
CCW #6: Child attacked another child in the Shelter. CCW used a modified basket hold	Yes	He was hitting another child.	The relationship stayed the same
CCW #7: The child went after another child who was taunting him. The child let us restrain him.	Yes	There was no other choice he was going to hurt another child.	Positively, the child did a turnaround. The child knew that we cared.

Table 5.5 continued: Effect on the Relationship			
CCW#8: Two kids were calling each other names, and the child was going after the other child.	Yes	The child pulled the door open while the CCW was pulling it shut.	This situation did not change a thing. The children here do these things. I don't take it personally.
Unit C			
CCW #9: Child was upset over breaking up with his girlfriend. He was hitting the wall.	No	I let the child talk.	The experience was positive. I felt that the child was closer to me after the incident.
CCW #10: CCW told the child to leave the recreation room and that hit his button. Child began to swear and run through the house. He had to be restrained outside.	Yes	He took a swing at another staff person during his swearing and run through the house.	I was much more cautious with the child after the incident.
CCW #11: The child was confronted by staff for lying and he became angry.	Yes	He lunged at a staff member.	It brought us closer together. We had a better understanding.
CCW #12: The child wanted to use the phone 3 minutes early. He was refused permission. He became more agitated and began swearing.	Yes	He touched the CCW. He pushed the CCWs chest with both of his hands.	He trusted me more. He saw we could control him without hurting him.
Unit D			
CCW#13: Child started to yell and punch the chalk board and toss books around.	Yes	The child was loud, knocked the chalk off the board and pushed the books to the floor.	For a couple of weeks I was guarded with the child.
CCW #14: Child got angry after a meeting and flipped over the pool table.	No	I knew to stay calm and speak calmly.	A little bit of a positive effect. He was sorry about dumping on me as a new staff and opened up to me.

Table 5.5 continued: Effect on the Relationship			
CCW #15: Child was very angry, another staff confronted him and he ran upstairs and ran into the door head first. He fell down and later started to cry.	No	I gave him alternatives	He felt safe with me
CCW #16: A child wanted to get out of the program. He could only get out by acting out. He was refusing everything and was in my face trying to get me to react.	Yes	When he would not take time out. We wanted to get him away from the group. There was a chance of getting hit.	The child left the program after this event. The supervisor decided that he should go to detention. He never came back.

Table 5.6: Child Careworker - Follow-up

	Physical Restraint	Incident Report Filed	LSI	Supervisor De-briefing	Treatment Team Review
Unit A					
Supervisor #1	Yes	No	Unk	No	No
CCW #2	Yes	No	Unk	Yes	No
CCW #3	Yes	No	Unk	No	No
CCW #4	Yes	Yes	Unk	Yes	Unk
Unit B					
CCW#5	No	No	Yes	Yes	Yes
CCW #6	Yes	Yes	No	No	No
CCW #7	Yes	No	No	No	Yes
CCW #8	Yes	No	Unk	Yes	No
Unit C					
CCW#9	No	Yes	Unk	No	No
CCW#10	Yes	Yes	Unk	Yes	Unk
CCW#11	Yes	Yes	Yes	Yes	Yes
CCW#12	Yes	Yes	Unk	No	No
Unit D					
CCW#13	Yes	Yes	No	No	No
CCW#14	No	Unk	Unk	Unk	Unk
CCW#15	No	Unk	Yes	Yes	Yes
CCW#16	Yes	Unk	Unk	Yes	Yes

Table 5.7: Worries or fears expressed by child care workers	
	Worries or fears expressed
Unit A	
Sup #1	• Staff take the acting out too personally. • Staff over-reacts and is overly aggressive to children who act out. • Lack of teamwork
CCW #2	• None
CCW #3	• I was afraid to put a child in a prone position because of an article that about a child who died when put in a prone position.
CCW #4	• I feel guilty when I restrain. I don't like to do it. It felt gross the first time.
Unit B	
CCW #5	• Getting involved with more aggressive children you or your partner can get hurt. • Liability issues if something happens and there is an accusation of excessive force. Some accusations have been valid. • Lack of support from some staff. • Lack of training • Passive - aggressive behavior on part of staff • Lack of willingness of staff to do a self-inventory and owning up to their behavior. • Lack of immediate and periodic supervision • More part-time than full-time staff
CCW #6	• Such a diverse group of kids - big and strong. • Danger with big children in trying to physically manage them.
CCW #7	• We can get whacked around by the kids. • Children with anti-staff sentiment can stalk staff
CCW#8	• Worried that I am going to get hurt. • Worried that I am going to hurt these kids. • Worried that restraints put the house in disarray for too long afterwards.

Table 5.7 continued: Worries or fears expressed by child care workers	
Unit C	
CCW #9	• The kids are real big • The male staff want more discipline and are harder on the kids. I do not think that is what the kids need all the time. They (male staff) get the kids hyped.
CCW #10	• No
CCW #11	• Yes getting bit. Getting diseases such as AIDS and Hepatitis.
CCW #12	• A lot of staff are not qualified, not enough experience with restraint. • Not enough working together as a team.
Unit D	
CCW#13	• I am afraid of getting hit or hurting one of the kids inadvertently. • I am concerned about a reaction to getting hurt, maybe I'd lose some control and perhaps use too much force.
CCW #14	• No
CCW #15	• I have fears about my co-workers. • Inadequate training. • Workers don't often cover each other. •
CCW #16	• Some of the sizes of the kids worry me. Do we really need to restrain the child or to show control?

Table 5.8: De-escalation or behavioral management techniques used prior to the incident

Circumstances surrounding the incident	Precipitating factors surrounding the event	De-escalation or behavioral management techniques used	Physical Restraint	Decision criteria for using intervention strategy
Unit A				
Sup #1: Child was kicking the banister and slamming the door during a staff meeting.	Child had been acting out over the past three weeks. Mother "fell off the wagon" and his plans for returning home became uncertain.	Lower voice, standing to the side, got down to his level, voiced encouragement	Yes	Child escorted to the time out room and started with verbal abuse.
CCW #2: Child was throwing things at another child.	Child was testing a new child care worker	I asked the other child to leave and for another staff to come up and help.	Yes	During an escort child took a swing at the CCW.
CC W #3: Child was throwing things, swearing and hitting other kids.	He had been bouncing around upstairs since wake-up.	First, I ignored it, then gave a verbal warning. Then I gave a Time out where he had to sit on a chair and face the wall.	Yes	Child was threatening, refusing program rules, refused to go to time out.
CCW #4: Child was kicking the railing of the stairs, swinging at CCW, attempted escort but fell with the child on stairs.	He wanted a snack and became disrespectful and I gave him a time out. He then got ready for bed and wanted a snack but it was too late. He got angry.	I offered an alternative snack, and then gave a "yellow" for swearing.	Yes	Child was swinging at CCW.
Unit B				
CCW #5: Child was asked to engage in a behavioral contract when he became upset.	The way that staff intervened. The way they directed and re-directed the child.	I allowed him to vent.	No	Child was not hurting himself, property or others.

Table 5.8 continued: De-escalation or behavioral management techniques used prior to the incident

CCW #6: Child attacked another child in the Shelter.	A phone call from Mom and Dad earlier. Name calling back and forth	I asked him to talk about it.	Yes	He was hitting another child.
CCW #7: The child went after another child who was taunting him.	Another child pushed the kids button by attempting to kick him. This kid had been instigating him for weeks.	None were used. It just happened	Yes	There was no other choice he was going to hurt another child. The child let us restrain him.
CCW#8: Two kids were calling each other names, and the child was going after the other child.	I don't know. I jumped in on the situation.	I told the child to calm down, to relax.	Yes	The child pulled the door open while the CCW was pulling it shut.
Unit C				
CCW #9: Child was upset over breaking up with his girlfriend. He was hitting the wall.	He had been kicked out of school earlier in the semester and was leaving for the Marines. His girlfriend broke up with him earlier in the day.	Brought him to a private office. I let him talk	No	He seemed ready to talk
CCW #10: CCW told the child to leave the recreation room and that hit his button. Child began to swear and run through the house. He had to be restrained outside.	He was not having a very good day. I am not sure what happened to him.	I did all the talking. I tried to get him to talk , he would calm down and then get himself excited again.	Yes	He took a swing at another staff person during his swearing and run through the house.

Table 5.8 continued: De-escalation or behavioral management techniques used prior to the incident				
CCW #11: The child was confronted by staff for lying and he became angry.	The kid was caught in a lie. Child thought he heard staff and kids laughing at him.	We had him take a time out, and tried to separate the other staff and child from him.	Yes	He lunged at a staff member.
CCW #12: The child wanted to use the phone 3 minutes early. He was refused permission. He became more agitated and began swearing.	The child was one of the 18 year olds. His time was short and he knew he was not going to spend much time here.	Talk to him. I used the "levels of confrontation with him".	Yes	He touched the CCW. He pushed the CCWs chest with both of his hands.
Unit D				
CCW#13: Child started to yell and punch the chalk board and toss books around.	He probably did not get his weekend.	I asked him to calm down.	Yes	The child was loud, knocked the chalk off the board and pushed the books to the floor.
CCW #14: Child got angry after a meeting and flipped over the pool table.	He was with his girlfriend and had just come back from running away. She confronted him, left and he was upset.	I asked him to calm down and help me put the pool table back.	No	I knew to stay calm and speak calmly.

Table 5.8 continued: De-escalation or behavioral management techniques used prior to the incident				
CCW #15: Child was very angry, another staff confronted him and he ran upstairs and ran into the door head first. He fell down and later started to cry.	Issues at home. He just got back from a weekend visit.	I called for a group. I gave him alternatives.	No	I gave him alternatives and he took them.
CCW #16: A child wanted to get out of the program. He could only get out by acting out. He was refusing everything and was in my face trying to get me to react.	Another resident hit him, staff took control and gave directives and that seemed to spark him.	Reassurance, I asked what he was afraid of and gave him directives and alternatives.	Yes	When he would not take time out. We wanted to get him away from the group. There was a chance of getting hit.

Chapter Six - Assessing professional and organizational learning

In order to assess the post implementation learning by child care workers and supervisors at the Children's Home, project staff continued to interview child care workers and supervisors about incidents where they intervened with children who were exhibiting acting out and aggressive behavior. The project used two strategies to examine the perception of staff as to how the implementation of *TCI* had changed the way they approached children in crisis. The first strategy was to interview supervisors in a group on two occasions - once in October of 1995 about a month after training was completed in the entire agency, and again in January of 1996, approximately four months after training was completed. The second strategy departed from the pre-implementation interview format and attempted to examine the events surrounding a physical restraint episode, and its resolution from the perspective of the child, the child care worker and the supervisor. This strategy was *not* entirely successful, and the project could not carry it out to completion. Yet, the limited number of interviews that took place, and the information that was gathered was helpful in assessing whether the knowledge and skills learned in training was carried out to the residential care units. For the purposes of this chapter both strategies and their results will be described below.

Group interviews with supervisors

The first group session with Children's Home supervisors was held in October 1995, approximately one month after the completion of the staff training programs. The session was held preliminary to a two-day training program for supervisors on how to conduct a de-briefing session for the staff after a critical incident, and especially a physical restraint episode. All supervisors except for the Unit A supervisor attended. The second group session was held in January 1996, approximately four months after the completion of training in conjunction with an advisory meeting. The first group session was begun with the question: "How did you feel about how physical restraints were handled in the Children's Home prior to the implementation of *TCT*?", and later followed up with "How has *TCI* changed or affected you or your organization?" The second session began with "Have you continued to see changes handling crisis events since implementation and training? The supervisory responses fell primarily into three categories.

Supervisors perceptions of physical restraints

Supervisors invariably regarded physical restraint episodes that either they or their staff engaged in with children as distasteful. *They made me very anxious* or *I became physically ill after some restraints* were common themes voiced during the group session. One supervisor said she *spent a lot of time thinking about restraints, a lot of sleepless nights.* They voiced some of the same concerns about colleagues assisting and teamwork in restraints as was

evident in care worker interviews. One supervisor articulated her feelings clearly when she reported after a restraint - *I became upset and angry when a colleague would not even help even though he was in the room with me. This staff had a relationship with the child. He knew the child better than me but he would not help.* Two supervisors commented that after a restraint they always felt that they *had unfinished business with the child.* One commented that after a restraint *I felt that the child was using me. Now he was calm and I am upset.* These comments give some indication of the personal and troubling perspectives that many supervisors carry with them about using physical restraint in residential care.

Imparting new staff skills

Overwhelmingly the supervisors perceived an increase in staff skills and understanding of children in crisis since implementation. They pointed to staff now having a *grounding* or *baseline* from which to approach children who were upset or in crisis. Supervisors reported staff as having more patience, more of an attitude of caring since they were not taking the child's behavior as personally as they did prior to training. Staff appear to allow the children more options when they are upset rather than *confine them to one or two options such as going to their room or taking a time out.* These *extra tools* have helped staff *fill in the practice blanks, increased staff skills in avoiding physical restraint.*

One supervisor summed up her perception of staff after training with the comment - *Staff have a foundation to build and have a focus point. Basically when staff approach a child who is upset they ask themselves What am I*

feeling? What does this child need? What is the best response? Another supervisor focused her remarks on her own skills when she reported that *I finally figured out what I'm doing and what I'm supposed to be doing. It helped me think about conflicts more. I am more pro-active with staff and children. TCI gave me some direction.* The only negative comment that came out of this session was that many staff reported that they use the pre-crisis intervention strategies but when the going gets tough they *don't have enough time to use all the techniques, especially the Life Space Interviews.* Similar comments were made by child careworkers during interviews.

Providing a consistent strategy for intervention

The second category of responses reported by supervisors is that staff now have a consistent strategy to use from shift to shift, and even unit to unit for dealing with children in crisis. One supervisor commented that it seemed to help administratively in that *it set standards for interaction with children* and gave the message that *we are here for the residents of this facility.* In other words *everyone is on the same page with kids in this facility* was a typical response. They mentioned that *TCI has challenged staff responses to crisis and it has shaken things up.* Another response was that staff now felt that there was *organizational approval* for safe handling of children, and that *TCI had given a description of a process to the crisis events in the facility.* One supervisor talked about her staff having more *structure and focus* to their interventions with children while commented that the training *brought the agency together, increased staff confidence by giving a name to the staff-child crisis behavior.*

In summary then as one supervisor said clearly, *TCI* appeared to help change the *mind set of child care workers dealing with children. It gave staff a new perspective of a child's behavior. A child's behavior is now viewed as a coping mechanism rather than merely a challenge.*

Interviews with child care worker after implementation

The second interview strategy employed by the project after training and implementation was originally planned to examine physical restraint episodes from the perspective of the child, the child careworker and the supervisor. The original plan was to examine up to 25 physical restraint episodes (75 interviews). After approximately six weeks into this aspect of the project, the team only collected partial information about 8 episodes - 9 child care workers, 8 supervisors and only 6 children. The information collected was valuable but there were two major problems which made continuing this plan this strategy unwise.

A decrease in the total number of reports

The total number of physical restraints fell as a result of the implementation of our Therapeutic Crisis Intervention over the past year (See Chapter 8). Although the reduction has not been consistent over the four units of the facility, in two of the four units there has not been a physical restraint episode in over two months. The interviews obtained were from the Unit B, and Unit A. Few restraint episodes occurred within Unit C or Unit D during the

interview period, therefore no interviews took place within those units. It was estimated that it will take 4 to 6 months or longer to interview up to 10 episodes in these units.

Timeliness of the interviews

Compounding the problem of the decrease in physical restraint episodes was that the interviewers were not able to interview the children, the child care workers and the supervisors quickly enough after the episodes to gather accurate and reliable information. Although the first 2 or 3 interviews were within a two week period, subsequent interviews took longer to schedule. The scheduling problem seems to be due to obtaining parental releases for the interviews. Parents have to be tracked down, some agree to the interviews and some do not. Project staff drove down to the facility only to be told that the parents have either not been reached, are unavailable, or they refused to agree to the interview for their children. This resulted in time lost, and a financial expenditure of over $200.00 per visit. Our limited resources to complete this project were running out.

The timeliness of interviews is especially problematic for the younger (8-12 yrs), emotionally disturbed children. Two weeks is just too long a time to gain accurate and reliable information from children who are younger that 10 or 12, and emotionally disturbed. For example, in three incidents the children have not re-called the specific incident to offer appropriate and detailed information. Interviews have to occur within 24 hours of the restraint episode. Interviewing within that time frame is impossible under

our current consent procedures and resources. In order for this strategy to be successful there will have to be another system of consent developed which provides access to children almost immediately after the event.

Still, the limited interviews provided rich information about how physical restraint episodes were handled after implementation of *TCI* in the Children's Home. The study domains and interview guide remained essentially the same as the pre-interviews so that some comparisons between pre and post implementation interviews could be made (See Table 5.1). The major difference between the pre and post interviews were the researchers selected child care workers and interviewed about recent acting out and aggressive incidents, where in the post interviews the researchers selected incidents and then interviewed the child care workers involved.

Who were the child care worker interviewed?

Eight child care workers were interviewed approximately four to five months after training ended. One staff was interviewed about two separate episodes. Four staff were interviewed from Unit A about four episodes, four staff were interviewed from Unit B about three episodes, and one staff from Unit D was interviewed about one episode. The staff interviewed were comprised of seven full-time and one part-time staff. They ranged in ages from 24 yrs to 46 yrs, and ranged in experience from 6 months to 15 years. All received the full complement of TCI training. (See Table 6.1 for a full demographic profile)

What types of incidents were described?

Eight episodes were described. Two child care worker described the same episode. All of the episodes described involved physical restraints, although one child care workers (CCW 5) did not consider her episode a "real restraint" (See Table 6.2). The episodes were distributed throughout the day with 3 incidents occurring in the morning hours (6 AM to 12 noon), one incident occurring in the afternoon hours (12 noon to 6 PM), and 4 incidents occurring in the evening hours (6 PM to midnight). The incidents happened in the bathroom, bedrooms, the lounge, the living room, the dining room and the nurse's office. The incidents range in duration from 3 to 60 minutes. Staff reported threat to self or others in five of the incidents but reported that no one was injured in any episode. In only one instance was there property damage reported. The children involved ranged from 10 to 15 years old.

Factors that related to incidents which resulted in physical restraint

The factors or circumstances that surrounded the episodes were instructive. Similar to the pre interviews, physical restraints are prompted by children's threats, swinging everyday items, or hitting or kicking the child care worker. In 4 instances the child was being escorted when he broke away and began swinging or hitting the child care worker. In two episodes the children threatened to throw or swing a household item, while in 2 instances the child care worker thought that the child was going to hurt himself or another. Similar to the pre interviews, external factors were perceived to precipitate the physical restraint event. Although it was not known until later, in two

instances telephone calls from family members and a county placement agency caseworker respectively occurred, upsetting children to the point of outbursts. In other episodes school had gone poorly, a child had just been returned to the facility after a runaway, and peer relationships were going badly. In many of these episodes both events internal and external to the facility combined to set the child off. More often than not, child care workers had little or no direct knowledge of these factors. (See Tables 6.3, 6.4, 6.5)

The aftermath of the episodes

The *TCI* training and the success of the crisis intervention strategy to meet the developmental needs of the child hinges on the child careworker using a Life Space Interview (LSI) with the child after an incident, and the supervisor de-briefing the child careworker after an episode. The project staff wanted to know whether these techniques were being used with any regularity. In four of the episodes there was an LSI attempted or completed with between the child and the care worker. A supervisor/child careworker de-briefing was held in four of the eight episodes, and when they were held they seemed to be helpful. In only one episode was it certain that the treatment team discussed the physical restraint episode. (See Table 6.5) This 50% rate remained the same from pre to post implementation.

Although it could not be directly attributed to the de-briefing session, six of the eight child care workers did discuss "learning" that took place after the episodes. Some learned lessons of preparation *I should practice more restraint holds.* While others learned to be more watchful or *catch the child*

quicker if I can. Another worker felt she learned a considerable amount about how she "reacted" to the child and questioned her entire strategy. *I don't think I would have escorted him into the bathroom. I take things a little too much at heart. My tone of voice and my actions escalated the child. My tone was more harsh and demanding than it needed to be.* The care worker who described her episode as not a "real restraint" found the experience re-affirming - *I learned that this is really what we are here for - to give some comfort to these children.* Another careworker reinforced this affirmation - *I believe a therapeutic restraint can be helpful if the outcome is good . What bothers me is if I do a restraint and nothing happens.*

How do the pre and post interviews compare?

Some readers may find the pre and post implementation interviews difficult to compare since there may be perceived threats to the validity of the comparison. The primary validity threat is that the interviews were gathered for a different purpose. With the pre implementation interviews, the researchers selected child care workers and interviewed about recent acting out and aggressive incidents, where as with the post interviews the researchers selected incidents and then interviewed the child care workers involved. Yet, as was said earlier the study domains and interview guide remained essentially the same for the pre and post interviews, therefore the information was obtained in the same format. The reader can make the final analysis as to the comparison between the pre and post implementation interviews.

For the sake of a comparative analysis, the project compared the four learning points discussed the previous chapter: critical incident reports, injuries to staff and children, critical incident follow-up, and consistency of training.

Critical Incident reports

The major finding in the pre implementation interviews was that in less than 50% of the incidents described was there a critical incident report filed. This non reporting of critical incidents was most evident in Unit A where it was said that reports were not filed because the child did not resist strongly enough, or that these incidents happened too frequently to take time to report them. In the post implementation interviews the *episodes were selected from critical incident reports* so there was no way of determining if there was still under reporting except to ask. The consistent answer from Unit A staff in post implementation interviews was that everything now was being reported since *TCI* training. As one of the Unit A staff reported *We would have never reported this kind of incident in the past.. Since the TCI training we file everything.*

Injuries to staff and children

The pre implementation interviews revealed that there were few serious injuries to staff or children in spite of 50% of the episodes having a high threat associated with them. In the post implementation interviews, the same high threat index was not found. In fact, there were no high threat

episodes reported by staff, and only one minor injury - a self-inflicted injury where a child bit his own arm. It is not possible to make a claim that *TCI* had some impact on this lowering of threat level, yet performing physical restraints in a safe and effective manner is a skill necessary for the successful completion of the training. In order to assess an overall change in the injury rates to children or staff, a revised critical incident instrument more sensitive to this issue would have to be devised.

Consistency of follow-up

The pre-implementation interviews found that a formal discussion between the child and the child care worker, and the child care worker and a supervisor after the episode is a relatively unpracticed standard at the Children's Home. What is called a Life Space Interview (LSI) between the child and the child care worker after an episode, and a de-briefing session between the child careworker and the supervisor only occurred in 50% of the incidents. The post implementation interviews revealed that the 50% standard remained the same. The supervisors were a rich source of information about why child care workers did not perform the LSIs more often. They suggested that the skill necessary to do them well are *still not well practiced.* Many staff are *mechanical in their approach to the LSI* but with practice and opportunity many supervisors felt that workers would become more comfortable with their use. Supervisors offered suggestions for further LSI training such as more creative ways to approach them, training LSI methods specific to the units and the populations of children that they

serve, and developing LSI strategies for children with learning and processing problems.

In the matter of de-briefing, child careworker reported that supervisors were not always around after a physical restraint incident. If they were then most were readily available for a de-briefing and many found them helpful. Supervisors who used them routinely were positive about their impact on the worker and the worker's learning. Many supervisors felt that the de-briefing procedures *lets staff know this is serious, and* that staff *don't yuk it up anymore after a physical restraint, they don't brag 'I really got him'.*

Consistency in policy and training

The pre-implementation interviews revealed that there were differences in the way that differing units in the facility dealt with children who were upset or in crisis. Some of this was understandable since each unit served children with different needs. In Unit A, for example, escorts appeared to be associated with physical restraints. This phenomenon was evident again at Unit A since escorts prefaced physical restraints in 3 of 4 instances. There is no way of knowing how many escorts occurred without physical restraint so that the strength of this association is unclear at best.

Summary

The post implementation interviews with child care worker and supervisors were a rich source of information. Although incomplete, they revealed "real

world" practices within the units from the perspective of the child care workers and their supervisors. The major finding from the interviews with staff and supervisors after implementation were that there was a more general consistency in policy and procedure in handling and reporting crisis events, and injuries continued to be low.

Table 6.1: Demographics - Supervisor and Child Careworkers - Post Interviews

	Age	Gender	Experience (years)	Position Status	Education	Training in Crisis Intervention
Unit A						
CCW #1	24	Female	6 mons	Full-time	3 yrs college	Yes
CCW#2	26	Male	8 mons	Full-time	BS	Yes
CCW#3	26	Male	8 mons	Full-time	BS	Yes
CCW#4	35	Female	15 yrs	Full time	MA	Yes
Unit B						
CCW#5	46	Female	12 yrs	Full time	HS	Yes
CCW #6	29	Male	1.5 yrs	Part time	HS	Yes
CCW#7	29	Male	1.5 yrs	Part time	HS	Yes
CCW #8	46	Male	12 yrs	Full time	MA	Yes
Unit D						
CCW #9	31	Male	7	Full time	BS	Yes

Table 6.2: Child Careworker - Perception of Incidents - Post Implementation

	TOD + DOW	Duration (Mins) Location	Threat	Fre-quency	Injury to self	Property Damage	Child's Age Gender	Injury to Child
Unit A								
CCW #1	7 PM W	Bathroom	Low	No	No	No	11 yrs Male	Yes He bit his arm
CCW#2	7 PM M	60 Bedroom	No	Yes	No	Yes Poking holes in ceiling	10 yrs Male	No
CCW#3	8 am F	15 Time-out room	Yes to self	average	No	No	10 Male	No
CCW#4	Eveni ng Sat	3-4 Living room	Yes to me and other kid	No	No	No	8 Male	No
Unit B								
CCW#5	10 am W	15 Bedroom	No	Yes	No	No	15 male	No
CCW #6	4:30 PM Tu.	30 Lounge	low self and others	No	No	No	15 male	No
CCW#7	noon M	Nurse's office	Medium	No	No	No	14 Male	No
CCW #8	noon M	20 Nurse's office	Medium	No	No	No	14 Male	No
Unit D								
CCW #9	6:30p Sat	5 Dining + time out	No	Yes	No	No		No

Table 6.3: Circumstances surrounding the event - Post Implementation

Circumstances surrounding the incident	Physical Restraint	Incident Report Filed	Decision criteria for using intervention strategy
Unit A			
CCW #1: CCW confronted children about a broken game just before they were to go out to basketball. The child lost his privilege to go to basketball because he was disrespectful. Child was being escorted when he picked up a plunger and banged it on the shower door.	Yes	Yes	I decided to use restraint when the child picked up the plunger.
CCW#2: Child was running around bedroom, swearing, poking ceiling with curtain rod. He would not calm down so I restrained him.	Yes	Yes	He was on top of the bed. I thought he was going to hurt himself.
CCW#3: Child found out he could not play Nintendo and started to act our. CCW escorted the child to the time out room and child swung at the worker	Yes	Yes	Swung at the child care worker during escort. Put child on floor because he was so upset.
CCW#4: Child began hitting another child. CCW began to escort child out of the room and child began kicking and hitting CCW	Yes	Yes	Child began kicking and hitting the child care worker
Unit B			
CCW#5: Child was trashing his room and the CCW went over to him and held him. CCW did not consider this a 'real' restraint. Child had heard he would not be placed	Yes	Yes	Child was trashing his room.
CCW #6: During fire drill child refused to comply. Child escorted toward outside and swung at the CCW	Yes	Yes	Child swung at the CCW.
CCW#7: Child was threatening to runaway and to throw a pot at the CCW	Yes	Yes	Child picked up a metal pot and threatened to throw it at the CCW.
CCW #8: Child was threatening to runaway and to throw a pot at the CCW	Yes	Yes	Child picked up a metal pot and threatened to throw it at the CCW.
Unit D			
CCW #9: Two boys began to be aggressive with one another after an alarm went off . CCW grabbed one of the boys and restrained him	Yes	Yes	The child began to shove another child.

Table 6.4: Effect on the Relationship - Post-implementation

Circumstances surrounding the incident	Physical Restraint	Decision criteria for using intervention strategy	Effect on Relationship
Unit A			
CCW #1: CCW confronted children about a broken game just before they were to go out to basketball. The child lost his privilege to go to basketball because he was disrespectful. Child was being escorted when he picked up a plunger and banged it on the shower door.	Yes	I decided to use restraint when the child picked up the plunger.	
CCW#2: Child was running around bedroom, swearing, poking ceiling with curtain rod. He would not calm down so I restrained him.	Yes	He was on top of the bed. I thought he was going to hurt himself.	
CCW#3: Child found out he could not play Nintendo and started to act our. CCW escorted the child to the time out room and child swung at the worker	Yes	Swung at the child care worker during escort. Put child on floor because he was so upset.	
CCW#4: Child began hitting another child. CCW began to escort child out of the room and child began kicking and hitting CCW	Yes	Child began kicking and hitting the child care worker	
Unit B			
CCW#5: Child was trashing his room and the CCW went over to him and held him. CCW did not consider this a 'real' restraint. Child had heard he would not be placed	Yes	Child was trashing his room.	

Table 6.4 continued: Effect on the Relationship - Post-implementation			
CCW #6: During fire drill child refused to comply. Child escorted toward outside and swung at the CCW	Yes	Child swung at the CCW.	
CCW#7: Child was threatening to runaway and to throw a pot at the CCW	Yes	Child picked up a metal pot and threatened to throw it at the CCW.	
CCW #8: Child was threatening to runaway and to throw a pot at the CCW	Yes	Child picked up a metal pot and threatened to throw it at the CCW.	
Unit D			
CCW #9: Two boys began to be aggressive with one another after an alarm went off . CCW grabbed one of the boys and restrained him	Yes	The child began to shove another child.	

Table 6.5: Follow-up after restraint - Post Implementation

Circumstances surrounding the incident	LSI	Supervisor De-briefing	Treatment Team Review
Unit A			
CCW #1: CCW confronted children about a broken game just before they were to go out to basketball. The child lost his privilege to go to basketball because he was disrespectful. Child was being escorted when he picked up a plunger and banged it on the shower door.	Attempted	No	No
CCW#2: Child was running around bedroom, swearing, poking ceiling with curtain rod. He would not calm down so I restrained him.	No	No	No
CCW#3: Child found out he could not play Nintendo and started to act our. CCW escorted the child to the time out room and child swung at the worker	No	Yes	No
CCW#4: Child began hitting another child. CCW began to escort child out of the room and child began kicking and hitting CCW	Yes	Yes	Uncertain
Unit B			
CCW#5: Child was trashing his room and the CCW went over to him and held him. CCW did not consider this a 'real' restraint. Child had heard he would not be placed	Yes	No	No
CCW #6: During fire drill child refused to comply. Child escorted toward outside and swung at the CCW	Uncertain	No	Uncertain
CCW#7: Child was threatening to runaway and to throw a pot at the CCW	No	No	No
CCW #8: Child was threatening to runaway and to throw a pot at the CCW	Yes	Yes	Uncertain
Unit D			
CCW #9: Two boys began to be aggressive with one another after an alarm went off . CCW grabbed one of the boys and restrained him	Yes	Yes	Yes

Table 6.6: Worries or fears expressed by child care workers - Post implementation	
Circumstances surrounding the incident	**What learning took place after the incident?**
Unit A	
CCW #1: CCW confronted children about a broken game just before they were to go out to basketball. The child lost his privilege to go to basketball because he was disrespectful. Child was being escorted when he picked up a plunger and banged it on the shower door.	I don't think I would have escorted him into the bathroom for hygiene. I take things a little too much at heart. My tone of voice and my actions escalated the child. My tone was more harsh and demanding than it needed to be.
CCW#2: Child was running around bedroom, swearing, poking ceiling with curtain rod. He would not calm down so I restrained him.	I don't know what I've learned.
CCW#3: Child found out he could not play Nintendo and started to act our. CCW escorted the child to the time out room and child swung at the worker	I think about this incident often, whether or not it should be done. I did not learn much but the restraint had to be done.
CCW#4: Child began hitting another child. CCW began to escort child out of the room and child began kicking and hitting CCW	I should catch the child quicker if I can.
Unit B	
CCW#5: Child was trashing his room and the CCW went over to him and held him. CCW did not consider this a 'real' restraint. Child had heard he would not be placed.	I learned that this is really what we are here for to give some comfort to these children.
CCW #6: During fire drill child refused to comply. Child escorted toward outside and swung at the CCW	Maybe I should be more prepared to use a particular kind of restraint. I should practice more restraint holds.
CCW#7: Child was threatening to runaway and to throw a pot at the CCW	

Table 6.6: Worries or fears expressed by child care workers - Post implementation	
CCW #8: Child was threatening to runaway and to throw a pot at the CCW	I believe a therapeutic restraint can be helpful if the outcome is good. If they turn out good, you can deal with them and it is part of the job. It help this kid and he is staying here and can comply and follow the rules. We almost decided to call and have someone come and get him when he would not cooperate so he would have been discharged and locked up. But by doing the restraint, we were able to work through the problem and he is still with us. What bothers me is if I do a restraint and nothing happens.
Unit D	
CCW #9: Two boys began to be aggressive with one another after an alarm went off . CCW grabbed one of the boys and restrained him	I learned again to expect the unexpected. This child seemed to re-create his family and he became a scapegoat.

Table 6.7: De-escalation or behavioral management techniques used prior to the incident - Post Implementation

Circumstances surrounding the incident	Precipitating factors surrounding the event	De-escalation or behavioral management techniques used	Decision criteria for using intervention strategy
Unit A			
CCW #1: CCW confronted children about a broken game just before they were to go out to basketball. The child lost his privilege to go to basketball because he was disrespectful. Child was being escorted when he picked up a plunger and banged it on the shower door.	CCW confronted children about a broken game just before they were to go out to basketball. The child thought we were trying to single him out. We were preparing to go to basketball. He lost his basketball privileges when he was brought upstairs for swearing. He told us later that his father was going to be at the game. The incident happened 10 minutes before they were going to leave for basketball.	I gave him warnings	I decided to use restraint when the child picked up the plunger.
CCW#2: Child was running around bedroom, swearing, poking ceiling with curtain rod. He would not calm down so I restrained him.	The child has problems eating with the group. He eats alone, I asked him to come in to eat with the group and he refused. I also think he received a telephone call and letters from his parents. I don't know what they were about.	I tried to keep talking in a calm voice. I gave him re-assurance. I deepened my voice and perhaps was a little more stern.	He was on top of the bed. I thought he was going to hurt himself.

Table 6.7 continued: De-escalation or behavioral management techniques used prior to the incident - Post Implementation			
CCW#3: Child found out he could not play Nintendo and started to act our. CCW escorted the child to the time out room and child swung at the worker	Staff misinterpreted the privilege levels. That was what set him off. He then found out that he could not play Nintendo. Lawrence has also been mainstreamed. He has been acting out as a result. This is the second time he has been restrained. I found out last week that the kids at school have been making fun of him.	Asked the child to calm down, chill out, take a time out. When he did not calm down I said: You earned the level you are at this is your fault.	Swung at the child care worker during escort. Put child on floor because he was so upset.
CCW#4: Child began hitting another child. CCW began to escort child out of the room and child began kicking and hitting CCW	We had been to a basketball game and the child was tired and he tends to get hyper.	Joking, talking, redirecting, proximity control and finally the basket hold.	Child began kicking and hitting the child care worker
Unit B			
CCW#5: Child was trashing his room and the CCW went over to him and held him. CCW did not consider this a 'real' restraint. Child had heard he would not be placed.	Two days prior to this he kept trashing his room. I learned later that the county caseworker called and told him over the phone that they could not find a foster home for him. Also, he had a brief contact earlier in the day with his sister. That always seems to upset him.	I spoke to him in a calm tone of voice, soft and gentle. I tried to be re-assuring.	Child was trashing his room.
CCW #6: During fire drill child refused to comply. Child escorted toward outside and swung at the CCW	He had been here for 4 weeks and had no family visits. Staff thought that was the reason for his conflict. Two hours before the fire drill he had been slamming doors and making a lot of noise.		Child swung at the CCW.

Table 6.7 continued: De-escalation or behavioral management techniques used prior to the incident - Post Implementation

CCW#7: Child was threatening to runaway and to throw a pot at the CCW	The child had just been returned from running away by the police. The police had just restrained him.	Talk, then silence, then just waiting	Child picked up a metal pot and threatened to throw it at the CCW.
CCW #8: Child was threatening to runaway and to throw a pot at the CCW	The child had just been returned from running away by the police. The police had just restrained him.	I wanted to get him to talk. I wanted to maintain him to try to calm him down.	Child picked up a metal pot and threatened to throw it at the CCW.
Unit D			
CCW #9: Two boys began to be aggressive with one another after an alarm went off. CCW grabbed one of the boys and restrained him	He was having some trouble with this kid. We are on the buddy system and this kid and his buddy did not get along	I did not use any. I should have been outside to prevent this.	The child began to shove another child.

Chapter Seven - Measuring Confidence

Since a major desired outcome of this implementation strategy is to increase child care staff confidence in crisis prevention, de-escalation and management (See Table 3.2), the project needed an additional measure beyond interviews of how crises events within the facility are perceived and managed prior to and after implementation. Consistent with a triangulated evaluation methodology, the project established a quantifiable measure for child care worker confidence - a 10 question 6 point Likert scale. The scale was based on four perceptual domains: personal knowledge and skill, co-worker knowledge and skill, organizational support, and crisis as an opportunity for learning. These domains with corresponding questions are listed in Table 7.1. The domains are linked to the project's hypotheses testing, the theoretical constructs present in the *TCI* crisis intervention training and discussed in the literature review, and the implementation staff's need to learn more about present practice in the facility. This pre-implementation baseline would be used to inform and shape the implementation strategy; while the post-implementation measure would assess the impact of *TCI* on confidence. The Likert scale questionnaire was initially tested on colleagues with child care experience for face validity. It was modified after this validity test, and later given to 32 child care supervisors and trainers who were participants in three separate Therapeutic Crisis Intervention training program unrelated to this

Table 7.1: Domains measured by confidence scale

Domain	Question
Perception of personal knowledge and skills	
• Prevention	1. I can prevent crisis from escalating in my unit.
• Management	2. I can effectively manage any crisis situation in my unit.
• Confidence in effectiveness of personal knowledge skill on child's coping	7. I can help child learn to cope more successfully with life crisis.
Perception of co-worker knowledge and skills and teamwork	
• Prevention	4. My co-workers and I can work together to prevent and de-escalate crisis.
• Management	3. My co-workers can manage any crisis situation effectively.
Perception of organizational and supervisory support	
• Facility management	5. Facility management is supportive if approved crisis management techniques are used.
• Policy and procedure	6. The facility policies and procedures for crisis management are know to all staff.
• De-briefing - Does it occur?	8. Following a crisis a de-briefing session with my supervisor or the treatment team always occurs.
• De-briefing - Does it help understand crisis in context of the child's life?	9. Session is helpful to me to understand the context of crisis in the child's life.
• De-briefing - Does it help explore impact of crisis on the worker?	10. The session explores the impact of the crisis on me.
Perception of crisis as opportunity for learning	
• Worker helping child	7. I can help children to learn to cope more successfully.

evaluation project. After each round of testing there was some modifications in language and question order.

Pre-Implementation

The test was then distributed to all employees of the Children's Home by either their direct supervisor or a member of the of the evaluation project. The questionnaires were returned via mail with 53 out of 115 or 46% of the full and part-time employees returning the questionnaire. There was no way of monitoring whether the 53 responses came from a representative sample of the facility in terms of gender, employment status, education or experience. In order to test for reliability the scores were subjected to a Cronbach Alpha measure. A score of .69 was achieved in this test population with this measure on the pre test. A score of .70 generally indicates internal reliability.

As a result the project viewed the data produced by this scale with caution. Although on one hand the project received additional information from 53 staff of the facility, the limited testing and the newness of the 10 question survey, the return rate of 46% which was less than half of the employees, and the lack of descriptive data about the population who returned the questionnaire all contributed to this caution.

Although we viewed that data with caution, the confidence scale gave us valuable additional information. It presented a profile of staff attitudes about their perception of personal and co-workers skills, organizational support, and their personal impact on the lives of the children who are under their care.

The results indicate a high rate of staff confidence in personal skill to prevent and manage crisis (See Table 7.2). It also shows a high rate of personal

confidence among staff in their abilities to help children cope which is a major element in a staff member's personal and professional satisfaction levels.

Table 7.2: Perception of personal knowledge, skills

	Prevention of crisis		Management of crisis		Helping children cope	
	N	%	N	%	N	%
Disagree	2	4	6	12	6	12
Agree	49	96	45	88	46	88

Prevention and Management: Missing cases 2
Helping Children Cope: Missing cases 1

In the second domain, confidence in co-workers and ability to work together, the results indicate a somewhat lower level of confidence in co-workers when compared to personal confidence but a very high level of confidence in the working together to prevent and de-escalate crisis (See Table 7.3). This conforms to the earlier results where an individual considers their skills they bring to a crisis as an essential ingredient in prevention and management.

Table 7.3: Confidence in co-workers and ability to work together

	Co-workers can manage crisis effectively		Can work together to prevent and de-escalate	
	N	%	N	%
Disagree	14	26	0	0
Agree	39	74	51	100

Missing cases 0 - Manage crisis
Missing Cases 2 - Work together

The next domain, the perception and confidence in organizational and supervisory support, is presented in Table 7.4. The results show that there is high confidence in management support if approved methods are used. On the other hand, 38% of respondents indicated that the agency policy and procedure is not known to all staff.

Table 7.4: Perception of organizational support

	Management is supportive if approved crisis management are used		Policy and procedures are known to all	
	N	%	N	%
Disagree	4	7	20	38
Agree	49	93	33	62

Missing cases 0 - Management supportive
Missing Cases 0 - Policy known to all

The second section of the organizational support domain is the support given by supervisors in a de-briefing session after a crisis event with a child. This domain is examined in three question: if a de-briefing session occurs, if it is helpful to understand the child's perception, and if it is personally helpful to the careworker. Forty-three percent of the respondents disagree with the

Table 7.5: Perception of supervisory support

	A de-briefing session occurs		If it occurs, it helps me understand the child		If it occurs, it helps me explore impact of crisis on me	
	N	%	N	%	N	%
Disagree	22	43	5	11	8	17
Agree	29	57	40	89	39	83

De-briefing session always occurs: Missing cases 2
Understand the child: Missing cases 8
Explore impact on me: Missing cases 6

statement that a de-briefing session always occurs (See Table 7.5). Yet, the respondents agree that when it does occur the de-briefing session is helpful to understand the child (89%) and it is also helpful to staff to explore their own feelings about the event (83%). This concurs with the findings of the child care workers interviews. The interviews confirmed the infrequency of the de-briefing but when they occurred that they were helpful.

The project also analyzed the pre- implementation confidence scale to determine associations between questions (See Table 7.6). Using Pearson's *r* to assess the strength and direction of the pattern of association between questions or variables, slightly over a quarter (26) of the potential question pairs were found to have a statistically significant correlation at the p=.05 level or less. Some discussion of these associations is valuable since it provides evidence of the dynamic link between perceptions of personal, collegial and organizational confidence and positive outcomes for children. For example, Question 1 - *I can prevent crisis from escalating,* Question 2 - *I can effectively manage any crisis in my unit,* Question 4 - *My co-workers and I can work together to prevent and de-escalate crisis,* and Question 6 - *The facility policies and procedures for crisis management are known to all staff* were highly correlated with Question 7 - *I can help children learn to cope successfully.* These correlation's indicates a positive link between perception and confidence in personal and collegial skills and organizational support with successful outcomes for children, and need to be explored more fully. The correlation among questions between the pre and the post-test were maintained in 12 instances and are repeated later in this chapter.

What did the project learn?

The benefits of a triangulated evaluation design allows the researcher an additional or contrasting view of the data available; yet, the project staff looked at this leg of the triangle with some caution. The confidence scale is new, with the Children's Home being its first full implementation. Later iterations of the test will attempt to improve on its reliability by increasing the number of test items, and incorporating the additional modifications in the language of the test. Still the confidence scale allowed the project staff to poll 53 additional staff members above the 16 interviewed. Simple frequency tables showed high levels of personal confidence in staff, collegial and organizational skills and support. These perceptions of personal, collegial and organizational confidence were reinforced by the associations between these factors and perceptions of positive outcomes for children. This dynamic link between personal, collegial and organizational variables, and the perception of being able to help children cope is one which the literature addresses as being necessary for a healthy relationship between the child and the care workers. In some ways these high levels of personal and collegial confidence contradicted the information gleaned in the interview process. A good example of this seeming contradiction is that the "worries and fears" of the staff in the interviews appeared considerable especially around working with colleagues; yet, the measures taken from the confidence scale appeared high. With the fears articulated by staff in the interviews concerning lack of collegial support and teamwork, one would have thought that the scores would have been lower within these domains and questions. Perhaps this effect can be explained by the bluntness of the confidence instrument itself, or the inexperience of the evaluators in

Table 7.6: Correlation's between confidence scale questions

	Pre		Post	
		Pearson's *r*		Pearson's *r*
1. I can prevent crisis from escalating in my unit.	**Question 2** **Question 4** **Question 6** **Question 7**	.4849** .2917* .2770* .5733**		
2. I can effectively manage any crisis situation in my unit.	**Question 3** **Question 5** **Question 6** **Question 9** **Question 10**	.2983* .4633** .4848** .3005* .3864**	**Question 5**	.4192*
3. My co-workers can manage any crisis situation effectively	**Question 4** **Question 5** **Question 6** **Question 8** **Question 9**	.4628** .3692* .4508** .4630** .4040*	**Question 4** **Question 6** **Question 9** **Question 10**	.6408** .3400* .4071* .5080*
4. My co-workers and I can work together to prevent and de-escalate crisis.	**Question 7**	.2852*	**Question 3** **Question 5** **Question 7** **Question 10**	.6408** ..4193* .3329* .4911*
5. Facility management is supportive if approved crisis management techniques are used.	**Question 6** **Question 8** **Question 9** **Question 10**	.5473** .4841** .5855** .3629*	**Question 6** **Question 8** **Question 9** **Question 10**	.3394* .3674* .4517* .4146*
6. The facility policies and procedures for crisis management are know to all staff.	**Question 7** **Question 9**	.3098* .3925*	 **Question 8** **Question 10**	 .5259** .4428*
7. I can help child learn to cope more successfully with life crisis.	**Question 2**	.3468*	 **Question 5**	 .3674*
8. Following a crisis a de-briefing session with my supervisor or the treatment team always occurs.	**Question 9** **Question 10**	.6986** .4713**	**Question 9** **Question 10**	.4792* .4590*
9. Session is helpful to me to understand the context of crisis in the child's life.	**Question 10**	.7184**	**Question 10**	.6046**

* p = ≤.05,
** p = ≤.001

interpreting the significance of the numbers. These contrasts, contradictions and agreements in the data also allows the evaluator to check the validity and reliability of the data from the two separate sources.

Thirty-eight percent of the respondents reported that they did not know agency policy in regard to crisis management. When one considers that this number is close to 2 out of 5 child care workers, uncertainty in the specifics of agency policy regarding crisis management can be projected to be a major problem faced by this agency. It reinforces the need for one overall approach to crisis management, and clear guidelines for implementation of that strategy.

Another aspect of crisis management within the Children's Home that was uncovered initially in the interviews and reinforced in this questionnaire, is the lack of de-briefing sessions for child care workers after crisis episodes. Of the 16 interviews in the pre-implementation phase, only 8 reported that they held a supervisor de-briefing. Both the interviews and the confidence scale revealed that de-briefing sessions were considered helpful when they were held.

What effect did training and implementation have on staff confidence?

In May 1996 the confidence scale was distributed to the staff of the four residential units of the Children's Home by supervisors at staff meetings. The same instructions were given as to how to fill the questionnaire out. The return rate was disappointing since only 39 questionnaires were returned for a return rate of 29%. This low number affected our reliability since there was

a degradation in the Cronbach Alpha from the .69 on the pre test to .52 on the post test. This degradation may be due to the low return of 39 cases with up to five missing values per questionnaire. Because of the limited number of test returns, the severe drop in reliability, and the fact that this confidence test is a new instrument with the consequences of the effect size unknown, the project staff analyzed the post test results and interpreted them with additional care and caution. The pre and post-test means were analyzed for statistical significance via a parametric *t* to test the hypothesis *that implementation and training would increase the confidence levels of the Children's Home staff when compared to their pre-implementation scores.*

A comparison of the pre and post-test scores is in order (See Table 7.7). First, the project staff compared the mean scores for each question, and in 9 of the 10 questions the mean scores rose. Within this analysis we examined the dispersion of pre and post test scores and found that in 9 out of 10 of the questions the standard deviation grew smaller indicating that there was more consistency and cluster in the post test scores. This analysis is confirmed by supervisor comments that staff in the residential units are now "on the same page" after training and implementation with clearer guidelines, practices and a common language and knowledge base. More importantly using a *t* test (two-tailed significance), in 3 of the 10 questions the mean increase was statistically significant to the .05 level, while in one question the significance reached the .01 level. One question approached statistical significance to the .07 level. The pre and post-test analysis suggests that implementation of *TCI* had a positive consequence in all four of the domains represented in the confidence scale: perception of personal knowledge and skills, perception of

Table 7.7: Comparisons of Means and Standard Deviations between Pre and Post Confidence scale questions				
	Pre		Post	
	Mean	SD	Mean	SD
1. I can prevent crisis from escalating in my unit.	5.0196	.8364	4.8718	1.1045
2. I can effectively manage any crisis situation in my unit.	4.6667	1.0520	5.0769*	.5797
3. My co-workers can manage any crisis situation effectively	4.3019	1.1533	4.8462*	.7448
4. My co-workers and I can work together to prevent and de-escalate crisis.	5.2549	.7167	5.1026	.6405
5. Facility management is supportive if approved crisis management techniques are used.	5.0943	1.0609	5.3846	.6331
6. The facility policies and procedures for crisis management are know to all staff.	3.9057	1.5722	4.6923**	1.0552
7. I can help child learn to cope more successfully with life crisis.	4.8462	1.0735	5.2308*	.6267
8. Following a crisis a de-briefing session with my supervisor or the treatment team always occurs.	3.7255	1.7330	4.3714	1.4968
9. Session is helpful to me to understand the context of crisis in the child's life.	4.8222	1.3192	4.9429	1.0556
10. A De-briefing is an opportunity to explore the impact of this crisis on my life.	4.7234	1.4700	4.9412	1.1791

* $p = \leq .05$,
** $p = \leq .01$

teamwork among colleagues, perception of organizational support, and confidence in effectiveness of personal skills (See Table 7.8). Although perception of supervisory support through de-briefing was not found significant at the .05 level or below, it did achieve an .07 level which might suggest that the implementation and training had some effect on numbers and levels of de-briefing sessions between care workers and their supervisors.

Table 7.8: Confidence scale questions that achieved or approached statistical significance

	t - value	df	p-level
Question 2: I can effectively manage any crisis situation in my unit.	-2.36	81	.02
Question 3: My co-workers can manage any crisis situation effectively	-2.74	89	.007
Question 6: The facility policies and procedures for crisis management are know to all staff.	-2.87	89	.005
Question 7: I can help child learn to cope more successfully with life crisis.	-2.14	84	.03
Question 8: Following a crisis a de-briefing session with my supervisor or the treatment team always occurs.	-1.79	84	.07

Summary

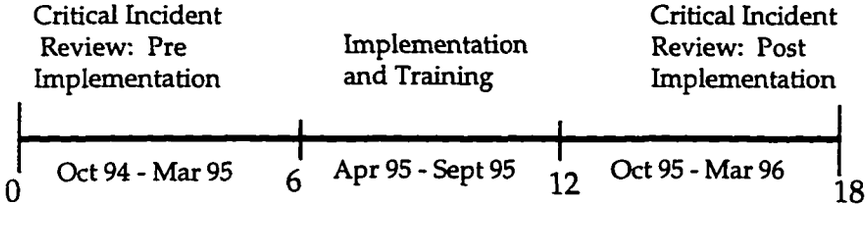
Their is statistical weight to the argument that *TCI* implementation increased the confidence of staff. Yet, caution is in order because of the newness of the 10 question confidence scale, its questionable reliability, and the lack of experience with interpreting the consequences of these effects. Still, with confidence scores from pre to post implementation increasing in a statistically significant manner with at least one question in each of the four perceptual domains: personal skills, teamwork, organizational and supervisory support, and crisis as an opportunity for learning, a modest claim can be made that there was a real increase in confidence levels from pre to post implementation. This finding has the benefit of being supported by the post

test training findings (See Chapter 9) and the post implementation supervisor interviews.

Chapter Eight - Critical Incident Reports

In order to test the two major hypothesis of this evaluation project concerned with the rise or fall of physical restraint episodes, the project designed a system to measure the impact of the implementation of *TCI* on overall critical incidents, in particular physical restraint reports, over an 18 month period of time. The project utilized an off-the-shelf database software package *Filemaker Pro* where the facility's Critical Incident reports were complied and inputted for later analysis. This component of the project's evaluation design began in the first months of the project with the collection of critical incident data through Children's Home's own Critical Incident Report system. The CIR baseline data collection period was for a 6 months prior to implementation - October 1994 - March 1995. The data collection was completed, for the purposes of this study, six months after implementation was accomplished - October 95 to March 96 (See Figure 8.1).

Figure 8.1: Monitoring and Evaluating the Implementation of Therapeutic Crisis Intervention



Critical Incident Reports examined

The Critical Incident Report system is designed to document the experience of residential child care personnel each time they encounter a situation defined as a critical incident. During the 18 months of the project 601 critical incident reports were collected by the project staff and classified according to residential unit (See Table 8.1). The 601 critical incidents included such diverse events as missed medications, accidental injury to staff or child, physical restraint, serious verbal threats, temper tantrums, destruction of physical property, and lack of supervision.

Table 8.1: Number of Total Critical Incident Reports by Residential Unit from October 1994 to March 1996

	Number of Reports	Percent of Reports
Unit A	206	34
Unit B	270	45
Unit C	88	15
Unit D	37	6
Total	601	100

One critical incident report could have multiple events checked, for example one incident report can have the category of physical restraint, fighting and serious verbal threat in the same report. Seventy-nine percent (79%) of the 601 critical incident reports over the 18 month period came from two units in the facility - Unit A (34%) and Unit B (45%). Unit C and the Unit D program accounted for 21% of the critical incident reports over the 18 month period of time.

Another descriptive measure for critical incidents is the comparison of the critical incident rates with the child populations served in the facility. This comparison gives the reader a picture of where critical incidents occur in relationship to the numbers of children served (See Table 8.2). For example, the total number of children served over the project period in Unit A comprises only 3% of the entire Children's Home child population, yet it is responsible for 34% of the critical incidents within the facility.

Table 8.2: Percentage of children served in the facility by unit compared to critical incidents over the study period

	Children Served (Estimated)		Critical Incidents Reported	
	Number	Percent	Number	Percent
Unit A	21	3	206	34
Unit B	547	83	270	45
Unit C	52	8	88	15
Unit D	36	5	37	6
Total	656	99*	601	100

* rounding error

On the other hand, Unit B accounted for 83% of the children served but only contributed 45% of the critical incident reports.

As was stated earlier, the purpose of gathering critical incident data was to quantify the impact of *TCI* on the numbers of physical restraint episodes within the facility. In order to measure increases or decreases in physical restraint episodes, the project staff compared the pre and post-implementation data as measured by physical restraint episodes noted in the

official critical incident reports. During the 18 month period from October 1994 to March 1996, a total of 601 critical incident reports were examined from the four residential care units. From these 601 critical incident reports, the study selected 237 reports where physical restraint had been checked off as a category during the 18 month study period. These physical restraint reports were reviewed and tabulated by residential unit for comparison and they formed the basis for statistical analysis (See Table 8.3).

Table 8.3: Number of Total Physical Restraint Reports by Residential Unit from October 1994 to March 1996

	Number of children served (estimate)	Percent	Number of Reports	Percent
Unit A	21	3	141	59
Unit B	547	83	75	32
Unit C	52	8	16	7
Unit D	36	5	5	2
Total	656	99*	237	100

When examined by unit over the 18 month study period, Unit A accounted for 59% of all noted physical restraint reports, Unit B had 32% of reports while Unit C and Unit D noted 7% and 2% respectively. The general patterns for the four residential units remained consistent when comparing total critical incident reports with physical restraint reports.

The previewed the 601 critical incidents and separated those that contained physical restraints, physical assault, serious verbal threats against others, runaways, and fighting between children from those that contained incidents such as missed medication, accidents and temper tantrums (See Table 8.4).

Table 8.4: Number of restraints, verbal threats, fighting, physical assault and runaways within the 601 critical incident reports over the 18 month project

	10/94 12/94	1/95 3/95	4/95 6/95	7/95 9/95	10/95 12/95	1/96 3/96	Total
Unit A - Critical Incident Reports	**6**	**30**	**21**	**47**	**55**	**47**	**206**
• Restraints	2	19	16	33	38	33	
• Verbal threats	0	0	2	3	4	0	
• Fighting	0	0	1	2		1	
• Physical Assaults	0	2	4	6	24	3	
• Runaways	2	1	1	5	0	1	
Unit B - Critical Incident Reports	**68**	**51**	**48**	**50**	**14**	**39**	**270**
• Restraints	22	14	19	8	6	6	
• Verbal threats	15	11	12	5	1	6	
• Fighting	12	7	6	4	1	6	
• Physical Assaults	16	6	6	8	1	8	
• Runaways	27	7	8	15	2	6	
Unit C Critical Incident Reports	**19**	**16**	**15**	**15**	**11**	**12**	**88**
• Restraints	2	2	3	3	3	3	
• Verbal threats	3	0	0	1	1	2	
• Fighting	1	4	3	2	1	1	
• Physical Assaults	2	1	2	0	2	5	
• Runaways	5	0	5	5	3	0	
Unit D Critical Incident Reports	**5**	**4**	**8**	**8**	**4**	**8**	**37**
• Restraints	1	0	0	2	0	2	
• Verbal threats	0	0	0	0	0	3	
• Fighting	0	0	0	0	0	0	
• Physical Assaults	0	0	0	0	0	2	
• Runaways	0	0	0	2	0	0	
TOTAL	**98**	**101**	**92**	**120**	**84**	**106**	**601**

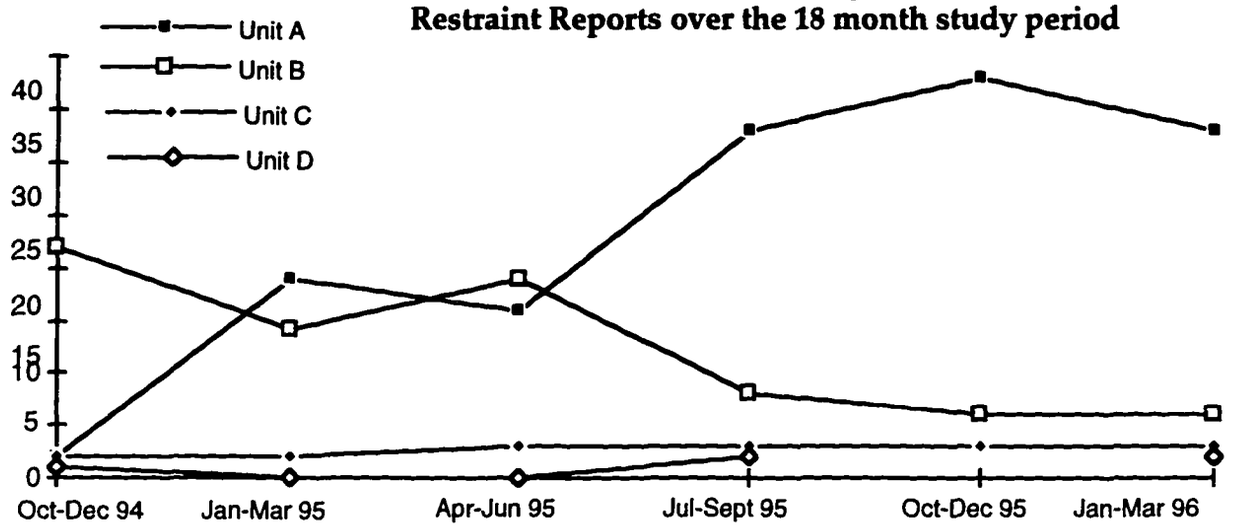
These five categories represent major disruptions in unit life, and have the high potential for injury to both staff and children; therefore, they are considered serious episodes by most residential child care staff. They also provide comparison and contrast for a later examination of physical restraint episodes within the facility.

What was the effect of implementation of TCI on critical incidents?

This project has two seemingly conflicting hypothesis concerning the consequences of implementation of *TCI* in the Children's Home. First, it is hypothesized that *after implementation of TCI there will be fewer overall episodes of physical restraints within the facility.* After an examination of the 16 interviews with facility staff, there was a likelihood that the impact of *TCI,* as measured by a decrease in physical restraint episodes, would be felt most significantly in Unit B of the facility. This is borne out by examining the critical incidents during the baseline period of the study since Unit B accounted for 58% of the physical restraints (See Table 8.5). Another seemingly conflicting hypothesis was also put forward that *the implementation of TCI might increase the reported incidence in one or more units of the facility* where they were currently under reported. After the 16 interviews with staff on critical incidents, it was determined that Unit A would be the most likely candidate for this increase in incident reporting. Reviewing the critical incident data at Unit A confirmed this impression since only 2 reports of physical restraints were recorded during the initial 3 months of the baseline period (Oct 94 - Dec 1994) while a steady increase occurred throughout the study period.

A more graphical portrait of the physical restraint episodes over the 18 month study period shows the dramatic increase in reports from Unit A, at the same time that Unit B reported dramatic decreases (See Graph 8.1).

Chart 8.1: Total Number of Physical Restraint Reports over the 18 month study period



In contrast to Unit A and Unit B, Unit C and the Unit D program saw little change in the type and frequency of critical incidents reported. This held true for physical restraint episodes, as well as the other serious episodes such as runaways, fighting, verbal threats, and physical assaults (See Table 8.2). Clearly some phenomenon was occurring within both Unit B and Unit A which contributed to a dramatic decrease and increase respectively in reported restraints over an 18 month period. A closer look at the monthly reporting statistics and an examination as to what was occurring within theses residential units, and the impact of TCI implementation is in order. For the purposes of this analysis then, the discussion of the effect of *TCI* on critical incidents will focus on Unit A and Unit B only.

Table 8.5: Total number of physical restraint reports

	Pre-implementation 10/94 - 3/95		Implementation 4/95 - 9/95		Post-Implementation 10/95 - 3/96	
	N	%	N	%	N	%
Unit A	21	35	49	58	71	78
Unit B	36	58	27	33	12	13
Unit C	4	6	6	7	6	7
Unit D	1	1	2	2	2	2
TOTAL	62	100	84	100	91	100

Unit B - Unit B serves over 80% of the total number of children of the entire residential component of the Children's Home. Together Unit B sees children from 5 to 18 in residential assessment and diagnostic services, and provides temporary shelter for children for up to 45 days. Children in both programs live, eat and are schooled together in the same quarters, and for the purposes of this study the two units will be seen as one. In many ways, *TCI* was developed for program like Unit B. Although the unit's services are designed for children from 5 to 18, the majority of its population is from 12 to 15, verbal and acting out. Staff has just a short time to learn about the children. Crisis and upset can occur easily since the child population is temporary and placed on an emergency basis, often for the first time in the midst of family upheaval and turmoil. As a result, the adult caretakers may have limited or very little knowledge of the specific child's needs and personality. The children themselves are new to the environment, frightened of this experience, taxed to their coping limits, defensive, and frightened of the other children in the facility. In this environment adult caretaker training in crisis management is essential to prevent, minimize and

de-escalate crisis events when they occur. Often physical restraint is necessary to protect children from themselves and others.

Within this context Unit B staff who are approximately 50% full-time and 50% part-time expressed concerns prior to training and in the interviews that there was a lack of training in crisis prevention and intervention. They discussed real issues such as worries about getting hurt and hurting children, of getting "whacked around" by kids, especially the bigger ones. They acknowledged seeing a diverse population of children who were frightened and needy. They also discussed a lack of support from colleagues when children became aggressive and dangerous, and restraint was needed for the child or others protection.

Examining critical incident reports and restraint data during the three major phases of the project (See Table 8.6 and 8.7) are in order, and subjecting them

Table 8.6: Pre - Implementation and Post - Implementation critical incident data for Unit B

							Total	Mean
Pre - Implementation	10/94	11/94	12/94	1/95	2/95	3/95		
	24	23	21	28	19	4	**119**	**19.83**
Post-Implementation	10/95	11/95	12/95	1/96	2/96	3/96		
	3	7	4	19	9	11	**53**	**8.83***

* t value 2.57(two-tailed), *df* 5 p<.04

to parametric statistical analysis is appropriate. A *t* test to examine the total critical incident reports and the physical restraint episodes for pre and post-

implementation phases were run on either a standard *SPSS* statistical package for *Windows* or *Microsoft Excel* for the Macintosh.

The pre implementation total of critical incidents (119) with the post implementation critical incident reports (53) represents a reduction of over 50%. When these totals are subjected to a t test, a t value of 2.57 (two-tailed significance) is achieved, *df 5*, which reaches a p- value of <.04. This level suggests that the reduction in critical incidents is statistically significant.

Table 8.7 Pre - implementation and Post - implementation restraint data for Unit B

							Total	Mean
Pre - Implementation	10/94	11/94	12/94	1/95	2/95	3/95		
	10	6	6	10	4	0	**36**	**6**
Post-Implementation	10/95	11/95	12/95	1/96	2/96	3/96		
	1	3	2	3	2	1	**12**	**2***

* *t* value 2.57 (two-tailed), *df*5, p<.04

A more powerful finding though is the 66% reduction of reported physical restraint episodes over the life of the project. When comparing physical restraint episodes within the pre (36) and post (12) implementation phases, a t value of 2.57 (two-tail significance), 5 df, achieved a statistical significance at the p <.04 level. This significance level suggests that the reduction of physical restraint episodes from pre to post is unlikely to be attributed to chance.

Unit A - As was stated earlier Unit A is one of the few licensed facilities in the state which provides children ages 6 to 12 with alternatives to psychiatric

hospitalization. Children with serious emotional disturbances who might otherwise be placed in large centralized facilities are placed if an assessment determines that they might benefit from close community and family contact within a group home setting. Children attend community schools, take part in sports activities in community facilities, and live in a neighborhood setting. These children have limited verbalization skills, and may suffer from neurological damage. The Therapeutic Crisis Intervention (*TCI*) methodology was not designed for this population because *TCI* assumes at least normal verbalization, understanding, and self-control.

At the pre-implementation stage, the unit presented itself as in some disarray. The four interviews with staff prior to implementation revealed a unit with multiple undocumented episodes of aggressive acting out on the part of the children. The first indication for the lack of documentation came out of the four interviews with Unit A staff during February 1995. Staff reported that they only filled out a critical incident form if the child exhibited serious aggression, or if the physical restraint was met with unusual physical resistance. The pre-implementation statistics indicated that in the first quarter (October 94 - December 94) prior to the Children's Home staff knowing about the project, only 6 critical incident forms were completed. During the second quarter (January 95 - March 95) of the baseline data collection, when the *TCI* implementation and evaluation project announcement was made, and meeting were held with supervisory staff throughout the facility explaining the project, the total number of critical incidents reported increased to 30, a 500% rise over the previous quarter (See Table 8.8). An increase in reports (but not actual episodes) due to our initial

information about the project alone was anticipated but a dramatic rise of 500% was a surprise.

Subjecting the 18 month critical incident data to statistical analysis was in order. The pre implementation rate of 36 episodes was compared to the post implementation rate of 102 documented episodes using a parametric t test. A t value of 2.57 (two-tail significance) , *df* 5, at a p level of <.02 was reached leading the project to believe that this change could not have been subjected to chance.

Table 8.8: Critical incident data for Unit A throughout the life of the project

							Total	Mean
Pre - Implementation	10/94	11/94	12/94	1/95	2/95	3/95		
	2	0	4	5	12	13	**36**	**6**
Post-Implementation	10/95	11/95	12/95	1/96	2/96	3/96		
	19	20	16	19	13	15	**102**	**17***

* *t* value 2.57 (two-tailed), *df*5, p<.02

When the project looked at physical restraint episodes over the 18 month study period, 21 episodes were documented during the baseline period, 49 episodes documented during the implementation period, and 71 episodes were documented during the post implementation period (See Table 8.9). Subjecting these pre and post rates to the same t test revealed a t value of 2.57 (two-tailed), *df* 5, at a p level of <.02. Again this significance level suggests that this change is not due to chance but to other factors in the facility such as a new sensitivity to restraint recording, an abrupt change in supervisory staff in the midst of the implementation project, and the fact that a major change

in care strategy and philosophy with this population may lead to turmoil and upset within the child population served.

Table 8.9 Pre - implementation and post - implementation physical restraint data for Unit A

							Total	Mean
Pre - Implementation	10/94	11/94	12/94	1/95	2/95	3/95		
	1	0	1	1	10	8	**21**	**3.5**
Post-Implementation	10/95	11/95	12/95	1/96	2/96	3/96		
	13	18	7	11	11	11	**71**	**11.83***

**t* value 2.57 (two-tailed), *df*5, p<.02

Summary

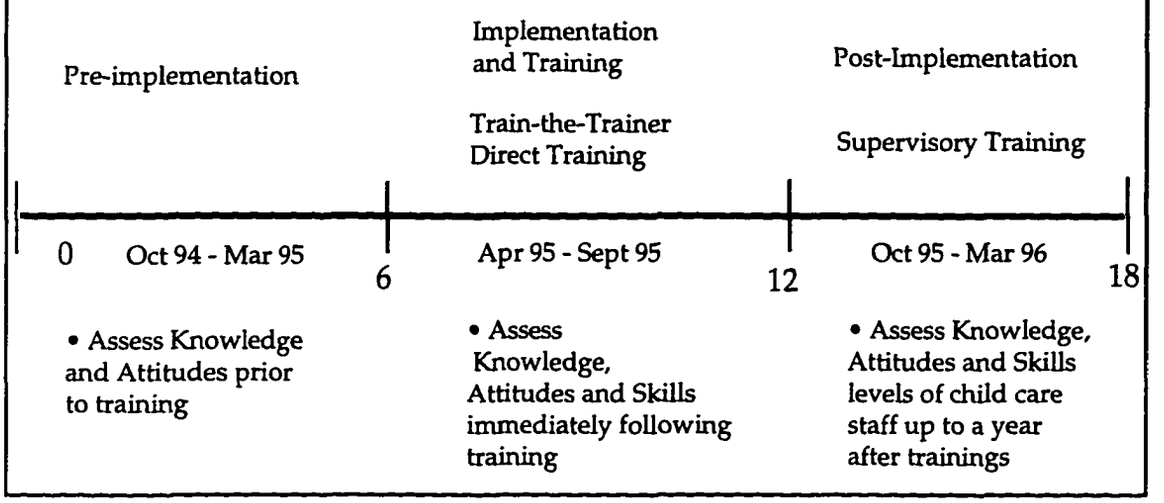
The primary reason that the project designed a system to measure the impact of the implementation of *TCI* on the overall rate of critical incidents in the Children's Home over an 18 month period of time. Particularly, it wanted to measure the impact of physical restraint reports in at least two of the residential units - Unit A and Unit B. The project found that restraint reports increased dramatically in Unit A while decreasing dramatically at Unit B. The increase at Unit A was significant at the p <.02 level, and the decrease at Unit B was significant at the p <.04 level using a *t* test (two tailed) in both instances. The changes in physical restraint reports at both Unit D and Unit C were insignificant, and indicated to the evaluation team that *TCI's* implementation effects in both of these units of the Children's Home were less quantifiable. This result is not a surprise since both of these units account

for less than 10% of the physical restraint reports coming from the facility. Any change in these numbers would be small and more accountable to chance.

Chapter Nine - Training

A major goal of this project is to increase the knowledge levels of the Children's Home staff to handle crisis events more effectively. An integral part of the implementation of Therapeutic Crisis Intervention is preparing the supervisory and direct care staff through training. Training was used as the chief vehicle for imparting the knowledge, philosophy and techniques of Cornell University's Therapeutic Crisis Intervention methodology throughout the project (See Figure 9.1), and for evaluating the knowledge, attitudes and skills of the direct child care staff.

Figure 9.1: Training and evaluation schedule of child care staff



The process of training preparation began with the selection of four of the Children's Home supervisory staff to go through one of the national residency train-the-trainer programs in the spring of 1995 sponsored by the

Cornell's Residential Child Care Project. These four staff became the Children's Home's core training staff who would later train all of the Children's Home's child care and supervisory staff starting in May 1995. From May 1995 to September 1995, all of facility's full and part-time child care and supervisory staff received a minimum of 28 hours of direct training. The four day program was generally run on four consecutive days during working hours, although some staff volunteered to engage in training during their off hours. The direct training goals are the same as the goals of train-the-trainer program, in that they strive to:

- prevent crisis from occurring;
- de-escalate occurring conflicts;
- manage acute crisis phases; and
- reduce potential and actual injury to children and staff.

In all phases of this intervention process from prevention, de-escalation, to therapeutic management, the program is oriented to residential child care personnel helping the child learn developmentally appropriate and constructive ways to deal with feelings of frustration, failure, anger and pain. The 28 hour training focused on the nature and stages of crisis, underlying contributions to crisis situations, de-escalation and prevention strategies, causes of aggressive behavior, philosophy and principles of therapeutic physical intervention, and the dynamics of crisis in group child care situations. Participants gain insight and awareness of personal values including how personal bias, attitude and professional style affect children in crisis. Specifically, the importance of avoiding power struggles, using personal and professional authority appropriately, children's perceptions of

adults, the key role an adult plays in crisis intervention, and team work are discussed. At a minimum, each participant has functional skills in techniques for the prevention, de-escalation and therapeutic management of crisis situations, intervention techniques which minimize power struggles, behavioral management skills, physical intervention skills to contain acute physical behavior.

What did the project learn about the Children's Home staff?

One hundred four Children's Home staff from all aspects of the facility completed the pre training demographics questionnaire, and the 34 item knowledge based multiple choice test prior to starting training in the 28 hour Therapeutic Crisis Intervention curriculum described above from May 1995 to September 1995 in seven separate programs (See Table 9.1). Ninety-six participants completed the post-training reaction questionnaire test and the 34 item knowledge based multiple choice test (See Appendix).

Table 9.1: Location of employment within the facility

	Number	Percent
Unit A	17	16
Unit B	34	33
Unit C	11	11
Unit D	21	20
Foster Care	14	13
Other	7	7
Total	**104**	**100**

The overwhelming number of participants were direct services staff (68%), while 11% were supervisory or administrative personnel. The facility's clinical and casework staff made up the remainder of the training population (21%). Of the staff trained 64% were full-time and 34% were part-time with 2% not sure of their employment status.

The demographic questions on the pre-test portion of the training evaluation provided the project with an excellent breakdown of facility staff. The Children's Home staff are almost equally divided according to gender - 52% are female and 48% are male. Education levels of staff range in categories from "some high school" to "master's degree" and are outlined in Table 9.2.

Table 9.2: Education levels of staff

	Number	Percentage
Some High School	2	2
High School	17	16
Some college	27	26
Bachelor Degree	37	36
Master's degree	20	19
Total	**103**	**99**

missing cases = 1

Participants categorized their area of study as social work (12%), psychology (25%), sociology (5%), education (13%) and other social sciences (12%). The remaining listed "other" as their area of study.

The demographic question on length of time in child care revealed a child care staff with one quarter of the staff having under 1 year of experience (See Table 9.3).

Table 9.3: Length of time in child care		
	Number	Percent
1 year or under	26	25
1 to 5 years	41	39
6 to 10 years	22	21
11 years and over	15	15
Total	104	100

How did the Children's Home staff regard the training upon completion?

Ninety - six participants completed the post-test administered immediately after training. Ninety-five percent of the participants rated the training as good (25%) or excellent (70%) on the post-test. Only one participant rated the training as fair. Eighty-five percent of the trainees thought that the training was "just right", while 11% thought that it was somewhat too basic. The remainder considered the training too advanced.

Table 9.4: Participants perception of usefulness of training		
	Number	Percent
Little or no relevance	1	1
Probably won't use	7	7
Don't understand well	1	1
Plan to use on my job	79	82
Already knew and using	5	5
Missing	3	3
Total	96	99

Two questions on the post-test attempted to gauge the perception of the training in terms of its "usefulness" and the participant's confidence in "performing" the skills learned in training. Over 82% of the participants plan to use the learning on the job, while only 7% indicated that they probably won't use the training (Table 9.4).

The evaluation measured how confident participants where after training in using the skills learned (Table 9.5) . Over 93% considered that they were definitely or probably be able to use the skills learned. Only 4% of the participants considered that they definitely or probably would not feel confident in using the skills and knowledge learned.

Table 9.5: Participants perception of confidence in performing the skills learned

	Number	Percent
Definitely able	60	63
Probably able	29	30
Probably not able	3	3
Definitely not able	1	1
No opinion	1	1
Total	94	98

missing cases = 2

What did the Children's Home staff learn and how long did the learning last?

The evaluation of the training addressed the learning gain of participants who completed training. Learning gain was assessed by comparing a 34 question multiple choice test that was based on the learning objectives of the

28 hour direct training course. The pre and post-tests were adapted from the train-the-trainer pre and post test used over a five year period by the Residential Child Care project with the questions pertaining to training knowledge and skills deleted from the test. The test was then re-compiled and used for the direct training at the facility. The trainers received written instructions which guided their test administration, and ensured consistency, for the seven offerings of training.

The knowledge based test was administered prior to the beginning of the training during the first hour, and the post-test was administered on the last day in the last hour of training. An analysis and comparison of the pre and post-test scores reveals that learning did take place during the training (Table 9.6).

Table 9.6: Pre and post test scores as a result of training

Pre Number =104			Post Number =96		
Average score (34 questions)	SD	Percent correct	Average score (34 questions)	SD	Percent correct
16.99	3.66	49.97	28.35	3.89	83.39

The mean post-test score of 28.35 questions correct represents a 65% increase over the pre-test score of 16.99 questions correct. Looking at the test scores another way, participants averaged 49.97% correct responses on the pre-test and 83.39 correct responses on the post-test or a 33.42 gain. On the pre-test less than 1 % achieved over 70% correct answers, while on the post-test 87.50% of the participants achieved above 70% on the post-test. Clearly the training achieved the goal of increasing the learning of participants in the seven direct training programs run by the Children's Home trainers.

When the project examined the knowledge test responses via an item analysis, of the 34 questions on the pre and post test 32 questions showed a learning gain. Specifically, in 32 of the 34 questions more participants answered correctly the respective post test question than the pre test question. The two questions where more participants answered the pre test question correctly were Question 13 - *Which of the following is most concerned with how the child is feeling?* - and Question 18 - *Who should write a detailed description of any incident of physical restraint?*. For Question 13 there was a minimal 5% decrease in learning gain from pre to post where on Question 18 the pre to post decrease was 25%. The Question 18 decrease was especially troubling since this question dealt with the policy and procedure of critical incidents. Evaluation feedback to the trainers (as well as the supervisors) at the facility to re-inforce that any staff involved in an incident was responsible for writing a critical incident was necessary.

On the more positive side, it is important to recognize the high learning gain of the participants in 32 of the 34 questions. The increase ranged from a minimum of one percentage point to a maximum of 76 percentage points. Specifically, in 19 of the 34 questions the number of participants answering correctly increased by a minimum of 30 percentage points. Even more dramatically, in 8 of the 34 questions the number of participants answering correcting increased by over 50 percentage points. These 8 questions with the most dramatic increases tested knowledge for physical restraint technique, crisis intervention strategies, self-assessment and the Life Space Interviews (See Table 9.7)

Table 9.7: Over 50% - Number of participants gain from pre to post test

	Pre test		Post test		Gain
	N	%	N	%	%
Question 3 - To properly and effectively do a team restraint on an adolescent, after the workers the workers have immobilized the arms across their torsos, the next move should be?	43	41	88	91	50
Question 11 - Which is the best approach to use during routines and transition times?	17	16	89	92	76
Question 12 - Which is the best approach to use with an older, more mature child?	6	6	89	92	76
Question 14 - What is the first silent question that a child care worker should ask in dealing with an upset child?	36	35	87	91	56
Question 26 - Which of the following is not a part of the Life Space Interview?	36	35	86	90	55
Question 27 - In the "Letting Go" process:	37	36	91	95	59
Question 30 - The last two steps in the Life Space Interview are:	38	37	93	97	60
Question 32 - The crisis cycle goes as follows:	28	27	79	82	55

The project wanted to know if there were any significant differences in learning in relationship to location or employment status. In order to examine the differences in learning between full and part time employees, the project was able to examine 80 paired pre and post-test scores from the 104 pre-tests and the 96 post-tests. From these paired tests, the project compared the learning gains of the full and part time employees (Table 9.8). An

examination of the learning gain revealed a non significant difference of 1.39 points between the two groups. What was troubling was that the standard deviations for the part time people increased from 9.66 to 11.17, indicating that there was a wider gap between participants after training than before.

Table 9.8: Learning gain by employment status

	Part time = 28		Full time = 51	
	Mean	SD	Mean	SD
Pre Score	49.26	9.66	52.48	8.93
Post Score	81.62	11.17	86.22	8.16
Learning Gain	32.35		33.74	

Examining the learning gains according to location of the participant revealed some differences (Table 9.9). Unit D participants appeared to have the largest learning gain, as well as the highest post-test scores. What is of

Table 9.9: Learning gain according to employment location

	Unit A (N=15)		Unit B (N=24)		Unit C (N=8)		Unit D (N=14)	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Pre test	53.53	8.33	49.26	9.94	52.57	8.38	48.32	8.30
Post test	85.69	7.85	81.86	11.94	81.25	10.06	88.87	7.13
Gain	**32.16**		**32.60**		**28.68**		**40.55**	

somewhat more interest to the implementation project, is the fact that the standard deviations in two of the four units increased from the pre and post test when it is anticipated they will decline with training. In Unit B and Unit

C the standard deviations increased 2 standard deviations and 1.68 standard deviations respectively.

Did the Children's Home staff maintain their learning over time?

One of the goals of the implementation project was to determine if learning was maintained, decreased or increased over time. The post-test was administered again at various staff meetings during the spring of 1996, approximately 8 to 10 months after the majority of the staff completed training. The project received 23 post-tests from this re-examination that we were able to match with the pre and post-tests administered at the beginning and end of training delivered in 1995. A mean score of 78.52% correct answers was achieved which resulted in a drop of only 4.87 percentage points during the 8 to 10 months since the training ended. One can assume that knowledge of crisis intervention was retained during this period.

Summary

Participants at all levels of the facility were trained in a 28 hour course taught by the Children's Home supervisory personnel. By all accounts the training during the implementation period was successful. On an average learning gains of over 33.42 percentage points were achieved at all levels of the facility, and these learning gains only dropped 4.87 percentage points from the end of training to a period 8 to 10 months later. The only troubling point was that the standard deviations of participants in some locations increased, indicating

that there was a wider gap in knowledge among staff at the facility after training. Overall participants considered training successful, relevant to their work and competence to use the knowledge and skills in their respective work environments.

Chapter Ten - Was the implementation of TCI successful?

The purpose of this project was to implement, evaluate and monitor a crisis intervention methodology whose goals are to:

- prevent crisis from occurring;
- de-escalate occurring conflicts;
- manage acute crisis phases.

In all phases of this process from prevention, de-escalation to management, the crisis intervention strategy was oriented to residential child care personnel helping the child learn developmentally appropriate and constructive ways to deal with feelings of frustration, failure, anger and pain.

Over the eighteen month implementation period, the project introduced and evaluated:

- Cornell University's therapeutic crisis intervention methodology in preventing, de-escalating and managing crisis situations between children and staff and between children;
- a curriculum for residential child care which teaches and supports the skills necessary for the prevention, de-escalation and management of crisis.

As a result of using the crisis intervention methods outlined in Cornell University's *Therapeutic Crisis Intervention* curriculum, child care workers from the Children's Home were able to prevent, de-escalate and effectively manage crisis situations with children in residential care. Implementation

staff worked closely with the residential facility to adapt the project's existing evaluation methodologies, curricula and protocol developed from previous implementation strategies with other child care agencies. As a result participating in this program it was anticipated that all levels of Children's Home staff:

- would more effectively manage and prevent crisis situations with children;
- felt more confident in their ability to manage crisis situations, and;
- worked as a team in prevention, de-escalation and acute crisis management.

Using a train-the-trainer approach, project staff trained selected supervisory staff in the project's crisis intervention methodology to deliver the *Therapeutic Crisis Intervention* curriculum to all levels of a residential child care staff. Throughout the initial implementation and training phases, all levels of residential child care personnel were mandated to attend workshops and seminars on the nature and stages of crisis, underlying contributions to crisis situations, multi-cultural dimensions of crisis, de-escalation and prevention strategies, causes of aggressive behavior, philosophy and principles of therapeutic physical intervention, and the dynamics of crisis in group child care situations. Participants gained insight and awareness of personal values including how personal bias, attitude and professional style affect children in care. Specifically they learned, teamwork, the importance of avoiding power struggles, using personal and professional authority appropriately, children's perceptions of adult behavior, and the key role an adult plays in crisis intervention. At a minimum, each participant has

functional skills in techniques for the prevention, de-escalation and management of crisis situations, conflict resolution techniques which minimize power struggles, behavioral management skills, and physical intervention skills to control acute behavior.

A pre/post evaluation was conducted to analyze the effectiveness of this approach in transmitting knowledge and skills and whether the knowledge and skills support the staff development functions of residential child care personnel.

Results of the implementation

During the eighteen month implementation period in which the project worked with the Children's Home, the following results were evident:

- staff were more confident in their ability to manage crisis situations;
- staff increased their confidence as a team in handling crisis situations
- a statistically significant reduction of physical restraint episodes were reported for Unit B;
- an statistically significant increase in reported event occurred in Unit A;
- staff increased their knowledge and skills in crisis intervention, and this increase in knowledge and skill persisted up to 10 months after training was completed, and
- selected supervisory staff learned basic and sophisticated techniques to conduct effective and long-lasting training programs.

Did the implementation of TCI produce these results?

The strength and the significance of these results depends largely on the strength of the research design followed in this project. In order to study the consequences of *TCI's* implementation on the Children's Home, the evaluation staff relied on a triangulated approach to evaluation which included both qualitative and quantitative methods. The staff conducted interviews with the child care staff, supervisors, and the executive director prior to implementation, met with supervisory staff during implementation and interviewed child care workers and supervisors after implementation. Pre and post measures of knowledge and confidence were taken, and critical incidents were recorded, compared, contrasted, and analyzed using parametric statistics.

Although the project can be reasonably certain that implementation proved successful in terms of the outcomes mentioned above there are a number of questions that were raised by this project. These question have to do with the generalizability of the results, the replication of the model to other facilities, and a discussion of the significant changes that would be made in future research designs.

To what extent is the learning generalizable?

A major point that has been raised in this study is how much of what we have learned about this facility and child care is generalizable to other residential child care facilities, and to the residential child care profession.

One of the purposes of this study was to provide future customers of our training curriculum with evidence that this strategy was effective in reducing potentially risk laden interactions between adults and children, and between children in facilities. To invest significant University and facility resources and time without findings that could be generalized with some confidence to the child care field would be considered a major and fatal flaw in the methodology.

The limitations with our methodology were numerous. For example, there were no control groups or interrupted-time series design within this study to compare and contrast the quantitative findings. In addition, the sample sizes were small, purposeful, and non-random, and dwindled over the 18 month period of the project. For the strict qualitative researcher, the pre and post interviews were not conducted in strict conformity of design. Many traditional researchers from both schools might be hesitant to accept the findings as reliable or valid, and to further "scientific" knowledge. Yet, our aims and goals are more limited than the scientist seeking the truth. An evaluator seeks useful information that is fairly specific to the implementation of one program (Patton, 1990). To that end, the methodology taught us a great deal about our work that can be used in our future implementation plans in other facilities.

The following are key points that were learned in the context of this implementation and training program.

The importance of leadership in implementation

One can view residential child care as primarily moral work where adult interactions with children symbolize a moral judgment and a statement about the child's moral worth. Within this context then, children placed in residential care are the "raw material" for an facility's structures and treatment strategies to transform into capable individual. Within our culture and context in the 1990s, the principles which guide residential child care comes primarily from the state, the professions of social work, psychology, and psychiatry, and within some facilities the religious or humanistic values of the auspices organization (Hasenfeld, 1992).

Few of us would question the role of leadership within any human services organization in establishing that organization's direction and mission. An effective leader also articulates a vision which provides purpose, meaning and clarity to an organization member's work.

The executive director of the Children's Home understood the value laden and symbolic nature of child care work. When he took the position at the Children's Home his initial assessment about the facility's lack of crisis management proved accurate. Various residential units of the facility were utilizing a variety of crisis management techniques without a common value center established and recognized by state regulation or the child care profession. The executive director understood that the *TCI* methodology had been reviewed by the residential child care profession, had been accepted as safe and therapeutic, and addressed the developmental needs of children within his facility. These were values that he sought to introduce to the facility to help manifest its "moral work". He entered into an "organizational

exchange" with Cornell, and committed facility time and financial resources to implement the project. He established and provided the resources, training, implementation priorities and performance standards for the facility in crisis management. Although some could argue that these were essentially bureaucratic tasks that any director should perform, other see them as essential leadership tasks brings reality to an articulated vision (Garner, 1989). This leadership commitment was the key and central variable in the success of this implementation and evaluation project.

Evaluation results must be viewed in context

An important learning point is that an evaluation project may in fact show consequences that on face value may not "look good" for the project or the implementation strategy. Our experience with the rise of reports in Unit A taught the evaluation project that only looking at the results of one leg of the triangulated methodology may portray the project as "doing more harm than good". If the evaluation project only assessed the rise or fall of critical incident reports within a unit, then the implementation project for Unit A would be seen as a "disaster", and the flat rate of reports from Unit C or Unit D as "having no effect". It was only through examining both the quantitative and the qualitative data that one could interpret the results accurately. Even viewing the evaluation data in context the message must be that *TCI is not a strategy that works with all units within a facility, or children within that facility*. Rather, it is a strategy that has been developed for a verbal, articulate, and developmentally normal population of children, and it therefore works best with that population.

Another aspect of this issue of reviewing findings within a context is that both the Children's Home and the *TCI* project had to review and assess their respective fundamental beliefs and ideologies throughout the implementation project. The process of evaluation is a process of self-examination for both the facility staff as well as the evaluators.

What changes in the evaluation strategy would I recommend?

Any research or evaluation project is dependent on the resources, time and talent available to the project, and few, if any, projects have unlimited quantities of either. Therefore, designing an evaluation methodology with limited resources becomes the "art" aspect of what is often considered a science. Since this was *TCI*'s first comprehensive evaluation project, there were many points that were learned particular to evaluation in residential child care facilities and generalizable to other human services organizations.

The limitation of distance

Future evaluation projects need to be undertaken "closer to home". Although a five hour drive initially did not seem like it was overwhelming, over time it became an obstacle. For example, there were times when the researchers could not reach a child care worker for an interview because of schedule, work or personal conflicts. The researcher did not have the luxury of scheduling outside of planned trips to the facility. A re-schedule often

meant a two week delay in the interview. What suffered was the accuracy and reliability of the re-collected memory of the events (see Chapter 3).

Distribution of the quantitative instruments

The distribution of the instruments measuring pre and post implementation knowledge, and confidence levels was dependent on the good will of the supervisory staff of the facility. With a small facility of this size, more personal attention should have been paid by the evaluation staff to distributing the instruments themselves to ensure a higher return rate. Although this might have added to the cost of the project, direct distribution of instruments would have produced a higher return rate, and therefore potentially more reliable and valid results from the data on confidence and knowledge retained.

Use of a control or contrast facility

The need for a control or contrast group or facility was evident during this project especially when trying to determine whether changes to the critical incident data was due to the implementation process or some other intervening variable such as a change in unit leadership or staff. Although the project learned much about the Children's Home within this evaluation methodology, the ability to more confidently generalize to the larger residential child care community would have been an asset. A comparison between units or facilities who received training and those who did not

would have helped the evaluators differences between groups or temporal changes other than the implementation or training.

Use more sophisticated instruments, measures and controls

In order to improve this monitoring and evaluation design it is important to review and utilize appropriate statistical measures and methodologies which might control for the myriad intervening variables that have the potential to affect critical incident rates. An important intervening variable to control for would be that "occupancy rate" per month of the facility or the residential unit. Although the evaluators were assured throughout this project that these rates remained relatively constant, even small increases or decreases in numbers here would have a major impact on statistical significance.

Another important area to examine is the usefulness of the critical incident report in obtaining information about events which occur in the facility. Since the project did not want to disturb the current record keeping system in the facility or add to the current burden of paperwork on the staff, the decision was made to use the current critical incident forms. Using this strategy, the limitations of the format became the limitations of the evaluation project. For example, there was little indication in the existing critical incident reporting system whether de-briefings or LSIs were done child care workers or children after the incidents. Being able to measure a change, or lack of change, in practice after training and implementation with a more precise instrument would be an important step in improving the overall evaluation design.

Using other record keeping instrument to measure implementation effect

It was clear that the use of the critical incident reports as a measure of actual critical incidents may be somewhat flawed. Critical incident reports represent the official version of an incident according to the child care worker, the supervisor, and to some degree the facility management. Other record keeping systems are available to the evaluator and the researcher to help determine the quality and quantity of crisis management within a unit, the levels of child upset, and the staff and unit reaction to this upset. An excellent tool to use would be the unit or facility logs. The logs are more informal journals of the life of the unit recorded by all staff on each shift. Incidents that might not be determined to rise to a level of "critical incident" and therefore not included in a report, may be logged nonetheless. Unit A staff all indicated that they logged all incidents prior to *TCI* implementation but rarely if ever wrote formal critical incident reports until it became known that the project would evaluate the impact of *TCI* based on counting critical incident reports. Evaluation staff asked facility supervisors if logs were available for review and they pointed to numerous file drawers full of unit and facility logs dating back years. The use of logs have been found to be a rich source of information portraying the daily happenings of the facility to measure adverse events (Rindfleisch & Foulk, 1992), and they should be considered as a measuring tool in evaluating program implementation.

What impact do these results have on the field of residential child care?

A crisis intervention strategy is a necessary and critical aspect of a residential child care facility's treatment and behavior management for children who have the potential for aggressive and self-destructive behavior. Although crisis intervention is an essential, highly regulated, and documented component of treatment within children's residential child care settings, few systematic examinations beyond the institutional maltreatment literature have been made to explicate these episodes, to examine their meaning, frequency, duration and potential for a child's developmental learning. These issues are also not generally included in an institutional quality of care review or assessed in the light of organizational learning on a day to day basis within management or supervisory meetings.

This project has the potential to raise the level of supervisory and executive oversight in residential child care. The notion of foreseeing and meeting the developmental needs of children as the central business of residential care was raised in the literature review section of this document. Foreseeability is the informed judgment of a professional or a professional's expert opinion based on experience and knowledge that an event or a circumstance is likely to occur. Foreseeability can be viewed empirically, measured and reduced to a scientific formula (Lowrance, 1976), or it can be seen more as an art with qualities of listening, reflection, and thinking in action (Schon, 1983). These two characteristics need not be mutually exclusive, and in fact, often it is the practitioner who combines both the artistic and scientific elements of a profession to extent both its boundaries and its impact on the community which it serves (Schon, 1987).

On a more modest scale and in residential care, foreseeability entails developing and maintaining institutional structures and treatment processes that help ensure successful outcomes for children. Institutional structures can encompass the physical environment or features of the facility, staffing patterns, and staff qualifications. Institutional processes can include treatment approaches, philosophy, and techniques. Outcomes, in their simplest terms, are related to a child's performance and for the most part are linked to developmental and maturational growth.

One of the major impacts on residential care is that the project has developed a monitoring and evaluation system to assess the effectiveness of a facility's crisis intervention methodology. This design can be used by treatment or executive staff to assess the impact of their decisions, plans, or of other influences on care giver-child interactions. For example, this monitoring and evaluation design can offer facility administration the capacity to track periods of the day which children and staff may be more vulnerable to crisis because of light staffing patterns, types of activities or free time enjoyed by children, or a combination of both. 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 systems (Freel & Epstein, 1993; Grasso & Epstein, 1987; Grasso & Epstein, 1993).

There are other potential uses for a monitoring and evaluation system initially established to monitor the progress and effectiveness of the implementation of a facility's crisis intervention methodology. For example, the literature on environmental influences of child maltreatment cites

numerous executive director leadership variables which make a strong correlation to child maltreatment in residential care. An important hypotheses to test using this evaluation and monitoring system would be the impact of positive, supportive child-centered leadership and supervision styles on the overall rate of adverse incidents within a facility.

In conclusion then, this project has shown the field a triangulated monitoring and evaluation system for implementing crisis intervention system designed to assist children in residential care with developmentally appropriate ways to handle anger, pain and aggressive behavior. The *TCI* methodology is based on the premise that children in care need adults who can offer care and commitment to their needs for a safe and therapeutic environment.

Appendix

Interview Guide

Interview Guide: Background information - Child Care Worker

• Age	• Years of experience in child care	• What kind of crisis intervention behavior/ management training have you received?
• Gender	• Educational background - highest level	

Question 1: Please describe the latest incident in which you intervened with a child who was exhibiting aggressive behavior.

Probes/Elements:

• Time of Day	Day of the week	Date - within three months
• Duration in minutes from the time you began any intervention to the end of the intervention	Physical Threat or Danger- defined as harm or the threat of harm to the child, you or others - high, medium or low	• Frequency - how many times have you intervened with this child - often, sometimes, never.
• Is this child in your unit?	Child's Gender	Child's Age

Question 2:. What were the precipitating factors surrounding the event?

Probes/Elements:

- What child behaviors or actions indicated that the situation was serious?
- What were you feeling at the time of the incident?

Question 3: Were there de-escalation/behavior management techniques used prior to the incident?

Probes/Elements:

- What techniques did you employ and in what sequences?
- Where did you learn these techniques?

Question 4: • Did you use physical restraint?

Probes/Elements:

- What were the deciding factors to use physical restraint?
- Exactly when did you decide to use physical restraint?
- Have you restrained this child previously, how often and under what circumstances?
- **Who** reviewed your decision to use physical restraint and how did you perceive the review process?

• Who did you discuss this incident with? Your supervisor, the treatment team, the facility management.

• Did you discuss this incident with the child's parents?

• Was this discussion helpful to you and in what way?

• Did you have any regrets about using physical restraint?

Question 5: How did this experience affect your relationship with the child?

Probes/Elements:

• Did this incident affect you subsequent action, behavior or feeling with the child?

Question 6: Do you have worries or fears about this aspect of your work? Can you be specific?

Probes/Elements:

• Did you have any regrets about using any of the techniques?

• What afterthoughts have you had about the incident?

• Would you have done anything differently?

• What have you learned from the incident?

Confidence Questionnaire

The following questions have to do with how you currently feel about managing and preventing crisis situations within the facility or unit in which you work. Please circle the statement that most closely conforms to your feeling.

1. I can prevent crisis situations in my unit from escalating into a full blown crisis.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

2. I can effectively manage any crisis situation within my unit.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

3. My co-workers can manage any crisis situation effectively within the unit.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

4. My co-workers and I can work together to prevent and de-escalate crisis.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

5. The facility management is supportive if approved crisis management techniques are used.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

6. The facility policy and procedures for crisis management is known to all staff.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

7. As a result of my knowledge and skills in crisis management, I can help children learn to cope more successfully with life crisis.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

8. Following a crisis situation with a child or children, a de-briefing session with my supervisor or the treatment team always occurs.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

9. If a de-briefing session with my supervisor or the treatment team occurs, the session is helpful to me to understand the context of the crisis in the child's life.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

10. If a de-briefing session with my supervisor or the treatment team occurs, the session is an opportunity to explore the impact of the crisis on me.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

To help with the analysis of this information please take further time and fill out the following demographic data.

1. In which location do you work?
   a. Unit A
   b. Unit B
   c. Unit C
   d. Unit D
   f. Foster Care
   g. Other

2. How long have you been in the child care field?
   a. 0 to 3 months
   b. 4 to 6 months
   c. 7 to 11 months
   d. 1 to 2 years
   e. 3 to 5 years
   f. 6 to 10 years
   g. 11 to 20 years
   h. more than 20 years

3. How long have you worked at the Children's Home?
   a. 0 to 3 months
   b. 4 to 6 months
   c. 7 to 11 months
   d. 1 to 2 years
   e. 3 to 5 years
   f. 6 to 10 years
   g. 11 to 20 years
   h. more than 20 years

4. How long have you worked in your present position?
   a. 0 to 3 months
   b. 4 to 6 months
   c. 7 to 11 months
   d. 1 to 2 years
   e. 3 to 5 years
   f. 6 to 10 years
   g. 11 to 20 years
   h. more than 20 years

5. What is your present position?
   a. Direct services/line worker/child care worker
   b. Supervisor
   c. Administrator
   d. Clinical services
   e. Staff training/development
   f. Educator
   g. Case worker

6. What is your position considered?
   a. Part-time
   b. Full-time
   c. Not sure

7. What is the highest level of education you have completed?
   a. Some high school
   b. Completed high school
   c. Some college
   d. Associate degree
   e. Registered Nurse
   f. Bachelor's Degree
   g. Master's Degree
   h. Doctorate

8. If you attended college and/or graduate school, what was your area of study?
   a. Social work
   b. Psychology
   c. Sociology
   d. Other social sciences (including history and economics)
   e. Education (including elementary, secondary, exceptional, physical)
   f. Other

9. Your gender?
   a. Female
   b. Male

10. Your race/ethnicity?
   a. Asian/Asian American
   b. African American
   c. Caucasian
   d. Hispanic
   e. Native American
   f. Other

11. Your age group?
   a. 18-25 years
   b. 26-30
   c. 31-40
   d. 41-50
   e. 51-60
   f. over 60

12. When did you receive the Therapeutic Crisis Intervention training?
   a. within the month
   b. 3 months ago
   c. 6 months ago
   d. 9 months ago

13. Below please indicate the last four digits of your social security number.

Thank you we appreciate your help in this survey.

RESIDENTIAL CHILD CARE PROJECT
Therapeutic Crisis Intervention

Pre-Test

INSTRUCTIONS:

Please record all responses to questions on the green answer sheet. Use a #2 pencil.

Starting with the spaces in the middle, on the left hand side of the form called "SOCIAL SECURITY NUMBER," darken the last four digits of your social security identification number.

Next, please fill in today's date by putting the month (e.g.. January=01), the day and year (e.g.. year=95) in the appropriate spaces on the form.

Go to the Demographics section and answer the first ten questions by darkening one letter for each question.

Thank you for your cooperation. All answers are confidential and will only be reported for group statistics. Please choose only one answer for each question.

1. In which location do you work?
   a. Unit A
   b. Unit B
   c. Unit C
   d. Unit D
   f. Foster Care
   g. Other

2. How long have you been in the child care field?
   a. 0 to 3 months
   b. 4 to 6 months
   c. 7 to 11 months
   d. 1 to 2 years
   e. 3 to 5 years
   f. 6 to 10 years
   g. 11 to 20 years
   h. more than 20 years

3. How long have you worked at the Children's Home?
   a. 0 to 3 months
   b. 4 to 6 months
   c. 7 to 11 months
   d. 1 to 2 years
   e. 3 to 5 years
   f. 6 to 10 years
   g. 11 to 20 years
   h. more than 20 years

4. How long have you worked in your present position?
   a. 0 to 3 months
   b. 4 to 6 months
   c. 7 to 11 months
   d. 1 to 2 years
   e. 3 to 5 years
   f. 6 to 10 years
   g. 11 to 20 years
   h. more than 20 years

5. What is your present position?
   a. Direct services/line worker/child care worker
   b. Supervisor
   c. Administrator
   d. Clinical services
   e. Staff training/development
   f. Educator
   g. Case worker

6. What is your position considered?
   a. Part-time
   b. Full-time
   c. Not sure

7. What is the highest level of education you have completed?
   a. Some high school
   b. Completed high school
   c. Some college
   d. Associate degree
   e. Registered Nurse
   f. Bachelor's Degree
   g. Master's Degree
   h. Doctorate

8. If you attended college and/or graduate school, what was your area of study?
   a. Social work
   b. Psychology
   c. Sociology
   d. Other social sciences (including history and economics)
   e. Education (including elementary, secondary, exceptional, physical)
   f. Other

9. Your gender?
   a. Female
   b. Male

10. Your race/ethnicity?
   a. Asian/Asian American
   b. African American
   c. Caucasian
   d. Hispanic
   e. Native American
   f. Other

11. Your age group?
   a. 18-25 years
   b. 26-30
   c. 31-40
   d. 41-50
   e. 51-60
   f. over 60

After you have completed the Demographics section, answer the remaining test questions in the "Test Section" provided at the bottom of the answer sheet.

1. In a single person restraint with an adolescent, once the staff has immobilized the arms, what is his/her next and best move?
   a. lift child up and slightly off ground
   b. move to a perpendicular position
   c. step backward and kneel with child on lap
   d. step forward and bring child down on floor

2. An adolescent has a bar arm choke hold on a worker. To safely and effectively release, the worker should:
   a. fall forward by dropping to knees
   b. quickly snap his head backward
   c. push up on child's elbow while pulling down on child's hands
   d. raise arms over head and twist body

3. To properly and effectively do a team restraint on an adolescent, after the workers have immobilized the arms across their torsos, the next move should be to:
   a. step backward and drop to knee level
   b. step forward and drop to knee level
   c. move adolescent to the wall
   d. walk backward and place adolescent on the couch

4. When transferring the arms in a team restraint, what part of the child's body is most likely to be momentarily unrestricted?
   a. arms
   b. legs
   c. head
   d. shoulders

5. A youngster has grabbed the staff's (her) arms. To safely get free, she should:
   a. immediately place her own foot against the child throwing him off-balance
   b. move child towards her and snap arms down
   c. step back and pull away, to break the child's grip
   d. turn her arms toward child's thumb and break cleanly

6. A youngster is biting a staff's arm. To release from the bite, staff (she) should:
   a. immediately drop to her knees
   b. place her free hand on the jaw and squeeze gently
   c. pinch child's nose with free hand and lift
   d. cover the kid's eyes with free hand to confuse them

7. When a child care worker wants to ask questions that keep the child exploring feelings and talking, what verbal techniques should the staff member use?
   a. closed specific questions
   b. open-ended questions
   c. closed but general questions
   d. credible questions

8. When a child is upset and emotional, what verbal technique should the staff member use to help the child express himself:
   a. interpreting the child's ideas
   b. expanding on the child's ideas
   c. reflecting the child's feelings
   d. analyzing the child's behavior/attitudes

9. Children in crisis are:
   a. best approached by peers
   b. best left alone for a brief period
   c. susceptible to the influence of others
   d. unapproachable by others

10. The primary purpose of active listening during a crisis is to:
   a. assist a child to begin the process of introspection
   b. encourage a child to "talk out" rather than "act out"
   c. settle disputes between you and a child
   d. solve problems children are having with one another

11. Which is the best approach to use during routines and transition times?
   a. accounting
   b. relating
   c. teaching
   d. reflecting

12. Which is the best approach to use with an older, more mature child?
   a. reflecting
   b. relating
   c. teaching
   d. structuring

13. Which of the following is most concerned with how the child is feeling?
   a. relating
   b. teaching
   c. reflecting
   d. accounting

14. What is the <u>first</u> silent question that a child care worker should ask in dealing with an upset child?
   a. How can I solve this child's problem?
   b. What does this child want from me?
   c. What does this child's behavior mean?
   d. What am I feeling right now?

15. Prolonged eye contact between you and a child in a crisis situation:
    a. is a physical stimulator
    b. gives you more control
    c. may "buy time" until help arrives
    d. helps to de-escalate the situation

16. The philosophy behind conflict resolution centers on determining each person's:
    a. feelings and behaviors
    b. interests, not positions
    c. positions and solutions
    d. behaviors, not feelings

17. Which of the following is not a stage in the crisis sequence?
    a. triggering phase
    b. equilibrium phase
    c. escalation phase
    d. recovery phase

18. Ideally, who should write a detailed description of any incident of physical restraint?
    a. just the staff member conducting the restraint
    b. any staff involved during the incident
    c. the supervisor of the unit
    d. the staff member involved in the restraint and the director at the agency

19. Which of the following behavior management techniques is considered to be non-verbal intervention?
    a. proximity control
    b. hypodermic affection
    c. hurdle help
    d. redirecting

20. Which of the following is not an example of a "directive statement?"
    a. Please go to your room and cool out.
    b. Didn't I tell you not to leave the table?
    c. Talk in a quiet voice.
    d. It's your bed time!

21. In an ideal situation, the number of staff to have involved in an episode of physical restraint is:
    a. one worker to one child
    b. two workers per child
    c. a three-member crisis team
    d. four workers if possible

22. The best way to physically restrain an adolescent is:
    a. against a wall or stable object
    b. going only as far as necessary
    c. face down on the floor
    d. placing a hold in a slow manner

23. In a team restraint:
    a. both staff are in charge of the restraint
    b. staff should be the same sex as the youngster
    c. only one staff is in charge of the restraint
    d. staff should move slowly and carefully

24. Which is not an element of active listening?
    a. reflections
    b. minimal encouragement
    c. open questions
    d. problem-solving

25. The first step in the Life Space Interview is to:
    a. call a group meeting of residents
    b. explore alternative behaviors child might employ
    c. find a private setting to talk with child
    d. make sure the child gets medical attention

26. Which of the following is not part of the Life Space Interview?
    a. inquire about child's perception of what is going on
    b. share our view of what is going on
    c. give advice about how to better handle problems
    d. make provisions for child to return to the program

27. In the "Letting Go" process:
    a. both staff conduct the process
    b. staff should be constantly talking to each other
    c. one person should be in charge
    d. the supervisor should monitor the process

28. Sometimes a child will refuse to talk during the Life Space Interview. It is important to:
    a. continue with the interview telling the child your point of view.
    b. tell the child that there will be consequences if he doesn't participate.
    c. indefinitely postpone the interview until the child asks for the interview.
    d. understand why the child is silent, convey support and reschedule the LSI.

29. The meaning in a spoken message is composed of what percentage of the following components:
    a. 55% facial expression, 38% tone of voice and 7% words
    b. 38% words, 55% facial expression and 7% tone of voice
    c. 87% facial expression, 10% words and 3% tone of voice
    d. 17% facial expression, 60% tone of voice and 23% words

30. The last two steps in the Life Space Interview are:
    a. planning and entering
    b. isolating and exploring
    c. sharing and connecting
    d. isolating and connecting

31. When is physical restraint justified, but should not be used:
    a. the child is going to injure someone
    b. the child is going to injure self
    c. the child has a dangerous weapon
    d. the child is destroying property

32. The crisis cycle goes as follows:
    a. child's behavior, adult response, escalation, acting out
    b. incident, behavior, response, outcome
    c. adult request, child response, feelings, behavior
    d. incident, child's feelings, child's behavior, adult response

33. In physically approaching the agitated youngster, it is important to keep in mind:
    a. his/her need for physical contact and nurturing
    b. the importance of constant face to face contact
    c. the need to respect his/her personal space
    d. doing a physical restraint may damage your relationship with the child

34. During an episode of physical restraint the child yells, "Get off me!" The best response staff can make is:
    a. "I'll decide."
    b. "You have 15 minutes."
    c. Give no response.
    d. "Are you sure?"

RESIDENTIAL CHILD CARE PROJECT
Therapeutic Crisis Intervention

Post-Test

INSTRUCTIONS:

Please record all responses to questions on the green answer sheet. Use a #2 pencil.

Starting with the spaces in the middle, on the left hand side of the form called "SOCIAL SECURITY NUMBER," darken the last four digits of your social security identification number.

Next, please fill in today's date by putting the month (e.g.. January=01), the day and year (e.g. year=95) in the appropriate spaces on the form.

After you have completed this information, answer each of the following questions by darkening the appropriate rectangle on the computer sheet. All answers are confidential and will only be reported for group statistics. Please choose only 1 answer for each question.

1. In a single person restraint with an adolescent, once the staff has immobilized the arms, what is his/her next and best move?
   a. lift child up and slightly off ground
   b. move to a perpendicular position
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34. During an episode of physical restraint the child yells, "Get off me!" The best response staff can make is:
    a. "I'll decide."
    b. "You have 15 minutes."
    c. Give no response.
    d. "Are you sure?"

For the following questions, please evaluate the course you have just completed. Enter your responses in the section marked *Reactions*.

1. The general level of the subject matter was:
   a. much too basic
   b. somewhat too basic
   c. just right
   d. somewhat too advanced
   e. much too advanced

2. I found the presentations/lectures to be:
   a. excellent
   b. good
   c. fair
   d. poor
   e. no opinion

3. I found the Trainer's Manual to be:
   a. excellent
   b. good
   c. fair
   d. poor
   e. no opinion

4. The technique of having trainees present material was:
   a. excellent
   b. good
   c. fair
   d. poor
   e. no opinion/not applicable

5. The group discussion and feedback sessions were:
   a. excellent
   b. good
   c. fair
   d. poor
   e. no opinion/not applicable

6. The use of video was:
   a. excellent
   b. good
   c. fair
   d. poor
   e. no opinion/not applicable

7. How useful will this training be for performing your job? (Select one response)
    a. It will have little/no relevance for my job duties
    b. I would like to use it, but probably will not be able to
    c. I would like to use it, but don't understand it well enough
    d. I plan to use this material on my job
    e. I already knew what was taught and am using it

8. How confident are you that you will be able to perform the TCI restraint techniques that you learned in this training on the job?
    a. I will definitely be able to perform the TCI restraint techniques
    b. I will probably be able to perform the TCI restraint techniques
    c. I will probably not be able to perform the TCI restraint techniques
    d. I will definitely not be able to perform the TCI restraint techniques
    e. No opinion

9. How confident are you that you will be able to train the TCI curriculum?
    a. I will definitely be able to train the TCI curriculum
    b. I will probably be able to train the TCI curriculum
    c. I will probably not be able to train the TCI curriculum
    d. I will definitely not be able to train the TCI curriculum
    e. No opinion

10. Would you advise a co-worker who performs similar duties to yourself to take this training?
    a. definitely yes
    b. probably yes
    c. probably not
    d. definitely not

11. Overall, how would rate this program?
    a. excellent
    b. good
    c. fair
    d. poor
    e. very poor

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