

Matua Raki

National Addiction Workforce Development

**Working with People in
the Criminal Justice Sector:
Reflective Workbook**



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Welcome to the ‘Working with People in the Criminal Justice Sector’ reflective workbook

In early 2008 Matua Raki, as the National Addiction Workforce Development Centre commissioned the development and delivery of a mobile training package as part of a suite of programmes within the Ministry of Health Effective Interventions First Step programme. The aim of the training was to support accelerated workforce development for the alcohol and other drug (AOD) sector to enable the sector to competently respond to people with AOD issues who are in, or have been in the justice system.

Abacus Counselling, Training & Supervision Ltd and HMA Ltd were jointly contracted as training organisations to develop and deliver training at eight pilot and twenty phase II sites throughout 2008 and 2009. Evaluation of the workshops indicated that there was improved engagement with clients involved in the justice system as well as services reporting improved networking and collaborative practices with justice services, in particular Community Probation and Psychological Service (CPPS).

As a result of this positive feedback, Matua Raki have taken the workshop workbooks and redesigned them into this reflective workbook so that the workshop material can be more widely accessed.

Matua Raki hopes that this manual may be utilised in a variety of ways including:

- A refresher for those who participated in the original training.
- A resource that services or teams may use to develop their own in service training.
- A reflective manual for individual staff to review their own practice with justice clients and associated services.

It should be noted that the material in this workbook reflects the ‘systems’ of the time. Whilst legislative changes may affect the range of sentences available to the Judiciary or pathways and processes through the criminal justice system, core values, attitudes and practices for working with people who have addiction-related harm will remain fairly constant.

** Addiction is a generic term used to denote alcohol and other drug as well as problem gambling.*

Contents

Module One: Attitudes	4
Module Two: Core Cultural Safety and Ethno-cultural responsiveness	25
Module Three: Skills of Engagement	42
Module Four: Ethics and Boundaries	66
Module Five: Justice Context	98
• Part 1: Introduction to the Justice Context	
• Part 2: Introduction to Assessment within the Justice Context	
Module Six: Working Across Systems	186

Working with People in the Criminal Justice Sector:

Module One: Attitudes

About this Module

Purpose

This section introduces participants to the workbook and explores attitudes needed for working effectively with justice clients who have alcohol and other drug (AOD) issues that are or have been involved in the criminal justice system.

Objectives

By the end of the section, participants will be able to:

- Understand some of the differences in the approaches to working with clients from the AOD and Justice sectors.
- Consider the different language used in the two sectors, and how it affects the way we think and deal with these clients.
- Examine their own thoughts and attitudes towards working with clients who have both related issues and who are, or have been part of the criminal justice system.
- Consider the most helpful elements required to work and engage with this client group.

1.1 Attitudes for working effectively with these clients

The health, social service and justice sectors often share the same clients. These sectors have been traditionally funded and managed separately, and accordingly, have also evolved in different ways. The focus of the addiction and justice sectors is different, and therefore staff members have been trained differently and have some different sets of knowledge and skills. There are many specialist skills and competencies required for working in the areas of mental health and addiction that contribute to recovery and well-being, just as there are specific skills and knowledge required around sentencing, enforcement, and managing offenders both in prison and in the community. Sometimes offenders are also mandated to undertake AOD treatment programmes and it is in these circumstances that the similarities and differences between the two sectors become obvious.

When the areas of health and justice overlap, the people responsible for the client's care need to have knowledge of both sectors, sufficient to be able to advocate on behalf of the client, and to ensure the best outcomes. The attitudes of the practitioners are also important, to enable them to be able to engage appropriately with this group and achieve a positive working relationship.

Accordingly, it is important to examine attitudes and consider these in relation to engaging and working with offenders who may also have addiction-related problems. If we give a negative impression to clients, or find it difficult to engage with them because of our internal prejudice or judgements, then the relationship is likely to fail and the client will not have had their needs met. This could mean additional long-term implications for the client their family or whānau or the wider community, including the potential for further reoffending, continued substance use and an additional drain on scarce resources.

Take a moment to reflect on your experience of the attitudes that you and others may have to offenders who have alcohol and drug issues -

- Are their rights to treatment for AOD issues always considered, or are they put aside until they have ‘done their time’ and then show genuine desire to attend treatment programmes?
- Are their requests for treatment programmes often thought of as an opportunity to avoid imprisonment?
- If an offender leaves treatment early, is it usually considered their fault, as ‘they weren’t genuinely motivated anyway’?
- If there is only one place on a treatment programme, and there are two candidates, a voluntary client with alcohol dependence, and a mandated drug using offender who has previously left a programme early, which would you choose? What would be your rationale for this, and what might be some reasons for the opposing view?

Write some of your thoughts here:

What might some of these attitudes mean for clients (both mandated and voluntary) accessing services?

Consider the section shown below, which introduces two items from the UK Drug Policy Commission Consensus Group's (2008) proposed vision of recovery. Read the statement, and consider your first reaction to the points made and whether you agree with both points without reservation.

The UK Drug Policy Commission Consensus Group's (2008) proposed vision of recovery includes these 2 points:

- Recovery must be voluntarily sustained in order to be lasting, although it may sometimes be initiated or assisted by 'coerced' or 'mandated' interventions within the criminal justice system.
- Control over substance use is a key part of recovery, but is not significant on its own. Positive health and wellbeing and participation in society are also central to recovery.

When you examine the first point, it highlights choice and self-responsibility on behalf of the client, however, this is followed by the concept of mandated treatment and coercion, to initiate or assist recovery, in some cases.

- How do these seemingly contradictory concepts fit together?

In the second point, positive health and well-being as well as participation in society are highlighted as important aspects of recovery.

- How might this work when societal attitudes to offenders usually include an expectation of 'punishment' and 'exclusion', and where there is generally a lack of acceptance, positive regard, and re-employment opportunities for offenders?

Write some of your thoughts here:

A positive practitioner attitude is also vital when considering the client's cultural context(s). Understanding and accepting cultural context(s) will help explain the way people behave and think, but also the types of supports they might best align to or need. Application of knowledge and skills throughout this workbook should always be viewed in relation to ethnocultural context(s) of the client and their family/whānau/fono.

The ability to 'negotiate the space' between context (cultural) and content (technical) is important to facilitate good outcomes (Mariner, 2008)

Although there are a number of concepts and models of practice we can use to deal with clients, when working with Māori and Pacific clients, their cultural context including whānau/fono must be considered. In many cases, consultation with, and working alongside, Māori and Pacific health workers, and utilising Kaumatua and Matua can greatly assist positive outcomes. Core cultural safety and ethno-cultural responsiveness will be further discussed in more depth in module two of this workbook.

1.2 Thinking about Attitudes

There are a number of different thoughts about how practitioners should work across the boundaries of the health and justice sectors. Some in the health sector believe that the focus is so different, that the two are incompatible. Others believe that there should be information sharing, but are unsure as to how much information should be shared about clients' health progress, if it is not relevant to the justice aspects of the clients' situation. Some believe that offenders' rights to treatment are compromised by their transgressing of the law, and others feel that if treatment is part of sentencing, readiness to change is not considered and recovery may be compromised.

On the other hand however, it is also felt that no opportunity should be lost in treating problems which also affect those around the offender, and that all attempts should be made to intervene to minimise addiction related harm including offending behaviour. No matter how clients come to specialist services (self referral, referral because of someone else's concerns, or referral as part of a justice initiative) it is a 'window' of opportunity for good work to be done. With the right approach from the person/service initiating the intervention, there is potential for positive outcomes.

For example, using a motivational approach the clients own concerns about their AOD use and offending may be uncovered which may generate some shifts within the client, even if only sowing the seeds for future interventions. If there is a continuing assumption that justice clients have no interest in change then the potential for opportunistic interventions will be overlooked, and the client will likely maintain unhelpful patterns, remain 'in the system', and continue to cause harm to themselves, their family, whānau and communities.

One of the things that treatment and counselling offers clients (their families and whānau) above all,

is hope. Even if some clients do not appear to make much progress, even small steps may mean a lot for them, in the context of where they come from. Practitioners have great potential to support clients to make change as long as they are prepared to have a positive attitude and find solutions that work for each individual client. The examination of our own unconscious attitudes or those that we project without realising it, is an important task when working with this client group.

Recovery

UK Drug Policy Commission Consensus Group

Earlier we introduced some items from a statement on recovery from the United Kingdom Drug Policy Commission (UKDPC). The UKDPC had invited a group of 16 individuals to take part in a two-day consensus meeting in March 2008. The 16 people represented a wide range of perspectives including several people in 'recovery', family members, as well as individuals coming from services providing a variety of addiction-related care and support. This included 12-step approaches, maintenance prescribing, general practice, residential rehabilitation and peer and family support groups, as well as service commissioners. Participants also came from different parts of the United Kingdom, were different ages and from different cultural backgrounds. The aim of the discussions was to identify common ground and develop a description of the process of 'recovery' from substance use problems, which would encompass the wide range of individual experiences of recovery, and the differing contributions that treatment and support services, make to assisting those in 'recovery'. Following the two-day meeting the statement was taken out to the sector for wider endorsement.

Following is a copy of the UK Drug Policy Commission Consensus Group's (2008) vision of recovery, containing their key features for recovery as defined by the group. As you will notice as you read through the key features that came out of this work, attitudes are a critical component in terms of 'recovery' and underpin everything else that occurs in relation to people making changes with their substance use.

UK Drug Policy Commission Consensus Group: Developing a vision of recovery – a work in progress

The key features of recovery from problematic substance use Identified in our discussions:

1. Recovery is about building a satisfying and meaningful life, as defined by the person themselves, not simply about ceasing problem substance use.
2. Recovery involves the accrual of positive benefits as well as the reduction of harms.

3. Recovery includes a movement away from uncontrolled substance use and the associated problems towards health, wellbeing and participation in society.
4. Recovery is a process, not a single event, and may take time to achieve and effort to maintain.
5. The process of recovery and the time required will vary between individuals. It may be achieved without any formal external help or may, for other people, be associated with a number of different types of support and interventions, including medical treatment. No 'one size fits all'.
6. Aspirations and hope, both from the individual drug user, their families and those providing services and support, are vital to recovery.
7. Recovery must be voluntarily-sustained in order to be lasting, although it may sometimes be initiated or assisted by 'coerced' or 'mandated' interventions within the criminal justice system.
8. Control over substance use is a key part of recovery, but is not sufficient on its own. Positive health and well-being and participation in society are also central to recovery.
9. Control over substance use means a comfortable and sustained freedom from compulsion to use, which in many cases may require abstinence from the problem substance or all substances, but may also encompass consistently moderated use and abstinence supported by prescribed medication, peer groups and families.
10. Positive health and well-being encompasses both physical and mental good health as far as they may be attained for a person, as well as a satisfactory social environment.
11. People do not recover in isolation. Recovery embraces inclusion, or a re-entry into society, the improved self-identity that comes with a productive and meaningful role, and also the idea of 'giving back' to society and others, such as family members, who may have been adversely affected by the individual's substance use.
12. Recovery-oriented services need to support the aspirations of each individual to assist individuals build recovery across all the above domains.

Take time now to consider the key features of ‘recovery’ (above) and reflect on the documents definition of ‘recovery’.

1. Do you agree with this definition of recovery? If so why? If not why not?

2. What does this definition mean for people who are abstinent?

3. How important is it that ‘recovery’ does not occur in isolation? Why?

Following are six statements about alcohol and drug clients and the justice system. As you read these statements, think about how certain processes and attitudes can get in the way of different sectors working together, with a resultant detrimental effect on outcomes for clients. In addition, identify your own thoughts and attitudes regarding these issues, and consider what changes might need to be made to embrace the UKDPC Consensus group’s two principles highlighted above.

Think about your reaction to these statements and whether you think they reflect helpful ways to work with AOD and justice clients, or whether they might create barriers to good practice and successful outcomes. Opinions and attitudes will vary greatly according to role, background, training and experience, and we all need to reflect on how this variation influences consistency and continuity of client care. To assist with your thinking, consider the reasons why you support the statement, or reasons as to why you do not support the statement. Write these in the spaces below:

Think about these statements:

- Offenders should have the same rights to treatment as other people with AOD related issues.

Thoughts:

I support this statement because:

I don't support this statement because:

- Clients' progress in AOD treatment shouldn't be fed back to referrers in Corrections, as it is health related, and nothing to do with their legal issues.

Thoughts:

I support this statement because:

I don't support this statement because:

- If treatment is mandated by the justice system and clients aren't 'ready' then they may resist it, so it shouldn't be mandatory.

Thoughts:

I support this statement because:

I don't support this statement because:

- AOD treatment is about recovery in health services, but is part of sentencing and punishment in the justice system.

Thoughts:

I support this statement because:

I don't support this statement because:

- Even mandated treatment can be useful as clients have many reasons to continue using, and any opportunity offering change should be considered.

Thoughts:

I support this statement because:

I don't support this statement because:

- Mandated treatment is sometimes necessary in order to help the service user, their family or whānau, and the community.

Thoughts:

I support this statement because:

I don't support this statement because:

Research has highlighted that mandated treatment can have effective outcomes. The Drug Interventions Programme (DIP) in the UK for example was introduced in April 2003 with the aim of developing and integrating measures for directing adult drug-misusing offenders into drug treatment and reducing offending behaviour. Research has identified that DIP has helped reduce offending behaviour and increase the number of ‘offenders’ accessing treatment (Skodbo et al, 2007).

1.3 Judgements and Attitudes: An Exercise

All behaviour is on a continuum from no harm to potential serious harm, and it is often a matter of judgement as to whether any behaviour is more or less serious, depending on your perspective. Where you believe harm may lie on this continuum will mean making a moral judgement, as well as identifying potential real harm to self, and others. When asked to comment on others’ behaviour, we tend to compare it to things that we or our family or whānau and friends/ acquaintances would do in certain circumstances, or what is considered normal or usual in our circles.

This does not take into account the perspectives of others in the context of their lives and social circumstances. In addition you may think differently about things depending on whether or not you think others will know or find out about it, whether you will get caught, or what you think you can ‘get away with’.

Sometimes, it may depend on whether there are ‘extenuating circumstances’ and other mitigating factors, which might make the behaviour more acceptable, or at least, understandable. There is a variation in how different people view or compare behaviors according to their own upbringing and experience, and this colours their opinions and Judgements of others.

There are a number of scenarios in the following exercise, which represent behaviours of people which occur on a regular basis, and sometimes bring people into the justice system. It is important to be aware of our own biases, so that these do not get in the way of providing services equally to all clients. This exercise provides an opportunity to examine your own attitudes to a variety of situations which could involve clients of both addiction services and the criminal justice system.

Rank the following 12 brief scenarios by seriousness with which you view this behaviour, with 1 being the most serious and 12 being the least serious, and enter the reasons for your choice. You may wish to alter your choices from initial reactions as you continue to read through the list and consider the reasons for your choices. Think about all factors including intent, and direct/potential impacts on the client and others. There are no right or wrong answers; how you answer is strictly up to your own judgement and rationale.

She gets in the car to drive home, knowing she's had a couple more drinks than she intended.

Rank:

Reasons:

He had a few beers at the pub on the way home to take the edge off his stress.

Rank:

Reasons:

Though he was disqualified from driving, he drove his mates home from the pub in the early hours of the morning as they were too drunk to drive.

Rank:

Reasons:

His wife bad-mouthed him in front of her mates so she deserved to be reprimanded with a back-hander.

Rank:

Reasons:

He knows from experience that women can't be trusted, so he calls her several times during the day to check up on her whereabouts.

Rank:

Reasons:

He's been prescribed some morphine tablets for pain, with 2 repeats, and a "friend" offers him \$300 for a packet – he takes it as he needs the money.

Rank:

Reasons:

Last night he forced his new girlfriend to have sex, rationalising that they both had a few drinks and she wasn't hurt anyway.

Rank:

Reasons:

While driving home after the party, he clipped a cyclist and saw them fall on the road, but kept going, rather than risk a drink-driving charge.

Rank:

Reasons:

He and his mates thought it was a great joke when they slipped some drugs into a woman's drink at a party – they found out later she was raped while passed out.

Rank:

Reasons:

She was desperate for some smack and offered the landlord sex so she could keep the rent money.

Rank:

Reasons:

Going home drunk, he noticed that a car door was unlocked, no-one was around, and the cell phone he wanted was just lying on the seat, so he took it.

Rank:

Reasons:

She was really upset that he hit her again, because she asked him where he had been after he came home drunk, and this morning he asked her how she got the black eye. He is shocked that he doesn't remember this.

Rank:

Reasons:

Now that you have completed the exercise, imagine that you have rearranged the behaviours in order of rank from one to sixteen, then think about your decisions which you have made in the context of your own beliefs and attitudes, training, and experience.

- What influenced you to place them in this order?
- How many times is good or bad luck a factor?
- We all may do things we regret, they are only an issue (apart from conscience), if someone finds out or we are 'caught', aren't they?
- How might your friends, family and colleagues have ranked these same scenarios, and why?
- What has the most effect on our judgements in these situations – our own beliefs and experiences, the influence of peers and colleagues, or your training and expectations as a professional?

1.4 Definitions, Language and Elements of Helpful Client Relationships

How we describe people and their behaviour is often a reflection of how we feel and think about them, and therefore this affects how we treat them. When we label people, it also enables us to stereotype them, and this can justify attitudes which can be unhelpful. There are a variety of ways to describe people and their actions and these all convey a message not only to the clients themselves, with associated effects on their attitude and self esteem, but also to practitioners, probation officers, and judges, who will manage their care.

In this part of the module, we briefly examine ways that labelling clients can affect our treatment and perceptions of them before we even meet and work with them. When others apply labels that have certain connotations, it tends to colour our judgements however subtly, and this can affect our engagement with that person, which in turn, can affect the ongoing relationship. This applies even more so, with issues like alcohol and drug use and offending, which are generally subject to stigma anyway.

This exercise offers the opportunity to consider attitudes and labels and reflect on how this can impact on your practice with clients.

In the case of terminology (language), we often note the changing trends of 'politically correct' words that are chosen to de-stigmatise, and ensure more equality of attitudes. It is certainly more respectful and more clinically accurate to be linguistically sensitive with the words we choose to use.

This section offers an opportunity to consider this and perhaps widen your repertoire of terms. It also provides an opportunity to consider the combinations of terms that apply to those affected by both AOD use and the justice system.

The following exercise lets us consider attitudes and labels and reflect on how this can impact on practice with clients. Below is a statement in which the language used could be seen as

judgemental and unhelpful, and conjures up a negative view of the person involved. Read the scenario, and consider the terms and their connotations, and what effect they might have on the way the client is respected and as a result, may be treated.

For example, what effect does referring to someone as an alcoholic have, in comparison to referring to someone as having alcohol dependence or problematic alcohol use?

Descriptions and Terminology

Think about the following statement:

“witnesses said that this drunk was beaten up by some nutter outside the hotel. He vomited and then passed out. He’s an alcoholic, and they think, probably a junkie as well. He’s also a known thief and con-man, and he’s been inside a few times and deserves everything he gets”

What assumptions could you make, and how would it affect your perception of this person before you met them?

From your existing knowledge, try rewording the statement and then consider what a difference that change is likely to make in perception about this person. The elements of empathy and respect for an individual are essential for building a successful relationship for working with clients, and stereotyping and labels can interfere with that.

Accurate and respectful terminology, with all its inherent connotations, is an important element in our communications, both verbal and written. Pejorative terminology lowers self esteem and contributes to reduced respect, prejudiced treatment, and accordingly, reduced expectations. Consider the notion of behaviour as a result of a disorder or illness as opposed to deliberately unacceptable or aggressive behaviour, and the different way that it is interpreted and responded to. Consider also, the effect of these perceptions on empathy, and the development of the relationship with the client.

Language has more impact than is often considered, and language and power are inextricably linked. As Thompson (2003) states, “Language not only reflects reality it constructs reality.” Williams (1998, cited in Thompson, 2003) further elaborates with “The construction of language and the selection of terminology is necessarily political. Common language in use reflects a world view and in itself can reproduce relations of dominance and subordination”. Language is a key medium through which dominating groups reinforce their superiority and prescribe the inferior status of minority groups.

The following terms have often been used to describe AOD users and offenders – which are the most appropriate? Is it just about being ‘politically correct’?

- Alcoholic/Junkie/substance misuser/drug addict
- Consumer of AOD services
- Alcohol and drug dependent client
- Drunk and disorderly offence
- Career criminal/ repeat offender/ recidivist
- Inmate/prisoner
- Ex-con

Which terms sound most negative, and which sound more appropriate for professionals of AOD services and justice services?

In your experience what effect do these negative terms have on the attitudes of professionals in these settings?

How does terminology affect treatment?

- Labelling people using judgemental terms affects how we (and others) think about them and it also affects their self –esteem and that of their families.
- If we think people are deliberately at fault in their behaviour, rather than compromised by something beyond their control, empathy is reduced. The language we use conveys this.

1.4 Conclusions

Finally, let's look at the elements of professional helping relationships that are the most effective when working with this client group. These elements recognise attitudes which encompass helpful and healthy attitudes toward the people we work with. In addition to the five points raised, there may be others that you consider important, in order to work with clients and other practitioners who are in both the AOD and the criminal justice sectors.

Helpful Elements in Client Relationships

- 'Unconditional positive regard'
- Te Mana a Ki
- Aroha
- Objectivity rather than conditionality
- "Know me before you judge me"
- Avoidance of labels
- Empathy and acceptance, but not collusion

The first statement (above) may be familiar as one of the key aspects of client-centred counselling and is an essential element in developing good engagement with clients and building trust and confidence. After the work we have done in this section on attitudes, consider for yourself if there are still barriers to applying this to clients and other practitioners who are in both the AOD and the criminal justice sectors.

There should be a good balance in relation to the professional's ability to not condone behaviour or actions, but still be able to offer service user's appropriate and equitable services i.e. dislike behaviour but not the person. By putting preconceived ideas and prejudices aside we have the possibility of achieving maximum potential for this client group and improving outcomes, based on a fresh experience of developing positive and productive relationships.

1.5 References and Further Reading

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Working with People in the Criminal Justice Sector:

Module Two: Core Cultural Safety and Ethno-cultural responsiveness

About this Module

Purpose

This section introduces you to cultural responsiveness and explores core worker competencies relating to cultural safety, cultural competence and Māori responsiveness.

Objectives

By the end of this section you will be able to:

- Understand how ethno-cultural responsiveness can benefit engagement and treatment and therefore be a positive responsivity factor.
- Reflect on your own cultural safety practice.
- Consider the importance of culturally congruent practice particularly when working with Māori.

2.1 Thinking about Cultural Responsiveness

In the context of working with people engaged with both the addiction treatment sector and the criminal justice sector attitudes related to ‘culture’ can affect client engagement and outcome, thus culture can be considered a responsivity factor. When working with offenders, we may encounter the term ‘responsivity’. Responsivity is a concept we will examine in more depth later but basically it means those factors that can hinder or enhance an intervention. The ‘risk-needs-responsivity model’ approach to the rehabilitation of adult offenders (Andrews and Bonta, 1994) suggests that effective rehabilitative services must be matched to each individual offender’s risk level, needs profile and responsivity profile.

- Our own judgements, attitudes and perspectives will, as we have already seen vary according to our own experience and training, and can colour how we work with people. As part of ethical and professional practice, we need to reflect on, and be aware of, our attitudes and values and how these can impact on our relationship with our clients at all times. Positive practitioner attitudes in regard to ethno-cultural responsiveness and competence can enhance or be a barrier to a rehabilitative or reintegrative intervention i.e. a responsivity factor.

- Clients as well as practitioners are shaped by various cultural factors and influences. Working in a culturally safe way requires that we reflect on and examine our own culture and whether we impose this on our clients and their world-views. The need for cultural safety applies to all people, not just non-indigenous people.
- Practitioners who will be working with Māori, and especially those who will work in kaupapa Māori services, will quite reasonably be expected to bring advanced Māori cultural knowledge and skills into the workplace with them.

The purpose of this section is to help engage you in thinking about how certain processes and attitudes related to ethnicity and/or to culture can effect client engagement and outcomes.

Responsivity

Responsivity tells us what we need to clear out of the way or build upon in order for a client to benefit from an intervention

Try brainstorming some things that you think might be responsivity factors. These may be things that can either enhance responsivity, or act as barriers to effective interventions. Enhancements will be factors we can build upon, and barriers will be things we may need to remove in order for an client to benefit from an intervention. List these below:

Enhancements: _____

Barriers: _____

2.2 Cultural Competence

The following is an extract taken from the Takarangi Competency Framework Workshop Manual (Huriwai et al, 2008).

Cultural competency of practitioners is becoming increasingly significant, as research continues to identify the significance culture provides to the recovery and wellbeing of tangata whaiora and whānau. The notion of cultural competence outside New Zealand has been promoted for many years as being about increasing the cultural responsiveness of non-indigenous services and practitioners. In 2001, the US Surgeon General defined cultural competence in the most general terms as “the delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values.”

Durie (2001), in his address to the Boards and Council Conference, indicated cultural competence and cultural safety are similar in that they are both about the relationship between the ‘helper’ and the ‘client’. Cultural safety centres on the experience of the client while cultural competence focuses on the capacity of the practitioner to contribute to whānau ora by the integration of ‘cultural and clinical’ elements within their practice. Jansen & Sorenson (2002) expand on this with regard to working with Māori, saying that cultural competence requires that providers have a willingness and ability to draw on Māori values, traditions and customs and work with kaumatua and other knowledgeable Māori, to communicate and develop responsive interventions.

More recently, the Whanau Ora initiative is said to be underpinned by an approach that emphasises Māori resources, language and culture ‘Ngā Kaupapa tuku iho’. Essentially these are the ways in which Māori values, beliefs, obligations and responsibilities are available to guide whānau in their day to day lives. There is an assumption that utilisation of ‘Ngā Kaupapa tuku iho’ will enhance engagement, access to relevant and effective services and thus effective outcomes.

A Reflective Exercise: What is Culture?

As stressed earlier, our own judgements, attitudes and perspectives will vary according to our own experience and training, and can influence how we work with people.

- Reflect on what you think culture is, and how it is expressed. If you have a colleague available to discuss this with, have a brief discussion to aid your thinking, and then see what ideas you can come up with. It might also be something you would like to explore in supervision if time permits.

Read the comment below and consider the reasons why these circumstances may have occurred and use the space below to write down your thoughts:

Scenario

“Māori were coming in to the programme, staying three or four days a week at the most then they’d go because, for most of them there was the cultural sort of misunderstanding.” - *Monica Stockdale (Cave et al. , 2008)*

List some thoughts on what may have contributed to the above scenario:

2.3 Responsivity

Culture as a Responsivity factor

- Cultures can have differing approaches to accessing, understanding and accepting care.
- This may influence the understanding of an issue or its resolution.

Remember the work we have done in the first section in regard to responsivity and its effect on interventions (as strengths or barriers). Put this into the context of our discussions around culture and consider the effect of the two statements shown above. Consider how cultural congruence might be a responsivity factor.

Cultural Congruence as a Responsivity Factor

- A lack of cultural congruence can be a responsivity barrier.
- On the other hand having some cultural congruence might enhance engagement and uptake.

Remember that culture is a dynamic factor that can include the values, beliefs, norms and behaviours that help identify membership of a particular group. People may be shaped by a number of ethnocultural and other cultural influences, so understanding that and being able to relate in culturally responsive ways is essential to enhance positive outcomes.

2.4 Definitions

Cultural Sensitivity

This is a term used often, but what does it really mean? In the space below, write some ideas about you think cultural sensitivity means.

Cultural Sensitivity

- Culturally sensitive approaches acknowledge that difference is important and must be respected.
- However, culturally sensitive approaches in health care tend to focus on ‘others’ as the bearers of culture.

As noted in the above statements, we are often sensitive to the cultures of others but don’t necessarily look at what impact our own cultures have on the relationship with our service users. It is essential that practitioners are not only culturally sensitive, but also bring their openness and cultural preparation to the relationship.

Cultural Safety

Cultural safety is a New Zealand coined term that is well-known and often criticised. Think about what is meant by this term and then write some ideas in the spaces below:

Cultural Safety

- *An acknowledgement of the beliefs and practices of people who differ from them in age, occupation, sex, sexuality, religious belief, disability, or any other different lived experiences.*

You need to acknowledge that your own culture potentially may be different from that of your clients in order to guard against imposing your beliefs. Also, note that cultural safety applies equally for Māori and for non-Māori.

‘You do not need to research and understand other groups’ beliefs and cultural practices; rather, acknowledge your own culture as different from those of the people you serve, to ensure that you do not impose your beliefs’ (Irihapeti Ramsden, 1997).

Reflect on the following statement:

Cultural Safety

- *Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual, family or group.*
- *Cultural safety “enables safe service to be defined by those who receive the service”*

Note that cultural safety (in the service provided) is defined by the client.

Cultural Safety and Cultural Competence

Cultural safety centres on the experience of the client, while cultural competence focuses on the capacity of the practitioner to contribute to wellbeing by the integration of ‘cultural and clinical’ elements within their practice.

Reflect for a moment on your practice and consider if engagement usually takes place with consideration of the roles of client and practitioner as described above. The aim of this module is to bring out and further develop the notion of integrating cultural and clinical practice. This suggests that a degree of cultural fluency will enhance ones competence when working with all clients.

Real Skills (Lets Get Real: Mental Health and Addiction, MoH, 2008), places an expectation on the mental health and addiction workforce, that all will have a degree of cultural fluency in relation to working with Māori. Real Skills describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction treatment services. Its aim is to create shared language and understandings and is meant to underpin all work with clients. To ensure integrity, it is essential that as part of professional supervision, a practitioner’s cultural competence is also supported.

Cultural Responsiveness

Here is another term which is becoming more widely used. In the spaces below, list some of your ideas on what is meant by this term:

Indigenous culture provides ways of knowing what is salient and congruent with the local ethos, as well as credible ways of defining problems and solutions.

In working with your client in culturally responsive ways, the essential aspects of their cultural needs will become apparent and also, solutions that are congruent with their cultural values and beliefs.

Cultural Fluency

Cultural fluency is defined as appropriate application of respect, empathy, flexibility, patience, interest, curiosity, openness, a non-judgemental attitude, tolerance for ambiguity and sense of humour. It implies a cultural familiarity and enhances the communicators understanding of cultural context and the degree to which a message is received and understood (Inoue, 2007)

**Make some notes here about what you think this actually means in your work with clients.
How would you know if you are being culturally fluent?**

2.5 Māori Responsiveness

Working with tangata whenua is not only relevant for this country, but also has special importance because of the client profile of both those in the criminal justice system and those who access addiction treatments services (Māori are over-represented in these services).

Matua Raki (2009) have been involved in implementing a competency framework for working with Māori, which relates to the application of Māori-centred practice in mental health and addiction settings – with competence being the application of vocational and Māori knowledge and skills. There are a number of agencies with their own Māori competency sets, but what they have in common is a defined set of behaviours, values and expectations of how these are manifest in practice.

Māori responsiveness is everyone's responsibility – both Māori and non-Māori.

Workers will not always be able to meet the wide range of skills needed by their clients. But more than anyone else they may be pivotal to mobilising the relationships necessary for positive development and the realisation of potential (Durie, 2001)

Some of the things you may have thought about in the exercise above are discussed below:

One of the cultural imperatives for Māori is the provision of food (kai) by the host for any gathering, and it is felt to be a priority to be able to provide this as part of the cultural protocol. The sharing of kai has a special place in Māori culture, following the formalities of the gathering. If Mary could not provide kai and indicated this to the whānau, they could bring kai with them, however, Mary may have felt too embarrassed (whakama) to let this be known. The expectation of providing food for guests would remain consistent in the future, and therefore Mary may behave in the same way again if she was in a similar situation.

- **Think about how would you work with Mary's cultural cognitive distortions?**
- **How would you use Māori values and practices to help Mary see the consequences in another way?**

Now consider how all of the definitions and discussion points raised in this section impact on work with your tangata whaiora. To help you summarise some of the key learning points for you in this session, there is a notes page at the end.

Additional brief notes on cultural competence:

Mason Durie in his address to Australian and New Zealand Boards and Council Conference (2001), said: "Cultural competence focuses on the capacity of the health worker to improve health status by integrating culture into the clinical context. Recognition of culture is not by itself sufficient rationale for requiring cultural competence; instead the point of the exercise is to maximise gains from a health intervention where the parties are from different cultures.

Culture is essentially a convenient way of describing the ways members of a group understand each other and communicate that understanding. More often than not the nuances of meaning are generated by behaviour rather than words, and much of the interaction between members is determined by shared values operating at an unconscious or 'taken for granted' level. Many groups have their own distinctive culture – the elderly, the poor, professional groups, gangs, the army".

Although generally, the comments in the address above are directed at doctors, the general principles apply equally to all health practitioners and are very relevant to our section on cultural safety and cultural competence.

2.7 Summary

Culture can be a responsivity factor

- Be aware that our culture can affect the relationship with the client
- Increasing our cultural fluency can enhance our cultural competence

In the final section above, there are a few salient points which will benefit the practice of everyone working with clients in the ethno-cultural context of New Zealand. Culture can be both a barrier and an enhancer to an intervention. We need to be aware of our 'own stuff' and how that can potentially influence and filter our perception of the client and their situation. This means examining our attitudes and increasing our understanding and acceptance of all aspects of culture. In addition to ethnicity, consider also (to mention a few), age, gender, sexual orientation, gender identity, socio-economic status, refugee status, consumers (addictions and mental health), those in recovery, and offenders.

In summary, by increasing our own cultural fluency, we can work more congruently with our clients, thus turning a potential responsivity barrier into a positive and enhancing factor.

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Working with people in the Criminal Justice Sector:

Module Three: Skills of Engagement

About this Module

Purpose

This section explores the process of engaging with mandated clients.

Objectives

By the end of the section, participants are able to:

- Prepare themselves for working with mandated clients
- Understand the process of engagement
- Recognise and work with resistance

3.1 Introduction: Engagement

In this section, it is important to make a distinction between voluntary and mandated (involuntary) clients. The terminology ‘mandated’ and ‘involuntary’ clients can be used interchangeably. Voluntary clients are those who choose to enter treatment for a variety of reasons, but there is no legal, institutional, or other external pressure for them to be there. However, mandated clients are in treatment because they are required or feel obligated to attend, whether or not they are internally motivated to be there. ‘Working with Involuntary Clients’ by Chris Trotter (2006) is a very useful book for practice ideas for working with mandated clients.

Whether or not clients are entering a treatment process voluntarily, successful engagement with the client is essential for good retention and outcomes. There are a number of studies that demonstrate the influence on client outcomes from good engagement processes, and the quality of the counselling relationship or working alliance. Others found amongst other things, that positive expectations about the therapy influenced session attendance, and inherent in this, is the client’s positive perception regarding this:

Some research findings...

According to Dearing et al. (2005) the following all predict greater client satisfaction and better outcomes for AOD treatment:

- Positive expectations about therapy
- Greater session attendance
- Positive perception of the working alliance

This study looks specifically at how client engagement matches with treatment satisfaction and drinking-related outcomes following the treatment. The findings detail that when clients had a positive perception of the working alliance, this seemed to predict greater client satisfaction and more positive drinking-related outcomes. The result of this study does of course have significant implications for treatment and reading the detail of this research is recommended.

Please see reference section at the end of this module for a full reference to this article.

The Process of Engagement

An important point to remember is that engagement is an on-going process, not just something that happens at the beginning of a client-worker relationship. This is often taken for granted, but if for some reason the process of continuing engagement is lost, then the working relationship with the client may become compromised sometimes leading to disengagement and uncompleted treatment. This is particularly true with mandated clients, who may be more difficult to engage in the first place. This is where a skilled practitioner can make a real difference by eliciting and engaging the client's internal motivation. Continuing engagement is an essential part of a motivational approach which will be discussed later in this section.

There will be times when you will assess and work with clients who have been 'coerced' to attend treatment. They may not be willing to negotiate or to participate during sessions, and they might be reluctant to provide any information at all during the initial assessment. Clients who are involuntary may present as pre-contemplators, and the AOD practitioners may need to consider a range of methods for engaging the client.

As engagement occurs throughout the course of a client-worker relationship, and goes beyond the initial process of rapport building, we want to explore the important area of engagement further. Think first about the skills and processes of effective engagement. What do you think needs to be taken into account when engaging the client, and what can get in the way of effective engagement? In the spaces below write some of your own ideas about these things. Also try to consider the issues in particular for justice clients (some hints: consider the client's experiences of the justice process, lack of family support or involvement, and cultural considerations).

The Process of Engagement Exercise

Brainstorm

- What are the skills and processes of effective engagement?
- What do you need to take into account when engaging with clients?
- What gets in the way of effective engagement?

Skills and processes of effective engagement:

Engagement Considerations and Barriers:

As you look at the points you have written, ask yourself the following questions:

- What do you see as the main themes emerging?
- How important is it to value the culture of the client?
- Are there particular issues that are specific to engaging justice clients?
- What attitudes promote engagement?
- How useful is self disclosure in the process of engagement, and what are the limits of self-disclosure?

Below are some more research findings about client engagement. The study highlighted here (Wild et al, 2006) found that clients who were actually seeking treatment had internal motivation because of the perceived benefits from reducing AOD use (problem severity was a factor in this), reducing the guilt around continued use, and commitment to the goals of treatment. This motivation also enhanced both the client and therapist's interest in the process of collaborating in the treatment episode (engagement). Note that with already motivated clients, the process of drawing out their internal reasons for change and supporting self-efficacy will be important, as a means of enhancing momentum towards goals and maintenance of change. Results also suggested that the presence of legal referral (mandated), and/or social network pressures to quit, cut down and/or enter treatment, does not affect client engagement at treatment entry. This also suggests that using motivational skills to work with people who present at the pre-contemplation and contemplation stages of change, as well as good engagement skills have a useful role with mandated clients and won't be compromised by the fact that treatment is mandatory.

Some research findings (Wild et al, 2006)

- 300 clients seeking AOD treatment rated extent it was sought because of coercive social pressures(external motivation), guilt about use, and choice and commitment to treatment goals (internal motivation).
- Internal motivation predicted perceived benefits of reducing AOD, attempts to reduce, and self/therapist ratings of interest in the upcoming treatment episode.

The results of this study suggest that the presence of legal referral and/or social network pressures to quit, cut down, and/or enter treatment does not affect client engagement at treatment entry. It may be useful to access the full details of this study and the reference details can be found in the reference section at the end of this module

3.2 Understanding and Engaging with Mandated Clients

Most people accessing an AOD service are coerced into treatment by family, employers, and the courts. Research shows that even mandated people can do well in treatment and in fact in some studies, do better than voluntary clients.

What being involuntary means is that there may not be a motivation to change behaviour but there is a motivation to avoid some other negative consequence of non-attendance. What we now know is that if we can get people into treatment and apply sound motivational techniques we increase the likelihood of a person recognising their problems and wanting to do something about them.

It is important to understand that sometimes an involuntary client may not acknowledge they have a problem. The job of an AOD worker is to work to increase awareness and readiness to change. At times, a client may behave in ways that challenge the AOD worker. Most of these behaviours are simply an irritation; however, there will be times when clients may become threatening or abusive. They may become agitated or aggressive during their assessment or session but if a good engagement process is followed these are negligible and manageable.

It is important to acknowledge and recognise that not all clients will be responsive to questions. Adopting appropriate skills and techniques to successfully deal with this type of behaviour is important. Clients referred from a criminal justice context may be ambivalent about having to front up for AOD treatment.

So, what does ‘ambivalent or ambivalence’ mean?

Ambivalence can be defined as:

- Conflict of ideas or attitudes: the presence of two opposing ideas, attitudes, or emotions at the same time
- Uncertainty: a feeling of uncertainty about something due to a mental conflict

Ambivalence should be seen as the ‘usual’ rather than as an exception. This means that working with resistance is a ‘normal’ part of the engagement and treatment process with clients, not just justice clients.

Feeling two ways about something or someone is a common experience – feeling 100% clear about something that is important is probably more exceptional than normal.

This phenomenon of ambivalence is often prominent in psychological difficulties. A person suffering from agoraphobia, for example, may say, “I want to go out, but I’m terrified that I will lose control.” So, too, a person who is socially isolated, unhappy and depressed may express ambivalence: “I want to be with people and make closer friendship, but I don’t feel like an attractive or worthwhile person.” With certain problems, the part played by ambivalence is even more central. A person who is having an extramarital affair vacillates between spouse and lover in an intensely emotional ambivalence. A compulsive hand washer or checker may desperately want to avoid going through this disabling ritual time and time again, yet may feel driven to it by fear.

Such approach-avoidance conflict is a characteristic of addictive behaviours as well. People who are struggling with problem drinking, drug dependence, bulimia, or pathological gambling often recognise the risks, costs and harms involved with their behaviour. Yet for a variety of reasons they are also quite attached and attracted to the addictive behaviour. They want to drink (or smoke, or

purge, or gamble), and they don't want to. They want to change, and at the same time they don't want to change.

It is easy to misinterpret such ambivalent conflict as pathological – to conclude that there is something wrong with the person's motivation, judgement, knowledge base or mental state.

We [Miller & Rollnick] regard ambivalence to be a normal aspect of human nature; indeed, passing through ambivalence is a natural phase in the process of change. It is when people get stuck in ambivalence that problems can persist and intensify (2002).

Brief reflection:

Below are two continuums ranging from one to ten.

1 being 'not at all', and 10 being 'extremely'

Place an X on the line where you think you sit on each of the two continuums.

How important do you think it is to engage with clients in order to deal with change issues?

1.....10

How confident do you feel in working with clients referred from Corrections or the court?

1.....10

- How open are you to learning more about engagement with justice clients who may be resistant to change work?
- What would help you increase your confidence?
- What would it be like to have increased confidence – how do you think that would influence your work?

If you are working in services with clients you should be having clinical supervision, and that is a helpful and appropriate place to take concerns about lack of confidence in dealing with difficult or resistant clients. Collegial supervision (running things past colleagues) is another way of checking out concerns, or getting ideas to improve confidence.

When we feel compelled to do something, we feel resistant, and our resistance may manifest in various ways, but what sits behind resistance? Reflect on the thoughts, feelings and behaviour in the previous exercise:

- What does this tell you about resistance?
- When you think about mandated clients coming for treatment, what might be similar for them to your reactions of being forced to do something? What might be different?

It is important not to take resistance at face value. We may not know for some time what the client's resistance is about and, as we know, it is risky to make assumptions.

Clients may display resistance for a variety of reasons. Some challenging behaviours can include:

- Verbal aggression
- Intimidation or threats
- Self-harming behaviour (or threats to do so)
- Physical aggression and/or violence
- Passivity / withdrawal – superficial compliance
- Non-compliance or silence
- Changing the subject
- Helplessness
- Bragging about their drug use and behaviour
- Arguing
- Putting forward 'rational' arguments (e.g. 'yes, but...')
- Complaints
- Lying
- Consistently pushing the boundaries of the working relationship.

Clients, like all people, are complex creatures. Sometimes it is not obvious what lies behind presenting behaviour. There might be a number of possible reasons why a client presents in a resistant way – see the next diagram.

Possible Reasons for Resistance



Resistance

Resistance can be expressed in different ways. Four distinct types of resistance have been identified. As we find out about these different types of resistance, think of clients that you have worked with.

Types of Resistance

- Reluctant - Not fully committed
- Rebellious – Likes the behaviour or doesn't like being told what to do
- Resigned – Lacks confidence
- Rationalising – Any of the above; in their head, not their emotions

For the first two types in the boxes below (Reluctant and Rebellious), think of your answers to the following questions:

- Can you think of someone you've worked with who fits this typology?
- What do you think sits behind this type of resistance (bearing in mind the previous diagram about what sits behind resistance)?

An example of a person who may be reluctant and rebellious is someone who has problematic substance use and is still in the 'contemplation' stage of change who has had previous negative experiences in treatment, and does not believe a treatment programme can help him.

Reluctant & Rebellious

Reluctant

Reason for the resistance

- not fully committed to change

How the resistance is shown

- May fail to complete treatment tasks or only do so after persuasion
- Tasks may be sketchily completed
- Lack of energy and investment in the work
- It's like 'wading through treacle'

Rebellious

Reason for the resistance

- Heavy investment in the problem behaviour
- Does not want to stop
- Hate being told what to do and therefore resist the process rather than the content of treatment

How the resistance is shown

Fails to complete treatment tasks
Responds to attempts to persuade with argument and forceful resistance
Digging their heels in, arguments and "bad grace"

Now look at the next section (Resigned and Rationalising), and think of your answers to the same questions:

- Can you think of someone you've worked with who fits this typology?
- What do you think sits behind this type of resistance (bearing in mind the previous discussion about what sits behind resistance)?

An example of a person who is resigned and rationalising maybe someone who feels like s/he has brought shame on the whānau, and approaches a mainstream programme feeling misunderstood and depressed and like s/he doesn't deserve treatment.

Resigned & Rationalising

Resigned

Reason for the resistance

- Lacks the confidence in their ability to change
- May feel it is too late for them to change
- Doesn't fit the client culturally
- May have had repeated attempts at change that have met with failure

How the resistance is shown

- Lack of energy and investment in completing tasks
- There is a feeling of hopelessness

Rationalising

Reason for the resistance

- May be any of the previous reasons:
- Not fully committed
- Heavy investment
- Doesn't like being told what to do
- Lacking confidence

How the resistance is shown

- Provides reasons galore why a certain task is not relevant, necessary or useful
- Uses cognition rather than emotion to block therapeutic work

After looking at the two boxes above, try to imagine what statements these type of clients might make and what behaviours might be observed. You may wish to think of a client you have worked with and recall things they said and did. Record these in the spaces below:

Reluctant and Rebellious resistance – statements:

Behaviours:

Resigned and Rationalising resistance – statements:

Behaviours:

For the two different types of resistance shown above, this time we would like you to come up with something you think you should do when working with someone demonstrating each type of resistance, and something you shouldn't do. These are things you could do or say that might address the resistance in a positive way that may have worked in the past, or things you have observed others do, that have had positive outcomes. Things you shouldn't do may reflect things that you have observed in the past that have not been effective, or made things worse. Write some ideas in the spaces below:

Reluctant and Rebellious – should do: (e.g. using MI skills?)

Reluctant and Rebellious – shouldn't do:

Resigned and Rationalising – should do:

Resigned and Rationalising – shouldn't do: (e.g. getting into arguments/debates?)

After filling in the headings above, answer the following questions:

- How easy is it to recognise different types of resistance?
- What are the benefits of being able to recognise different types of resistance?
- In the past, have you fallen into the trap of doing one of the things that you identified as not to do?
- Can you recognise which type of resistance that you might find the most challenging to deal with?
- From this exercise, what are you left thinking about in terms of your practice, and if necessary, what resources do you have that could increase your skills and confidence?

Consider this ...

“Resistance is something that occurs only within the context of a relationship or system”

Remember, a relationship is a two-way street – a client may be resistant, but the other side of the story is what the practitioner does with that resistance.

Resistance – What sits behind it?

We have looked at a number of theoretical constructs of what resistance is and what sits behind it, what are some of the broader aspects that we need to consider when we notice that a client is resistant?

- Cultural
- Gender
- Shame
- Etc..

Resistance & Relationship

- Resistance does not occur in a vacuum – the client may experience or exhibit resistance, what then happens is strongly influenced by what you do as a worker, and not simply by what the client does.
- This means how you behave towards someone affects how they behave back to you .

Think about how often you hear clients being labelled resistant, particularly mandated or involuntary clients. It's often said in a pejorative way. The term 'resistance' seems to suggest that things are not going smoothly because of something one person (the client) is doing. It risks setting up an unhelpful dynamic in the practitioner-client relationship, with the client getting 'blamed' for the resistance when in fact it might be that the practitioner has poor engagement skills.

Resistance cannot occur in a vacuum. The client may certainly begin by expressing resistant behaviours, but once these behaviours are expressed, what happens to them is strongly influenced by what the practitioner does, and not simply by what the client does. Hence, how you behave towards someone affects how they behave back to you.

Style:

Often motivation is viewed more like a fixed client trait (particularly in the criminal justice field). Therefore if the client displays little motivation (often expressed as lots of resistance), the temptation is to attempt to break through the denial, rationalisations, cognitive distortions and excuses: for example “you’ve got a problem”, “you have to change” or “you’d better change or else.”

But think for a moment of a time when you had to do something that you didn't want to do. What kind of thoughts did you have about it? What were you feeling? What behaviour did you engage in? And... think about the effect on your relationship with the person involved. Perhaps you might be thinking - “who do you think you are to tell me what to do?” whilst feeling angry and resentful.

When you think about that relationship now, it can be tinged with suspicion. So how different are our clients? Not so very much!

A research study with problem drinkers (Miller and Rollnick, 2002) found that a directive-confrontational style produced twice the resistance, and only half as many 'positive' client behaviours, as did a supportive, client-centred approach. The researchers concluded that the more staff confronted, the more the clients drank at twelve-month follow up. Problems are compounded as a confrontational style not only pushes success away, but can make matters worse.

Research clearly demonstrates that a change in style can directly affect the level of client resistance, driving it upward or downward. This means that it is not fixed and that there is something you can do about it. It is obviously desirable to decrease client resistance because this pattern is associated with long term change.

Miller and Rollnick advocate a more relational view, in which client resistance behaviour is, at most, a signal of dissonance in the relationship.

Practise

We now want to bring together our thinking about resistance with our experience of engagement. Think about the type of resistance that you think would be the most challenging for you to deal with or that you've already experienced as challenging. You can have the opportunity to test out how to engage with this type of resistance in a short (3 – 4 minutes) skills practise if you are able to enlist the help of a colleague (or supervisor).

If you are able to set up a practise session, both you and your colleague can have a turn at playing AOD worker and client. The situation for the practise is a first meeting – at this point, the focus is on engagement and rapport building so it is not necessary to adhere strictly to agency procedure. The person playing the AOD worker needs to brief the person playing the client on the type of resistance that they would find the most challenging, so that they can practice managing this type of resistance. Ask the person playing the client to demonstrate the resistance, but not to the extent that it defeats the purpose of this being a learning experience for the person playing the AOD worker. So, no very difficult clients.

To debrief, ask the person who played the AOD worker in your scenario to identify something they did well first (very important) and then to notice one thing where they think they could do with more practise. The person playing the client can offer feedback from their experience, commenting on something they thought their partner did well, and one thing they could develop further. If you can use motivational interviewing skills with your colleague, the opportunity to learn from this experience will be useful for them too.

Now answer the following questions for yourself:

- What worked well?
- What was particularly challenging?
- What have you learnt that you can take back into your practice?

Reflective Practice:

Resistance is inevitable, as there is no such thing as a consistently perfect practitioner; so given this, what does this mean for your practice? As it's about relationship, it means that one of the things you need to do is take a good look at yourself. Reflective practice is a critical aspect of all client work, so here are some questions to begin the reflective thinking process in relation to resistance:

- What is my level of investment in the client making a change?
- How able am I to let the client make their own choices (even when I think the choice is less than wise)?
- What kind of resistance do I react to?
- What am I doing to influence the resistance?
- What is the resistance telling me about myself and about my client?

3.4 Skills of Engagement

Now that you have had a chance to work through some of the differences you may encounter with mandated clients and working with resistance, we will revisit some of the knowledge and skills around general skills of engagement, and attitudes to be aware of during engagement. There are a number of general counselling and therapy skills which can be revisited here, and also some things to be aware of from Rogerian style counselling, which will assist with client engagement, and the building of trust in the counsellor/client relationship? We should also be thinking about ethno-cultural considerations such as protocols, communication styles and values.

In regard to resistance, we have explored some of the issues around the nature and types of resistance we may encounter, but there are many aspects of that which can be defused by the attitude and approach of the counsellor. The building of trust is important, and will influence the quality of the relationship and the depth of work done in regard to meeting goals and other outcomes of the treatment episode. We are now going to revisit some of the basic skills of engagement, and also consider how our own, (and our client's) attitudes can get in the way of achieving engagement and trust, if we don't consider these aspects and make any changes necessary.

First Contact

The first contact that a worker has with a client is critical for establishing the nature of the ongoing relationship. The law of primacy states that the first impression or pieces of information which we get about a person will greatly influence how we react to them. If we get off to a difficult start with a client, it is often difficult to overcome this. Once we make our mind up about someone, it can be difficult to change our perception. This is true for both clients and workers. It's very difficult to 'unteach' a client if we get things wrong at the beginning.

The initial engagement with a client is therefore critical. Engagement does not just happen during the first part of forming a relationship, but occurs each time that you meet with that client. Also, remember, that in the context of justice clients, you are working with involuntary / mandated clients. We often take it for granted but attending to what we might consider the 'rituals of encounter' can effect the development of a therapeutic alliance. In fact with some Māori, these small things may lead into the use of Māori therapeutic paradigms that contribute to whānau ora.

The principles of Mihi mihi, karakia, whakawatea and whakamana ensure that the client is given a shared space to express themselves, a process that honours their mana but also allows challenge and guidance. To some degree these will be enacted every time there is a meeting.

(for further information see Lets Get Real and the Takarangi Competency Framework).

For some clients initial engagement may involve exploring the reasons they came and their expectations. This will be particularly important for those referred by the justice system or who are mandated clients. For others it might be an engagement process that includes families, whānau or referrers. Ongoing engagement is about development of a relationship with a person, not a diagnosis or a legal status.

What to cover in the initial meeting with a client to build engagement:

Build rapport with the client, using the skills of reflective listening and asking open ended questions. Show genuine interest in them as a person not just as a client. It can be very easy for us to take this process for granted, particularly the more experienced we are. Remember that this is the critical piece of our work to get right, as it influences everything that comes after it.

Find out from the client their understanding of why they are attending the meeting. Rather than the worker doing all the talking, it is useful to ask the client what their understanding is. Clarify or explain the purpose of the meeting – i.e. fill in the gaps in the client's understanding.

Find out the client's expectations of your time together, your role and their role. Again, asking the client their understanding rather than you doing all the talking. Clarify or explain your role and their role, including what is negotiable and what is not. Again, fill in the gaps from the clients'

understanding. Find out from them what they understand the bottom line is in terms of what is not negotiable, especially if there are any special conditions attached to their attendance.

The agency requirements of confidentiality should also be covered in a first meeting. Consideration should be given to having a 3-way meeting with the client and their probation officer at the initial meeting. At this time what information can and will be shared can be negotiated and agreed on. It also allows for clarification of roles and responsibilities.

Rogerian Therapy (Person-centred therapy)

Developed in the 1930s by the American psychologist Carl Rogers, client-centred therapy departed from the typically formal, detached role of the therapist emphasised in psychoanalysis and other forms of treatment. Rogers believed that therapy should take place in a supportive environment created by a close personal relationship between client and therapist. Rogers's introduction of the term 'client' rather than 'patient' expresses his rejection of the traditionally hierarchical relationship between therapist and client and his view of them as equals. In person-centred therapy, the client determines the general direction of therapy, while the therapist seeks to increase the client's insight and self-understanding through informal clarifying questions.

Self-actualisation, a term derived from the human potential movement, is an important concept underlying person-centred therapy. It refers to the tendency of all human beings to move forward, grow, and reach their fullest potential. When humans move toward 'self-actualisation' they are also pro-social; that is, they tend to be concerned for others and behave in honest, dependable, and constructive ways. The concept of self-actualisation focuses on human strengths rather than human deficiencies. According to Rogers, self-actualisation can be blocked by an unhealthy self-concept (negative or unrealistic attitudes about oneself).

Rogers adopted terms such as the 'person-centred approach' and 'way of being' and began to focus on personal growth and self-actualisation. He also pioneered the use of encounter groups, adapting the sensitivity training (T-group) methods developed by Kurt Lewin (1890-1947) and other researchers at the National Training Laboratories in the 1950s. While person-centred therapy is considered one of the major therapeutic approaches, Rogers's influence is felt in schools of therapy other than his own. The concepts and methods he developed are used in an eclectic fashion by many different types of counsellors and therapists.

Process:

Rogers believed that the most important factor in successful therapy was not the therapist's skill or training, but rather his or her attitude. Three interrelated attitudes on the part of the therapist are central to the success of person-centred therapy: congruence; unconditional positive regard; and

empathy. Congruence refers to the therapist's openness and genuineness—the willingness to relate to clients without hiding behind a professional facade.

Unconditional positive regard means that the therapist accepts the client totally for who he or she is without evaluating or censoring, and without disapproving of particular feelings, actions, or characteristics. The therapist communicates this attitude to the client by a willingness to listen without interrupting, judging, or giving advice. This attitude of positive regard creates a non-threatening context in which the client feels free to explore and share painful, hostile, defensive, or abnormal feelings without worrying about personal rejection by the therapist.

The third necessary component of a therapist's attitude is empathy ('accurate empathetic understanding'). The therapist tries to appreciate the client's situation from the client's point of view, showing an emotional understanding of and sensitivity to the client's feelings throughout the therapy session. A primary way of conveying this empathy is by active listening that shows careful and perceptive attention to what the client is saying. Person-centred practitioners employ a special method called reflection, which consists of paraphrasing and/or summarising what a client has just said. This technique shows that the therapist is listening carefully and accurately, and gives clients an added opportunity to examine their own thoughts and feelings as they hear them repeated by another person. Generally, clients respond by elaborating further on the thoughts they have just expressed.

According to Rogers, when these three attitudes (congruence, unconditional positive regard, and empathy) are conveyed the practitioner merely facilitates self-actualisation by providing a climate in which clients can freely engage in focused, in-depth self-exploration.

Normal results:

The expected results of person-centred therapy include improved self-esteem; trust in one's inner feelings and experiences as valuable sources of information for making decisions; increased ability to learn from (rather than repeating) mistakes; decreased defensiveness, guilt, and insecurity; more positive and comfortable relationships with others; an increased capacity to experience and express feelings at the moment they occur; and openness to new experiences and new ways of thinking about life.

Outcome studies of humanistic therapies in general and person-centred therapy in particular indicate that people who have been treated with these approaches maintain stable changes over extended periods of time; that they change substantially compared to untreated persons; and that the changes are roughly comparable to the changes in clients who have been treated by other types of therapy. Humanistic therapies appear to be particularly effective in clients with depression or relationship issues.

Person-centred therapy, however, appears to be slightly less effective than other forms of humanistic therapy in which therapists offer more advice to clients and suggest topics to explore.

Skills of Engagement (from Rogerian counselling)

- Therapist demonstrates understanding of the client's inner world (empathy).
- 'Accurate empathy' assists the client to feel the therapist's 'unconditional positive regard'.
- Demonstrated by 'active listening' – reflections (paraphrasing essence of what the client says) and summaries of client's statements, which shows counsellor is listening. When hearing their thoughts repeated, client can agree, correct, or feel reinforced by them.
- Therapist accepts client unconditionally; doesn't judge or disapprove of actions or behaviour. This does not mean that the therapist condones illegal offending behaviour but is able to separate the client from the behaviour and continue to offer an equitable service.
- Therapist is an understanding listener.
- Attitude of unconditional positive regard creates a non-threatening context.
- Client is free to explore and express difficult and painful feelings/actions without fear of rejection.

Although practitioners may consider themselves capable of developing a good client-centred relationship with almost anyone, there may be instances where even unconscious reactions to aspects of presenting client's issues or attitudes, a clash of values or beliefs, or even a clash of personalities can be picked up by clients, and vice-versa. It is helpful to reflect on this if engagement doesn't go well, and using resources such as supervision may help to defuse and resolve these issues. Some skills of engagement are shown below:

Skills of Engagement

- Are you fully 'present' to the client – are there distractions/barriers to this (time/preoccupation)
- Attending – ways to be present with client physically and psychologically ('open posture', eye contact, relaxed, leaning forward slightly – shows interest)
- Listening – capturing accurately the communications of clients – verbal, non-verbal, clear or vague
- Be aware of client's affect – underlying emotions that go with experiences, behaviours and expressed goals and achievement (and expressions of motivation)

These points relate to the way that the counsellor interacts with the client, both physically (including body language) and verbally (including content, as well as tone, rate, and volume), as well as the need to focus on the client, without having your thoughts or concerns 'somewhere else'. These points highlight the importance of being client-centred and having good attending and listening skills.

It is important also to be attuned to the client's emotion in the delivery of information and in goal-setting statements, as these alert the practitioner to the strength of motivation ('commitment talk'). A lot of the client-centred principles in Motivational Interviewing are based on the general approach of Rogerian therapy.

When the client is valued and accepted and the practitioner is open and genuine there is a basis for trust, and ability to take more risks in disclosure, as well as the building of self-esteem.

Engagement (from Rogerian Counselling)

- Relationship is person to person
- Most important factor for success is therapist attitude (unconditional positive regard)
- Client is regarded as having self worth and value regardless of feelings, issues or behaviour
- Respected and accepted as is, with all their potentialities
- Therapist is open, real and genuine – can self-disclose (appropriately), and doesn't hide behind professional façade

Potential barriers

- Over-familiarity.
- Gender/cultural issues.
- Large discrepancy between age/values.
- Emotive issues/problems, e.g. sexual abuse/violence.
- Client prior negative experience/attitude to counselling.
- Consider how your verbal and non-verbal messages come across to the client and vice-versa

Exercise In pairs (if possible)

- Referring to the principle of 'unconditional positive regard', discuss with your partner or supervisor how important this is in regard to building trust and being able to work with addictions, mental health or clients in the criminal justice system.
- Use your own experience or your work with clients as a resource for discussion.

Now you have finished this module you will be:

- better prepared for working with mandated clients
- able to understand the process of engagement
- be able to recognise and work with resistance

3.5 References and further reading:

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Working with People in the Criminal Justice Sector

Module Four: Ethics and Boundaries

About this module

Purpose

This section explores ethics and boundaries, with a focus on identifying and resolving ethical issues in a way that is consistent with both agency requirements as well as with the DAPAANZ professional code of ethics. This section explores some of the ethical issues that could arise for AOD workers when working with mandated clients.

Objectives

By the end of the section, participants are able to:

- Describe the meaning of ethics and boundaries in relation to their work
- Explore and resolve ethical and boundary issues utilising a method approved by their agency, such as supervision or an ethical decision making framework
- Understand a range of cultural perspectives on ethics
- Relate theory to practice through an exploration of typical ethical or boundary issues within their practice setting.

4.1 Ethics and Boundaries

Most ethical systems have their foundation in religion and philosophy. In Western civilization, that means the Judeo-Christian tradition and the teachings of ancient European philosophers.

Every profession has its own set of ethical guidelines specific to its practice and its place in society. There are ethical guidelines for doctors, nurses, social workers, lawyers, accountants, architects, fire and police officers, judges: every profession that involves work with other people in which the professional is greatly trusted.

Ethics are a code of behaviour that normally guides our actions at work. For some professions such as police, teachers or AOD workers, ethical guidelines may also affect how we act when we are not actually working. For example, others may see us in our work role, therefore expecting the same standards of us regardless of whether we are at work or not.

Is there a difference between ethics and boundaries?

In some codes of ethics, the differences between ethics and boundaries are spelled out very clearly and any behaviour contrary to those guidelines is considered an ethical violation. However, some boundaries will be up to you to decide.

While ethics provide us with a specific code that tells us exactly what our behaviour must be, boundaries are more general guidelines. Some of our boundaries will be based upon the expectations of our job, while others will be based upon our own personal values and choices.

This section explores ethics and boundaries in relation to working with clients who are or have been in the justice system. It is important to have a clear understanding of what these terms mean and how to identify and work through an ethical or boundary issue. Working with clients from the justice system is challenging with respect to ethics and boundaries for a number of reasons including:

- It is likely that some of the actions and choices made by the client will challenge the ethics and boundaries of the AOD worker.
- The focus of many treatment agencies is around personal empowerment, working with families and harm reduction, whilst the focus of the justice system is on keeping the community safe and the accountability of the individual offender.
- The principles of the DAPAANZ code of ethics that guide AOD workers and some of the expectations of the justice system can sometimes be in conflict around issues such as privacy, autonomy and treatment goals.
- There is a possibility that the treatment goals listed in the special conditions for a client mandated to treatment by the criminal justice system (e.g. abstinence) may be in conflict with the treatment goals recommended by you as an AOD worker (e.g. harm reduction strategies).

Read the scenario below (scenario one) and consider what the dilemmas might be for you if you were working with the client in this scenario. Consider how you might feel in this situation, what sorts of issues might come up for you, and how you might approach the situation.

Scenario 1

You are working with a single father in a treatment programme who is a disqualified driver. You know that he has three months of his sentence left to complete.

One of his special conditions is that he completes 300 hours of community work at the local Marae.

Yesterday when you were at the Marae for a meeting you saw him getting into his car with his daughter (who is three years old) and drive off without placing his daughter in a car seat.

- Do you bring this up in discussion with him?
- Do you have any responsibility to inform his probation officer?

Now read scenario two below, and consider the nature of the dilemma if you were working with a client in this situation. How might you feel, and what sorts of issues come up for you? How might you go about dealing with this situation?

Scenario 2

You are working with a client who tells you during a counselling session that they have committed a number of offences for which they haven't been charged.

The client is making good progress with their AOD issues and tells you that they wanted to get this off their chest. They don't want the Police to know but wanted to tell someone.

- What do you do with the information you have been given?

Some things that may have come up for you in regard to scenario 2

Within the boundaries of confidentiality what the client says normally remains within the session, unless there is a safety issue at which time confidentiality may need to be broken. In other words, if either the client or other persons are potentially at risk from their actions/intended actions, then professionally, we are required to take this information out of the session, to ensure safety. All clients should be notified that this provision exists during contracting/engagement with them. The client has said they just wanted to get it off their chest (a normal and helpful part of counselling), but they do not want authorities to know, and in effect are requesting your acceptance and silence on the matter. They do not want further punishment, but do want recovery, and the other offences may have been committed under the influence of alcohol/other drugs. If no-one is at risk, then it becomes purely an ethical issue.

You may be concerned that if you work with the client around further disclosure to others (a useful strategy) that the client will lose confidence and trust in you as a counsellor, therefore putting the counselling relationship at risk. Since the client has been making good progress, you may feel that bringing this issue up with them will undermine their recovery or put their continued treatment at risk. It is important to be open, up-front, and consistent discussing boundaries and limits of confidentiality at the very beginning of your working relationship and assuring them that you will

discuss any issues with them before taking any action.

Ethical Dilemmas

When faced with ethical dilemmas, it may be helpful to explore these issues with your professional supervisor or with experienced senior colleagues who can (confidentially) support you and assist you to work your way through the issues. It is important not to face these things in isolation; it is better to 'share' these types of dilemmas confidentially with your support networks, to avoid feeling conflicted and powerless, and to avoid stress and burnout.

As we progress in this section, we will explore these sorts of issues, to understand the ethical challenges inherent in working with offenders referred for treatment, and to work out what to do when our professional boundaries are challenged.

Before moving on in this section and before looking below, think about how to actually define ethics and boundaries. What do these words actually mean? What cultural differences around how ethics and boundaries are viewed should we be aware of?

Remember that as a counsellor or practitioner working with clients, we not only have to take into consideration what is right and just in the situation for the client, but also reflect our own set of values and ethics, and consider other organisations we are accountable to and the wider family, whānau and the community.

Now in the space below, quickly jot down some bullet points which describe what you understand to be a definition or description of what is meant by 'Ethics':

Now, do the same for "Boundaries":

There are a variety of definitions for ethics and boundaries, and a few are listed below:

Definition of Ethics

- A system of values, a set of rules or standards governing the conduct of the members of a profession
- The decisions, choices, and actions (behaviours) we make that reflect and enact our values
- The study of what we understand to be good and right behaviour and how people make those judgements
- A set of standards of conduct that guide decisions and actions based on duties derived from core values
- The discipline dealing with what is good and bad and with moral duty and obligation
- A set of moral principles or values.
- A theory or system of moral values; and/or a guiding philosophy.

Definition of Boundaries

- Rules that define the limits of professional behaviour, and the limits of what is appropriate in professional relationships.
- Limits which protect the space between the professional's power and the client's vulnerability.
- Boundaries are the limits that allow for safe connections between individuals.
- A boundary is the ability to know where you end and where another person begins
- Professional boundaries are important because they define the limits and responsibilities of the people with whom you interact in the workplace.
- Professional boundaries separate therapeutic behaviour of the AOD worker from any behaviour which, well intentioned or not, could lessen the benefit of treatment to clients, families and communities

4.2 Māori Ethical Perspectives

As mentioned earlier, there may be cultural differences in the way ethics and boundaries are viewed that we should be aware of.

The following information has been sourced from the work of Smith (2001) and Hudson (2005) who have considered Māori ethical frameworks in relation to research. Smith and Hudson's work provides a useful reminder for AOD workers that ethical perspectives are different across cultures and that some of the key tenants of western perspectives on ethics such as the rights of the individual are in direct conflict with key components of Māori perspectives on ethics which value relationship and community.

While respect is a universal principle with no prescribed method of practice, there are some key Māori concepts that can act as a guide for workers. There have been a small number of ethical frameworks developed specifically from a Māori perspective. Each framework seems to contain within it a similar set of values that informs practice and ethical processes.

Mātauranga Maori, tikanga Māori and ethics

Mātauranga Māori and tikanga Māori provide a framework to address ethical issues, either traditional or contemporary. Mātauranga Maori encompasses the indigenous knowledge and philosophies of Māori. Tikanga Māori reflects the cultural values and ethics of this group. As an indigenous form of ethics, tikanga Māori provides a culturally congruent framework for addressing ethical issues by aligning them with mātauranga Māori to situate the decision-making process within a Māori paradigm. This provides a necessary counter-balance to existing ethical deliberations, which often frame these discussions within pre-determined values and outcomes based on western constructs of knowledge and ethics.

Whānaungatanga

This concept refers to the building and maintaining of relationships. It can also be thought of as the process of establishing meaningful, reciprocal relationships establishing connectedness, engagement and commitment with other people.

Manaaki

This concept refers to being involved in activity that enhances the mana of others (te mana-a-kii). It promotes sharing, hosting and respect. This is one of the values that underpins a collaborative approach.

Aroha

Aroha is an empowering action that can manifest as compassion, healing, and respect. It can be passive or active and within context may mean making tough decisions.

Mahaki

Mahaki relates to being humble, having humility, empathy and compassion. This is about finding ways to share knowledge, to be generous with knowledge without being a 'show-off' or being arrogant. Sharing knowledge is about empowering a process.

Mana

Mana is a term that relates to power, dignity and respect. "Kaua e takahia te mana o te tangata – Do not trample on the mana or dignity of a person".

Titiro, whakarongo ... korero

"To look, and listen first, and then maybe start to speak". This value emphasises the importance of observing and listening in order to develop understandings and find a place from which to speak.

4.3 Pacific Peoples' Perspectives on Ethics

These definitions are drawn from a range of sources and are intended as a guide for the discussion on ethics rather than attempting to provide a comprehensive set of perspectives.

Individual vs. community perspectives

For Pacific peoples, the focus is on the collective or community rather than the person/individual. There is an inherent tension between western views on the rights of individuals vs. a number of cultural perspectives that value the collective or communal rights.

There is a tendency within western ethical discourse for individual rights to be given priority over the collective rights of communities. Maori and Pacific peoples would argue that communal right should take precedence over individual rights.

Universality

The concept of “universality” runs counter to the ideal of cultural diversity. A focus on universal principles may threaten fundamental freedoms with respect to cultural specifics. Universal perspectives on ethics can be seen as imposing standards from elsewhere on the activities of those in the Pacific.

There is potential that the focus on universal principles of ethics may lead to marginalisation of indigenous cultures.

Traditional knowledge

There are questions around whether “traditional knowledge” in relation to views on ethics should be put in the public domain. It raises the issue of whether this may contribute to losing protection of cultural knowledge.

The social context

There are powerful links between culture and ethics. Empowerment of communities is essential. Ethics has to be seen in a social context – what is right/wrong/fair/just are socially set.

Ethics is fundamentally about action, not intentions, guidelines or sets of rules. It is not just about words, it is about doing the ethical thing. Again, the right/just action has a social context.

The following is a summary of the considerations outlined above. When considering ethical dilemmas in the context of the individual client with respect to their culture, take into account all of the following:

Differences in Ethical Perspectives across Cultures

- Universality vs. cultural diversity
- Individual vs. collective or community perspectives
- Freedom of choice vs. collective responsibility
- Sacred vs. open knowledge
- The role of Christian values
- The place of Tikanga in providing an ethical framework around values such as Whānaungatanga, Manaakitanga, Aroha, Mahaki and Mana
- The importance of understanding what is going on for the client before offering advice; e.g.
 - * Titiro, Whakarongo then maybe ... Korero

Example:

You are a counsellor in an alcohol and other drug agency and you have booked in a client for assessment. The client is Māori and arrives with three members of his whānau and a Māori healer. The client has been referred by his probation officer who wishes to get feedback on the assessment. The client says that he wants to have the session hosted by you, but wishes the traditional healer to determine the treatment plan and does not wish any information disclosed to the probation service as there are issues of shame about the whānau that are private. He asks you not to write any notes and to respect his treatment needs, as he has tried mainstream before and it has not worked for him. This goes against agency protocols in procedure and against the request for information from the probation service.

Reflect on how you might approach this situation while respecting the needs of the client for both their treatment preferences and their cultural processes. You will have to balance your own needs in regard to assessment and procedures, as well as the expectations of the healer, the client and whānau, and the probation officer who referred the client.

Some suggestions for this situation are:

Before engaging in a pōwhiri process you might well consider whether you need to bring someone more versed in things Māori with you to the Hui (or get some advice). The pōwhiri process will assist in negotiating a safe space for discussion to take place and lead naturally into mihimhi, karakia (clearing the spiritual space) and then whakawhanaunga. Attention to these processes will help initiate engagement, build trust and allow you to discuss the needs of the various parties. The client is obviously engaged and wishes to make changes, so how do we make the most of this window of opportunity?

The discussion will also allow you to get some clarification as to the clients understanding of their problem and how the proposed solution fits. This will also give you a better appreciation of what sort of information or procedures need to be discussed/ negotiated with the whānau. It will also give you a chance to discuss how your skills and knowledge can complement what else is going on. Given the possible nature of the healing being considered, is your office in the here and now the best place? If another Hui is rescheduled, this might give you time to seek advice and assistance.

At the end of the Hui it is important that transition process from the Hui is initiated so mihi whakamutunga and karakia can occur. These mark the end of the transaction but also allow a cleansing so that all parties are freed up to move back into secular 'real-time'.

4.4 Responding to Ethical Statements: an exercise

This exercise is designed to warm you up to start thinking about ethical issues and what it means to behave in a consistent, professional manner. We do not always know in advance when it will be necessary to make ethical decisions. While ethical dilemmas can be unpredictable, what is predictable is that we will be required to make ethical decisions. To get you thinking about ethical issues and how to respond to them, we are going to do an exercise called 'Responding to Ethical Statements'. Following are a number of ethical dilemmas you might encounter as an AOD worker. Within a five-second period, you need to make a decision about whether you agree or disagree with the statement, or if you don't know. Rather than a test, this exercise is designed to get you thinking and summing up potential ethical dilemmas quickly.

Read the following statements and if you agree, tick the statement and if not, put an x beside it. If you are undecided, put a question mark (?) beside it. These should be responded to quickly (within 5 seconds), and at the end check your markings and take a little time and consider your decisions:

- I can tell a client my views on the police or the probation service if they ask me.
- I can lend money to a client who is on a programme I am facilitating.
- I can sell my second-hand car to the client I am working with.
- I can get my client to sign a form giving me permission to use information we hold on them for the purpose of teaching my colleagues.
- I can contact psychological emergency services if I have concerns for the welfare of my client.
- I ran a programme that a client graduated from three months ago; I can now have a sexual relationship with them.
- I can accept a gift of food from a client who has been out gathering kai moana.
- I can accept a gift of food from a client who has been out gathering kai moana who is at risk of being put out of the programme for failing to attend.
- I can have a drink in the pub with a client who was referred from Corrections.
- It's okay to have a drink in the pub with a client who is whānau.
- I can swear with a client if they swear.
- I can tell a client about my personal life such as whether I have been in trouble with the law.
- I can offer a client physical comfort, e.g. put my arm around them, if they are distressed.
- I should always report a disclosure of any offence by the justice client to the probation officer.
- I can use the case note history of a client who used to be on my case load in a paper I am writing for university.
- If I know my client is struggling I can buy groceries for them.
- I can tell an offender I smoked dope in the past when they ask me if I smoke dope.

These statements are all examples of situations where our professional boundaries could be challenged, and we would be required to make an ethical decision or response.

How did you go?

Which situations in particular were challenging?

What issues has this raised?

What do you need to know more about?

What sort of framework or decision-making process did you use?

What personal, social and cultural aspects did you consider?

Were these decisions based on what is best for the client personally, the ‘institutions’ requirements and community expectations, your own standards, or all of these?

How many (if any) did you feel undecided about and how would you go about resolving these dilemmas if they did arise?

Who could you discuss these dilemmas with?

4.5 An Ethical Decision Making Framework

You were asked to think about how you would respond to the ethical dilemmas we've already explored in the last section. As we discovered during the exercise, this isn't always straightforward. There are a number of ways to work through ethical dilemmas including: seeking advice from colleagues, taking the ethical or boundary issue to supervision, referring to codes of ethics and using an ethical decision making framework.

Consider in your workplace, what methods are used in working through ethical and boundary issues. Below is a step by step framework for an ethical decision making process:

An ethical decision making framework

Define:

What is the ethical boundary or issue (s)? What are the key facts of the situation? Who is involved? What are their rights and duties and your rights and duties?

Explore:

What ethical principles have a bearing on the situation? Which principle or principles should be given priority in making a decision? Who do you need to discuss this with before making a decision?

Options:

What options are available to you in the situation? What alternative courses of action exist? What help, means and methods do you need to use?

Impact:

Explore the impact of each option: given each available option what consequences are likely to follow from each course of action open to you? Which is the most ethical thing to do?

Decide:

Having chosen the best available option, determine a specific action plan, set clear objectives and then act decisively and effectively.

In addition, three key steps are considered as fundamental to choosing alternative courses of action that reflect moral reasoning:

- **Separate questions of fact from questions of values**
- **Identify both clients' and workers' values systems**
- **Consider ethical principles and concepts**

There are times when it is not easy or it may not be helpful to make an immediate decision, and you would like more time to think about the issues, or you may wish to discuss it with your supervisor, manager, or senior colleagues (confidentially). At these times it is best to be open with the client and say that you need more time to reflect on the situation, so that you can assist them in achieving the best and safest outcome rather than making a hasty decision. It is also good to mention that clinical supervision (which maintains their confidentiality under the Privacy Act), is a resource for all practitioners, which enables the counsellor to discuss issues like this, so you can act in the best interests of the client and others to maintain safe practice. You can then arrange a further appointment to resolve the issues.

4.6 Exploring Ethical Dilemmas

You are now going to work through a number of ethical scenarios (Case Studies) which are detailed below, using the framework in the previous section as a guide.

In the first instance, for each case study, consider the following and write the answers on a separate piece of paper to help guide your thinking:

- What are the ethical issues?
- What ethical principles have a bearing on the situation?
- Who do you need to discuss this with?
- What options are available to you?
- What are some of the impacts relating to each of the options available to you?
- What is your decision and plan?

Now, take time to read through each scenario and answer the questions that follow each one:

1. Mandatory treatment strategies can run contrary to recent developments in problematic substance use treatment, including harm reduction approaches. Harm reduction is founded on the notion of offering participants choices and options for their treatment, while recognising that many individuals with 'problematic substance use' may not be willing or able to stop using drugs. In such cases, it is important to "meet them where they are" in order to gradually reduce high-risk and harmful behaviours.

How would you respond?

3. An ethical issue for treatment providers involved in mandatory or involuntary treatment may involve potential breaches of client confidentiality when legal and court-appointed case management authorities enter into the treatment process. The DAPAANZ Code has a standard around confidentiality and privacy where confidentiality signifies loyalty towards a client and his/her family/ whānau when entrusted with information that should normally remain private.

How would you manage this issue if a justice client discloses information about an offence that they have committed or are planning to commit?

4. Judy, aged 20, is an AOD Justice client referred for mandatory treatment, who you learn from initial sessions, has a history of being abused. She tells you her use of drugs is a way to dull the memories of abuse, but also says she doesn't want anyone to know about the abuse, because it was a close relative and no-one knows.

At the third session, Judy has turned up clearly high on drugs, and discloses that she was going well until she accidentally came across the family member who abused her at a family gathering. She says she flipped out and bought some drugs to switch off the horrible thoughts that wouldn't go away. She promises that it won't happen again, that she has turned up and wants to put it behind her. The protocol with her probation officer is that if she is using drugs, they are to be notified, as it is a condition of her sentence to be drug and alcohol free. You reschedule her session, then consider what to do about notification.

What are the ethical issues in this situation?

How do you respond?

4.7 Codes of Ethics

Codes of ethics provide structures by which ethical principles and core values for professional practice can be defined.

AOD workers must often comply with a range of ethical codes and standards. For those registered with one or more professional bodies, compliance with all will be required and may include:

- The DAPAANZ Code of Ethics
- The Practitioner Competencies for Alcohol and Drug Workers in Aotearoa-New Zealand
- Competencies for Pacific Alcohol and Drug Workers Working with Pacific Clients in Aotearoa-New Zealand.

Many of the same ethical requirements will be canvassed in the various codes of those working within the health practitioner environment.

For DAPAANZ, there are three overarching frameworks for its core principles.

These are:

- Self responsibility for own ethical practice and ongoing competence
- Primary responsibility is to clients and community
- Professional practice within organisations – the practitioner has a major role in implementing standards, management and accessing and participating in research and education.

Ethical issues to consider when working with AOD clients mandated by the justice system

Several issues may appear to conflict with AOD practitioners' roles when working with AOD clients who have a history of offending. These clients who have a history of offending are mandated to receive treatment and remain clients of both settings. Issues arise as to the perception of 'treatment as punishment', client centeredness verses directed treatment as well as the weighty issue of confidentiality and obligations to inform justice sector workers when breaches occur.

Mandation vs. client centeredness

Although there is a therapeutic issue to be addressed for justice clients who have been mandated to attend treatment, there are a number of potential ethical issues to consider in relation to the DAPAANZ Codes of practice as well.

Clients are mandated to attend treatment and it is possible to perceive this as placing the client's care as being secondary to the safety and wellbeing of the community even though the purpose of the care is to improve public safety and wellbeing i.e. treatment contributing to reduction in reoffending. The DAPAANZ Code states in Principle 1 that the practitioner must show respect and dignity for others and should avoid dual or multiple relationships, and other conflicts of interest, where possible. In principle 5, the DAPAANZ Code states that clients should normally be allowed to choose their own treatment. The issue of compulsory treatment can be considered ethically sound where the goal of 'recovery' is both an AOD and justice sector goal and if the client is treated with the utmost respect.

Confidentiality vs. the expectation to inform a Probation officer of any breaches

An important principle (DAPAANZ Principle 4) for AOD practitioners is to respect the confidentiality of clients, with the Health Information Privacy Code (1994) also placing high standards on practitioners to maintain this confidentiality with clients. As a clinical issue confidentiality is an important initial issue when attempting to gain the confidence of clients. However, under the Health Information Privacy Code (1994), rule 11 (limits on disclosure of health information) a practitioner does not have to maintain confidentiality (i) "to avoid prejudice to the maintenance of the law by any public sector agency, including the prevention, detection, investigation, prosecution and punishment of offences; or (ii) "for the conduct of proceedings before any court or tribunal (being proceedings that have been commenced or are reasonably in contemplation)".

As an ethical issue DAPAANZ requires that practitioners be aware of relevant legislation and provide informed consent regarding confidentiality (Principle 4).

The expectation of the Department of Corrections is that it is informed promptly when non-attendance occurs, and seeks reports as to client's progress. Under s22C of the Health Act 1956 the Health Information Privacy Code³ is relegated in favour of the Health Act which states:

"1) Any person/agency providing services may disclose health information (if required by law... 2) Any probation officer within the meaning of the Criminal Justice Act 1985, for the purpose of exercising or performing any of that person's powers, duties, or functions under any enactment"

Therefore permission to disclose health information is possible without the consent of the client, but it is not compulsory for the AOD practitioner to disclose this information.

Part of the initial engagement with the client and their probation officer must be clarity about roles

and responsibilities and agreement about the types of information shared (purpose, parameters etc). as well as establishing protocols for disclosure.

4.8 References

Drug and Alcohol Practitioners Association Aotearoa New Zealand (DAPAANZ) (2005). Code of Ethics [online] www.dapaanz.org.nz

Hudson, M (2005). Tapahia te ihu poaka: matauranga Māori, tikanga Māori and ethics. Indigenous Knowledge Conference Presentation. Victoria University.

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Working with People in the Criminal Justice Sector

Module Five: Justice Context

Part One: Introduction to the justice Context

Purpose

This section introduces the systems and processes that operate in the justice system for clients who may be referred for AOD treatment as part of sentence management.

Objectives

By the end of the section, participants have:

- An overview and understanding of court processes.
- An understanding of the care and control contexts of working with justice clients.
- An understanding of the post-sentence tasks for the probation officer.
- Be able to reflect on their own attitudes to the justice system.

Part Two: Introduction to Assessment within the justice Context

Purpose

This section explores the process of assessment and case planning for justice clients with AOD issues.

Objectives

By the end of this section participants are able to:

- Understand the focus of assessment from a justice perspective.
- Understand assessment in relation to risk of reoffending, rehabilitative needs, and responsivity.
- Develop an understanding of the role and tasks of a probation officer in relation to assessing AOD issues.
- Understand the links between risk, need and responsivity in relation to assessment and case planning.

Part 1: Introduction to the justice Context

As a starting point, we will obtain an overview of the justice process in order to understand the pathway that clients have taken to get to us, as well as who is involved in that pathway. We are particularly interested in the probation officer role and our work with clients referred to AOD treatment as part of their sentence conditions.

Before we start, reflect on the following:

What do you know already about the criminal justice process, and in particular what do you know about an offender's experience from the time of their arrest to their conviction and sentence?

5.1.1 Criminal Justice Process - Courts

New Zealand Courts

Courts resolve disputes between the state and individuals or between individuals through either the criminal or civil justice systems. The court process is basically a judicial decision-making process where Judges consider the evidence on all sides of each case, interpret the law as it applies to that evidence and determine judgements. Judges make decisions by interpreting the laws passed by Parliament.

The courts conduct more than 1,600 criminal trials a year and hear more than 1,000 substantive civil cases between individuals or between individuals and the Government (www.courtsofnz.govt.nz). The majority (95%) of all criminal trials, including jury trials on all but the most serious matters, are heard in the District Court.

Within the District Court jurisdiction are offences ranging from very serious offending such as rape, aggravated robbery, and sexual violation, to minor offences such as disorderly behaviour. The only charges that cannot be heard by the District Court are murder, manslaughter and Class A drug offences, and a small number of other very serious crimes.

The Court Process

The justice system is a complex and dynamic system. A case can progress through the Court system in a number of ways.

Criminal cases begin when the Police or other prosecuting authority file an 'information' with the Court. An 'information' is the formal method of accusing someone with breaking the law, and is often called a summons. The person accused of breaking the law is referred to as the defendant.

The defendant is then summonsed to the court and if the charge is denied, and a plea of not guilty entered, the case is adjourned (put off) for the Judge to hear the evidence against the person. If the

defendant pleads guilty or the charge against the defendant is later proved beyond reasonable doubt, a conviction usually follows, and the Judge then sentences the defendant.

The hearing of less serious charges (called summary offences) can be conducted by a Judge alone, while more serious charges (called indictable offences) are heard before a Judge and jury. If a defendant is charged with an offence that carries a penalty of three months or more imprisonment, the defendant can usually elect trial by jury.

All criminal cases will be initiated in the District Court; in other words, this is where the information is laid. Depending on what the offence is (seriousness) and how it is laid (summarily or indictable) will determine whether the case will be heard entirely in the District Court or, for more serious charges, referred to the High Court for hearing or sentence.

5.1.2 Criminal Justice Process - Sentencing

The Purpose of Sentencing

Sentencing Options

The Department of Corrections managed 67,684 new sentences and orders during 2006/07: 22,268 prison-based and 45,416 community-based. Community work and supervision make up the bulk of new community-based sentences with much of the rest being community-based orders for offenders released from prison.

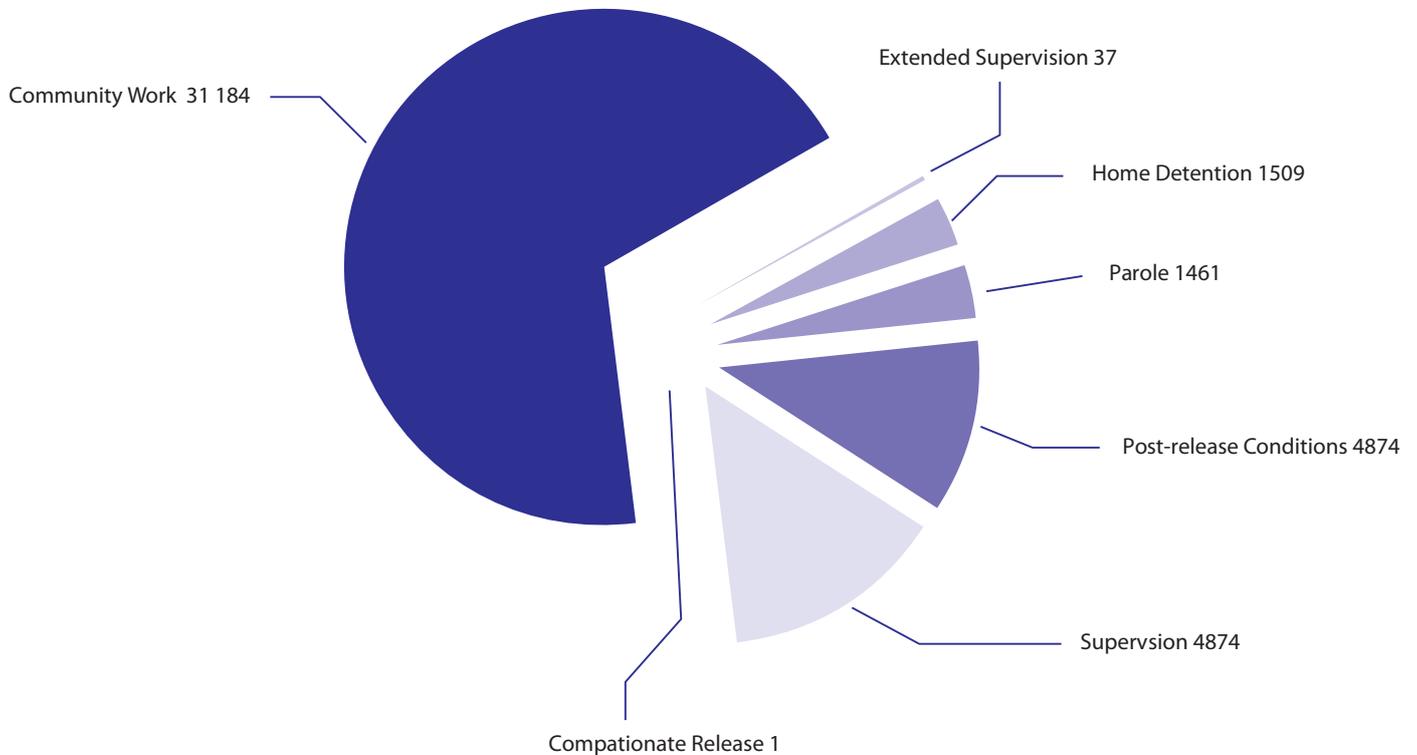
Imposing sentences is one of the most exacting tasks undertaken by Judges. A sentence must reflect a number of considerations, some of which may be in conflict. The most important considerations are:

- the seriousness of the offending.
- the interests of the victim.
- consistency with sentences imposed for similar offending.
- the personal circumstances of the offender.

The Sentencing Act 2002 outlines a number of purposes for sentencing (Section 7 Sentencing Act, 2002). A sentence may be imposed for any one, or any combination of two or more of the following purposes:

- To hold the offender accountable for harm done to the victim and the community.
- To promote in the offender a sense of responsibility for, and acknowledgment of, that harm.
- To provide for the interests of the victim of the offence.
- To provide reparation for harm done by the offending.
- To denounce the conduct in which the offender was involved.
- To deter the offender or other persons from committing the same or similar offence.

- To protect the community from the offender.
- To assist in the offender’s rehabilitation and re-integration into the community.



Imprisonment

Imprisonment of offenders is the most serious sentence or order available to the courts. The sentencing laws, the sentencing Judge, and the Parole Board determine release from prison.

Community based sentences

New community-based sentences were implemented in October 2007 as part of the Effective Interventions strategy. The new sentences provide the judiciary with a broader range of sentencing options as alternatives to prison sentences.

All sentences have standard conditions imposed, such as reporting to a probation officer, and some may have special conditions imposed, such as attendance at a treatment programme.

Home Detention

Home Detention (HD) is a community-based order where offenders serve their sentence at home under electronic monitoring managed by a probation officer. It is the second most severe sentence after imprisonment.

HD sentences may range in length from 14 days to 12 months. Offenders on HD must wear an electronic anklet to monitor their whereabouts at all times. If they try to remove the anklet or leave the monitored property without permission an alarm is triggered and a security guard is sent to the address.

The sentence can help offenders to maintain family relationships, keep working or actively seek work, attend training or rehabilitative programmes. Offenders can apply for approved absences such as for rehabilitation, study or health care. These absences are monitored.

Community Detention

Community detention (CD) is a sentence targeted at offenders whose likelihood of re-offending could be reduced by restricting their movements at particular times, and those whose punishment by means of a partial restriction of liberty is considered appropriate.

CD requires the offender to comply with an electronically-monitored curfew imposed by the court. Offenders can be sentenced to CD for up to six months. Curfews can total up to 84 hours per week. This sentence cannot be imposed without the consent of the offender. The judge must be satisfied that the offender and the proposed curfew address are suitable for CD before imposing it

The minimum curfew period is two hours. Offenders on CD are required to wear an electronic anklet during their sentence. This will monitor their whereabouts during their curfew periods and any tampering or interference with the monitoring equipment.

Intensive Supervision

Intensive supervision is a sentence that requires the offender to comply with a range of standard and special conditions imposed by the court.

It is targeted at offenders convicted of serious offences, with severe and/or complex rehabilitative needs and a high risk of re-offending. Offenders can be sentenced to intensive supervision for between six months and two years.

Supervision

Supervision is a rehabilitative community-based sentence lasting between six months and two years requiring offenders to address the causes of their criminal behaviour under the supervision of a probation officer.

A sentence of supervision may be imposed only if the court is satisfied that the sentence would reduce the likelihood of further offending by the offender through the rehabilitation and reintegration of the offender.

Supervision is targeted at offenders who require only one or two community-based programmes/ services and limited oversight by the probation officer.

Extended Supervision

An Extended Supervision order imposes parole-like conditions on higher-risk child-sex offenders for up to 10 years after their release from prison.

Although child-sex offenders have much lower rates of re-offending than other kinds of offenders, their risk of re-offending continues for several years after release. Extended supervision orders are used to impose conditions on child-sex offenders for longer than otherwise possible.

Community Work

Community work is a sentence requiring offenders to do unpaid work for non-profit organisations and community projects. Offenders can be sentenced by courts to between 40 and 400 hours of community work for an offence punishable by imprisonment or specifically punishable by a community-based sentence.

Community work can be done anywhere in the community from parks and reserves to schools, marae, and churches. It can involve painting, gardening, building, graffiti cleaning, restoration, recycling, and more.

While serving community work sentences, offenders work:

- Up to 10 hours a day.
- Preferably at least eight hours a week.
- In teams supervised by a community work supervisor, or
- Individually in an agency placement monitored by the agency, or a combination of both.

Offenders who are sentenced to community work for 80 hours or more and who have basic work and living skills needs may be eligible to convert up to 20 percent of their community work hours into

training to address those needs. Basic Work and Living Skills (BWLS) training can only be an option if the court has authorised to do so.

Community work was introduced by the Sentencing Act 2002 and replaced the sentences of periodic detention and community service. The terms 'periodic detention' and 'community service' are no longer used.

Parole

The Parole Act 2002 allows offenders serving prison sentences of more than two years to be considered by the New Zealand Parole Board (NZPB) for release into the community, under the supervision of a probation officer, before their sentence ends. Probation officers manage offenders on parole to ensure they comply with conditions and stay motivated to avoid re-offending. All offenders serving determinate (fixed term) sentences of more than two years are eligible for consideration for parole after serving one-third of their sentence, unless the court has imposed a minimum non-parole period.

Release on parole is not automatic. The NZPB considers offenders who are eligible for parole at hearings and decides at what point in their sentence they will be released.

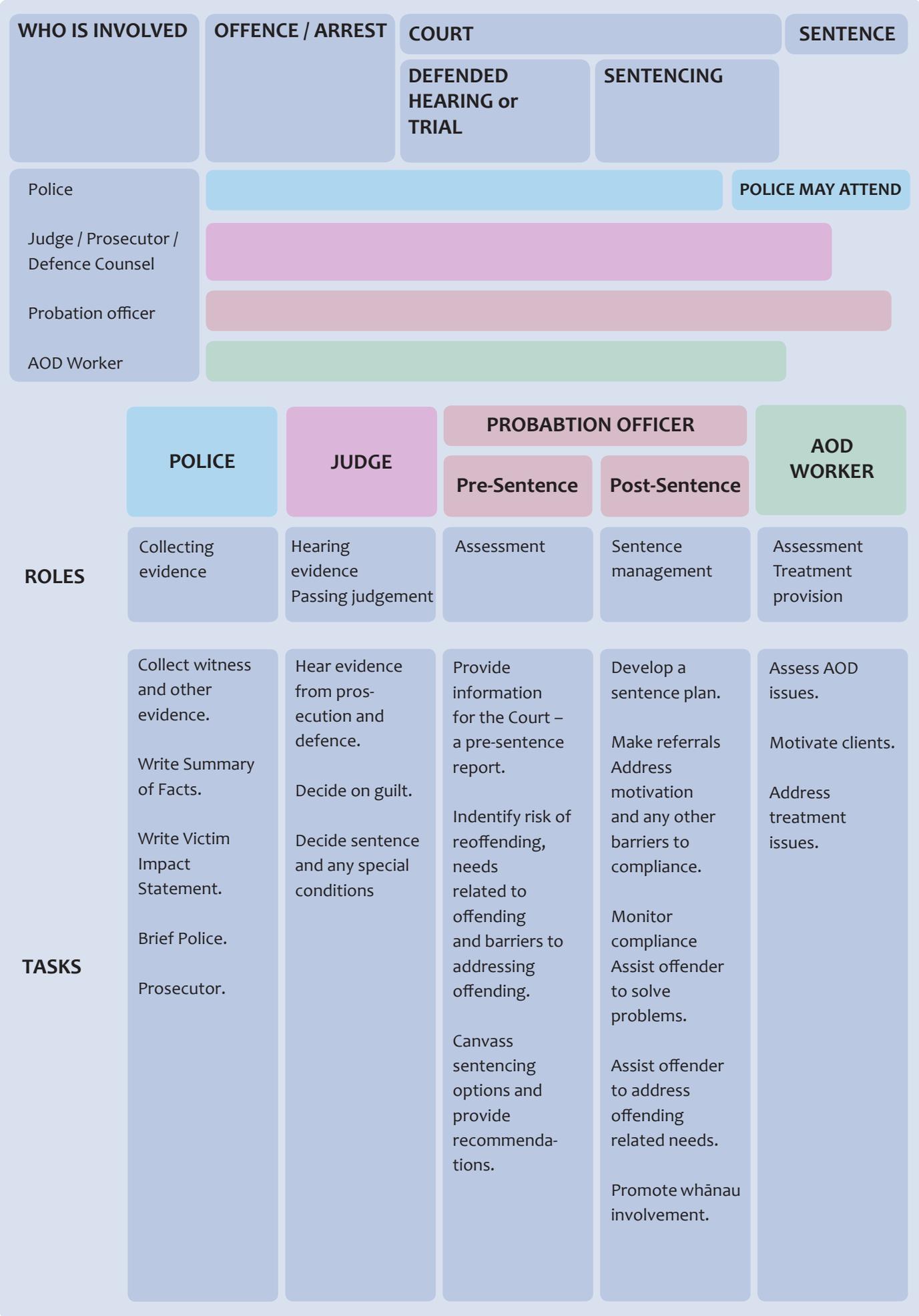
Pre-Sentence Reports

In order to assist the Judge to make appropriate sentencing decisions, probation officers are called upon to deliver reports. A probation officer may be requested to deliver one of four different types of report. The briefest of these is an oral report, followed by a short report (done on the same day as sentencing). A full report and a full report with appendix are produced after a more in-depth assessment and the offender would be remanded in custody in order for the probation officer to complete the report.

The type of report required by the Judge is determined by the risk of the offender, which includes the seriousness of the current offence; any previous offending and, the length of any previous offending and its seriousness; and the perceived complexity of issues facing the offender. The likely sentencing option will also determine the type of report required.

This table on the next page summarises the types of information/reports probation officers may be required to deliver to the court.

Type of information provided	Purpose
<p>Front of court services</p> <ul style="list-style-type: none"> Includes on-strength information, and advice about sentencing options. 	<p>To provide immediate advice and information to the Court.</p>
Provided in court, on request.	
<p>Oral reports</p> <ul style="list-style-type: none"> Very brief additional information, collected via a very short discussion with the offender at court. Average of 20 minutes allowed for preparation of report. 	<p>To provide rapid additional information to the Court to enable same day sentencing or decision to re-mand for a further report.</p>
<p>Short reports</p> <ul style="list-style-type: none"> Includes a short interview and some investigation. Average of two hours allowed for completion of a short report. 	<ul style="list-style-type: none"> To provide more information about the offender's circumstances, on the same day. Allows for same day sentencing to Community Work, Supervision, or cumulative sentences of Community Detention or Home Detention.
<p>Full reports</p> <ul style="list-style-type: none"> Includes a detailed assessment of the offender's circumstances, needs, and approach to addressing their offending. Average of six and a half hours allowed for completion of a full report (no appendix). 	<ul style="list-style-type: none"> To provide detailed information about the offender. Allows for sentencing to any sentence, except the electronically-monitored sentences (Community Detention and Home Detention) which require an additional appendix.
<p>Full reports with appendix</p> <ul style="list-style-type: none"> In addition to the full report, the appendix considers all the issues relating to the possibility of an electronically-monitored sentence. Average of nine and a half hours allowed for completion of a full report with an appendix. 	<ul style="list-style-type: none"> To provide all the information required if a sentence of Community Detention or Home Detention is to be imposed. Includes evidence of the informed consent of relevant occupants, suitability of the proposed address etc.



Exercise

The criminal justice system can be a complex process. An offender can take a number of pathways through the process.

We are going to use two examples (below) to demonstrate the criminal justice process; one where the conviction is likely to lead to a community based sentence and the other to a term of imprisonment.

We will walk through the process from the offender's point of view and as we do, ask yourself the following:

- **What happens at each point?**
- **Who is involved at each point? (refer to table above)**
- **What do they do at each point? Pay particular attention to the role of the probation officer at the pre-sentence step, drawing out assessment of risk and needs related to offending which assists the Judge to make decisions regarding appropriate sentencing. (The role of the probation officer post-sentence is covered in the next section of this module).**

Example 1: Karen

Offences – possession of cannabis and dangerous driving.

Map of the process:

Offence/Arrest > Information laid summarily (plead not guilty) > Remanded on bail (unless there are serious concerns, the offender would likely be remanded on bail) > Status Hearing > Defended Hearing (if the offender pleads not guilty) > Conviction > Sentencing.

In our example, the sentence is a concurrent one of supervision and 100 hours community work. They have a special condition to attend AOD treatment. Reporting to a probation officer within 72 hours of sentencing is standard practice. A probation officer would then be responsible for inducting the offender into their sentence and creating a sentence plan to cover their sentence.

> Report to probation officer > Induct offender into sentences > Sentence Plan > Referral to AOD treatment.

Example 2: John

Offences – dealing in Class C drugs, resisting arrest.

Map out process:

Offence/Arrest > Information laid summarily (plead not guilty) > Remanded in custody > Preliminary Hearing > Trial by Jury > Conviction > Sentencing

These offences would be laid summarily, but because they carry a penalty of more than three months imprisonment, the offender can elect trial by jury (rather than a defended hearing). In our example the offender elects trial by jury and is remanded in custody. In our example, there is enough evidence so the case goes to trial and the defendant is found guilty.

Sentencing is the next step, and the defendant (John) is sentenced to a term of 2 years imprisonment. John would be received into prison, assessed (in the Assessment Unit) and a sentence plan developed. He is eligible for release on parole after serving one third of his sentence.

In our example, John is released on parole after eight months, with standard conditions and a special condition to attend AOD treatment. Reporting to a probation officer within 72 hours of sentencing is standard practice. A probation officer would then be responsible for inducting the offender into their sentence and creating a sentence plan to cover their sentence.

> Imprisonment > Received > Assessed > Sentence Plan > Parole Board Hearing > Release > Report to probation officer > Induct offender into sentence > Sentence Plan > Referral to AOD treatment.

Questions

Based on the above examples, consider the following questions by coming up with at least two points that each of the questions raises for you.

Remember that the clients' experience of the criminal justice system affects their level of motivation to engage in treatment post-sentence, which in turn influences the engagement processes for the AOD worker.

1. What impacts might a time delay between being charged with an offence, going to court and the post-sentence requirements have on:

The client?

You (the AOD practitioner)?

2. What additional issues might a client who has been in prison bring to:

Treatment?

To their relationship with you (the AOD practitioner)?

3. What issues might you need to work through with a client who potentially sees you (the AOD practitioner) as ‘just another player’ in the criminal justice system? How might this affect your engagement with him or her?

4. If a client entered a plea of not guilty but was convicted and sentenced to mandatory treatment, how might this affect their attitude to treatment? What additional challenge does this present for you as the AOD practitioner?

5. With clients referred from justice, how might their views on the criminal justice system impact on treatment? How might this impact on you (the AOD practitioner)?

6. What are some of the differences for you (the AOD worker) and the client if the client was sentenced to a community based sentence rather than a prison sentence?

5.1.3 Post-Sentence

Sentence Management

Most sentences/orders are managed in Community Probation and Psychological Services (CPPS) according to what is known as sentence management phases. Each of the three phases requires a different level of reporting by the offender and monitoring by the probation officer. Specific activities must be completed within each phase. Progression through the phases is not automatic, but is dependent on the offender's compliance with, and response to, the requirements of the sentence.

Activities of each phase

The following table outlines the specific activities that are to be completed within each phase. The timeframes specified for each phase are the minimum length of time an offender may be managed within the phase. Compliance with all conditions of the sentence/order is required throughout phase I (not just when the offender progresses to the 'establishing compliance' phase).

Phase	Timing	Minimum Length	Specific Activities
I	Month 1	4 weeks	<p>Setting up the sentence:</p> <ul style="list-style-type: none">• Induction• Installation of any electronic monitoring equipment (if applicable)• First home visit• Sentence planning• Completing initial/urgent referrals
II	Months 2 & 3	9 weeks	<p>Establishing compliance with the sentence:</p> <ul style="list-style-type: none">• Any further assessment• Second home visit (if required)• Establish pattern of routine reporting in accordance with phase II frequencies• Commence any direct interventions• First sentence plan review

Activities of each phase continued

Phase	Timing	Minimum Length	Specific Activities
III	Remainder of sentence	As required	<p>On-going management of the sentence:</p> <ul style="list-style-type: none">• Additional programme referral(s)• Monitor/maintain compliance with programme requirements• Maintain pattern of routine reporting in accordance with phase III frequencies• Subsequent home visits (if required)• Complete any direct interventions• Any additional sentence plan reviews• Sentence completion report

Induction

Offenders are required to report into a Community Probation and Psychological Services (CPPS) Service Centre usually within 72 hours once they have been sentenced to a community-based sentence. At this report in, the probation officer will induct the offender into their sentence.

Purpose of initial induction

The purpose of this initial induction is to:

- Explain the requirements of the sentence or order and the consequences of non-compliance.
- Engage offenders in their sentence/order.
- Provide offenders with accurate and comprehensive information about their sentence(s)/order, rights and complaints procedures.
- Identify, assess and manage offenders who may be at immediate risk of self harm/harm to others or who have immediate needs.
- Formally notify offenders of their reporting instructions by issuing a written instruction to report (ITR).

A good induction...

A good initial induction provides probation officers with information they need to establish and effectively manage the sentence/order, and helps offenders understand what is required of them, including the consequences of not complying, so they can make informed decisions about how they will respond to their sentence/order, and take responsibility for their actions.

- Boundaries of confidentiality (including information sharing between agencies).
- Offender's rights and responsibilities.
- The requirements of the sentence, including standard and any special conditions.
- Consequences of non-compliance.
- Safety screening.
- Reintegrative needs requiring immediate attention (e.g. accommodation, access to a bank account or benefit, victim issues).

For those released on parole

For offenders released on parole, the probation officer must also advise them of their liability for recall and outline the conditions associated with the NZPB monitoring.

The Sentence Plan (CPPS)

Probation officers create a formal sentence plan for all offenders on their caseload. This is completed within four weeks of the sentence/order start date.

What the Sentence Plan Covers

The sentence plan covers:

- Sentence details, including sentence type, release date and any special conditions.
- Key rehabilitative objectives and activities, e.g. programmes or counselling.
- Key reintegrative objectives and activities, e.g. accommodation, employment, education.
- Key compliance objectives and activities, e.g. reporting in frequency.
- Assessment results.
- Review dates.

Developing the Plan with the Offender

The probation officer drafts a sentence plan, then discusses, and further develops it with the offender. In doing so, the probation officer needs to communicate to the offender:

- the main purpose of the offender plan, which is to help the offender meet the requirements of the sentence; that it helps identify and address the offender's goals and avoid further offending.
- that the offender plan "belongs" to them and they are responsible for making it work to their advantage.

However, the probation officer needs to be clear that the offender has to comply with the requirements of the sentence. Their agreement is being sought in respect of how these requirements will be met – not whether they will be met. Any failure/refusal to meet the requirements of the sentence/order will be treated as non-compliance, and may result in enforcement action.

Together, the probation officer and the offender:

- review and confirm their identified needs (rehabilitative and integrative), as identified when the pre-sentence report was written and reassess the offenders level of motivation to address those needs.
- identify and prioritise relevant objectives, and develop activities for each part of the offender plan.
- confirm the reporting requirements, including the sentence management phases.

Any urgent referrals required as part of the offender plan are made at this point, and a decision is made about when subsequent referrals will be made.

Two copies of the plan are made; the offender signs both. One copy goes to the offender and the other is kept on file.

Planning Special Conditions

Most offenders subject to rehabilitative sentences/orders will have special conditions imposed by the Court or the New Zealand Parole Board (NZPB). These are designed to address the identified needs of the offender, thus reducing the risk of further offending.

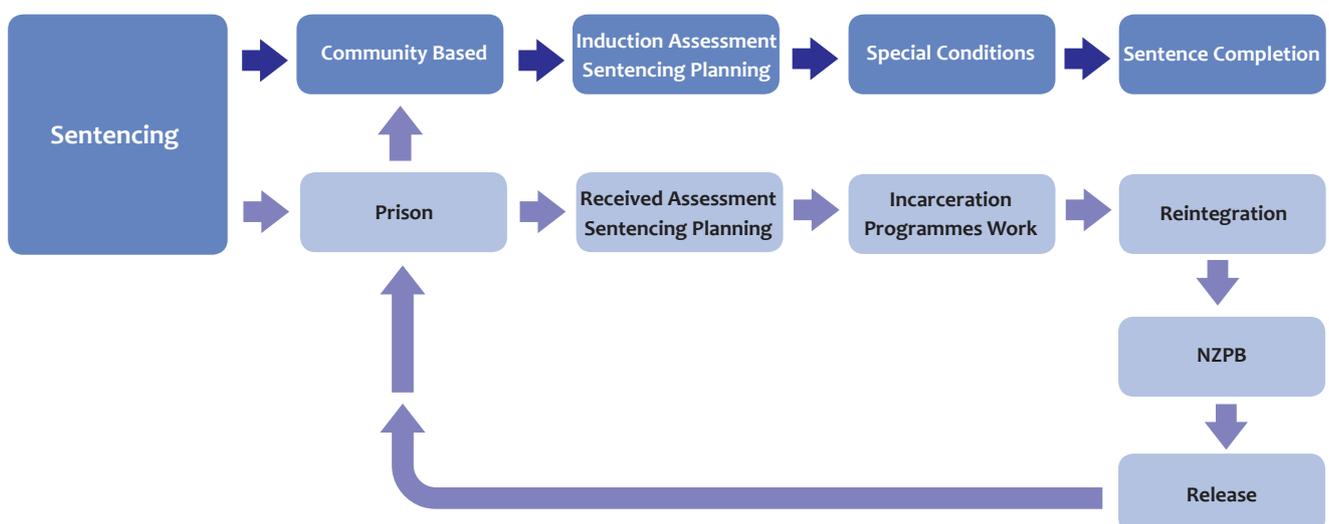
The probation officer is responsible for:

- ensuring the offender complies with the special conditions, or
- taking appropriate enforcement action should the offender fail to comply.

To prioritise the special conditions, the probation officer and offender should discuss at the start of the sentence the special conditions and plan how they are to be managed/achieved within the sentence timeframe. This will include prioritising the conditions and should take into account the following:

- risk/responsivity.
- sentence length.
- programme availability.
- unmanaged addiction issues, i.e. these should be addressed before making a programme/counselling referral.
- offender employment, i.e. where possible attempts are made to manage special conditions around the offender's employment.

Sentencing to sentence completion process



5.1.4 Balancing Care & Control

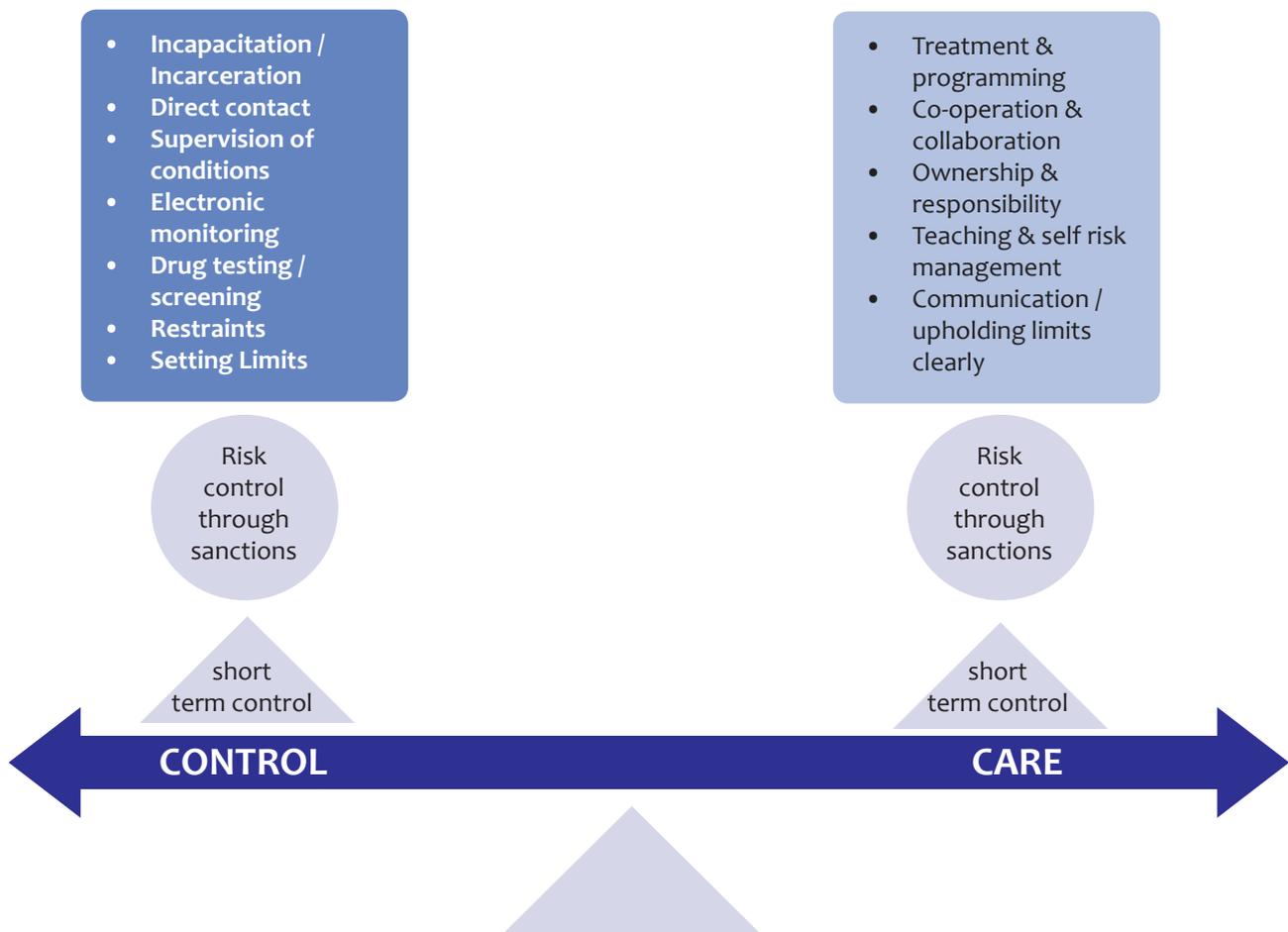
The Department of Corrections is charged with improving public safety, and to do this, they must focus on ensuring sentence compliance and reducing reoffending.

For the probation officer, this provides an interesting challenge for their sentence management work with offenders – they have to balance the control aspects of the sentence with the care involved in a rehabilitative approach to reducing reoffending .

Balancing care and control is a central aspect of casework. Managing the control aspects of a sentence does not mean that the care or rehabilitative aspects of the sentence need to be ignored. Risk management does not have to be seen as an either/or approach to offender case management. On the one hand, managing risk can be accomplished through control (imprisonment, electronic monitoring, setting limits, etc). These are short term measures and while they help protect the community, they do not usually bring about lasting change.

Long term risk reduction is normally achieved through developing within offenders an internal focus, self reflection, self regulation and an ability to make informed choices. This can be achieved through clear, firm, fair and consistent casework.

CONTROL versus CARE:



5.1.5 Care & Control Exercise

As we know, the probation officer is a key player in the criminal justice process and the person in the criminal justice system that you are likely to have the most to do with. The fundamental purpose of the Department of Corrections is to improve public safety and to achieve this its focus is on ensuring compliance with sentencing and reducing reoffending. For example, if a parolee fails to report, the client from the probation officer's point of view is the community (i.e. potential victim).

We now want to begin to explore this tension between care and control from a probation officer's perspective and contrast it with the focus of AOD practitioners. Consider the two case studies below and answer the questions.

- What were the risk issues that you identified from the probation officer's perspective? How might they affect your work with the client? How do these risk factors influence your work with the client?
- What did you identify as tensions between care and control? How might the probation officer seek to address this tension? How might you be involved?

Case Study one:

Peter is a 36 year old man who has been referred to you by his probation officer for an AOD assessment. He is serving concurrent sentences of Supervision and 200 hours Community Work. He has a special condition to attend AOD counselling and to complete an anger management course.

His current sentence is the result of a Male Assaults Female conviction against his partner, which occurred after they had been drinking together. He also has to abide by a Protection Order lodged in the Family Court. He has a history of domestic violence against a previous partner and a number of Protection Order breaches.

The probation officer has explored with Peter the benefits of tackling his alcohol use, so that when he fronts up for the assessment, he is prepared to be open. At the assessment, he is willing and motivated to engage in treatment.

When taking his details, it appears that the address he gives is different from the one he has been ordered to reside at.

From the probation officer's perspective, what are the areas of concern or risk?

What is the tension for them between care (rehabilitation) and control (compliance)?

How is this different from the AOD worker's focus?

Case Study two:

Liz is a 27 and has been using a variety of drugs since she was 14. She has an extensive offending history including burglary, receiving, fraud, possession and cultivation of cannabis, possession of controlled drugs and breach of community work. She is known to have gang associations.

Liz was convicted of possession of controlled drugs and spent eight months in prison. She is now released on conditions relating to regular reporting in to CPPS, where she can live and who she can't associate with. She has a special condition to participate in AOD treatment and has been doing this for six weeks.

Liz is motivated to address her drug use issues as she has a three year old daughter and has just discovered that she is pregnant. Her mother has custody of her daughter.

While Liz has been consistent in her attendance at AOD treatment, she has been inconsistent in reporting in to CPPS.

From the probation officer's perspective, what are the areas of concern or risk?

What is the tension for them between care (rehabilitation) and control (compliance)?

How is this different from the AOD worker's focus?

5.1.6 Reflection on Attitudes to the Criminal Justice System

Consider the questions below, which are designed to give you the opportunity to reflect on your beliefs and attitudes to the criminal justice system, and write your brief answers in the spaces below. Some of the questions may apply to you and some may not:

What are my beliefs and attitudes to the criminal justice system?

Where have these beliefs and attitudes come from?

What in my attitude might I need to reappraise / reconsider?

What influence does my current attitude to the criminal justice system have on my work?

What useful attitudes I can strengthen or adopt?

After writing your answers above and reflecting on your beliefs and attitudes regarding the justice system, do a self-evaluation on the following:

- Over the course of this session, have you found that your attitudes to the criminal justice system / 'players' in the criminal justice system have shifted? If so, in what way? If not then why not?
- Have you gained a new / different appreciation for the work of probation officers?
- Have you been able to identify the influence that your beliefs / attitudes have on your work?
- What sort of influence do those beliefs / attitudes have?

Part Two: Introduction to Assessment within the Justice Context

5.2.1 Assessment and Treatment Planning

The focus of this session is on understanding assessment and sentence planning from a justice perspective. Using material that would be available to a probation officer, we are going to look at a case involving Simon Brown, someone who could well be referred to you for treatment. The details of the case material (Simon Brown) used in this session have been altered to preserve client confidentiality.

(A) Summary of Facts

To start, we want to get a first impression of this offender/client, so read Simon Brown's 'Summary of Facts' and consider the following questions:

- What risks can you see? (What is your evidence?)
- What do you think is driving or causing the offending behaviour? (What is your evidence?)
- If Simon were referred to you for AOD treatment, what would get in the way of that treatment being effective? (What is your evidence and what's your hunch?)

CAPTION SHEET

POLICE vs	NAME: Address: DOB: OCC:	Simon Charles BROWN 6 Fiction Street, Christchurch 01/01/1953 Unemployed
CHARGE(S):	Offence: Act/Section: Penalty:	Male assaults Female (manually) Crimes Act 1961, Section 194(b) 2 Years Imprisonment
CHARGE(S):	Offence: Act/Section: Penalty:	Breach of Protection Order Domestic Violence Act, Section 49 Laid Summarily 6 months
		Imprisonment or Fine of \$5000
WITNESS: EXHIBITS: HEARING:	T.B.C T.B.C A.D.C	

SUMMARY OF FACTS:

On the 18th October 2002 the defendant BROWN was the respondent of Protection Order issued by the Christchurch District Court.

The Applicant of the Protection Order is Hine VINCENT.

On the evening of Sunday 11th February 2007 BROWN was at the address of 6 Fiction Street.

Also present at the address was the victim in this matter Ms Hine VINCENT.

The defendant and VINCENT were both in an intoxicated state and seated in the living room watching T.V.

The defendant has begun a heated verbal argument with the victim.

The defendant then began to smash things around the house including the T.V they were watching.

The defendant has also kicked VINCENT in the back, stomach and head after throwing her to the ground.

The defendant has punched VINCENT about the face with a closed fist.

The defendant has also slapped the victim all over the body with both hands.

The defendant then held the victim in a 'sleeper hold' around her neck while standing behind her. The pressure applied was sufficient for the victim to lose consciousness for a short period of time.

The assault continued throughout the evening and into the early hours of the morning of the 12th February.

The defendant held VINCENT in a bedroom and when he finally fell asleep, the police were called.

Upon Police arrival the defendant was located at the address. He could not be woken up for questioning so an ambulance was called.

VINCENT has bruising to her face, back and stomach and a cut lip.

When spoken to later by the police, the defendant stated "I don't have to answer your questions".

The defendant is a 53 year old male who has previously appeared before the courts.

The Summary of Facts for Simon Brown indicates the following:

Risks	Drivers/causes of the offending behaviour	Potential Barriers
<ul style="list-style-type: none">• The nature of the violence (smashing things, the damage caused to the victim, causing the victim to lose consciousness, the period of time the assault continued; preventing the victim escaping)• Recidivist offending (necessity of a Protection Order, breaching the Protection Order, has appeared before the courts previously)	<ul style="list-style-type: none">• Using violence• Using alcohol (Disinhibition)• Not managing the argument with his partner	<ul style="list-style-type: none">• Attitude (“I don’t have to answer your questions”)• Lack of victim empathy (prolonged nature of the assault)• Use of alcohol• Disregard for legal processes (breach of Protection Order)• Age (53) suggesting sustained pattern of behaviour?

(B) Pre-Sentence Report

The nature of Simon's offence and his previous offending would mean that the Judge would call for a full pre-sentence report. Think about what your assessment of Simon would be at this point?

We are now going to see what conclusions the probation officer came to after interviewing and assessing Simon:

20 June 2007 - The Presiding Judge

Court:	Christchurch District Court	
Pre-Sentence Report on:	Simon Charles BROWN	
Of:	Christchurch Prison	
Date of Birth:	01/01/1953	
For Sentence:	03 July 2007	Age: 53 years
Offence(s):	Male Assaults Female Breach of Protection Order	Counsel: Mr D. Lawyer

SOCIAL AND CULTURAL FACTORS

Simon Brown is a 53-year-old New Zealand born male of European descent. He has been on remand in custody for two months. At the time of the offending he had been living with the victim for about five years. He described the relationship as tumultuous as a result of their heavy consumption of alcohol and other drugs.

Mr. Brown stated that the relationship was now over and he hoped to live with his sister once released from prison. His sister, Deanne Kennedy, confirmed her brother's social circumstances. Mr. Brown reported leaving school at age 15 with no formal academic qualifications. He described brief stints of employment in the fields of fibreglass laminating and concreting, but advised that much of his adult life was spent unemployed because "drug taking didn't really go with working". Mr. Brown reports currently being unemployed with no immediate work prospects. Mr. Brown's alcohol and other drug use was screened using departmental tools, and a referral to the Salvation Army Bridge programme made.

He advised that he began drinking alcohol and smoking cannabis at the age of 14 and five years later, he started using heroin. Mr. Brown said that despite being on the methadone programme for years he continued to use heroin until his imprisonment in January 2003. Mr. Brown stated he now uses heroin once a week, “just enough to give me a treat but not enough to form a habit again”. Mr. Brown advised that his alcohol consumption became problematic about 15 years ago but he had never addressed it. Prior to his remand in custody, he had been drinking alcohol daily from “morning until night” and had been using diazepam, Rivotril, cannabis and heroin on a weekly basis. Ms Kennedy recounted that her brother had abused alcohol and other drugs most of his life.

Mr. Brown’s alcohol and drug use was formally assessed using departmental screening tools, confirming that his use of both substances was both substantial and harmful.

OFFENDING

Mr. Brown appears for sentence today on one charge of Male Assaults Female and one of breaching a Protection Order. He reported that he was unable to comment on the police summary of facts, as he was so heavily intoxicated at the time of the offending. Mr. Brown believed he had “blacked out” and only recalls waking up in hospital handcuffed.

At interview, Mr. Brown said he felt badly over how he had treated his partner and he now realised that as a consequence the relationship was over. Mr. Brown has made no offers of amends and no reparation has been sought in relation to this offending. The restorative justice process is not considered appropriate given the offending involves domestic violence.

Mr. Brown has a history of violent offending against his partner. Of the eight violence-related convictions between 2003 and 2006, five were committed against the same victim in this offending. He has contravened a Protection Order on two previous occasions. Mr. Brown’s other convictions are mostly drug-related.

MOTIVATION AND READINESS TO CHANGE

The key factors identified as having contributed to Mr. Brown’s offending are his use of violence, abuse of drugs and alcohol, and absence of relationship skills. Mr. Brown agreed that these factors contributed to his offending. He stated that he was not normally violent and that it was his use of alcohol and other drugs that fuelled his aggression towards the victim.

Mr. Brown also conceded that his attitudes supported his offending behaviour, acknowledging paying no attention to the Protection Order.

At interview, Mr. Brown also recognised that a lack of meaningful structure in his life, compounded by regularly seeking drugs from friends and heavy use of alcohol had contributed to his offending lifestyle.

Mr. Brown described a repetitive cycle of alcohol and other drug abuse followed by violence since meeting the victim five years ago. He reported feeling “shocked” over his treatment of her and talked of abstaining from alcohol and other drugs to avoid further similar offending.

Community Probation & Psychological Services records note that Mr. Brown has previously been sentenced to imprisonment followed by a term of release on conditions to undertake a substance abuse programme. He complied with his sentence and attended a 10-week evening programme at Community Alcohol and Drug Services. His counsellor advised that Mr. Brown needed to undertake a residential substance abuse programme given his long term substance abuse.

Aroha Maki, the admissions administrator at the Salvation Army’s residential Bridge Programme, confirmed that Mr. Brown had been accepted into their programme. Mr. Brown expressed a high level of interest and intent to undertake the next residential programme which starts in two months. However, he remained ambivalent over receiving any counselling for violence prevention.

Mr. Brown is assessed as being at medium risk of further offending; although this risk could be assumed to be higher should he continue to use alcohol and other drugs.

SUMMARY

Mr. Brown appears for sentence today for assaulting his partner and breaching a Protection Order. He claimed to be so intoxicated that he is unable to remember what happened. Mr. Brown expressed remorse for his offending behaviour but acknowledged a five-year pattern of similar violent offending perpetuated against the same partner.

Given the repeated and serious nature of Mr. Brown’s offending, it is highly likely that the Court is considering a term of imprisonment. Therefore, community-based sentencing options are not recommended. However, the Court may wish to consider Home Detention as an alternative to imprisonment.

Mr. Brown is considered to be a suitable candidate and if sentenced to Home Detention would be able to undertake the Salvation Army’s residential programme, an option not available in prison. Mr. Brown advised that while he did not consider violence an issue for him, he would undertake anger management counselling if sentenced to Home Detention.

Once Mr. Brown has completed the residential component of the alcohol and other drug programme, he will be further assessed as to which anger management provider is best suited to his rehabilitative needs. If Mr. Brown is unable to complete the rehabilitative interventions before the end of a Home Detention sentence, he could have an opportunity to do so under post detention conditions. An appendix specifically addressing the suitability of Home Detention at the proposed address is attached.

It is expected that once an entry date is set for the Bridge Programme, an application for variation of the Home Detention address will be made. The Bridge Programme has been used before as a residence for offenders subject to Home Detention and continues to be suitable for this purpose.

RECOMMENDATION

A sentence of Home Detention with the following special conditions:

- Undertake and complete alcohol and other drug counselling administered by the Salvation Army Bridge Programme and abide by the rules of the programme to the satisfaction of the programme provider and probation officer.
- To reside at 100 Madeup Road and not to move address without the prior written approval of a probation officer.
- To abstain from the consumption of alcohol for the duration of Home Detention.
- To attend and complete appropriate anger management counselling to the satisfaction of your probation officer and provider. Details of the appropriate provider to be determined by your probation officer.

Post detention conditions with the following special conditions:

- Undertake and complete alcohol and other drug counselling administered by the Salvation Army Bridge Programme and abide by the rules of the programme to the satisfaction of the programme provider and probation officer.
- To attend and complete appropriate anger management counselling to the satisfaction of your probation officer and provider. Details of the appropriate provider to be determined by your probation officer.

The minimum time required to complete both the proposed residential alcohol and other drug programme and the anger management programme is 14 months.

These may be completed as part of a sentence of Home Detention together with post detention conditions.

Signed:

A. Probation officer

Probation officer

SOURCES OF INFORMATION

- Interview with Simon Brown, Christchurch Men's Prison (28 May 2007)
- Interview with Deanne Kennedy – sister (30 May, 2007)
- Aroha Maki – admissions administer at the Salvation Army's residential Bridge Programme
- Community Probation & Psychological Services Records
- Alcohol Use Disorders Identification Test (AUDIT)
- Drug Abuse Screening Test (DAST)
- Problem Gambling Screening Test (G9)
- Offending and Needs Assessment
- Combined Criminal and Traffic History
- Fines Summary
- Police Summary of Facts
- Ministry of Justice

ATTACHMENTS:

- Combined Criminal and Traffic History
- Police Summary of Facts
- Fines Summary
- Home Detention Appendix
- Offender's Agreement
- Occupant's Agreement

Appendix 1:

Detailed information about the suitability of Home Detention for Simon Charles Brown for sentence on 3 July 2007 at Christchurch District Court .

Suitability of Proposed Address

It is initially proposed that Simon Brown reside with his sister, Deanne Kennedy, at 100 Madeup Road, Rangiora, before entering the Salvation Army Bridge Programme. Ms Kennedy has rented the two-bedroom unit for two years and is the only occupant. The unit is one of three at the end of a cul-de-sac located down a shared driveway. Mr Brown would have his own bedroom and there is a small fully fenced courtyard.

The property is located near a major bus route and the central business district is about a 15 minute drive. The home appears to be suitable for electronic monitoring and there are no concerns about its overall

suitability in terms of managing a sentence of Home Detention.

It is expected that once an entry date is set for the Bridge Programme, an application for variation of the Home Detention address will be made. The Bridge Programme has been used before as a residence for offenders subject to Home Detention and continues to be suitable for this purpose.

Suitability of Proposed Occupants and Support

Deanne Kennedy was interviewed at the proposed Home Detention address on 30 May 2007. She said she was aware of her brother's current and past offending and like other members of the family was prepared to continue offering her support. Ms Kennedy said she had witnessed her father's abuse of alcohol over the years and as a result had zero tolerance for the presence of drugs or alcohol in her home. Ms Kennedy expressed relief at the prospect of her brother receiving residential treatment and she hoped that his relationship with the victim was now finally over.

Ms Kennedy works full-time but anticipated being at home most evenings and weekends to support her brother during any term of Home Detention. She indicated that various other family members were more available during the day to support Mr Brown and help provide transport if necessary.

Ministry of Justice enquiries indicate that Ms Kennedy has one minor criminal conviction, which has no consequence to her suitability as a relevant occupant for the purposes of Home Detention. She was made aware of the expectations and potential impact in terms of the management of Home Detention. Ms Kennedy supported the proposal for such a sentence and willingly signed the attached occupant's agreement.

There appear to be no safety or welfare concerns with regard to the occupant.

Suitability of Offender

Mr Brown was interviewed on 28 May, 2007 in relation to a pre-sentence Court report. Mr Brown confirmed that the relationship with the victim was now over and they had not been in contact since the offending.

The possibility of Home Detention was discussed with Mr Brown and he anticipated that his sister would support him serving the sentence at her house. The requirements and expectations of a sentence of Home Detention were explained to him and Mr Brown willingly signed the attached agreement.

Mr Brown reiterated his desire to enter the Salvation Army's residential Bridge Programme. He acknowledged that should he be sentenced to Home Detention it would be a challenge remaining abstinent from alcohol and other drugs in the community as he awaited entry into the programme. However, Mr Brown stated that his sister did not allow either substance in her home and he had no intention of abusing her house rules and risking further imprisonment. Mr Brown is considered to be a

suitable candidate for Home Detention.

Other Relevant Information

Mr Brown is currently unemployed with no immediate work prospects. He is able to seek financial assistance from New Zealand Work and Income. New Zealand Police advised that it would have no concerns if Mr Brown was to receive a sentence of Home Detention.

Sentence / Order Specific Considerations and Requirements

Ms Kennedy advised that she would attend her brother's Court sentencing and that she would transport him directly to her home should he be sentenced to Home Detention.

The following conditions are recommended to be completed either during a period of Home detention or as Post Detention conditions:

- Undertake and complete alcohol and other drug counselling administered by the Salvation Army Bridge Programme and abide by the rules of the programme to the satisfaction of the programme provider and probation officer.
- To reside at 100 Madeup Road, Rangiora, and not to move address without the prior written approval of a probation officer.
- To abstain from the consumption of alcohol and any prescription drugs (unless prescribed for your use) for the duration of the sentence of Home Detention.
- To attend and complete an appropriate anger management counselling programme to the satisfaction of your probation officer and provider. Details of the appropriate provider to be determined by your probation officer.

Enquires with programme provider confirm that a period of at least 14 months will be required for all conditions to be completed.

Signed:

A. Probation officer

Review Questions on Process of the Report:

- What is the focus that the probation officer is taking when assessing Simon?
- What is the probation officer taking into account that leads them to their recommendations?
- What processes did the probation officer use to come to their recommendations?
- What screening tools did the probation officer administer?
- What do you think Simon's response would be to an assessment of this nature? How would he view the pre-sentence report?
- How helpful would a report of this nature be to the sentencing Judge? How would it help him/her?

The focus of the probation officer's assessment of Simon is on:

- His previous history and pattern of offending history indicating his risk of future reoffending.
- The contributory factors to his offending.
- The offender's current view of his offending and his level of willingness to address the contributory factors.
- Previous attempts to address offending behaviour.
- Sentencing recommendations and rehabilitation.

The probation officer uses AUDIT, DAST and G9 to screen for alcohol use, drug use and gambling. Note that the questions used in the screening tools are for the 12 months prior to the interview, regardless of whether the offender has spent some or all of that time in custody. Note too, that the DAST used by the Department of Corrections covers 10 screening questions (not 20), and covers questions regarding which classes of drugs they have used.

(C) Sentence Plan

We are now going to jump ahead in time to when the offender is sentenced and reporting to his probation officer. We are going to examine the sentence plan that was developed between Simon and his probation officer. The policy of the Department of Corrections is that this type of sentence plan is developed within 28 days of the sentence commencement date.

Look at the plan and consider your first impressions of it:

See following page

Sentence Plan

Name:	Simon Charles BROWN	Personal Record No:	222222222
AKA Indicator:	Y	Date of Birth:	01/01/1953
Address:	100 Madeup Road No Town	Age:	53 years
Telephone:	123 4567	Gender:	Male
		Ethnicity:	NZ European
		Probation officers:	A Probation officer
		Plan Date:	14/07/07

Sentence/Order

Details:	Home Detention	Start Date:	3 July 2007
Sentence Length:	9 months	End Date:	2 April 2008

Conditions:

To reside at 100 Madeup Road and not to move address without the prior written approval of a probation officer.

To abstain from the consumption of alcohol and/or illicit drugs for the duration of Home Detention.

To undertake and complete alcohol and other drug treatment administered by the Salvation Army Bridge Programme and abide by the rules of the programme to the satisfaction of the programme provider and probation officer.

To attend and complete appropriate anger management counselling to the satisfaction of your probation officer and provider. Details of the appropriate provider to be determined by your probation officer.

Post-Detention Conditions:

Sentence Length: **6 months**

Start Date:

End Date:

Conditions:

To undertake and complete alcohol and other drug counselling administered by the Salvation Army Bridge Programme and abide by the rules of the programme to the satisfaction of the programme provider and probation officer.

To attend and complete appropriate anger management counselling to the satisfaction of your probation officer and provider. Details of the appropriate provider to be determined by your probation officer.

Key Rehabilitative Activities

Programmes: To complete the Salvation Army Bridge Programme

Counselling: To attend anger management counselling

Key Re-integrative Activities

Employment: To gain employment related skills/employment

Relationships: To improve relationship skills

Victim Issues: To develop skills/strategies for managing contact with the victim

Key Compliance Activities

Reporting Requirements:

To report as per phase requirements. It is expected that you will progress to phase 2 before the next review. Progression through the phases is dependant on your compliance with all the requirements of your sentence.

Concurrent Sentence:

Client - Signature: _____ Date: _/ _/ _

PO - Signature: _____ Date: _/ _/ _

SM - Signature: _____ Date: _/ _/ _

Sentence Plan Timetable

Offender:	Simon Charles BROWN	Plan prepared on:	14/07/07
Probation officer:	A probation officer	Review on:	14/07/07
		Reviewed:	
		Reviewed by:	

TIMETABLE

PLAN ACTIVITIES	Start Date	End Date	14/10/07	14/01/08	02/04/08
1.1 Complete referral process to appropriate programme/agency/ service provider	03/07/07	17/07/07			
1.1 Attend alcohol and drug assessment, counselling and/or treatment at the Salvation Army	03/07/07	02/04/08			
1.1 Attend anger management counselling at Living Without Violence	01/01/08	02/04/08			
2.2 Facilitate access to WINZ or other community employment agency	01/01/08	02/04/08			
2.4 Session with probation officer to improve relationship / communication skills	03/07/07	14/10/07			
2.6 Session with probation officer to develop strategies for managing victim issues	03/07/07	14/10/07			
3.1 Reside at 100 Madeup Road, or at an address approved by the probation officer	03/07/07	02/04/08			
3.1 Monitor offender progress and sentence compliance	03/07/07	02/04/08			
3.1 Complete quarterly sentence plan reviews within two weeks of due date	03/07/07	02/04/08			
3.1 Complete sentence pre-termination assessment within two weeks of actual sentence end date	15/03/08	02/04/08			

SENTENCE PLAN REVIEWS

NO	DATE	PO COMMENTS	OFFENDER COMMENTS

Sentence Plan Objectives

1.1 Identify and Manage the Factors that Drive Offending Behaviour

Assessment Results:

This objective was included because of information gained from the pre-sentence report, which identified both significant, chronic substance abuse, and the lack of ability to control and manage anger appropriately as contributing to Simon’s offending.

Comments:

Simon has been assessed as suitable to undertake residential treatment at the Salvation Army Bridge Programme and is waiting for a place to become available. It is expected this should be within three months. In the meantime, he will be required to attend and participate in weekly alcohol and other drug counselling sessions. Simon will be referred to anger management counselling once he has completed the residential programme.

Goals for Client:

I want to get some help with my drug and alcohol problems and stay out of trouble. I haven’t got a problem with anger except when I drink but if I have to go to counselling, then I will.

Activities & Strategies:	START	END	RESP
1. Complete referral process to appropriate programme, agency/service provider	03/07/07	17/07/07	PO
2. Attend alcohol and drug assessment, counselling and/or treatment at the Salvation Army	03/07/07	02/04/08	Simon
3. Attend anger management counselling at Living Without Violence	01/02/08	02/04/08	Simon

OBJECTIVE REVIEWS			
NO	NO	PROGRESS	ACTIONS ARISING
1			
2			

Objective Achieved:

2.2 Objective: Obtain Employment

Assessment Results:

This objective was included because of information gained from the pre-sentence report, and the Re-Integrative Needs Assessment undertaken post-sentence – both of which identified the need to address Simon’s long-term unemployment resulting from substance abuse issues. It is considered assisting Simon into employment may reduce his risk of further offending.

Comments:

Once Simon has completed the residential treatment programme he will be referred to a community employment support agency for assistance in gaining employment related skills.

Goals for Client:

I would like to be able to get a job and get off the dole.

Activities & Strategies:	START	END	RESP
1. Referral to WINZ or other community employment support agency	01/01/08	14/01/08	PO

OBJECTIVE REVIEWS			
NO	NO	PROGRESS	ACTIONS ARISING
1			
2			

Objective Achieved:

2.4 Objective: Manage Relationship Issues

Assessment Results:

This objective was included because of information gained from the pre-sentence report and the Re-Integrative Needs Assessment completed post-sentence that identified Simon's inability to maintain satisfactory relationships as an issue, which contributed directly to his offending, and may contribute to further offending if not addressed.

Comments:

Simon would benefit from some assistance with managing relationships and will work with his PO to improve his communication and relationship skills.

Goals for Client:

I would like to get another partner and not stuff it up this time.

Activities & Strategies:	START	END	RESP
1. Session with probation officer to improve relationship/communication skills.	01/01/08	14/01/08	PO & Simon

OBJECTIVE REVIEWS			
NO	NO	PROGRESS	ACTIONS ARISING
1			
2			

Objective Achieved:

2.6 Objective: Prevent Victim-Related Problems

Assessment Results:

This objective was included because of information gained from the Re-Integrative Needs Assessment completed post-sentence, which identified it was likely Simon would have contact with the victim and that potential problems may arise for Simon as a result of this contact.

Comments:

Simon would benefit from undertaking some work with his PO to develop skills to appropriately manage the situation should he come into contact with the victim.

Goals for Client:

I will probably end up seeing her at some time and don't want to end up getting into any more trouble because of her.

Activities & Strategies:	START	END	RESP
1. Session with probation officer to develop strategies for managing victim issues	03/07/07	14/10/07	PO & Simon

OBJECTIVE REVIEWS			
NO	NO	PROGRESS	ACTIONS ARISING
1			
2			

Objective Achieved:

3.1 Objective: Meet Obligations and Requirements of Sentence Orders and Parole Licenses

Assessment Results:

This objective is linked to the special and standard conditions of Simon's sentence of Home Detention, and the monitoring of his progress against the sentence plan. To ensure successful completion of the sentence, Simon will need to comply with all requirements of the sentence. His progress against the sentence plan will be monitored, and formally reviewed on a quarterly basis.

Comments:

The PO will maintain contact with Simon's sponsor and also liaise regularly with counsellors and programme providers to monitor progress.

Goals for Client:

To get through my sentence without getting into any more trouble and to get some help with my alcohol and other drug problems.

Activities & Strategies:	START	END	RESP
1. Reside at 100 Madeup Road, or at an address approved by the probation officer	03/07/07	02/04/08	Simon
2. Abstain from consumption of alcohol and/or illicit drugs for duration of the sentence	03/07/07	02/04/08	Simon
3. Monitor offender progress and sentence compliance	03/07/08	02/04/08	PO
4. Complete quarterly sentence plan reviews within two weeks of due date	03/07/08	02/04/08	PO & Simon
5. Complete pre-termination assessment within two weeks of actual sentence end date	18/03/08	02/04/08	PO & Simon

OBJECTIVE REVIEWS

NO	NO	PROGRESS	ACTIONS ARISING
1			
2			

Objective Achieved:

CPPS Sentence Plan Analysis:

Reflect on the Sentence Plan for Simon Brown and consider the following questions:

- **What objectives relate to the “care” needs of the offender?**

- **What objectives are connected to public safety?**

- **What crossover is there between the rehabilitative focus and the concern for public safety?**

- **Where is the voice of the offender in the sentence plan?**

- **What does Simon appear motivated to address and what does he appear to be less motivated to address?**

- **What do you notice about the focus of the objectives in Simon's sentence plan?**

- **What underlies the assessment?**

- **How will such a plan guide the probation officer's work with the offender?**

- What did you make of the prioritisation of objectives?

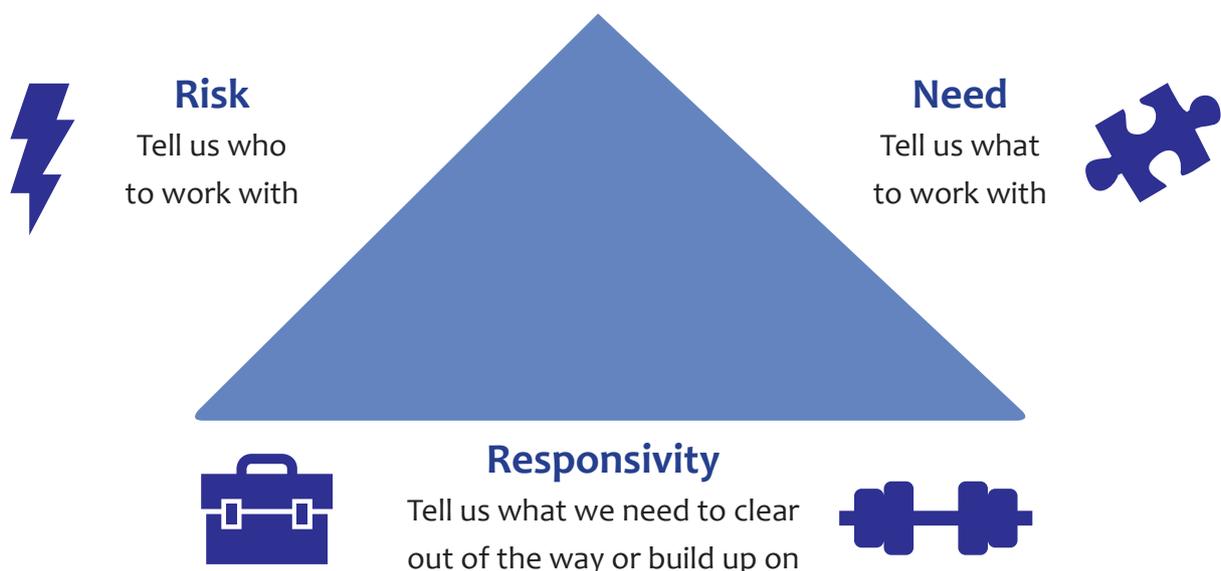
- What do you think Simon would make of this plan?

5.2.2 Assessment of Risk, Need and Responsivity:

In current correctional practice, there are three key ideas that drive assessment. These are based on research and literature aimed at the question of “what works” with offenders. At some level, these ideas influence all decisions made in the corrections context.

The mainstream approach to the rehabilitation of adult offenders was published in 1994 (Andrews and Bonta, *The Psychology of Criminal Conduct*), and established the ‘risk-needs-responsivity’ model, which suggests that effective rehabilitative services must be matched to each individual offender’s risk level, needs profile and responsivity profile.

The Risk, Need & Responsivity Pyramid



Risk:

Risk is focussed on the risk of reoffending (risk of harm to others). That is not to say that risk to self is not assessed, but in general terms when the idea of risk is talked about, it is in relation to reoffending risk.

The principle of risk tells us who to target, and drives treatment allocation post-sentence. The Department of Corrections risk assessment tool is the RoC*RoI (Risk of Reconviction times Risk of Imprisonment) and it was developed in New Zealand. This type of risk assessment uses an actuarial approach based on research with large samples of offenders, where specific characteristics of individual offenders are correlated with outcome.

These specific characteristics are known as static factors, e.g. age at first conviction, seriousness of offence, etc, which have been reliably shown to be related to reoffending risk.

Behind a low, medium or high risk level sits a percentage which correlates to the likelihood that an offender will reoffend within the next 5 years, e.g. an offender with a .15 risk rating has a 15% likelihood of reoffending, whereas an offender with a .73 risk rating has a 73% likelihood of reoffending and is therefore of greater risk.

General prison populations in New Zealand tend to divide up approximately as: 10-15 percent of inmates assessed as low risk, 35-50 percent as medium risk and 50 percent as high risk. Within Community Probation, approximate figures are 30-40 percent low risk, 30-35 percent medium and 30-35 percent high risk.

The major value of assessing risk at the beginning of an offender's sentence is that it assists decision making about who should have priority for programmes. Priority should be given to those rated medium or high risk (in fact studies have shown that treating low-risk offenders can actually be counter-productive, as it can increase their recidivism rate). High-intensity treatment should be delivered to high-risk cases; low-intensity treatment (or no treatment) should be reserved for low-risk cases.

Need:

While the risk principle tells us who to target, it does not tell us what to target. This is where the need principle comes in.

Needs are dynamic risk predictors, which are aspects of an individual's current functioning related to the occurrence of risk. In a heart disease example, smoking, an unhealthy diet, a high cholesterol level and a stressful job are all dynamic risk factors.

Andrews and Bonta (1994), key researchers in the field of the psychology of criminal conduct, explain the need principle like this:

“Many offenders, especially high risk offenders, have a variety of needs. They need places to live and work and/or they need to stop taking drugs. Some have poor self-esteem, chronic headaches or cavities in their teeth. These are all ‘needs’. The need principle draws our attention to the distinction between criminogenic and non-criminogenic needs. Criminogenic needs are a sub-set of an offender’s risk level. They are dynamic attributes of an offender that, when changed, are associated with changes in the probability of recidivism. Non-criminogenic needs are also dynamic and changeable, but these changes are not necessarily associated with the probability of recidivism.”

Within the Department of Corrections, criminogenic needs are assessed for as rehabilitative needs. Some factors can be either static or dynamic factors, depending on circumstances. For example, some mental health difficulties can be managed effectively by medication or intervention over a relatively short period of time and are therefore dynamic. Other mental health problems might be more difficult to manage with medication, or intervention may not change them, and they are therefore static. Details of the rehabilitative needs that the Department of Corrections assesses for and the programmes they are then referred to, are detailed in (2.3) Rehabilitative Needs.

Responsivity:

The risk principle helps in deciding who might profit most from intensive programming, while the need principle suggests appropriate targets for such programming. Responsivity has to do with choosing the most appropriate mode of service. Responsivity tells us what we need to clear out of the way or build upon. It is about a person’s amenability to interventions and ability to benefit from these change opportunities.

Offenders, like most other people, are most likely to benefit from an intervention when there are no barriers to prevent engagement and there is clear benefit for engagement. These barriers to engagement can be internal – intrinsic to the person or external, which is anything else. The most common internal barrier is motivation, closely followed by AOD use. External barriers include such things as unavailability of suitable programmes, transport, childcare, etc.

Ethno-cultural congruence can be both a positive and negative responsivity factor. Working with someone who understands features of culture and or ethnicity can be a vehicle for engagement and/or treatment. Understanding the principles behind both cultural safety and cultural competence are important in considering responsivity and is worthy material for supervision.

Responsivity is most usefully considered as unique to each individual and their situation, not a one size fits all. Historically, responsivity has been heavily focused on obstacles internal to the offender. While this is obviously important, it is only part of the whole picture.

Responsivity is essentially dynamic, with some obstacles having to be accepted as immovable, e.g. intelligence; but still able to be worked with or around by workers. This means that responsivity can be actively targeted for change just as rehabilitation needs are targeted.

Note: Responsivity can be significantly impacted on, in both helpful and unhelpful ways, by the attitude and behaviour of workers.

Assessment of Risk

Read the information presented below, and then try to answer the question below in the spaces provided:

Assessing Risk

- The principle of risk tells us who to target and is concerned with the risk of reoffending
- The corrections risk assessment tool is the RoC*RoI, it uses an actuarial approach where specific characteristics of individual offenders are correlated with outcome
- These specific characteristics are known as static factors, e.g. age at first conviction, seriousness of offence, etc., which have been reliably shown to be related to reoffending risk

Risk assessment drives treatment allocation post-sentence

How does this align with what you considered to be the drivers or causes of the offending behaviour when examining Simon Brown's Summary of Facts?

Assessment of Responsivity

Read the information presented below, and then try to answer the question below in the spaces provided:

Assessing Responsivity

- Responsivity tells us what we need to clear out of the way or build upon
- It is about a person's amenability to interventions and ability to benefit from these change
- Offenders are most likely to benefit from an intervention when there are no barriers to prevent engagement
- Barriers to engagement can be:

- * Internal – intrinsic to the person, like motivation
- * External – anything else, like availability of a suitable programme

- Workers also have a part to play in either decreasing or increasing an offender’s level of motivation.

How does this align with the barriers that you considered when examining Simon Brown’s Summary of Facts?

5.2.3 Rehabilitative Needs:

The Department of Corrections assesses eight different rehabilitative needs for those offenders who pose a greater risk of reoffending. These rehabilitative needs are:

- Violence Propensity
- Alcohol and Other Drugs
- Gambling
- Relationship Difficulties
- Offence-Related Sexual Arousal
- Offending Supportive Associates
- Unhelpful Lifestyle Balance
- Offending Supportive Attitudes and Entitlement

Violence propensity (VP)

Definition

VP refers to the natural tendency or inclination to use violence against others. Violence is defined as either:

- physical violence, including destruction of property
- psychological violence, including threats and intimidation, or
- sexual violence

Family or domestic violence should be identified and treated as a specific type of violence (with different programmes).

Examples of VP

- Threatening a victim with a weapon
- Threatening a victim with physical harm if they do not comply
- Physically assaulting a victim to gain compliance
- Using restraints (e.g. rope, handcuffs) to obtain compliance
- Using force to deal with resistance

When to identify VP

VP should always be identified when the offending is a violent offence or if any violent behaviour is linked to the offending.

Programmes

In terms of identifying programme/treatment options, there are three types of violence: family, sexual and other violence. Resources available to target VP could include:

- community stopping violence programmes (family violence).
- psychological counselling (sexual violence).
- departmental programmes (other violence) (Medium Intensity Rehabilitation Programme [MIRP] / Short Rehabilitation Programme [SRP] – depending on RoC*RoI).
- Montgomery House (other violence).

Alcohol and other drugs (AOD)

Definition

AOD refers to alcohol and other drug use. AOD does not refer to alcohol and other drug-related offending that does not specify use by the offender, for example:

- supplying alcohol to minors
- possession for supply or,
- theft of chemicals to manufacture drugs for profit

When to identify AOD

AOD should always be identified for direct alcohol-related offending (e.g. excess-breath alcohol (EBA)). AOD can also be identified in cases where:

- there is a clear link between the effects of alcohol and/or other drug usage and any offending. Links are usually related to either reducing inhibition or to negatively affecting judgement leading to poor or impaired decisions.
- the offending behaviour was primarily motivated by a desire to obtain drugs and alcohol for personal use, for example:
 - a burglary offence is specifically committed to obtain money to purchase alcohol and/or other drugs.
 - a chemist shop is burgled to obtain drugs for personal use.
 - the offender has been using illegal drugs in the company of other people who either actively or passively endorse the offender's use of illegal substances.

Programmes

Resources available to target AOD could include:

- community alcohol and other drug treatment programmes (including residential)
- individual one-on-one alcohol and other drug counselling
- departmental programmes.

Gambling

Definition

Gambling refers to both positive and/or negative gambling-related attitudes and behaviour that can be linked to an offence. Examples of gambling as a rehabilitative need include:

- A theft is committed to enable gambling behaviour to take place
- A domestic assault is committed after an offender loses at gambling

When to identify

A clear association between the offender's motivation to offend and their gambling desire needs to be established. No actual episode of gambling needs to have occurred leading up to the offence.

Gambling Programmes

Resources available to target gambling could include:

- community gambling programmes
- individual one-on-one gambling counselling
- departmental programmes (MIRP/SRP – depending on RoC*RoI)

Relationship difficulties (RD)

Definition

RD specifically relates to relationship issues within close, interpersonal relationships. RD reflects the absence of relationship skills, including the inability to helpfully manage negative relationship-related attitudes (thoughts and feelings).

Relationships do not include casual acquaintances (e.g. irregular sexual liaisons).

When to identify RD

To identify RD, negative relationship-related attitudes need to be linked to the primary offence. RD can also be identified in cases where the offender's absence of relationship skills in relation to a specific relationship situation (this can include partner, ex-partner, close and immediate family members) contributed to their primary offending behaviour.

To assess this need, no actual episode of a relationship interaction needs to have occurred in the offending. If the offender's partner/ex-partner or close and immediate family member is the victim of their offending, consider whether family violence need is the predominant need rather than relationship difficulties.

Examples of RD

- Arguments between person and partner that are responded to with substance abuse
- Damage to ex-partner's property as revenge for past grievances
- Commission of an offence with brother-in-law who is a patched gang member

Programmes

Resources available to target RD could include:

- relationship services
- family therapy/relationship counselling
- court approved family/relationship counselling
- departmental programmes (MIRP/SRP – depending on RoC*RoI)

Offence related sexual arousal (ORSA)

When to identify ORSA

ORSA should always be identified when the offending includes a sexual offence. This rule is based on the assumption that every sexual offence has some degree of sexual arousal or sexual desire/ excitement associated with it.

ORSA can also be identified in the absence of a sexual conviction when offence-related sexual attitudes and actions can be linked to the offending. For example, following a domestic burglary conviction, the offender acknowledged sexual excitement at the possibility of a sexual encounter while in the house.

Programmes

Resources available to target ORSA associated with offences against children could include:

- STOP programme
- SAFE programme
- psychological counselling/departmental psychologist
- Resources available to target ORSA associated with offences against adults could include psychological counselling/departmental psychologist.

Offending supportive attitudes and entitlement (OSA&E)

Definition

OSA&E reflects a general anti-social/pro-criminal attitude where engaging in illegal activity may be considered a 'legitimate pathway' or an occupation. It may also reflect individuals who simply do not consider that the law applies to them. These offenders often have a strong sense of entitlement and an egocentric perception. This need relates to the offender's criminal history and patterns of behaviour, not just the current offence.

When to identify OSA&E

OSA&E can be identified when:

- an offender's decision to engage in the illegal activity is a deliberate and often pre-planned decision
- an individual is actively associated with organised crime (i.e. where offending is considered a business) and/or actively involved with gangs
- offending patterns reflect recidivist offending with little concern about legal consequences or court sentencing (i.e. court sentences have little impact with regards to changing OSA&E and subsequent offending behaviour)
- it can also incorporate lifestyle burglars, drug dealers, and recidivist driving offenders, including drunk driver.

Examples of OSA&E

- An attitude of the rules (laws) are meant to be broken and don't apply to me
- An attitude of 'you are only offending if you get caught for it'
- An attitude of entitlement (e.g. 'I have the right to beat my wife because I am the head of the house')
- Victim stance (e.g. 'the victim got what they deserved for victimising me')
- Adherence to a "criminal code" (e.g. no narking, Police or authority generally seen as 'the enemy')

Programmes

Resources available to target OSA&E include the Department's Medium and High Intensity Rehabilitation Programmes. Referral to these programmes is dependent on the risk profile of the offender.

Unhelpful lifestyle balance (ULB)

Definition

ULB refers to a situation where:

- an offender has a significant lack of purposeful, meaningful, or constructive structure in their daily routines, or
- an offender's usual routines involve engaging in a number of negative, unhelpful, or illegal activities

This need relates to the offender's criminal history and patterns of behaviour, not just the current offence.

When to identify ULB

ULB is identified by looking at how an offender typically uses their time. It can be identified when: a lack of lifestyle balance increases an offender's pre-disposition towards offending and places them at increased risk of engaging in illegal behaviours

- an offender's usual routine does not involve using their time in a structured, purposeful way that is self-enhancing or positive for them, or
- an offender's usual pastimes involve engaging in negative, unhelpful or illegal activities

Examples

- An unemployed person who gets up at a normal time and engages in positive routines, such as exercise, gardening, actively seeking employment, attending their appointments, maintaining positive social connections, or engaging in volunteer work, would not be considered to have an unhelpful lifestyle balance despite being unemployed
- An unemployed person who gets up when they wake up, engages in regular substance use, associates with other drug users, watches TV/DVDs or plays PlayStation/Xbox all day and does not seek employment would be considered to have an unhelpful lifestyle balance

Programmes

Resources available to target ULB include the Department's Medium and High Intensity Rehabilitation Programmes. Referral to these programmes is dependent on the risk profile of the offender.

Offending supportive associates (OSA)

Definition

OSA focuses on the social influence towards offending in general. The social influence towards committing offences can either be active (i.e. directly endorsed) or passive (i.e. not discouraged). This need relates to the offender's criminal history and patterns of behaviour, not just the current offence. It is only canvassed when undertaking the full pre-sentence report assessment interview.

When to identify OSA

OSA should always be identified when offending involves a co-offender as this suggests that the offender's associates are offence-supportive. OSA can also be identified if the offender acknowledges regularly associating with individuals who are involved in illegal activities (e.g. gang members or associates involved with either using or selling illegal drugs).

Example: An offender's cannabis-smoking mates who also assist with burglaries and/or the distribution of stolen property or drugs would be considered offending supportive associates.

Programmes

Resources available to target OSA include the Department's Medium and High Intensity Rehabilitation Programmes. Referral to these programmes is dependent on the risk profile of the offender.

5.2.4 Reintegrative Needs

Probation officers assess rehabilitative needs pre-sentence, and post-sentence, they will also focus on reintegrative needs. These needs are things that will assist offenders to reintegrate into the community. There are seven areas of reintegration that they focus on.

Accommodation

The offender has this need if they...

- are living with other offenders
- have no accommodation or unsuitable accommodation
- are or their dependants are at risk of harm from others residing at that address

Employment

The offender has this need if they...

- are not in training or education
- have no job (may not apply if the offender is in voluntary employment, a single parent, primary caregiver, a sickness beneficiary or retired)

Finances

The offender has this need if they...

- have no income source (may not apply if the offender is supported by a partner or parents or is under age for benefits)
- owe money (including child support, court fines/reparation)

Relationships

The offender has this need if they...

- Have difficulties with important relationships (partner, children, family/whānau).

Positive Community Support

The offender has this need if they...

- have no involvement with community organisations
- have no hobbies or interests that are non-criminal
- have no supportive non-criminal family or friends

Victim Related Problems

The offender has this need if they...

- Are likely to have contact with a victim that would cause problems for the offender and/or the victim.

Healthcare Continuity

The offender has this need if they...

- Have on-going health issues or problems.

5.2.5 Motivation Responsivity

Consider the role of motivation on responsivity. Motivation is an element that is internal to the offender only... or is it?

Motivation is a responsivity issue, and it is not just an internal obstacle of the offender's. In other words, motivation is also a product of the interactions between the person, their situation and those who are involved in their sentence management.

In summary to the concepts of risk, need and responsivity, ask yourself the following series of questions:

- What does the risk principle tell us if we want to reduce reoffending?
- What does the need principle tell us if we want to reduce reoffending?
- What does the responsivity principle tell us about reducing reoffending?
- Which of these principles is the most important to gaining the desired outcome of reducing reoffending?

(Answers are below):

- (it tells us who to target, i.e. higher risk offenders)
- (it tells us what to target, i.e. rehabilitative/criminogenic needs)
- (it tells us that some factors may exist that will either reduce or increase an offender's amenability to interventions and their ability to benefit from these; the probation officer and the AOD worker have a role in identifying and working with the offender/client on these)
- (all of them are important and none can afford to be ignored without having a detrimental impact on outcomes)

5.3 References

Andrews, D.A. & Bonta, J. (1998) *The Psychology of Criminal Conduct* (2nd edition). Cincinnati: Anderson Press

Working with People in the Criminal Justice Sector

Module Six: Working across Systems

About this module

Purpose

This section explores the importance of working as part of a team, collaborative working relationships (including communication) and working with probation services.

Objectives

By the end of the section, participants are able to:

- Know what to expect when receiving a referral from a probation officer.
- Understand what makes good collaborative relationships work.
- Understand confidentiality in the Department of Corrections.

6.1: Working as Part of a Team

We are all used to working as a team at some level, and organisations usually have different teams according to the focus of their work. Various teams within an organisation work together towards the goals of the organisation, for example, clinical teams working together with administration and management teams for the benefit of clients. What we would like to discuss here is working across different organisational teams who are all working with the client, which in this example, would be AOD clinical services and justice services (as well as others who may be involved with the client and their family and whānau).

As a way of illustrating this concept, we have set out a quadrant below, with the following headings:

- the risks to client when not working effectively as a team
- mitigations of the risks
- factors that make a good team
- what it means for me

Let's imagine for a moment that you have been referred a client from a probation officer, because the offender has a special condition to attend AOD counselling. Think through the answers to the following questions:

1. What do you expect from a probation officer when receiving a referral for a client with a mandatory requirement for treatment?
2. What information would you expect a probation officer to share with you about the client?
3. What information about the client would you expect to share with the probation officer?
4. What are some of the potential risks to the client if you are not working as part of a team?

After consideration of the first three questions, write your answers to 4) above in the top left quadrant. Next, while looking at those risks to the client (top left), consider what things might mitigate (reduce or eliminate) these risks, and write your answers in the top right quadrant.

Comment: It is important when working with an offender to consider the team of professionals who are supporting the aims to reduce reoffending and make the community safer. So, what do you think makes an effective team? Write your thoughts on this in the bottom left quadrant below. Now, ask yourself: “What does that mean for me to be working as part of a team – what is required of me?” Enter these ideas in the bottom right quadrant:

Risks to client when not working as an effective team	Mitigations

Factors that make a good team	What it means for me

In drawing together the themes covered, we can recognise the importance of establishing and maintaining sound relationships with Corrections staff, particularly probation officers, in order to have meaningful conversations with them. The points made in the quadrants below are some examples of what could usually appear in the spaces under each heading. If you found the initial quadrants difficult to complete or if some points in the example below do not appear in your quadrant, then you may wish to fill in the bottom left quadrant “What it means for me” in the sample below. The resulting points could have important implications for your practice and the agency that you work for.

Risks to client when not working as an effective team

- lack of communication about the client – risks, experiences, previous interventions
- lack of communication around client’s challenges and progress, in terms of progress or risk, which needs to be understood within the wider context of their sentence
- client feeling unsupported
- misdirection of casework / treatment (unaligned with the risks, needs and responsivity issues identified by the probation officer) or working at odds with the probation officer
- inability to support wider safety planning
- lack of co-operation with, or alienation of, probation officers and the potential for strained relationships between the agency and the Department
- lack of credibility

Mitigations

- talking to others
- regular updates/conversations with the probation officer
- putting effort into networking
- knowing the role of the probation officer and sentence management processes (and taking into account the wider justice context)
- having a clear direction in casework
- asking the offender to talk about other aspects of their sentence
- providing the probation officer with examples of the offender’s progress and giving suggestions on how the probation officer can support the offender’s treatment/learning

Factors that make a good team

- belief in working collaboratively
- good communication
- building relationships in the team and knowledge of the people involved in the team
- clarity of roles
- respect for each other’s strengths and role

What it means for me

6.2 Collaborative Working Relationships

Adapted from Christensen, Todahl, & Barrett (1999).

Introduction

As a practitioner you know that many caseworkers or probation officers may be reluctant to talk to mental health professionals about therapeutic outcomes. There has been a belief that ‘therapy’ was not theirs to question.

The practitioner or programme provider should not assume that because the caseworker or probation officer does not ask about the therapy that they do not care. Quite the contrary, they may care a great deal but are too respectful to bring up issues so as to not ‘invade the therapist’s turf’.

It is therefore helpful for the practitioner to extend an interest in discussing the client/family and whānau with the caseworker or probation officer and assist the worker in organising the information by asking questions that elicit useful information.

Talk Early & Often

It is critical for caseworkers and programme providers to have contact at the time of referral. However, the conversations should not stop there. All members of the team must resist the ‘no news is good news’ assumption that is so prevalent in the busy professional’s life.

‘No news’ is almost always bad because it means that the team members are not communicating their efforts, not updating progress, not examining setbacks and lapses, and not reminding themselves what the original outcomes and objectives were.

This lack of communication, even after a case has started out correctly, not only puts collaboration at risk but could also put members in the team into an adversarial relationship.

Creating an Audience for Change

How soon can progress be noted? Many programme providers, therapists, etc. are cautious when answering this question, as are many caseworkers and probation officers. They are waiting for the ‘other shoe to drop’ and do not want to look foolish. These professionals are locked into a conceptual map that goes back to the disease model i.e. the disease is not gone as long as any of its symptoms remain.

Based on this old model the professional is always on a ‘search and destroy mission’ for signs of disease (problem behaviour). But from a solution-based approach to relapse prevention, the professional understands that the new behaviour (healthy behaviour) is already present in a person’s life, it is just not sufficiently applied during high-risk situations.

They also understand that the old behaviour will remain a potential in the person after the treatment work is done. However, it will be more under control, will be less intense, and won't last as long. The criterion changes from 'present or not' to 'affecting family life or not'.

So when is it too early to notice change? The simple answer from a solution-based approach is that it is never too early. In fact, the practitioner, programme providers, caseworker and probation officer should assume that change has already begun before the client came to see them. This might be the result of the referral, the safety plan, or the client's own efforts to get control of the problem. Searching for solutions, the worker enquires about change that has already occurred prior to attending counselling or treatment. Since the worker wants to draw attention to that change, s/he may ask the client whether anyone has noticed the new behaviour or attitude. The worker assumes that the old behaviour is still a significant risk, and may always be a risk for them. However, by attending to the new behaviour, the worker becomes an initial audience for the emerging new story about the client.

The next critical question is, "Who else needs to know that is occurring?" Celebrating change need not wait until the new skill is safely acquired. An awareness of risk and encouraging progress can and should go hand in hand. Obviously, this gives both the casework and the practitioner/programme provider something to talk about and notice.

Share Lapses in a Specific and Timely Manner

Time alone is a risk factor in ongoing cases and it takes considerable effort just to keep everything on track. Therefore, the reliance of the entire partnership on the case plan is critical. Sharing progress and difficulties in a specific and timely manner is best done with specific reference to the particular tasks they were supposed to occur in the client's prevention plans.

If a client is having difficulty documenting his/her efforts around a specific task, then the partnership should consider that difficulty a lapse back into risk behaviour, and the issue should trigger contact between team members. This timely response to a lapse into the old pattern is contrasted with the policy of waiting to contact team members until a true relapse has occurred. The latter tendency to wait until there is a problem is reactive versus preventative and results in more intrusive remedies. When a client is working steadily on their issues, most practitioners/programme providers, caseworkers and probation officers assume that there is nothing to contact each other about. However, from a solution-based perspective, it would be helpful to notice and capture exactly those times (exceptions).

This is a possible list of issues for caseworkers and providers to discuss at any time:

- What topics and situations are hot for them right now?
- On what developmental issues do they seem to do OK?
- How quickly are they able to recognise that tension is building?
- Are they able to recognise any thoughts that warn them escalation is near?
- What have they decided to do in order to avoid high risk issues/situations?
- What seems to work for them in these high risk times?
- What are they going to try and do if they think tension is building?
- Have they had occasion to use their safety plan?

Benefits and Challenges of Shared Casework Goals

We have started to think about what it means to work as a team across systems. We want to take what we have considered so far and apply this to considering the idea of shared casework goals.

Balancing Care and Control needs for AOD services and Justice:

Control aspects (Justice): (short term risk control through sanctions)

- Incapacitation / incarceration
- Direct contact
- Supervision of conditions
- Electronic monitoring
- Drug testing /screening
- Restraints
- Setting limits

Care aspects (AOD): (long term change risk reduction through intervention)

- Treatment and programming
- Co-operation and collaboration
- Challenging choice
- Ownership and responsibility
- Teaching and supporting self-risk management
- Communication / upholding limits clearly

What crossover is there between the rehabilitative focus and the concern for public safety?

Is the voice of the offender usually in the justice sentence plan?

Benefits and challenges of shared casework goals

	Benefits of shared casework goals	Challenges of shared casework goals
Agencies (AOD & Justice)		
Clients		

Considering the balance of AOD and justice services needs and using the framework shown above consider the benefits and challenges of shared casework goals from both an organisational perspective (justice and AOD), and a client perspective. See if you can come up with at least two different ideas for each.

Having Meaningful Conversations with probation officers: An exercise

The points of contact that a probation officer should be having with an AOD provider include;

- at referral
- at regular intervals during the programme
- at programme termination.
- The probation officer may also have contact with the programme provider pre-sentence when canvassing sentencing options.

The points of contact a programme provider could have with a client's probation officer are;

- at regular intervals over the course of treatment
- when nearing treatment completion
- when there are concerns regarding risk or non-compliance.

We have been discussing the nature of our relationships with probation officers and the desirability of working together as a team. We need to think about when we talk to them and what we talk with them about.

Now, think about a generic or typical client who is likely to be referred to you as part of their special conditions. Your task is to think about the points throughout the treatment / counselling when they think it would be important to have contact with the probation officer. The timeline across the space below represents the course of the treatment / counselling, and you can map the contact points onto this. (You may wish to use a separate piece of paper for this exercise).

Timeline:

Start.....Discharge

Next, record (under the timeline) what you need to talk about at each point of contact – think about this both in terms of what you need to know from the probation officer and what you as programme/ treatment providers need to let the probation officer know. Think about this in terms of both progress towards change and risk identification and management.

6.3 Probation officers Making Referrals

Community Probation officers’ Operations Manual

The procedure for probation officers making referrals is covered in the Community Probation Officers’ Operations Manual.

<http://www.corrections.govt.nz/policy-and-legislation/cpps-operations-manual.html>

Referral Procedure

An AOD service might negotiate with their local CPPS Office around processes and protocols to be used in any referral system.

A probation officer has to make a referral for each special condition outlined in the offender’s sentence plan. All referrals should have been either actioned or scheduled in the offender plan within one month of sentence/release. For particularly high risk offenders included in the Department of Corrections offender warning system (OWS), the first referral is made within one week of sentence or release.

If the order/licence does not specify the intervention, the probation officer needs to match the offender to an appropriate agency or programme. They are to provide the offender with information about the agency or programme requirements.

The probation officer also has a responsibility to explore and identify any barriers the offender may have to participating in an internal programme or external programme/counselling and, where necessary, work with the offender to develop strategies to overcome barriers. The probation officer must also discuss with the offender the boundaries of confidentiality.

Monitoring

The type and frequency of contact that a probation officer has with a programme facilitator or sponsor will depend on the nature of the programme or intervention being undertaken.

There are a number of types of contact:

- by three-way meeting with probation officer, offender and programme facilitator/sponsor
- by meeting with the programme facilitator/sponsor
- by telephone, or
- through written reports, in conjunction with direct contact.

In terms of frequency of contact, the Operations Manual says that as a guide, minimum contact should be monthly depending on the intensity of the programme and the requirements of the sentence. For offenders subject to Home Detention or those on parole with residential restrictions, contact should follow each session to confirm attendance with the special condition and the approved absence.

While on a programme, the offender needs to continue their scheduled reporting to their probation officer. If the programme is residential, the offender may report to the probation officer at agreed times at the residential facility.

6.4 Confidentiality within the Department of Corrections

Within the Department of Corrections, confidentiality is based on the principle that information about an offender's characteristics, circumstances or behaviour is private, and should be made known to others only if necessary. It may be necessary to share information to comply with relevant legislation, or in order to reduce a specified risk.

It is important that offenders are made aware of the limitations to confidentiality, both in terms of the information provided by them and information known about them.

Legislative references

Information held by the Department of Corrections is governed by six pieces of legislation:

- Privacy Act 1993
- Official Information Act 1982
- Victims' Rights Act 2002
- Sentencing Act 2002
- Parole Act 2002
- Criminal Justice Act 1985

The basic principle of the Official Information Act is that information should be made available unless there is good reason for withholding it. The Privacy Act on the other hand, works on the principle that personal information about offenders is private and it may only be collected and used for lawful purposes.

The Sentencing Act and the Parole Act 2002 make provision for the disclosure of information in specific instances.

Offender rights versus community interest

Determining good reason for collecting, using, withholding or releasing information involves weighing up the intrusion on the privacy of an individual offender against the public interest in the release of the information.

What is, and what is not 'necessary' sharing of information can be controversial when the confidentiality of the offender conflicts with the need of the community to know about the offender, either to:

- help the offender, or
- protect the community

Helpful Conversations with probation officers

In your work across systems, it may be helpful to think about creating a checklist to aid you in having helpful conversations with the probation officers who refer offenders for treatment/counselling. First, think about what you need to know when a probation officer contacts you regarding a referral, and then think about what you need to share with the probation officer and what information you need from them during the course of treatment/counselling. Create your own list using some suggestions below:

What do you need to know? (some examples)

- Sentencing arrangements, length of sentence, requirements specific to alcohol and other drug treatment programmes, other issues regarding identified needs (for example, mental health etc), family and whānau considerations (including child protection issues), identified security or other risks, etc.

What do you need to share? (some examples)

- Criteria for attending, length/nature of your treatment programme (residential or outpatient), medication needs (if any) and possible effects for their information (for example, methadone), other identified treatment needs (mental health etc, if not already known), if the client has not attended or is discharged, etc.

Think about your service and what it offers, and what would improve the present relationship with justice services, keeping in mind the goals of both.

6.5 Building Local Relationships

This section allows the opportunity for you to consider your local relationships with Community Probation and Psychological Service and to begin planning on how to build, develop or strengthen those relationships. What would best practice look like for relationships between Community Probation and Psychological Services and ourselves? Are there any specific issues for us to consider from a Māori or Pacific Islands perspective?

Use this as an opportunity to begin to plan how to build, develop, or strengthen local relationships between your service and those you interface with, including justice services.

Questions to consider in your plan include:

1. Who are the people we need to build relationships with and what's the current status of those relationships (consider the status from both perspectives – yours and the probation officers)?
2. What is it that we want to achieve? Describing it is one step closer to it happening.
3. What steps do we need to take to get there?

After thinking about the present situation, think about creating new systems and relationships that will be beneficial not only to services, but clients as well.

Some possibilities may be:

- Identifying liaison people in both services who could be contact points for each service.
- Checking out the limits of confidentiality for clients when referred from justice services, and establishing what the needs of probation officers are which don't conflict with these.
- Designing confidentiality forms appropriate to needs above, so clients feel confident about their rights and services have clients' signatures and are consistent with boundaries.
- Visiting each service (reciprocal) with presentations, information, in order to build relationships and understand each other's needs.
- Create opportunities to share perspectives on clients' progress (review) which benefits the client, without compromising confidentiality.
- With complex justice/AOD/mental health clients, have a primary case manager who liaises with other services and shares pertinent information, and manages crisis situations with support from the rest of the team, including probation officers.

The important thing is to develop a plan and add in things pertinent to the nature of your service, and make a commitment to sharing this with others in the treatment team as well as managers, so that an effective plan for working across services is developed and maintained. This makes everyone's work with their respective clients easier, and has positive benefits for these types of clients, who over time are likely to appear across various clinical and social services, as well as the justice system.

6.6 References

Christensen, D., Todahl, J. & Barrett, W. (1999) *Solution Based Casework: An introduction to clinical and case management skills in casework practice*. New York: Walter de Gruyter.

