JSM

Journal of Safe Management of Disruptive and Assaultive Behavior

Volume 19, Issue 1 • March 2011 • ISSN 1065-3341

In This Issue

Professional Development

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Subscriptions should be addressed to the publisher. Subscription rate is $45 US ($53 CDN) for one year, $70 US ($82 CDN) for two years, and $90 US ($106 CDN) for three years.

Changes of address should be sent to the publisher six weeks prior to their effective date and should include both old and new addresses.

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A Note From the Editor

Robert D. Rettmann
Editor

Professional Development

When attempting to calculate the return on an investment in training, there are many benefits some might consider intangible. After all, how does one really estimate an accurate number that truly reflects the benefits gained through increased safety or staff confidence?

What may be even more difficult to assess are the benefits gained toward the professional development of staff. More than simply the sum of the skills learned in training, how a training program adds to each participant's body of learning may be the most intangible benefit of all.

And after all, if you are an organizational leader, what benefit is it to you if your employees get to pad their résumés? There is always the risk that you're helping your employees land their next job.

But research shows otherwise. Srinivas (2008) exemplifies that mid-career employees who received employer-sponsored training are actually less likely to leave than those who received no training.

Perhaps even more interesting is that the employer-sponsored training showed the greatest statistical significance, in fact the only significance, when the training was part of an ongoing training effort.

"These results are intriguing as they demonstrate that the employee retention effect[s] are only significant when the training is a part [of] a training program offered by the employer to regularly update the worker's skill" (Srinivas, 2008, p. 96).

In this sense, the employer's efforts to dedicate the resources needed to ensure ongoing professional development opportunities are seen by staff as a commitment to staff. In return, staff return that commitment by staying on the job longer.

This issue of the *Journal of Safe Management of Disruptive and Assaultive Behavior* offers a series of articles that explore this relationship further. A commitment to ongoing training in a program like the *Nonviolent Crisis Intervention*® program not only shows an employee that your organization is investing in staff safety, it also shows that your organization is dedicated to the professional development of the staff that you hope to retain for many years to come.

Articles in this issue: Ann M. McCreedy discusses the professional development opportunities N Street Village offers to staff in **"Development of a Co-Created Training Model for Improved**

Staff Efficacy and Retention." John Picone writes about the role that professional development plays in retaining staff in rural school districts in **"The Importance of Professional Development Among Rural Educators."** Celeste Waddy shows how nursing professors at CUNY have introduced the *Nonviolent Crisis Intervention*® program for nursing students entering clinicals in **"*Nonviolent Crisis Intervention*® Training Comes to the Associate Degree Nursing Program at the New York City College of Technology of the City University of New York."** Steve Nguyen shares some of the results he experienced while introducing training in the Commonwealth of the Northern Mariana Islands in **"Less Talk, More Action—The PAR Technique."** Lastly, Keith Jamison writes about how the skills added in training are put into practice in **"Extending Training to the Milieu."** ■

Srinivas, S. (2008). Employer-Sponsored training and job retention of mid-career employees. *Journal of Business and Economics Research, 6*(11), 89–97.

Interested in Submitting an Article for Publication?

If you would like to submit an article for publication, please send a proposal to Robert D. Rettmann (research@crisisprevention.com). The proposal should detail your article idea in a few succinct paragraphs. Please include your contact information. We will respond to you within a few weeks. If your article is published, you have the choice of receiving $100 US, a scholarship to attend a *Nonviolent Crisis Intervention*® Two-Day Workshop, or a scholarship to attend the 2011 CPI International Instructors' Conference (if you are already a Certified Instructor).

September 2011 Issue: The theme for this issue is **Choices, Limits, and Consequences**. We make sure that the limits we set are reasonable, clear, and enforceable, but sometimes the client still makes the wrong choice. How we frame the natural consequences of these choices can go a long way to ensuring that the client is able to learn from the consequences of choices that were made. We invite you to discuss your methods of setting limits and applying consequences to discuss the lessons learned (by the client and staff). The deadline for article submission is July 1, 2011.

Development of a Co-Created Training Model for Improved Staff Efficacy and Retention

by Ann M. McCreedy

About the Author

Ann McCreedy serves as the Director of Programs at N Street Village, a community of empowerment and recovery for women in Washington, D.C. She holds a master's in business administration from The George Washington University and is a certified instructor for CPI's *Nonviolent Crisis Intervention*® training program. She is also the Vice President of the Board of Directors for Open Arms Housing, which provides permanent supportive housing for women with major mental illnesses.

N Street Village understands that our staff efficacy and retention depends on investing in the professional development of our staff. Up until 2008, employees could apply for up to US $5,000 in education assistance from the organization to pursue training, certifications, or degrees that would advance their careers. After the downturn in the economy, N Street Village discontinued this assistance program and leveraged the strengths of our homegrown resources by developing an internal training program offered monthly to all staff.

N Street Village, founded in 1972, is a Washington, D.C.-based nonprofit that offers a safe, empowering community for women facing homelessness, poverty, and related challenges such as mental illness, addiction, and chronic health problems. At the time of the 2010 annual count of D.C.'s homeless population, we were providing services to approximately 46% of the adult, single homeless women in the city. In 2009 we provided safe shelter or housing to 162 women and provided daytime support services to an additional 720 women. In 2010, 70.4% of the women served reported receiving a mental health diagnosis, and 42.7% reported a history of substance abuse.

Training Program Format and Methods

Ongoing training programs are linked to employee retention. According to research by Srinivas (2008), staff training is related to retention only when it is part of an ongoing program offered to regularly update workers' skills. N Street Village staff can depend on our regular training schedule. The 90-minute sessions are offered every second Tuesday and Wednesday of each month. We offer an evening training and an afternoon training to accommodate staff on all three shifts.

The training program requires an investment in staff time for planning and execution. The program is coordinated by our clinical services coordinator, who is a licensed independent social worker, and our director of programs, who has a master's degree in business administration. Together they spend between two and four hours planning and a total of seven hours executing the two monthly trainings. Most of the time, the trainings are led by these two individuals, but several times each year, other staff are called on to lead trainings in their areas of expertise. For example, this year, three staff who are registered addictions counselors will lead the training on substance abuse recovery and relapse. Another staff member will lead a training on micro-aggressions related to racism. Staff generally appreciate the opportunity

to share their areas of expertise with their peers and demonstrate leadership in a way that their day-to-day responsibilities may not afford them.

The theme of the trainings is Building Productive and Healthy Helping Relationships. The content of the trainings is informed by M. Bogo's 2006 work titled *Social Work Practice: Concepts, Processes and Interviewing*, and by the principles of CPI's *Nonviolent Crisis Intervention*® training. From Bogo's work, we obtain the three tenets to creating healthy and productive helping relationships, and these tenets act as the backbone of our training program.

> . . . staff training is related to retention only when it is part of an ongoing program offered to regularly update workers' skills.

The three tenets are: focus on the client; strive to be self-reflective and develop dynamic self-awareness; and aim to think, speak, and act in an intentional way.

The training program also provides opportunities to reinforce the principles of *Nonviolent Crisis Intervention*® training. We offer a full-day CPI training class and a half-day refresher course each year. However, a review of many of the CPI principles happens naturally during our monthly trainings. During debriefing of role-plays and/or training videos, participants provide feedback on staff's nonverbal, paraverbal, and verbal intervention skills. For example, during our most recent training, two staff participated in a role-play about engaging a client with a major mental illness in the intake process for our agency. After the role-play, a staff member who had observed the role-play offered feedback to her peer, saying that her peer's nonverbals and paraverbals were very supportive, but that she found the way her peer had phrased a sentence very triggering, and she suggested an alternative way for her peer to communicate the same message.

Staff reinforcing the principles with each other is at least as effective, if not more so, as the formal *Nonviolent Crisis Intervention*® trainings we offer twice annually.

The trainings follow a similar format each month. We open by asking the group for feedback on the previous month's training, what was useful to them in their work, and whether they have any constructive feedback for improvement. For the first year we offered the training program, we solicited feedback using a written evaluation form at the end of each training, but we discontinued the written form when we realized that we got more meaningful feedback through discussion with the group. Depending on the topic of the training, there may be a brief introduction to the topic in lecture format lasting 10–15 minutes.

Next, we often as a group watch a video related to the topic, and then break into small groups to discuss our observations about the material and how it applies to our work. The videos we've incorporated have been varied. We've used professional training videos depicting behavioral health workers engaging with individuals with major mental illnesses. We've gotten feedback that staff like and learn more from the videos that offer examples of professionalism and excellence rather than videos of poor client engagement. We've also used popular music videos like "Hurt" by Johnny Cash when we've talked about empathy and client engagement. By keeping an open mind, we've found inspiration for training in a variety of media.

After or instead of a video, we ask participants to role-play common situations with clients. Some participants are sometimes initially reluctant to participate in role–plays, but there are always volunteers willing to go first, and usually other participants will join in after someone else breaks the

ice. We dedicate one month a year to role-playing scenarios submitted by staff of situations they've experienced. The staff who submit the scenarios are not necessarily the people who act out the role-plays in the training. They have the opportunity to observe how someone else would have handled the situation. After the role-play is completed, the individuals who were acting in the role-play have the first chance to share their reflections about how they felt. Then the audience has the opportunity to affirm good work and suggest ways they might have done it differently. One of the take-aways from role-plays is that there may be several methods to get to the same positive outcome.

To close the training, we reiterate the key points of the training and offer participants an opportunity to reflect on what they learned.

Co-Creation: Involving Clients in Staff Training

One unique element of our training program is the involvement of clients in the training. Clients participate in the training and describe what productive and healthy helping relationships look like from their perspective. In *A Place for Some Kind of Flowers*, Conklin (2007) concludes that women who are experiencing homelessness need to be the leaders in their co-creative effort to end their homelessness. He identifies that this co-creation will require an evolution within the social services process. Staff will need to be trained about this new model, and a key element is to "include among the trainers those who are actually expert on the matter: the women who have used or are using the service infrastructure. Without this inclusive, co-creative component, the training risks perpetuating oppression, and change within the service delivery system will become implausible." (Conklin, 2007, p.77)

Staff will need to be trained about this new model, and a key element is to "include among the trainers those who are actually expert on the matter: the women who have used or are using the service infrastructure . . ."

In order to maintain confidentiality of all clients in the community, clients and staff agree not to discuss any real-life situations they have had, but rather to focus on what can be learned from the shared experience of watching the video and/or role-play. It has been our observation that staff and clients often take note of different elements of the same scene. Both clients and staff have *ah-ha* moments when they learn something from each other and look at an interaction in a new way.

The idea of including clients in the training program was initially controversial within our staff team. In hindsight, we could have learned from Gates's (2007) strategies to support successful integration of peers in the trainings. She suggests that the organization's leadership needs to "create an understanding among all staff and clients in the community about the peer role and the policies and practices which support the peer contribution to services . . ." (Gates, 2007, p. 305).

We didn't lay the groundwork as Gates suggested. As a result, several staff members expressed anxiety about the clients they worked with on a regular basis being present during training. Even though no real-life situations were referenced during the training, a few staff experienced the clients' feedback as if it was a critique of their work. Additionally, we received the feedback that staff were unable to focus on their own learning because they had to be mindful of their clients' perception of them in the training environment.

If we could go back and do it differently, a month before the first training was to occur with clients, we would have talked with staff about the clients' roles and the format of the training, and offered staff an opportunity to express their concerns. We might have avoided some of the push-back we received from staff if we had prepared them ahead of time for the inclusion of clients.

We continue to include clients because we believe the benefits outweigh the concerns. We will be most effective as an organization when our clients are the leaders in the co-creation of the solutions to their problems. In addition to participating in trainings, clients are involved in co-leading process groups, welcoming and orienting new clients, sitting on panels when prospective staff are being interviewed, and in many other ways. We still have far to go in creating a fully co-creative environment; however, creating a co-learning environment increases transparency to the client community, and the clients offer a unique perspective that is impossible to re-create in any other way in the training environment.

Co-learning with clients also challenges our staff to reflect on the power dynamics in their client relationships and to consider

how they can help their clients become the leaders in their working relationships. When a staff member expresses discomfort with something a client says during training, it offers a great opportunity to debrief during supervision to determine why it bothered the staff member and what it might suggest about the staff member's working relationship with that client. This process of self-reflection supports the second of our three key tenets for creating healthy and productive helping relationships: Strive to be self-reflective and develop dynamic self-awareness.

Additionally, we use good judgment about which clients are included in co-learning environments. We serve clients with a wide range of mental illnesses, trauma histories, and other concerns. We select clients who are able to adhere to the ground rules of not talking about specific situations from their lives, and are able to follow the format of the training and offer their feedback about the videos or role-plays. We also want to ensure that the topic of the training would not feel overwhelming to the clients based on where they are in their recovery. The clients we invite aren't all "model citizens" in the community. We want a variety of perspectives, including voices of discontent, to be included in the conversation.

Training is Worth the Investment

Our internal training program has resulted in staff satisfaction with the organization. Staff often recall client situations and how the training material influenced their response in a positive way. Our feedback from staff is that the trainings are valuable, and this is reinforced by the fact that several come in on their days off to participate in the trainings.

The organization has benefited over time from the trainings through staff retention. We have 31 direct service staff. The newest person has been with us for 21 days, and our most veteran staff member has been with the organization since 1995. On average, our current workforce has been with the organization for 652 days (as of December 27, 2010). In January 2008, before our training program started, our workforce averaged 360 days with the organization. While there have been several factors that have contributed to this, we believe that the training program has been a critical factor in our improved retention rates because our staff feel supported and equipped to be successful in their work.

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We also benefit from training when we look to promote from within. Four out of five of our current program managers were promoted from direct service positions. The trainings help develop the skills of the direct service staff so that when a position opens, we don't need to look externally to find qualified candidates.

Additionally, our training program garners positive public perception of our organization. We've presented to a group of over 60 area nonprofits about our internal training program, and have provided pro bono consulting to a nonprofit agency in our area that is trying to build a similar program. The opportunities to share information about our training program may make a difference in the quality of care being delivered across the continuum of care in our area, and help our organization become better known as a leader in the community.

Creating and maintaining an internal training program requires an investment of staff time and energy. For N Street Village, the investment has paid off in staff satisfaction and retention, improvement in the quality of staff interventions, and progress toward our goal of building a co-creative environment with clients. ■

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The Importance of Professional Development Among Rural Educators

by John Picone

About the Author

John Picone is a special educator and educational consultant in the central-eastern region of Missouri. He holds a doctorate in education from Walden University and a master's in educational administration degree from William Woods University. He is an autism consultant through Project Access and a Master Associate Level Instructor in CPI's *Nonviolent Crisis Intervention*® training program.

As an educator in a rural school district in central Missouri, an independent educational consultant, and a provider of professional development in rural school districts throughout Missouri and central Illinois, I have witnessed firsthand the vital role professional development plays in training and development among rural educators.

When I began teaching in rural school districts, I found access to continuing education to be limited. Due to my geographical location, it was challenging to find training that allowed me to advance in my career field through traditional means. The provision of professional development opportunities by our district has helped me gain the knowledge I needed to become an in-district autism consultant (IDAC). As an IDAC, I provide training to other members of our school community and positively impact our school system as a whole.

I was selected by the district to become a *Nonviolent Crisis Intervention*® Certified Instructor. By using *Nonviolent Crisis Intervention*® training as a professional development resource, I have been able to better prepare the staff of our small district to meet the demands of modern public education by improving *Care, Welfare, Safety, and Security*SM throughout our school system.

This article, based on research in rural education, reviews the importance and the benefits of professional development as they apply to rural public education facilities, and provides examples of rural educators who made effective use of professional development to improve themselves as educators.

Often, educational staff members receive training and use the knowledge they gain to build competencies throughout their districts. Many rural education staff members have found professional development opportunities to be a catalyst in their pursuit of career advancement. While professional development has limitations in terms of applicability toward educational certification, it functions as the primary source of research-based knowledge dissemination in many rural school districts (Borko, Elliott, & Uchiyama, 2002).

Professional development provides public educators with a means to improve their instructional skills and construct new educational competencies (Harris & Harris, 2005). Continuing education is generally required for most modern public education staff members (Little, 1993). Professional development on-site makes continuing education requirements easily manageable for most educators. This is especially true among rural educators (Reeves, 2003). In a rural education setting, professional development

represents not only a convenient, but also an essential component of career development (Howley & Howley, 2005).

In the United States, rural public education facilities often experience difficulties meeting adequate yearly progress due to a lack of resource availability compared to larger urbanized school districts (Farmer et al, 2006). Rural schools often look to professional development programs to serve as a vehicle for educational resource expansion (US Department of Education, 2000).

Teacher shortages in high-need subject areas have a disproportionate impact on rural districts (Tompkins, 2003). Professional development can provide motivation for educators to explore various curricular areas. Teacher retention is another significant problem faced by rural school districts (Lowe, 2006). Research has shown that quality professional development has a positive impact on staff retention in rural school districts (Rural Policy Matters, 2001).

Rural school districts often have trouble attracting new staff members (Dessoff, 2010). This is due in part to a lack of career development opportunities in rural districts. Dedication to providing quality professional development sends a message to potential applicants that the provision of quality training opportunities is a priority for the district.

Teacher attrition in rural districts is disproportionately higher when compared to attrition in urban school systems. New staff members generally leave rural school districts prior to tenure (Finding and Keeping, 2004). New teachers often seek out districts with greater training opportunities (Inman & Marlow, 2004). Provision of effective staff development within rural districts provides new educators with training opportunities that might otherwise be pursued through relocation.

Rural educators often experience limitations of training availability due to geographic isolation. They generally receive smaller salaries in comparison to their peers at larger urban schools. This demographic difference can make it difficult for rural educators to pursue training through traditional post-secondary schooling options (Huang & Howley, 1991).

Rural administrators often encounter the same barriers as rural educators in terms of pursuing training (Institute for Educational Leadership, 2004). Professional development in a rural education setting can provide solutions to training limitations that might otherwise go unaddressed. Professional development creates career development opportunities for rural educators and makes district-wide school improvement possible (Barley & Beesley, 2007). Educators in rural districts have context-specific needs, thereby requiring training that is responsive and feedback-oriented. The use of evaluation-gathering tools serves to ensure quality professional development in rural school systems (Mitchem, Wells, & Wells, 2003).

Todd Smith, a high-school principal, began his career in education as a teacher's aide in a rural Missouri school district. Todd attended professional development conferences and workshops concerning classroom management and student motivation while he was working as a paraprofessional. He saw the positive results of applying the knowledge gained during professional development and became inspired to pursue more advanced training in instructional application, which eventually led him to a teaching certification.

Todd worked collaboratively with other members of the scholastic community as an instructor at the secondary level. While teaching at the high-school level, he attended professional development programs that focused on learning communities and vision-sharing among educational stakeholders. When asked about the role of professional development in his decision to become an administrator, he responded: "Professional development exposed me to new and innovative ideas. I was excited by the opportunities

for positive change that it outlined and I wanted to be a bigger part of that change."

Exposure to professional development inspired Todd to pursue his master's degree in educational administration and eventually led him to take a position as a high-school principal.

Christina Parrish also began her career in education as a teacher's aide. Christina worked with special-needs students in general education classrooms. She felt that she could have a greater impact on student achievement if she were better acquainted with techniques for establishing positive expectations among both general and special education students. She describes her feelings by saying, "I felt like these kids could go so much further academically if we could just eliminate some of the behaviors that were getting in the way."

In order to familiarize herself with effective Positive Behavioral Interventions and Supports (PBIS) techniques, she took advantage of professional development seminars that focused on corrective behavior management. These trainings were provided to the district by the Regional Professional Development Committee (RPDC).

When asked what made her decide to advance in her career as an educator, she responded: "I decided to go further after the students I was working with began to respond to the positive-behavior-building techniques that I implemented based on our RPDC training. The training led to positive behavior and positive behavior led to increased academic progress. Once I saw that I could make that big of a difference, I was hooked on being an educator."

The techniques learned during the trainings began to yield results that caused Christina to become further invested in the educational process. She began taking courses, working toward certification as an instructor, and now serves as an alternative school director for a rural school district in the Midwestern US.

Professional development is an influential resource for education facilities in rural America. It provides learning opportunities for rural educators that they would otherwise remain unexposed to. It can be used as a tool to disseminate statewide educational initiatives among rural educators who are limited in the availability of content-specific training, and it provides a platform for the relay of dynamic educational information that can serve to inspire educators to greater achievements. ■

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Nonviolent Crisis Intervention® Training Comes to the Associate Degree Nursing Program at the New York City College of Technology of the City University of New York

by Celeste Waddy, RN, MSN

According to the Department of Justice National Crime Victimization Survey for the years 1993 through 1999, on average, there were 1.7 million episodes of victimization at work per year (Duhart, 2001). The health care sector continues to lead all other industry sectors in incidence of nonfatal workplace assaults. In 2000, 48% of all nonfatal injuries from violent acts against workers occurred in the health care sector (BLS, 2001). Health care and social services workers have the highest rate of nonfatal assault injuries (BLS, as cited in American Association of Critical Care Nurses, 2004). Nurses, nurse's aides, and orderlies suffer the highest proportion of these injuries (BLS, 2001).

The New York City College of Technology (City Tech) of the City University of New York (CUNY) provides *Nonviolent Crisis Intervention*® training to third-semester (second year) students in its associate degree nursing program. It is a requirement of the nursing department that third semester students complete psychiatric clinical experience in a hospital setting. Students are charged with obtaining this experience under supervision in Brooklyn and Queens at several hospitals with which the college has contracts.

The *Nonviolent Crisis Intervention*® program, designed by CPI, provides training that prepares human-service providers and educators with skills to safely and effectively respond to anxious, hostile, or violent behavior while balancing the responsibilities of care.

As an assistant professor for the associate degree nursing program since the fall of 2008, I teach psychiatric nursing in the third semester. I have also been a *Nonviolent Crisis Intervention*® Certified Instructor since January 2006.

As a result of tremendous encouragement and guidance from City Tech colleagues Barbara Grummet, dean of professional studies; Kathryn Richardson, RN, MSN, chairperson of the nursing department; and Lydia Brent, RN, MA, adjunct associate professor of nursing, a proposal was submitted to CPI to provide the program to third-semester nursing students, and approval was given for this training. The training began in the fall of 2009. The students are in this course for one day. Three of the lessons within the course encompass the CPI training.

Prior to entering academia, I worked as a nurse educator for the department of psychiatry

About the Author

Celeste Waddy is currently an assistant professor in the City Tech department of nursing. She teaches psychiatric nursing in the third semester of the associate degree program. Her specialization is psychiatric and community health nursing. Professor Waddy graduated from New York City technical college with an associate degree in nursing in 1994. She received certification as a legal nurse consultant from Long Island College in 2001. She received a bachelor of science in nursing in 2005, and a master's of science in nursing, with a specialty in nursing education, in 2008 from St. Joseph's College. Professor Waddy is a recipient of the Senator Patricia K. McGee Nursing Faculty Scholarship.

at Mary Immaculate Hospital in Jamaica, NY. I also have many years of nursing experience in long-term care, management, community health, psychiatric, and mental health nursing. My teaching interests include psychiatric nursing, mental health, substance abuse, mental health service delivery, palliative care, as well as children and adults with intellectual disabilities. The main reason I suggested implementing the *Nonviolent Crisis Intervention*® program was to hone the therapeutic communication skills of nursing students and provide them with necessary techniques to respond appropriately when clients exhibit escalating behaviors.

I understood the need for this training because when I was a nursing student, I too experienced fear and anxiety—fear of the unknown and potential harm from psychiatric clients. I recall that prior to my psychiatric clinical experience, I attended orientation for a psychiatric course, followed by a discussion on a video about schizophrenia. Once on a unit, I was extremely nervous to speak to or even go near a psychiatric client, fearing that I could be attacked at any moment. I did not understand how to look beyond the client's illness and view the client as a person. It took me several weeks on the unit before I became less fearful when interacting with psychiatric clients. A training session in the *Nonviolent Crisis Intervention*® program would have greatly reduced the discomfort I felt.

The main reason I suggested implementing the *Nonviolent Crisis Intervention*® program was to hone the therapeutic communication skills of nursing students and provide them with necessary techniques to respond appropriately when clients exhibit escalating behaviors.

Through the Integrated Experience portion of the training, which deals with the concept that behaviors and attitudes of staff impact the behaviors and attitudes of clients, students are trained in how to instinctively react to familiar behaviors. They learn better ways to respond to inappropriate behaviors and how better responses can be achieved. They are given two scenarios to role-play. One scenario depicts appropriate behavior, and one depicts inappropriate behavior. Some students portray the staff and others portray the clients. These scenarios allow students to see how staff behavior affects client behavior. Through this role-playing experience, students learn that if a student approaches a client with fear and anxiety, the client will detect that fear, and if a student approaches a situation with confidence, the client will take the lead of the student, which helps calm the situation.

As a result of the *Nonviolent Crisis Intervention*® training that is now offered as part of the psychiatric clinical orientation at City Tech, nursing students are able to look beyond the behavior of the client, and beyond the stigmatization of disease. This training allows students to develop empathy and view the client as a person in need of help, rather than someone to be afraid of.

In the various health care settings I have worked in, I have witnessed patients exhibiting violence toward health care workers. Many health workers become victims due to lack of awareness of and preparation in how to respond appropriately to client behavior. After becoming Certified Instructors of CPI's *Nonviolent Crisis Intervention*® training at Mary Immaculate Hospital, we started implementing the program in February 2006. As a result of the training provided to behavioral health employees, I noticed that it was effective in giving staff the skills to appropriately communicate and prevent the escalation of

violent behaviors on the parts of numerous clients.

As we continue our program to deliver the *Nonviolent Crisis Intervention*® training program to CUNY psychiatric nursing students, certain goals guide us as Instructors. Our goals in implementing *Nonviolent Crisis Intervention*® training are to adequately prepare our nursing students for their psychiatric clinical experience, and to assist them in maintaining and providing a standard of *Care, Welfare, Safety, and Security*℠ for all clients, nursing students, and other healthcare workers—essentially, everyone involved in a crisis situation.

Specifically, the goals of the program are to:

- Help students organize their thoughts about responding to agitated, disruptive, and assaultive individuals.
- Build and improve students' confidence to deal with crisis situations appropriately, at any time, and in any setting.
- Enable students to use techniques to control their own anxieties during interventions and maintain the best professional attitude.
- Provide students with nonverbal, paraverbal, verbal, and physical intervention skills to maintain the best possible *Care, Welfare, Safety, and Security*℠ for all individuals involved—even in the most violent moments.
- Work as a team to resolve disruptive and dangerous situations effectively, safely, and respectively.

Our goals in implementing *Nonviolent Crisis Intervention*® training are to adequately prepare our nursing students for their psychiatric clinical experience, and to assist them in maintaining and providing a standard of *Care, Welfare, Safety, and Security*℠. . .

- Teach good communication skills. Students learn good body language, and how to establish Therapeutic Rapport with agitated and acting-out patients.

After the training, students provide feedback such as:

> *"I am happy this training was implemented at the college, because I was extremely terrified going to my psychiatric clinical rotation."*
>
> *"My fear and anxiety has decreased immensely, because I have learned techniques on how to stay calm and handle a crisis situation in any setting."*
>
> *"After attending* Nonviolent Crisis Intervention® *training, I feel less anxious and better prepared because I know what to expect on a psychiatric unit."*

Many key contributors such as Margaret Rafferty, RN, associate professor; Lydia Brent, RN, adjunct associate professor; Patricia Lynch, RN, associate professor; Irene Pearlman, RN, adjunct assistant professor; and Janet Ferguson, RN, adjunct assistant professor, have been instrumental to the increasing success of this training at City Tech over the last three semesters.

In the future, I plan to collaborate further with other departments at CUNY, and to implement a research project on the effectiveness of the training in 2011. ■

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Less Talk, More Action—The PAR Technique

by Steve Nguyen

About the Author

Steve Nguyen is a Birkman Certified Consultant. He is a professional with exceptional relationship building, people development, and problem solving skills. He has a bachelor's in philosophy, a master's in counseling psychology, and is currently pursuing a Ph.D. in industrial-organizational psychology (psychology of work). His interests include leadership, coaching psychology, executive coaching, training & development, employee health & well-being, and workplace incivility, stress, and violence.

In *Good Boss, Bad Boss,* Robert Sutton talks about a problem many of us see in our workplaces—too much talking and not enough doing. Sutton says too often people (this includes bosses and their subordinates) know what needs to be done but rather than doing it, they talk (hold endless meetings), write about it, and study it to death.

Professor Sutton shares about a restaurant chain that hired a consulting firm to create a detailed plan to improve their operations. During the presentation, a long-time executive shared that a decade earlier, the company had received the same report. The executive then proceeded to read from the old report which had almost the same advice as the new one. The lesson: Management had known for quite some time what needed to be done, but they just didn't do it.

For today's post, I will use the PAR technique (Problem, Action, Results) also called STAR (Situation or Task, Action, Result) to share about my experiences living and working on an island in the North Pacific Ocean—an island called Saipan. This PAR method (I hope) will help you see how simple it is to not just talk about a problem, but to act to resolve it.

Background

Yearning for adventure, excitement, and something different, I left Texas in January 2004 to live and work on an island in the North Pacific Ocean as a behavior specialist. My job covered 20 schools on the islands of Saipan (15 schools), Rota (3 schools), and Tinian (2 schools) totaling over 12,000 students. It included assessing at-risk and conduct/behavioral problem students, observing and conducting functional behavior assessments, designing appropriate behavior intervention plans, and assisting teachers and school staff in the proper implementation of the prescribed behavior program.

On a daily basis, I provided consultations to school staff to train and assist in behavior and classroom management, positive behavior support, school crisis management, and traumatic stress and crisis intervention response.

(P)roblem

Saipan, Rota, and Tinian (collectively called CNMI or Commonwealth of the Northern Mariana Islands) posed a particular challenge due to their geographical locations (eight hours west of Hawaii), their relatively young educational system (public education did not start until the mid-1940s when the first public school, WSR Elementary, was established in 1946, with others soon following in the 1950s, 60s, 70s, and 80s) and cultural values and norms.

There are more than 20 ethnicities and nationalities from East, West, as well as Pacific communities, including Chamorro, Carolinian, Filipino, Chinese, Japanese, Korean, Indian, Bangladesh, Russian, Thai, Vietnamese, Micronesian (Yapese,

Chuukese, Pohnepeian), Palauan, Hawaiian, Marshall Islands, American, Australian, and various European communities.

Although the island (population 82,000) is considered Chamorro and Carolinian, more than half of the population is comprised of foreign "guest workers" employed in the garment and tourist industries. In fact, there are roughly 17,500 garment workers and laborers in the CNMI, most of whom are non-English speaking Chinese.

With the stigmas and misinformation surrounding mental health and mental illness, coupled with an educational system still in its infancy and an economy dependent on U.S. federal support, counseling services and school crisis management were at the bottom of the priority scale in the eyes of the cash-strapped government and local school system.

(A)ction

Being one to never back down from a challenge and understanding that (as my friend and coworker described) the CNMI was "fertile soil" to work in, I was able to set and attain two goals: (1) Being part of a six-member Counseling Steering Committee Team that successfully implemented a Monthly Level-Sharing program (CMLS) to train school counselors; and (2) Conducting 25 workshops and training to over 700 teachers and school staff on *Nonviolent Crisis Intervention*® Training and Behavior & Classroom Management.

(1) I partnered with a team of counselors in the local school system and the local mental health agency to educate and train other counselors and to equip them with basic counseling and trauma response skills to address the psychological and emotional needs of students at school and other children and adolescents in the community.

(2) Together with a colleague, I wrote two grants, secured funding, and became a *Nonviolent Crisis Intervention*® Certified Instructor to educate and train teachers, administrators, and school staff on how to best manage anxious, hostile, and/or violent crisis situations in their classrooms and on their campuses.

As a result of the *Nonviolent Crisis Intervention*® workshops as well as trainings and presentations on classroom management and anti-bullying, over 700 educators, counselors, and administrators were trained on best-practices models in managing crisis and potentially volatile situations.

(R)esults

The responses and feedback were phenomenal.

(1) Through our CNMI Counselors Monthly-Level Sharing Meetings/ Trainings, we tackled difficult topics including child sexual abuse, suicide, and self-injurious behaviors. School counselors reported an increase in feelings of confidence and competence in addressing some of these issues in their schools.

(2) As a result of the *Nonviolent Crisis Intervention*® workshops as well as trainings and presentations on classroom management and anti-bullying, over 700 educators, counselors, and administrators were trained on best-practices models in managing crisis and potentially volatile situations.

Here is an example of data from the *Nonviolent Crisis Intervention*® training conducted at an elementary school (on Feb. 6–7, 2006), a high school (Apr. 1–2, 2006) and during two PSS Statewide Professional Developments (Feb. 8–10 & Aug. 17–18, 2006).

Of those who attended the Statewide Professional Development workshop (on Aug. 17–18, 2006) and who responded to the workshop questionnaire on a scale of 1–5 (5 being very useful), 14 out of 14 (100%) said they "strongly agreed" that they had met the program objective to use nonverbal techniques to prevent acting-out behavior; 14 out of 14 (100%) said they "agreed" or "strongly agreed" they had met the program objective to use CPI's Principles of Personal Safety to avoid injury to all involved in a crisis situation; 14 out of 14 (100%) said they "agreed" or "strongly agreed" they had met the program objective to use safe physical intervention procedures as a last resort when a person is a danger to self or others; all participants or 100% gave the overall *Nonviolent Crisis Intervention*® training program the highest approval rating of "5" (strongly agree). These figures reflect the overwhelmingly positive response to the *Nonviolent Crisis Intervention*® training program.

What I Learned— The Key Lessons

As with many important things which transcend the lessons and printed materials drawn from textbooks, what my job and

interactions in the CNMI have taught me are the following:

(1) A collaborative spirit and attitude work best.

(2) **Keep things simple, practical, and relevant in order to link talking to action.**

(3) Everyone, from children to adults, from the under- to the over-educated has a story to share. Make time to listen to their stories.

(4) Don't ever assume you know them, their problems, or traumas—you don't.

(5) Above all else, treat everyone with kindness and respect because no one likes being talked down to.

Side note to #2: The older I get and the more "education" I receive, the more I realize that simple is often best and that the smartest, wisest people are those who ask questions rather than speak. There are also people who are impressed with what Robert Sutton calls "jargon monoxide" or gobbledygook, nonsense. They tend to talk more and do less, rather than the opposite—talk less and do more. In my own experience, I have discovered that people who have a tendency to spew out "jargon monoxide" are those trying to hide their own incompetence or those trying to impress others. It's even funnier when these same people use big words to which they don't know the meanings to. Sometimes, real life is much more entertaining than television. ■

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Extending Training to the Milieu

by Keith Jamison, RN

As technology changes and trends continue to drive us to improve, that same inclination is applied to the development of hospitals, health care agencies, administration, policies, and the practices performed by medical professionals worldwide.

Professional development may start in the training room, but it must extend throughout the milieu. In this way, professional development does not necessarily have to be a self-serving goal. When professionals look for advancement with the intention of providing better care (and hopefully better outcomes), they extend the discussion of the benefits of training and professional development beyond "where am I in my career?" They can feel more fulfilled in their careers knowing that their efforts to advance make a difference in the lives of the people they care for.

In this new day of mental-health and substance-abuse treatment, more awareness is being placed on the importance of staff and agency personnel using the least restrictive measures possible when dealing with out-of-control patients. However, not many clear guidelines or solid solutions are being offered in some institutions.

A former coworker, Karen English, RN, BSN, and I began to sort through what was applicable and truly relevant to our facility, which at that time was a North Carolina state psychiatric hospital. By researching worldwide information and techniques that seemed to be effective, we were able to develop some suggestions that would allow us to provide a safer milieu for our mental-health and substance-abuse patients.

The information consists of:

- A coping agreement (signed in the admissions office by the patient).
- A plan (to be taught to all facility employees from administrators to HCTs and CNAs). The plan has three elements, which gives autonomy to management, staff, and patients, bringing about positive results.
- A survey to be taken on the computer by all employees through the staff development site. The survey allows employees to have a voice and provide information to the administration for later use.
- Patient autonomy and inclusion in treatment plans.

The goal is to begin, at first contact with a patient (during the admission process), to develop a coping agreement that outlines what works best for that individual to help him de-escalate when he's feeling overwhelmed. During this crucial time, it is also important to identify any triggers for acting-out behavior. Being a CPI Senior Associate Level Instructor, I realize how important prevention is.

The plan portion of this proposal first consists of management being visible and available to staff

About the Author

Keith Jamison currently serves as the nursing education coordinator at Julian F. Keith ADATC in Black Mountain, NC. He is a registered nurse with 20 years of experience in health care. He attended Foothills Nursing Consortium. Keith also has 24 years of experience in youth ministry. He serves as youth pastor at Living Waters Tabernacle in Old Fort, NC. Keith is a Senior Level instructor in CPI's *Nonviolent Crisis Intervention*® training program.

as much as possible by doing daily rounds and talking with staff and patients. This gives staff the opportunity to voice concerns or suggestions, and to feel that they are more than a number to the management team. This may give the administration (or the management team) an opportunity to foster a sense of participation in the decision making that affects the hospital, thereby creating a sense of autonomy for staff.

This process also provides a wealth of firsthand information to management and allows them the opportunity to see—not just hear—where the staff and the agency are in the process of providing the necessary patient care.

Giving staff the opportunity to speak with the management team has the added effect of improving staff morale. Feelings of warmth and respect, along with feelings of being listened to, understood, valued, and appreciated, bring about an increased positive engagement in the workplace. This process also improves staff retention and lowers turnover rates, thus alleviating the need to train new staff, and ultimately resulting in saving the agency's time and money. The result is improved patient care.

Care provided should be quality care, not just treatment. Applying medication to a wound is treatment, but taking the time to carefully clean the wound, dress it, assess the patient's well-being, find out how the wound occurred, provide teaching on how to avoid reoccurrence, and apply the proper medicine is quality care.

The third step in the plan is staff members' resulting improved job satisfaction, which causes patients to begin to respond to staff in a positive manner. Instead of feeling that there's a power struggle, patients will feel that they are truly being cared for by employees who appreciate their team, as well as the patients they care for.

Patients will begin to recognize that they, too, are more than a number and are individuals who are appreciated and are being provided with individualized and patient-centered care. In spite of their circumstances and though they have things in common with some of their peers, patients are the most important resources for information on their individual cases. This enables patients to provide staff with a wealth of information regarding themselves as individuals, as well as information about their personal needs. They will share what works and what doesn't work for them when they are suffering anxiety, withdrawal, or any other psychiatric issue.

This step will decrease the need for seclusion and/or restraints, and it will also decrease the risk of staff and/or patient injury, thus improving the milieu, reducing lost time and workplace injuries, and saving the agency money as a result. This plan will aid in providing the best *Care, Welfare, Safety, and Security*SM for all, which is the grounding philosophy of the *Nonviolent Crisis Intervention*® program.

The plan also involves an assessment-intervention log sheet, which provides detailed information about what was tried with an individual patient in times of need (based on information gathered at the time of admission) to avoid hands-on intervention or even seclusion. This log also provides information regarding the staff involved, so it can be used as a tracking sheet to reveal if certain staff are possible triggers, or if the weight of responding to possible escalating situations falls on certain staff more than it should.

The purpose of this plan is to reduce the need for emergency restrictive interventions and to aid in providing optimal standards of care and reduced risks of physical or emotional harm to patients, staff, or others per CMS, JCAHO, the National Association of Psychiatric Health Systems Training, and the Psychiatric Nurses Association.

Everyone wants to reduce the use of Emergency Restrictive Interventions (ERIs), protect patient dignity, provide a supportive environment for all patients, and keep all employees safe from harm.

> Feelings of warmth and respect, along with feelings of being listened to, understood, valued, and appreciated, bring about an increased positive engagement in the workplace.

But where do we begin and how do we begin? We work together following the chain of command per policy. From the beginning, we assess the situation. We look, listen, and feel, which enables us to fulfill the purpose we, as health care providers, have to treat the whole person and to lead others. We become more aware of the complete picture. Internal motivation provides increased compliance with patient needs, and brings better compliance with treatment, better clinical outcomes, and greater maintenance of change over time.

Administration provides and supports increased staff dignity, input, growth, autonomy, and ability to focus on meeting patient needs, which leads to an improved milieu on the units. All of these proposed improvements could lead to less administrative time taken due to outside facility surveys and more supervisory time free to focus on staff and staff-related issues, which can improve interdisciplinary relationships.

Staff regain a sense of pride in their facility, their value as individuals, the jobs they have been assigned, and an understanding of policy and expectations—all of which lead to improved patient/staff relations and the reduction of ERIs and staff injury.

Patients are allowed to have input into their own patient-centered treatment plans, individualizing their treatment plans by signing an agreement at the beginning of the admissions process. They will experience a positive and more therapeutic environment in which they don't feel controlled, but they do feel like they are included in their treatment, thus leading to compliance and better outcomes.

A plan implemented in this fashion can help meet the goal to provide the best *Care, Welfare, Safety, and Security*SM for all. Remaining calm and having a plan are two of the most important steps toward reducing the need for seclusion and restraints.

By utilizing a plan such as the one outlined in this article, the process of professional development continues. There is always room for growth and improvement in our ongoing pursuit to become the best professional health care providers possible.

A special thank you with the editing process goes to our team at JFK ADATC: Debbie Mangham, RN, clinical improvement consultant; Karol Gebbia MS, LPC, staff development director; Michael Hardimon, RN, BSN, MBA, special projects director; Archie Pertiller, crisis prevention coordinator; and to Robert D. Rettmann, CPI research & communications services coordinator and editor, *Journal of Safe Management of Disruptive and Assaultive Behavior*. ■

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Oklahoma City, OK ▪ March 22–25
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Fresno, CA ▪ March 29–April 1
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Springfield, IL ▪ March 29–April 1
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Nashville, TN ▪ May 10–13
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Raleigh, NC ▪ May 31–June 3
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