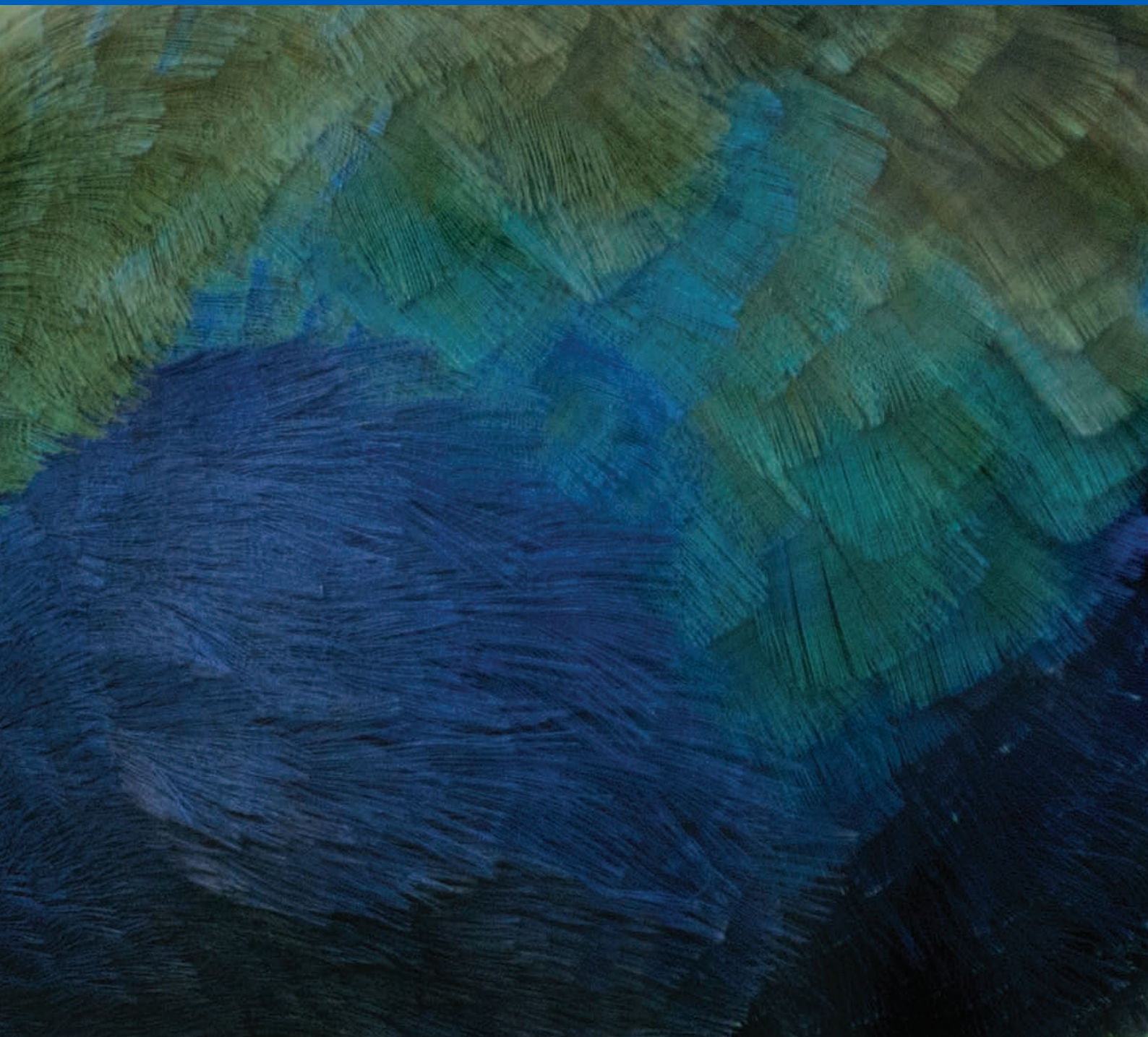
Matua Raki
National Addiction Workforce Development

Supporting people with mental health and/or addiction problems who are involved with the justice system

A reflective workbook



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Disclaimer:

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Contents

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Introduction

Welcome to the *Supporting people with mental health and/or addiction problems who are involved with the justice system* reflective workbook. In early 2008 Matua Raki, commissioned the development of a training package as part the Ministry of Health's Effective Interventions First Step programme. The aim of the training was to support workforce development in the addiction sector[1] to enable the workforce to competently respond to people with substance use issues who are in, or have been in, the justice system.

Abacus Counselling, Training and Supervision Ltd and HMA Ltd were jointly contracted to develop and deliver training throughout 2008 and 2009. Evaluation of the workshops indicated there was improved engagement with people involved in the justice system as well as improved networking and collaboration with justice services, in particular Community Probation Service (CPS).

In 2011 Matua Raki redesigned the workshop materials into a reflective workbook so the workshop information could be more widely accessed and to support self-directed learning. The current update reflects changes in the justice sector since this time and also recognises the high prevalence of mental health and other co-existing problems amongst people who are involved with the justice sector. The content of this workbook, however, does not address the needs of the forensic mental health workforce who are supporting people with mental health and addiction problems receiving care and treatment from forensic mental health services.

Matua Raki and Te Pou hope this workbook will be used in a variety of ways, including:

- as a resource services or teams may use to develop their own in-service training
- as a reflective manual for individual workers to review their own practice with people who are in, or have been in, the justice and/or corrections system.

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

1 - In this context addiction is used as a generic term used to refer to the alcohol and other drug and problem gambling sectors.

Section one: Attitudes

Purpose

This section introduces the workbook and explores attitudes and values needed to work effectively with people who have addiction (substance use, gambling) and/or mental health problems, and who are or have been involved in the justice system (outside of the forensic mental health system).

Objectives

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

- understand some of the different ways in which the mental health, addiction and justice sectors engage with people
- consider the different language used in these distinct sectors, and how this may affect the way you think about and work with people
- examine your own thoughts and attitudes towards working with people who are or have been part of the justice system
- consider elements required to work and engage effectively with people in this situation.

1.1 Attitudes to work effectively with people who are involved with the justice system

The health, social service and justice sectors often work with the same people, but have traditionally been funded and managed separately and have evolved in different ways. The focus of the mental health and addiction sector is different from the justice sector and workers have different sets of knowledge and skills despite many sharing similar qualifications. There are specific skills and competencies required to work in the areas of mental health and addiction that contribute to recovery and wellbeing, just as there are specific skills and knowledge required to work with offenders both in prison and in the community. Sometimes offenders are also mandated by the court to undertake treatment programmes (for example addiction and/or anger management) and it is in these circumstances that the similarities and differences between the sectors become obvious.

About the justice sector

The Ministry of Justice is the lead government department in the justice sector, which includes the New Zealand Police, the Department of Corrections, the Crown Law Office, the Serious Fraud Office and Child Youth and Family (part of the Ministry of Social Development). The sector's shared aim is to reduce crime and enhance public safety.

The justice sector is involved at every level with the pathway through the criminal justice system. It extends from the investigation of crime, arrests and prosecutions, through to courts, sentencing, and sentencing management and rehabilitation. In this highly regulated system, policies and approaches in one part of the system can have significant effects on others.

Areas of health and justice overlap when the respective workers are involved with a person with mental health and/or addiction problems who has been convicted of a criminal offence. To ensure the best outcomes for the person, the workers need to have knowledge of each other's sectors. The attitudes of the respective workers towards people who have offended and towards people with mental health and/or addiction problems need to be appropriate for effective cross-sector collaboration to occur.

For this reason it is important for mental health and addiction workers to examine their own attitudes about people with mental health and addiction problems who have committed offences. If we give a negative impression to people, or find it difficult to engage with people who have offended because of our own prejudice or judgements, then the therapeutic relationship is likely to be ineffective. This is likely to mean people's needs go unmet with additional long-term implications for the individual, their family and whānau and/or the wider community. Some of these implications may include the potential for further offending and under-treated addiction and/or mental health problems.

Take a moment to reflect on the attitudes you and others may have to offenders who have mental health, substance use and/or gambling issues.

- Are people's rights to treatment for health issues always considered, or are they put aside until they have done their time and then show genuine desire to receive support or attend treatment?
- Are their requests for treatment often thought of as an opportunity to make a good impression in court or avoid imprisonment?
- Do attitudes change in response to different types of crime; violence towards women and/or children, property, fraud, sex crimes etc.?

Write some of your thoughts here.

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

Recovery

There are many different definitions of recovery that seek to define what it might mean for people who experience mental health and addiction challenges, although it is a very personal experience. *The Competencies for the mental health and addiction service user, consumer and peer workforce* (Midland DHB Mental Health and Addiction Regional Network, Northern Regional Alliance and Te Pou o Te Whaakaro Nui, 2014) define recovery as "creating a meaningful, self-directed life regardless of challenges faced, that includes building resilience, having aspirations and the achievement of these".

Consider the following statements adapted from the UK Drug Policy Commission Consensus Group's (2008) definition of recovery.

- Recovery must be a personal choice in order to be lasting, although it may sometimes be initiated or assisted by coerced or mandated interventions within the justice system.
- Control over substance use and/or improvement in mental wellbeing can be key parts of recovery, but may not be a necessity. Positive health and wellbeing and participation in society are also central to recovery.

How do these complex concepts fit together and work in reality?

The first point highlights the person's choice and self-responsibility followed by the concept of recovery potentially being initiated through mandated treatment and coercion.

The second point highlights positive health, wellbeing and participation in society as important aspects of recovery.

The role of mental health and addiction workers is to support the person to take self-responsibility to manage their own wellbeing and, in terms of justice involvement, to manage their own behaviour including their offending. However societal attitudes to offenders usually include an expectation of punishment and exclusion, and there is generally a lack of acceptance of offenders in wider society along with limited employment opportunities. What impact is this likely to have on recovery?

Write some of your thoughts here.

1.2 Thinking about attitudes

There are a number of different thoughts about how practitioners should work across the interface between the health and justice sectors. Some common assumptions and concerns from those in the health sector about working with people who have been involved with the justice sector might include that:

- sharing health information with those in the justice sector is inappropriate
- rights to access treatment are compromised when people commit a crime
- if treatment is part of sentencing then recovery may be superficial as motivation is only extrinsic or external.

However, many practitioners believe that any potential opportunity to treat addiction and mental health problems should be utilised and that all attempts should be made to intervene to minimise addiction and mental health related harm, including harms to family, whānau and the community. No matter how people get to specialist services (self-referral, referral because of someone else's concerns, or referral as part of a justice process) it is a window of opportunity for intervention.

For example, using a motivational approach with someone allows the person to explore their own concerns

about substance use, gambling, mental health and/or offending. If there is a continuing assumption that people involved with the justice sector have no interest in change then the potential for opportunistic and timely interventions will be overlooked and the person may maintain unhelpful patterns of thinking and behaviour, remain in the system, and continue to cause harm to themselves, their family, whānau and communities.

One of the most important things treatment can offer people (their families and whānau) is hope. Some people may not appear to make much progress, but even small steps can mean a lot to them in the context of their background. Mental health and addiction workers have great potential to support people to make change as long as they are prepared to maintain a positive, non-judgemental attitude and explore solutions that work for each individual and their family and whānau.

Recovery

Recovery is supported by treatment services that follow these principles:

- self-direction and self-determination
- consumer empowerment
- individualised and person-centred care
- holistic and integrated care
- non-linear journeys of personal growth and healing
- strengths-based approaches
- peer support
- hope.

(Mental Health, Drugs and Regions Division, Victorian Government, 2011:4)

Recovery is about building a satisfying and meaningful life, as defined by the person themselves, not simply about reducing or stopping problematic substance use, gambling and/or the absence of mental health challenges.

Both addiction and mental health challenges include features of social withdrawal and a tendency to isolate from supports. People do not recover in isolation. Recovery embraces social inclusion, or a re-entry into society, and the improved self-identity that comes with a productive and meaningful role. For people who experience addiction problems, recovery often includes the idea of giving back to society and others, such as family and whānau members, who may have been adversely affected by the individual's substance use and/or gambling.

Take time now to consider the key features of recovery and reflect on the description of recovery.

Do you agree with this description of recovery? If so why? If not, why not?

What does this description mean for people who do not abstain from substances and/or gambling and/or are still experiencing mental health problems?

How important is it that recovery does not occur in isolation? Why?

There are six statements below about people who use addiction and mental health services and have been involved with the justice system. As you read these statements think about how certain processes and attitudes can negatively impact on the different sectors working together and lead to poor outcomes for people.

As you consider your own thoughts and attitudes regarding these issues, think about what changes could be made to embrace the description of recovery described above.

Write the reasons why you support or do not support the statements or reasons below.

1. **Offenders should have the same rights to treatment as other people with substance use, gambling and/or mental health problems.**

I support this statement because:

I don't support this statement because:

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

I support this statement because:

I don't support this statement because:

3. **If treatment is mandated by the justice system and people aren't ready or motivated then they may resist it, so it shouldn't be mandatory.**

I support this statement because:

I don't support this statement because:

4. **Treatment is about recovery in mental health and addiction services, but in the justice system it is part of preventing reoffending and punishment.**

I support this statement because:

I don't support this statement because:

5. **Even mandated treatment can be useful as people have many reasons for not seeking help and any opportunity to offer and support change should be considered.**

I support this statement because:

I don't support this statement because:

6. **Mandated treatment is sometimes necessary in order to help the person, their family and whānau, and the community.**

I support this statement because:

I don't support this statement because:

Research has highlighted that mandated treatment can have effective outcomes. A 2011 study of outcomes for people directed to attend a community alcohol and drug treatment programme in Auckland (Wheeler et al., 2011) indicates they had significantly reduced alcohol and cannabis use at three and six months and that physical and psychological health was also improved at six months. Participants also indicated treatment had helped them to reduce their level of offending.

Mandated treatment for mental health problems has been found to be cost effective (Swanson et al., 2013) but has been challenged on ethical grounds, especially when provided in institutional settings.

Meta-analysis of the research into the effectiveness of mandated treatment has shown contradictory outcomes, but results appear to be confounded by inconsistent use of terminology and comparing community and custodial settings. Treatment appears to be more effective when provided in the community especially when levels of coercion are less extreme.

1.3 Values and attitudes

All behaviour has consequences but how people view these consequences depends on their personal background, beliefs, perspectives, values and attitudes. When we consider other people's behaviour we tend to compare it to our own upbringing and experiences and to what we or our family and whānau and friends and/or acquaintances would do in certain circumstances, or what is considered normal or usual in our social circles. This can colour our opinions and judgements of others. We tend to judge behaviour in several ways including:

- the actual outcome of the behaviour
- the intent attributed to the behaviour
- what factors contributed to the behaviour (including background and circumstances).

You may also think differently about behaviour depending on whether or not you think others will know or find out about it, whether it is legal, whether you will get caught, whether others are harmed by it or what you think you can 'get away with'.

Sometimes it may depend on whether there are mitigating factors which might make the behaviour more acceptable or, at least, understandable.

Exercise

The scenarios in the following exercise represent common behaviours that sometimes bring people into the justice system. This exercise provides an opportunity to examine your own attitudes to a variety of situations which could be relevant to people who are involved with both health services and the justice system.

Read through all of the scenarios then rank them 1 to 12 by how acceptable you think each behaviour is, with 1 being the least acceptable and 12 being the most acceptable, and enter the reasons for your choice. Think about all factors including intent and direct or potential consequences for the person and others. There are no right or wrong answers and how you answer is strictly up to your own judgement.

1. **She got in the car to drive home after the party, knowing she'd had a couple more drinks than she intended, as she felt fine.**

   Rank:

   Reason:

2. **To alleviate feelings of anxiety she shoplifted some perfume.**

   Rank:

   Reason:

3. **Though he was disqualified from driving, he drove his mates home as they were too drunk to drive.**

   Rank:

   Reason:

4. His wife bad-mouthed him in front of her mates so she deserved a back-hander.

Rank:

Reason:

5. He stopped taking antipsychotic medication while continuing to smoke cannabis and later attacked his mother because his voices told him she was the devil.

Rank:

Reason:

6. He's been prescribed some morphine tablets for pain because of prostate cancer, with two repeats, and a 'friend' offers him $300 for a packet – he took it as he needs the money.

Rank:

Reason:

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

Rank:

Reason:

8. **He stole the charity box at the dairy to use the change to play the pokies.**

   Rank:

   Reason:

9. **She was desperate to buy 'p' and offered the landlord sex so she could keep the rent money.**

   Rank:

   Reason:

10. **Going home from seeing her therapist, she noticed that a car door was unlocked, no-one was around, and the cell phone was just lying on the seat, so she took it.**

    Rank:

    Reason:

11. **She was really upset when he came home drunk and he hit her, and this morning he is shocked that he doesn't remember how she got the black eye.**

    Rank:

    Reason:

12. He drove home after a party, hitting a cyclist, but kept going, rather than risk a drink-driving charge.

Rank:

Reason:

Now that you have arranged the behaviours in order from 1 to 12, think about the decisions 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. It's only an issue (apart from conscience), if someone finds out or we are 'caught', isn't it?
- 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 our professional training and expectations?

1.4 Definitions, language and elements of helpful relationships

How we describe people and their behaviour often reflects how we feel and think about them and therefore how we respond to and treat them. Categorising people can enable us to talk about them as a group but it also serves to allow stereotypes to develop 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 to the person concerned, with associated effects on their attitude and self-esteem, and also to practitioners, probation officers, and judges, who might be involved in their care.

In this part of the module we briefly examine how labelling people can affect perceptions of them before we even meet. When others apply labels that have certain connotations it tends to colour our judgements, sometimes subtly, and this can affect our engagement with that person. In turn this can affect the ongoing relationship. This applies even more so with issues like substance use, gambling, mental health problems and offending, which are all generally subject to stigma.

This exercise offers an opportunity to consider labels and associated attitudes and to reflect on how these can impact on your engagement with people.

In the case of terminology (language), words that are chosen to de-stigmatise have fewer negative connotations and encourage equality of attitudes. It is both respectful and clinically accurate to be considerate with the words we choose to use about people and their issues. For example, what effect does referring to someone as an *alcoholic* have, in comparison to referring to someone as being severely dependent on alcohol or having an alcohol use disorder? What effect does it have to refer to someone as a *nut job* rather than as having bipolar disorder?

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 substances, gambling, mental health challenges and the justice system.

Below is a statement in which the language used could be seen as judgemental and unhelpful. It 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 person is perceived and, as a result, may be treated.

> **"...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 schizo 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 about the people described, and how would these affect your perception of them 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 the people in this scenario. Empathy and respect are essential for building a successful relationship for working with people and stereotyping and labels can interfere with that.

Accurate and respectful terminology is an important element in our professional communications, both verbal and written. Pejorative, negative or stereotyped terminology contributes to reduced respect, prejudiced treatment and reduced expectations. Consider the concept that some behaviour is a result of a disorder or illness. Consider the different way these behaviours could be interpreted and responded to. Consider also the effect of these perceptions on empathy, and the development of a relationship with the person.

Language has more impact than is often acknowledged. 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 "common language in use reflects a worldview and in itself can reproduce relations of dominance and subordination". Language is a key medium to reinforce social, cultural and sub-cultural paradigms and worldviews.

The following terms have often been used to describe people who use substances, gamble and/or have

mental health problems and have been involved with the justice system. Which are the most appropriate? Is it just about being politically correct?

- Alcoholic/junkie/substance abuser/addict/pothead/stoner/pisshead/druggie
- Nuts/crazy/insane/unbalanced/psycho/mad/loopy
- Punter/shark/pathological gambler
- Consumer/service user/patient/client/person/tangata whai ora
- Substance use disorder/alcohol dependent/opioid dependent
- Mental health disorder/experiencing psychosis/depression/borderline personality disorder
- Gambling disorder/problem gambler
- Drunk driver/hooligan
- Driving with excess breath alcohol/drunk and disorderly
- Inmate/prisoner
- Ex-con/thief/crim/bad
- Career criminal/repeat offender/recidivist/criminally insane.

Which terms sound most negative, and which sound more appropriate for health and justice professionals?

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 and whānau. Some people also self-stigmatise and this further erodes their self-esteem which can prevent them from seeking help.

If we think people are deliberately at fault in their behaviour, rather than being compromised by something beyond their current control, empathy is reduced. The language we use conveys this.

1.5 References and further reading

Mariner, K. (2008). *Attributes for Effective Management of Pacific Health Services in New Zealand: Counties Manukau District Health Board and Le Va.* Retrieved from www.leva.co.nz

Mental Health, Drugs and Regions Division, Victorian Government. (2011). *Recovery Orientated Practice: Literature Review*. Victoria, Australia: Mental Health, Drugs and Regions Division, Victorian Government. Retrieved from http://docs.health.vic.gov.au/doc

Midland DHB Mental Health and Addiction Regional Network, Northern Regional Alliance and Te Pou o Te Whaakaro Nui. (2014). *The Competencies for the mental health and addiction service user, consumer and peer workforce*. Retrieved from www.tepou.co.nz/library/tepou/competencies-for-the-mental-health-and-addiction-service-user-consumer-and-peer-workforce

Ministry of Health. (2008). *Let's get real: Real Skills for people working in mental health and addiction*: Wellington: Ministry of Health.

Swanson, J. W., Van Dorn, R. A., Swartz, M. S., Robbins, P. C., Steadman, H. J., McGuire, T. G., and Monahan, J. The Cost of Assisted Outpatient Treatment: Can It Save States Money? *Am J Psychiatry* 2013; doi:10.1176/appi.ajp.2013.12091152.

Thompson, N. (2003). *Communication and Language: A Handbook of Theory and Practice*. Basingstoke: Palgrave Macmillian.

UK Drug Policy Commission. (2008). *The UK Drug Policy Commission Recovery Consensus Group: A vision of recovery*. London: UKDPC.

Wheeler, A., Websdell, P., Wilson, P., Pulford, J., Galea, S., and Robinson, E. (2011). Outcome evaluation of a community alcohol and other drug intervention programme for offenders serving community sentences in Auckland, New Zealand. *New Zealand Journal of Psychology*. Vol. 40, No. 3, 120-128

Notes page

What has been my key learning in relation to this module?

1

2

3

4

5

What level of knowledge or skills about this section did I have before I read it?

What gaps in my knowledge or practice have I identified?

What do I plan to do from here to increase my level of skill or knowledge? (supervision, support, cultural advice/support, further training).

Section two: Core cultural safety and cultural responsiveness

Purpose

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

Objectives

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

- understand how cultural responsiveness can benefit engagement and treatment
- reflect on your own cultural safety practice
- consider the importance of culturally congruent practice particularly when working with Māori.

2.1 Thinking about culture

Let's get real (Ministry of Health, 2008), places an expectation on the entire mental health and addiction workforce, that they will have a degree of cultural fluency in relation to working with Māori. It 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 it is meant to underpin all work with people. To ensure that workers have, or are working towards, cultural fluency it is essential that cultural competence is also supported as part of professional supervision.

As stated in section one our judgements, attitudes and perspectives will vary according to our own experience and training. Everybody is shaped by various cultural factors and influences that can influence how they work with people. A normal part of ethical professional practice is to become aware of and reflect on our own attitudes and values and how these can impact on our relationship with the people we work with. So too is reflecting on and examining our own culture and whether we impose this on the people we work with. The need for cultural safety applies to all people not just tāngata whenua. Practitioner attitudes and behaviours in regard to ethno-cultural responsiveness and competence can enhance or be a barrier to effective interventions.

What is culture?

Reflect on what you think culture is and how it is expressed or demonstrated. If you have a colleague available to discuss this with, have a brief discussion and see what ideas you can come up with. It might also be something you would like to explore in supervision.

Culture

- A key feature of any culture is language. Consider your responses in the previous section and how the language you use identifies your culture(s).
- Culture includes the ways group members understand each other and communicate that understanding.
- Much of cultural identity is generated by behaviour rather than words, and much of the interaction is determined by shared values that are taken for granted or operating unconsciously.
- People can belong to multiple cultures simultaneously.
- Many groups have their own distinctive culture, e.g. the elderly, the poor, professional groups, gangs, the army.

Reflecting on your practice, and using the space below, brainstorm the different cultures you have been aware of amongst the people you have worked with and how this has affected treatment. Remember culture is not just about ethnicity.

2.2 Definitions

Cultural sensitivity

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

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 being the bearers of culture.

As indicated 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 relationships we have with people using services. It is essential that mental health and addiction practitioners are not only culturally sensitive but also bring awareness of their own culture and cultural fluency to these relationships.

Cultural safety

Think about what you think is meant by the term *cultural safety* and then write some ideas in the spaces below.

Cultural safety is an acknowledgement of the beliefs and practices of people who differ from us in age, occupation, sex, sexuality, religious belief, disability, or any other different lived experiences.

We need to acknowledge that our own culture may be different from those of the people we work with in order to guard against imposing our beliefs. Workers do not need to research and understand other groups' beliefs and cultural practices; rather they need to acknowledge their own culture as different from those of the people they serve, to ensure that they do not impose their beliefs (Ramsden, 1997).

Reflect on the following points:

- unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual, family, whānau or group
- cultural safety and what constitutes safe service is defined by those who receive the service.

Cultural competence

Cultural competence is recognised as one of the essential competencies for health practitioners. In the spaces below, list some of your ideas for a definition of cultural competence.

Mason Durie, in an address to the Australian and New Zealand Boards and Council Conference in 2001, stated:

> "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."

In 2001, the US Surgeon General defined cultural competence in 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) also commented that 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 person 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 and 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.

Whānau Ora is underpinned by an approach that emphasises te Aō 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 and the access to relevant and effective services and thus effective outcomes.

The definition of cultural competence provided by the US Surgeon General above provides a relatively narrow perspective on culture and assumes that cultural competence is about the majority working with the minority. What would our expectations of competence be for a Samoan that is working with a Samoan, a woman that is working with another woman, or a person in recovery working with someone starting on that journey? Our approach to culture should be cautious in regard to making assumptions, and we also need to take into account that even those who appear to share specific cultural aspects will vary according to their personal lived experience.

Cultural responsiveness

In the spaces below, list some of your ideas on what is meant by this term.

Indigenous cultures provide ways of knowing what is salient and congruent with local values and beliefs, and providing credible ways of defining problems and solutions. When working with people in culturally responsive ways, the essential aspects of their cultural needs will become apparent as will 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 communicator's understanding of cultural context and the degree to which a message is received and understood (Inoue, 2007).

What do you think this actually means in your work?
How would you know if you are being culturally fluent?

2.3 Culture as a responsivity factor

Responsivity (see section six) tells us what we need to clear out of the way or build upon in order for someone to benefit from an intervention.

Cultures can have differing approaches to accessing, understanding and accepting care.

This may influence the understanding of an issue or its resolution.

Taking these two statements into account, consider the possible impact of culture on how the provision of care is perceived. Consider how cultural competence might be a responsivity factor.

Try brainstorming some things you think might be culturally relevant 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 a person to benefit from an intervention. List these below.

Enhancements:

Barriers:

Cultural competence as a responsivity factor

A lack of cultural competence can be a barrier to being appropriately responsive.

On the other hand having some cultural competence 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 diverse cultural influences, so understanding that and being able to relate in culturally responsive ways is essential to enhance positive outcomes.

2.4 Māori responsiveness

Being able to work in a culturally congruent way with tāngata whenua has special importance as Māori are over-represented proportionally in the justice system and in mental health and addiction treatment. 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 the people they work with. But more than anyone else they may be pivotal to mobilising the relationships necessary for positive development and the realisation of potential."
> (Durie, 2001)

There are a number of Māori competency frameworks but what they have in common is a defined set of behaviours, values and expectations of how these manifest in practice. Matua Raki (Huriwai et al., 2008) has 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 demonstration of integrated professional and Māori knowledge and skills.

The following is an extract taken from the Takarangi Competency Framework Workshop Manual.

> "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." (Huriwai et al., 2008)

Example:
You are a worker in a community mental health and addiction service and you have booked in somebody for assessment. The person is Māori and arrives with three members of his whānau and a traditional healing practitioner. He has been referred by his probation officer who wishes to get feedback from the assessment. He says 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 for the whānau that are private. He asks you not to write any notes and to respect his treatment needs, as he has tried mainstream approaches before and they did not work for him. His requests go against service protocols and against the request for information from the probation service.

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

Here are some suggestions for this situation.

Before engaging in a pōwhiri process you might consider whether you need to bring, or get some advice from, someone more versed in Māori kawa (protocol). The pōwhiri process will assist in negotiating a safe space for discussion to take place and lead naturally into mihimhi, karakia 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 person is obviously engaged and wishes to make changes, so how do we make the most of this window of opportunity?

This discussion will allow you to get some clarification as to the person's understanding of their problems and how the healer's proposed solution fits. This will give you a better appreciation of what sort of information or procedures need to be discussed and/or 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 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 a transition process 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'.

Scenario and exercise

Read the scenario below and consider why her assessor felt she was at high risk of reoffending.

Scenario 1

Mary was convicted of receiving stolen goods, namely meat stolen from a local butchery. When asked why she did it she said that she had whānau coming to visit and didn't have any kai. She said she knew it was wrong and was very sorry.

Why do you think her assessor felt she was at high risk of reoffending?

In considering the question above, think about possible cultural considerations that are implicit in this scenario and how you might respond to, and work with, this person.

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 be ongoing and therefore Mary may behave in the same way again if she was in a similar situation.

Think about how you would work with Mary's cultural beliefs.

How would you use Māori values and practices to help Mary see the consequences in another way?

2.5 Summary

- Be aware that our culture can affect our engagement and relationship with people.
- Increasing our cultural fluency can enhance our cultural competence.

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 our perception of people and their situation. This means examining our attitudes and behaviours and increasing our understanding of how many of these are culturally determined and using this awareness to increase our acceptance of the varied aspects of culture. In addition to ethnicity, consider also age, gender, sexual orientation, gender identity, socio-economic status, gang affiliation, refugee status, consumers (addiction and mental health), those in recovery and offenders.

In summary, by increasing our own cultural fluency we can work more congruently in a person and whānau-centred way and turn a potential barrier to engagement into a positive and enhancing factor.

2.6 References

Cave, T., Robertson, P., Pitama, S., and Huriwai, T. (2008). *He Tete Kura: Māori Addiction Treatment: 1980-2008*. Matua Rak̲i: Otautahi New Zealand.

Durie, M. (2001). *Cultural competence and medical practice in New Zealand. Address to the Australian and New Zealand Boards and Council Conference.* Wellington.

Huriwai, T. (2002). Re-enculturation: culturally congruent interventions for Māori with alcohol- and drug-use-associated problems in New Zealand. *Substance Use Misuse*. 37(8-10):1259-68.

Huriwai, T., Milne, M., Eramiha, T., Rata, N., Leef, S., Armstrong, P., Robertson, P., and Winiata, T. (2008). *Takarangi Competency Framework Participant Workshop Manual.* Matua Rak̲i: Wellington.

Huriwai, T., Sellman, J.D., Sullivan, P., and Potiki, T. (2000). Optimal treatment for Māori with alcohol and drug problems: An investigation of the importance of cultural factors in treatment. *Substance Use and Misuse*. 35(3): 281-300.

Inoue, Y. (2007). Cultural fluency as a guide to effective intercultural communication: the case of Japan and the U.S. *Journal Intercultural Communication (15)*. Retrieved from http://www.immi.se/intercultural/nr15/inoue.htm

Jansen, P., and Sorenson, D. (2002). Culturally competent health care. *NZFP (5)*:306-1.

Ministry of Health. (2008). *Let's get real: Real Skills for people working in mental health and addiction.* Wellington: Ministry of Health.

Nayar, S., and Tse, S. (2006). Cultural competence and models in mental health: Working with Asian service users. *International Journal of Psychosocial Rehabilitation. 10 (2)*: 79-87.

Pulotu-Endemann, F., Suaali'i-Sauni, T., Lui, D., Mc Nicholas, T., Milne, M., and Gibbs, T. (2007). *Seitapu Pacific Mental Health and Addiction Cultural and Clinical Competencies Framework.* Auckland: The National Centre of Mental Health Research and Workforce Development.

Ramsden, I. (1997). Cultural safety: implementing the concept. The social force of nursing and mid- wifery. In Te Whaiti, P., McCarthy, M. and Durie, A. (Eds). *Mai I Rangiatea: Māori Wellbeing and Development.* Auckland: Auckland University Press.

Sheik, S., and Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry and Psychiatric Epidemiology. 35*: 326-334.

Tseng, W. and Streltzer, J. (Eds). (2001). *Culture and Psychotherapy: A Guide to Clinical Practice*. Washington: American Psychiatric Press.

U.S. Department of Health and Human Services. (2001). *Mental health: culture, race, and ethnicity. A report of the Surgeon General.* Maryland: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Notes page

What has been my key learning in relation to this module?

1

2

3

4

5

What level of knowledge or skills about this section did I have before I read it?

What gaps in my knowledge or practice have I identified?

What do I plan to do from here to increase my level of skill or knowledge? (supervision, support, cultural advice/support, further training).

Section three: Ethics and boundaries

Purpose

This section explores ethics and boundaries, with a focus on identifying and resolving ethical issues in a way that is consistent with both service requirements and professional codes of ethics. This section explores some of the ethical issues that could arise for workers when working with people who are mandated to attend treatment.

Objectives

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

- describe the meaning of ethics and boundaries in relation to your work
- explore and resolve ethical and boundary issues utilising a method approved by your service, 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 your practice setting.

3.1 Professional codes of ethics

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

Mental health and addiction workers must often comply with a range of ethical codes and standards. For those registered with one or more professional body, compliance with all will be required. The bodies workers could be members of, or registered with, may include:

- Aotearoa New Zealand Social Work Association
- New Zealand Nurses Organisation
- Nursing Council of New Zealand
- Addiction Practitioners Association Aotearoa New Zealand
- New Zealand Association of Counsellors
- New Zealand Psychologists Board
- Occupational Therapy New Zealand
- Medical Council of New Zealand
- Royal Australian and New Zealand College of Psychiatrists.

Many health practitioner codes of practice have similar ethical requirements with three overarching core principles:

1. self-responsibility for our own ethical practice and on-going competence
2. primary responsibility to the people and the communities we work with
3. professional practice within organisations – implementing standards, management and accessing and participating in research and education.

3.2 Ethics and boundaries

Most professions have their own set of ethical guidelines specific to their practice and their place in society. There are ethical guidelines for most professions that provide a service that involves work with other people in which the professional is expected to be trustworthy and not abuse their power, e.g. doctors, nurses, social workers, lawyers, accountants, architects, fire and police officers and judges.

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 less clear.

Ethics provide us with specific guidelines that tell us exactly how to behave while boundaries are more general guidelines. Some boundaries will be based upon the expectations of our job, while others will be based upon our own personal values and beliefs.

Working with people from the justice system can be challenging with respect to ethics and boundaries for a number of reasons.

- It is likely some of the actions and choices made by the person will challenge the personal values, professional ethics and boundaries of the worker.
- The focus of treatment agencies is around personal empowerment, wellbeing and recovery, while the primary focus of the justice system is on keeping the community safe and the offender accountable.
- The principles of the codes of ethics that guide health workers can sometimes be in conflict with some of the expectations of the justice system, especially around issues such as privacy, autonomy and treatment goals.
- There is a possibility that the treatment goals listed in the special conditions for a person mandated to treatment by the justice system (e.g. abstaining from a substance or taking medication) may be in conflict with the treatment goals recommended by you as a worker (e.g. safer substance use or gambling strategies or CBT).

Read the scenarios below and consider what the dilemmas might be for you if you were working with each person. 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, recently released from prison who is a disqualified driver.

Yesterday when you were in town 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?

Scenario 2

You are working with a young woman recently released from prison. Her offending history is all related to drug offences. She appears to be doing really well, managing her life in general, but she tells you she has started smoking cannabis again. Given that she needs to remain drug free as part of her parole conditions and that cannabis is an illegal substance, what do you do?

Do you bring this up in discussion with her?

Do you have any responsibility to inform her probation officer?

Scenario 3

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

The person is making good progress with their 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?

Here are some things that may have come up for you in regard to these scenarios.

Within the boundaries of professional confidentiality what a person says and discloses normally remains within the workplace – unless there is an immediate safety issue at which time confidentiality may not apply. In other words, if either the person or other people are potentially at risk from their actions or intended actions then professionally we are required to take this information out of the session to ensure safety. Every person attending a service should be notified of this possibility at first contact. 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 people that you will discuss any issues with them before taking any action.

For example, the person in Scenario 3 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 wellbeing. You may be concerned that if you work with the person around further disclosure to others (a useful strategy) that they will lose confidence and trust in you as a worker, therefore putting the relationship at risk. Since they have been making good progress you may feel that bringing this issue up with them at this stage will undermine their recovery or put their continued treatment at risk. If no one is at risk, and depending on the seriousness of the offending, then it becomes purely an ethical issue.

Ethical dilemmas

Ethics are based on our values and ethical dilemmas occur when two values are competing with each other and we find it difficult to decide which one is more important to adhere to at that time.

When faced with ethical dilemmas, it is helpful to explore these issues with your professional supervisor and/or with experienced senior colleagues who can 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 with your professional support networks, to avoid feeling conflicted and powerless, and to avoid stress and burnout.

Remember, as a mental health and addiction worker, that when working with people we not only have to take into consideration what is right and fair in the situation for the person, we also have to act congruently with our own personal and professional values and ethics, and consider those other organisations we are accountable to, including wider family, whānau and the community.

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 in how ethics and boundaries are viewed should we be aware of?

In the space below, jot down some bullet points about how you understand, define or describe what is meant by ethics.

Now, do the same for boundaries.

Definitions 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.

Definitions 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 person's vulnerability
- The limits that allow for safe connections between individuals
- The ability to know where you end and where another person begins.

Professional boundaries are important because they define your limits and your responsibilities in regard to the people with whom you interact in the workplace.

Professional boundaries separate the therapeutic behaviour of the worker from any other behaviour which, well intentioned or not, could reduce the benefits of interventions and treatment for people, families, whānau and communities. Professional boundaries may be different for different professions. For example; peer support workers might be expected to share their story with the people they are working with, while for other professions this form of self-disclosure is not an expectation.

3.3 Cultural ethical perspectives

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

3.3.1 Māori ethical perspectives

Smith (2001) and Hudson (2005) considered Māori ethical frameworks in relation to research work. This provides a useful starting point for mental health and addiction workers to begin considering ethical perspectives that are different across cultures, such as how the rights of the individual, a key feature of western ethics, are in direct conflict with Māori perspectives which value relationships and the collective or 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. These have been derived from a range of ethical frameworks that have been developed specifically from a Māori perspective and that contain broadly similar values to inform practice and ethical processes.

Mātauranga Māori and tikanga Māori

Mātauranga Māori and tikanga Māori provide a framework to address ethical issues, either traditional or contemporary. Mātauranga Māori 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.

Whakawhanaunga

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-kiī). It promotes sharing, hosting and respect. This is one of the values that underpin a collaborative approach.

Aroha

Aroha is an empowering action that can manifest as compassion, healing, and respect. It can be passive or active and, depending on the 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.

3.3.2 Pasifika perspectives on ethics

For Pasifika peoples the focus is also on the collective or community rather than the individual, with the resulting tension between western views on the rights of individuals vs. cultural perspectives that value the collective or communal rights.

Pasifika peoples would argue that communal rights should take precedence over individual rights.

3.3.3 Ethics in context

There are powerful links between culture and ethics. Ethics also have to be seen in a social context – what is right/wrong/fair/just are socially determined.

Ethics are 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 and/or 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 with respect to their culture, take into account:

- universality vs. cultural diversity
- individual vs. collective or community perspectives
- freedom of choice vs. collective responsibility
- sacred vs. open knowledge
- the role of Christian or other religious or spiritual values
- the place of tikanga in providing an ethical framework around values such as whakawhanaunga, manaakitanga, aroha, mahaki and mana
- the importance of understanding what is going on for the person before offering advice; e.g. titiro, whakarongo then maybe korero.

3.4 Responding to ethical statements

This exercise is designed to start you 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. However you can be sure that in your work with others you will be required to make ethical decisions. Below are a number of ethical dilemmas you might encounter as a mental health and addiction worker. Within a five-second period you need to make a decision about whether you agree or disagree with the statement, or whether you don’t know. Rather than a test, this exercise is designed to get you considering 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 each be responded to within five seconds. At the end check your responses and take some time to consider how you arrived at your decisions.

I can tell somebody if they ask me what I think about the police or the probation service. ◯

I can lend money to someone who is in a group I am facilitating. ◯

I can sell my second-hand car to a person using our service. ◯

I can ask people to give me permission to use their information to teach my colleagues. ◯

I can contact the police if I have concerns for the welfare of someone. ◯

I can work with someone who is the partner of a friend. ◯

Six months ago I ran a group and was attracted to someone who attended; it is now ok to have sex with him or her. ◯

I can accept kai moana from someone using my service. ◯

I can accept a gift of food from someone who is at risk of being discharged for failing to attend. ◯

I can have a drink in the pub with someone I am working with who was referred from Corrections. ◯

It's okay to have a drink in the pub with someone I have been working with who is whānau. ◯

I can swear with someone I am working with if they swear. ◯

I can tell somebody some things about my life such as whether I have been in trouble with the law. ◯

I can offer someone I am working with a hug if they are distressed. ◯

I should always report the disclosure of any offending by a person referred by Corrections to their probation officer. ◯

I can use the case notes of someone who used to be on my case load for a paper I am writing for university. ◯

I can buy groceries for someone who I know is struggling to make ends meet. ◯

If asked, I can tell someone I am working with that I smoked cannabis in the past. ◯

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.

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 person, organisational requirements, 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?

3.5 An ethical decision-making framework

It is likely that you discovered during the last exercise that it isn't always straightforward making a decision about what is an ethical dilemma. There are a number of ways to identify and work through ethical dilemmas including: seeking advice from colleagues; taking the ethical or boundary issue to supervision; and/or referring to codes of ethics and using an ethical decision-making framework.

Consider your workplace and what methods are used in working through ethical and boundary issues.

Below is a step by step framework for an ethical decision-making process that may be useful.

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 for the person, family and whānau, the community and yourself. 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.

1. Separate questions of fact from questions of values.
2. Identify both the persons' and the workers' values systems.
3. 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 confidentially with your supervisor, manager, or senior colleagues. At these times it is best to be open with the person 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 the person's confidentiality under the Privacy Act) is a resource workers can use to discuss issues like this, so that you can act in the best interests of the people you work with to maintain safe practice. You can then arrange a further appointment to resolve the issues.

3.6 Exploring ethical dilemmas

You are now going to work through a number of scenarios with potential ethical dilemmas 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?

Take time to read through each scenario and answer the questions that follow.

1. **How would you manage a situation where you believe a harm reduction approach, that is offering pragmatic advice about safer substance use which recognises that many people may not be willing or able to stop using substances, would be a more effective treatment goal than abstinence for someone the court has referred for treatment as a condition of their sentence? Their probation officer appears to expect them to give up substances completely, but you do not believe this is a realistic treatment goal for this person. What do you do?**

2. **John, who experiences episodes of bipolar disorder which can contribute to his offending, has been mandated to attend for assessment and treatment, but has rung to say sorry for not attending his second session. He has failed to attend this session on two other occasions in the last fortnight, and you find the reasons he has offered for not attending difficult to accept as being true. He has promised to attend the next session.**

   On the day before the session his probation officer rings to check that John is complying with his treatment programme. His probation officer has told you beforehand that John has previously been given a lot of chances and that he has taken advantage of programme providers in the past, and will not be allowed to do so again. John is personable, has a young family, and a new job. What do you do?

What are the ethical issues in these two situations?

How would you respond?

3. **How would you manage the issue of a person who had been referred by Justice disclosing information about an offence that they have recently committed or are planning to commit?**

4. **Judy is a 20-year-old woman referred by Justice for mandatory treatment who, you learn in initial sessions, has a history of being abused. She tells you she uses substances as a way to stop the nightmares and 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 in her family knows.**
   In the third session Judy has turned up obviously stoned, and discloses that she was going well until she unexpectedly saw the family member who abused her at a family gathering. She says she panicked and bought some cannabis to switch off the horrible thoughts and memories that wouldn't go away. She promises it won't happen again, that she has turned up and wants to put it behind her.
   The protocol that was agreed on with her probation officer is that if she is using substances 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 would you respond?

3.7 Ethical issues to consider when working with people mandated by the justice system

Several issues may appear to conflict with workers roles when working with people who have a history of offending. People who have a history of offending are often mandated to receive treatment and remain part of the justice system. Issues can arise when there is:

- the perception on the part of the person of their treatment as punishment
- prescribed treatment rather than person-centred treatment
- the issue of confidentiality and obligations to inform justice sector workers when breaches of mandated treatment goals occur.

Mandated treatment vs. person-centred treatment

Although there is a therapeutic issue to be addressed for people who have been mandated by Justice to attend treatment there are a number of potential ethical issues to consider in relation to codes of practice as well.

When people are mandated to attend treatment it is possible to perceive this as placing the person's care as secondary to the safety and wellbeing of the community as the purpose of the care is to improve public safety and wellbeing, i.e. treatment contributing to reduction in reoffending.

The issue of compulsory treatment can be considered ethically sound where the goal of recovery is both a mental health and addiction and justice sector goal and if the person is treated with respect.

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

An important principle for all health workers is to respect the confidentiality of people they are working with as long as their safety or the safety of others is not compromised by doing so. As a clinical issue, confidentiality is important when attempting to gain initial confidence, trust and engage with people, but absolute confidentiality can never be guaranteed. Professional codes of ethics and/organisational policies generally require that practitioners are aware of relevant legislation and provide informed consent regarding confidentiality.

The Health Information Privacy Code 1994 defines the expectations and exceptions for workers to maintain confidentiality and under rule 11 (limits on disclosure of health information) a practitioner can breach 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)."

The expectation of the Department of Corrections is that it is informed promptly when non-attendance occurs,

and it seeks reports as to people's progress. Under s22C of the Health Act 1956 the Health Information Privacy Code 3 is relegated in favour of the Health Act which states:

> "Any person (being an agency that provides services or arranges the provision of services) may disclose health information…
>
> a. If that information…
>
> i. is required by any person specified in subsection 2; and
>
> ii. is required… for the purpose set out in that section…"

Specifically included in subsection 2 is being able to disclose health information to:

> "Any probation officer within the meaning of the Corrections Act 2004, for the purpose of exercising or performing any of that person's powers, duties, or functions under that Act."

Therefore it is possible to disclose health information without the consent of the person, but it is not compulsory to do so.

Part of the initial engagement with the person and their probation officer should include being clear about roles and responsibilities and agreement about the types of information that will be shared (purpose, parameters etc.) as well as establishing protocols for disclosure.

3.8 References

Addiction Practitioners Association Aotearoa New Zealand (*dapaanz*). (2005). *Code of Ethics.* Available online at www.dapaanz.org.nz

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

New Zealand Legislation. *Health Act 1956.* Retrieved from www.legislation.govt.nz/act/public/1956/0065/latest/DLM306636.html

Privacy Commissioner (1994). *Health Information Privacy Code 1994*. Retrieved from https://privacy.org.nz/the-privacy-act-and-codes/codes-of-practice/health-information-privacy-code/

Smith, L. H. (2001). *On Tricky Ground: Researching the Native in the Age of Uncertainty.* In Denzin, N. and Lincoln, Y. (Eds). (2001). *The Landscape of Qualitative Research. (Third edition).* Texas: University of Illinois.

Notes page

What has been my key learning in relation to this module?

1

2

3

4

5

What level of knowledge or skills about this section did I have before I read it?

What gaps in my knowledge or practice have I identified?

What do I plan to do from here to increase my level of skill or knowledge? (supervision, support, cultural advice/support, further training).

Section four: Skills of engagement

Purpose

This section explores the process of engaging with people who are mandated to attend services for treatment.

Objectives

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

- be prepared for working with people who are mandated to attend
- understand the process of engagement
- recognise and work with ambivalence and discord.

4.1 Introduction: Engagement

Brief reflection:

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

How important do you think it is to engage with people in order to support them to change?

1	10
Not at all	**Extremely**

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

1	10
Not at all	**Extremely**

How open are you to learning more about engagement with people sent by Justice who may not be interested in changing their behaviour?

1	10
Not at all	**Extremely**

What would help you increase your confidence?

What would it be like to be more confident – how do you think that would influence your work?

In this section, it is important to make a distinction between voluntary and mandated (involuntary) attendance at a service. The terms 'mandated' and 'involuntary' can be used interchangeably. Those people who attend a service voluntarily enter treatment for a variety of reasons and may have been strongly encouraged or coerced by family, whānau and/or employers. However people who are mandated to attend a service are in treatment because they are required to attend, whether or not they are internally (intrinsically) motivated to be there. *Working with Involuntary Clients* by Chris Trotter (2006) is a very useful book for practice ideas for working with people mandated to attend treatment.

Whether or not people are entering a treatment process voluntarily, effective engagement is essential for good retention and outcomes. There are a number of studies that demonstrate the positive influence on outcomes due to good engagement processes, and the quality of the therapeutic relationship or working alliance.

Some research findings

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

- positive expectations about therapy
- greater session attendance
- positive perception of the working alliance.

This study looked specifically at how engagement matched with treatment satisfaction and drinking-related outcomes following treatment. The findings detail that when people had a positive perception of the working alliance there seemed to be greater satisfaction and more positive drinking-related outcomes.

In a recent review of the impact of therapeutic alliance in psychotherapy (counselling) Ardito and Rabellino (2011) summarised the results of a series of meta-analyses as identifying:

- a reliable association between good therapeutic alliance and positive therapeutic outcomes
- that the quality of alliance was more predictive of positive outcome than the type of intervention.

The process of engagement

An important point to remember is that engagement is an ongoing process, not just something that happens at the beginning of a therapeutic relationship. If for some reason the process of continuing engagement is lost, the working relationship may become compromised, sometimes leading to disengagement and uncompleted treatment. This is particularly true with people who are mandated and those who are voluntary but coerced to attend and who may be more difficult to engage in the first place. A skilled practitioner can make a real difference by evoking and engaging the person's internal motivation. Continuing active engagement is an essential part of a motivational approach which will be discussed later in this section.

When you assess and work with people who have been coerced to attend treatment they may not be willing to negotiate or participate in sessions, and they might be reluctant to provide any information at all during their initial assessment. People who are attending a service without intrinsic motivation may present as pre-contemplators (*Stages of Change*; Prochaska and Diclemente, 1983) and practitioners may need to consider a range of methods for engaging the person.

Think about the skills and processes of effective engagement. What do you think needs to be taken into account when engaging with people, and what can get in the way of effective engagement? In the spaces below write some of your ideas about these things. Also try to consider the person's experiences of the justice process, level of family and whānau support, and cultural considerations.

Exercise

Brainstorm

- What are the skills and processes of effective engagement?
- What do you need to take into account when engaging with people?
- 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 person?
- Are there particular issues that are specific to engaging people sent for treatment by Justice?
- What attitudes promote engagement?
- How useful is self-disclosure in the process of engagement, and what are the limits of self-disclosure?

Wild et al. (2006) found that being mandated or coerced into addiction treatment did not negatively affect engagement when people had internal motivation that enhanced their own and the therapist's interest in the process of treatment. This suggests that using motivational skills to work with people to enhance positive engagement has a useful role with people who are mandated.

4.2 Understanding and engaging with people who are mandated to attend treatment

Being mandated to attend treatment can mean there may not be motivation to engage with treatment and/or change problematic behaviour(s), however there may be motivation to avoid some other negative consequence of non-attendance. What we now know is that if we can get people in the door and apply sound motivational techniques we can increase the likelihood of a person engaging in treatment, recognising their problems and wanting to do something about them.

When a person who is involuntarily sent to treatment does not acknowledge they have a problem (or problems) the role of workers is to increase awareness and readiness to change. In the initial engagement and assessment stage it is important to acknowledge and recognise that not everybody will respond to direct questions, and being aware of this possibility and adopting appropriate skills and techniques when needed will help successfully deal with this. It may also pay to be mindful that due to previous experience people may have told their story numerous times already or be afraid to disclose too much information.

At times some people may behave in ways that challenge the worker. Most of these behaviours may simply stem from irritation; however, there will be times when people may become threatening or abusive. They may become agitated or aggressive during their assessment or in ongoing sessions, but if a good engagement process is followed these behaviours are usually negligible and manageable.

People referred from a justice setting may also be ambivalent about having to front up for mental health and/or addiction treatment, possibly acknowledging that they have problems but not necessarily wanting to change their behaviours.

What does 'ambivalent' or 'ambivalence' mean?

Ambivalence can be defined as:

- A 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.

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

Ambivalence should be seen as the norm rather than as an exception. This means that working with uncertainty and internal conflict is a 'normal' part of the engagement and treatment process with people, not just people from Justice. Ambivalence is often a prominent feature of a range of psychological difficulties. A person who experiences 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 friendships, 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 affair can swing between partner and lover in an intensely emotional ambivalence. Someone who compulsively washes their hands or needs to check things may desperately want to avoid going through this disabling ritual time and time again, yet may feel driven to it by anxiety and fear.

Such approach-avoidance conflict is characteristic of addictive behaviours as well. People who are struggling with a substance use, an eating, or a gambling disorder 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 (inject, smoke, purge, or gamble), and at the same time 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 internal conflict as pathological – to conclude that there is something wrong with the person's motivation, judgement, knowledge base or mental state.

> "We 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." (Miller and Rollnick, 2002)

4.3 Exploring ambivalence

"I don't want to!"

Exercise

Think of a recent time when you had to do something you didn't want to do.

- What were your thoughts at the time?
- What were your feelings at the time?
- What were your actions and/or reactions at the time?
- What were your thoughts a week later?
- What were your feelings a week later?
- What were your actions and/or reactions a week later?
- What sort of thoughts did you have?
- What feelings did it arouse in you?
- What behaviour did you engage in as a result of the situation and your thoughts and feelings?
- What happened to those thoughts and feelings over the course of time?
- What impact did this situation have on your relationship with the person involved?

Use the following space to write your answers:

When we feel externally compelled to do something we may react in various ways, but what sits behind these reactions?

Reflect on your thoughts, feelings and behaviours in the previous exercise.

What does this tell you about how people might react to being mandated to attend treatment?

When you think about people who are mandated to attend 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 reactions to compulsion at face value. We may not know for some time what the person is reacting to and, as we know, it is risky to make assumptions. By not negatively responding to the person's apparent reactions to being mandated to attend treatment the worker can reduce the possibility of discord in the therapeutic relationship.

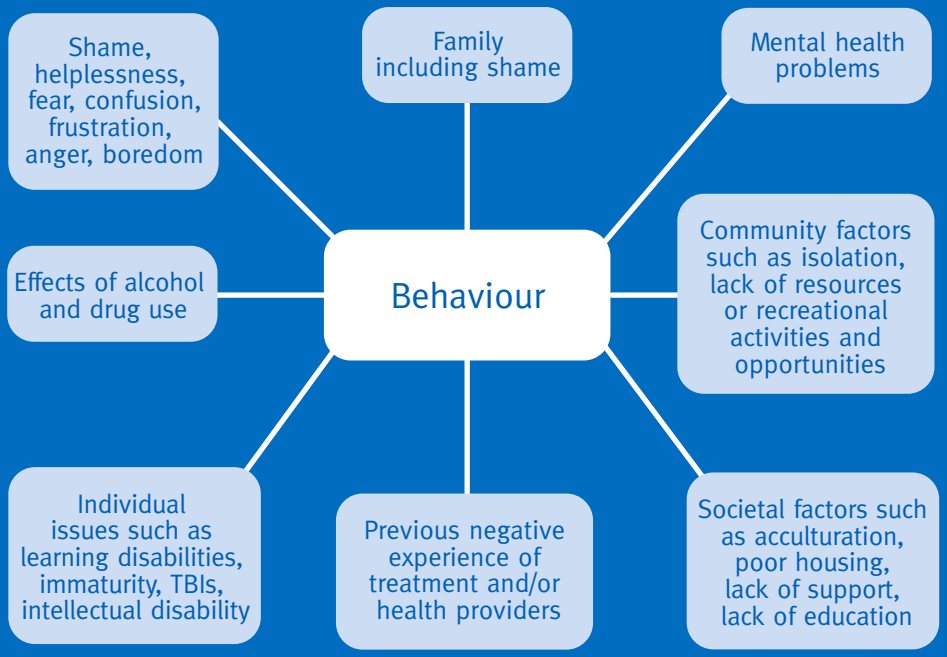
Reactions to being mandated or compelled to attend treatment can include:

- verbal aggression
- intimidation or threats
- self-harming behaviour (or threats to do so)
- physical aggression and/or violence
- passivity and/or withdrawal – superficial compliance
- non-compliance or silence

- changing the subject
- helplessness
- bragging about drug use and behaviour
- arguing
- putting forward rational arguments (e.g. “yes, but…”)
- complaints
- lying
- consistently pushing the boundaries of the working relationship.

Sometimes it is not obvious what lies behind the behaviour people present with. There might be a number of possible reasons why someone presents in this way.

Possible reasons for behaviour



Discord and relationships

Think about how often you hear people being labelled resistant, particularly those who are mandated or involuntary. It's often said in a pejorative way. The term 'resistance' seems to suggest things are not going smoothly because of something the person is actively doing and the person is at blame for the resistance.

In the 2013 edition of *Motivational Interviewing; Helping people change,* Miller and Rollnick took "leave of the concept of resistance" and proposed two new concepts to describe movement away from change: *sustain talk* and *discord*. Sustain talk is a normal part of ambivalence when people verbalise their desire to maintain the 'status quo' rather than change. Discord is when people are "talking at cross purposes or (there is) a disturbance in the relationship" (p.197).

The person may certainly begin by reacting in a challenging way to being compelled to attend treatment, but once these behaviours are expressed, what happens to them is strongly influenced by how the practitioner responds, and not simply by what the person says and does. Discord does not occur in a vacuum and can be a sign of poor initial engagement, not listening to the person, rushing them or taking control.

This means how you behave towards someone affects how they behave toward you.

Discord within the relationship can be expressed in different ways.

According to Miller and Rollnick (2013: pp. 204-206) discord is usually expressed by the person you are working with in one of four ways.

- **Defending** – It is a sign something is not working if the person feels the need to defend themselves by blaming, minimising or justifying.
- **Squaring off** – If people take an oppositional stance that seems to imply you are an adversary rather than an advocate.
- **Interrupting** – If a client talks over you or interrupts what you are saying this may be a sign of discord.
- **Disengagement** – If a person seems disinterested, inattentive, distracted or ignoring you, this is probably a sign something is wrong.

It is also important to note the contribution you can make to discord. If you are feeling tired, under stress or distracted, this may be picked up by the person you are working with. Reflecting on how you are feeling and its potential impact on your working relationship will be important in order to limit the impact this may have.

Try to imagine what sort of statements people might make, or how they behave that shows discord in the relationship. You may wish to think of a person you have worked with and recall things they said and did. Record these in the spaces below:

***Defending* – statements:**

Behaviours:

***Squaring off* – statements:**

Behaviours:

***Interrupting* – behaviours:**

***Disengagement* – behaviours:**

For the behaviours above, come up with something you think you could do when working with someone who is demonstrating them, and something you think would not be helpful. These are things you could do or say that may have worked in the past or things you have observed others do, that have had positive outcomes. Things you think would not be helpful may reflect things you have observed in the past that have not been effective, or made things worse. Write some ideas in the spaces below.

***Defending* – helps/does not help:**

***Squaring off* – helps/does not help:**

***Interrupting* – helps/does not help:**

***Disengagement* – helps/does not help:**

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

- How easy is it to recognise different ways discord is expressed?
- What are the benefits of being able to recognise different signs of discord?
- In the past, have you fallen into the trap of doing one of the things you identified as not helpful?
- Which behaviours, or signs of discord, would you 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?

Remember

A relationship is a two-way street – a person may express discord in the relationship, but it is up to you as the practitioner how you respond to that discord. Style

Often motivation is viewed more like a fixed trait (particularly in the justice field). Therefore if the person displays little motivation (often expressed as lots of challenging behaviour) 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 back to the exercise above when you had to do something 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? 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?" while feeling angry and resentful.

Research (Miller and Rollnick, 2002) with people experiencing problematic alcohol use found that a directive-confrontational style of intervention produced twice the resistance, as they referred to it at that time, and only half as many positive behaviours as did a supportive, person-centred approach.
The researchers concluded that the more workers confronted them the more the people drank at twelve-month follow up.

This demonstrated that a change in intervention style can directly affect the level of discord in a therapeutic relationship, 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 discord because less discord is associated with long-term change.

Miller and Rollnick advocate a more relational view, in which discord is, at most, a signal of dissonance or a mismatch in the relationship.

Practise

Think about the type of behaviour or signs of discord that you think would be the most challenging for you or that you've already experienced as challenging.

If you are able to set up a practice session with a colleague take turns playing the worker and the person in treatment for about 3-4 minutes. The situation for the practice session 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. Brief your colleague playing the person in treatment on the type of behaviour you would find the most challenging so you can practise managing this. Ask your colleague playing the person in treatment to demonstrate discord in the relationship, but not to the extent that it defeats the purpose of this being a learning experience for you, the person playing the worker.

To debrief the person who played the worker in your scenario you can identify something they did well first (very important) and then one thing where they think they could do with more practice. The worker playing the person in treatment 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 approaches the opportunity to learn from this experience will be useful for both of you.

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

Discord is inevitable, as there is no such thing as a consistently perfect practitioner; so what does this mean for your practice? Reflective practice is a critical aspect of all person-centred work, so here are some questions to begin the reflective thinking process in relation to discord.

- What is my level of investment in the person making a change?
- How able am I to let the person make their own choices (even when I think the choice is less than wise)?

- What kind of challenging behaviours or signs of discord do I react to?
- What am I doing to influence the discord?
- What is the discord telling me about myself and about the other person?

4.4 Engagement

Now that you have had a chance to work through some of the differences you may encounter with people mandated to treatment and working with discord, 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 which will assist with engagement and the building of trust in the helping relationship. We should also be thinking about cultural considerations such as protocols, communication styles and values.

In regard to challenging behaviour and discord we have explored some of the issues around the nature and types of behaviour and discord we may encounter which can potentially be defused by the attitude and approach of the worker. Trust building is important and will influence the quality of the relationship and the depth of work done in regard to meeting treatment goals. We are now going to revisit some of the basic skills of engagement and also consider how our own (and the other person's) attitudes can get in the way of achieving engagement and trust.

Principles for engagement

Principles for Engagement (Te Pou, 2011), describes some basic strategies identified by mental health and addiction practitioners in Aotearoa New Zealand that can help enhance engagement. These include:

- investing time to prepare well for the first meeting
- taking the time to connect and build rapport
- demonstrating respect and incorporating cultural protocols into the therapeutic approach
- drawing from cultural and family support and expertise where appropriate
- ensuring good communication is enabled
- actively partnering with service users and family and whānau in goal setting and recovery plan development
- regularly seeking feedback.

First contact

The first contact a worker has with someone is critical for establishing the nature of the ongoing relationship. The psychological construct of primacy states that the first impressions we get about a person will greatly influence how we subsequently react to them. If we get off to a difficult start with someone it is often difficult to change this. Once we make our mind up about someone it can be difficult to change our perception. This is true for both the people who are in treatment and for workers.

The initial engagement with a person is therefore critical, remembering that engagement does not just happen during the first part of forming a relationship, but also occurs each time you meet with that person. Also remember that, in the context of working with people sent by Justice, you are working with people whose attendance is usually involuntary. We often take it for granted, but attending to the rituals of encounter can affect the development of a therapeutic alliance.

With many Māori the use of Māori therapeutic paradigms that contribute to whānau ora, such as mihi mihi, karakia, whakawatea and whakamana, ensures the person is given a shared space to express themselves, and a process that honours their mana while also allowing for challenge and guidance.
To some degree these will be enacted every time there is a meeting (for further information see section two).

For some people initial engagement may involve exploring the reasons they came and their expectations. This will be particularly important for those referred by the justice system and/or who are mandated to attend. 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 person to build engagement

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

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

Find out their expectations of your time together, your role and their role. Again, ask the person their understanding rather than you doing all the talking before clarifying or explaining your role and their role, including what is negotiable and what is not. 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. Again, fill in the gaps in the person's understanding.

The agency requirements of confidentiality should also be covered in the first meeting. When time and resources allow consideration can be given to having a three-way initial meeting with the person and their probation officer. 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. It is a good idea also to give this information in written form for people to take away with them. This allows them to re-read if necessary at a later date.

Person-centred care

Initially developed in the 1930s by the American psychologist Carl Rogers, person-centred care considers that therapy should take place in a supportive environment created by a close personal relationship between the person and the therapist. In person-centred care the person determines the general direction and goals of therapy, while the therapist seeks to increase the person's insight and self-understanding through informal clarifying questions.

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 people without hiding behind a professional façade.

Unconditional positive regard means the therapist accepts the person as a worthwhile human being without evaluating or censoring, and without disapproving of particular feelings, actions, or characteristics. The therapist communicates this attitude to the person by a willingness to listen without interrupting, judging, or giving advice. In the context of working with people who have offending backgrounds it is important to accept the person, while not condoning their offending. Unconditional positive regard is about the person but not all of their actions.

Empathy (accurate empathic understanding) is about trying to appreciate the person's situation from their point of view, taking into account their life experiences, showing an emotional understanding of, and sensitivity to, the person's feelings throughout the therapy session.

A primary way of conveying empathy is by *active listening* that shows careful and perceptive attention to what the person is saying. Person-centred practitioners employ a technique called *reflection*, which consists of paraphrasing and/or summarising what a person has just said. This technique shows that the therapist is listening carefully and accurately, and gives a person an added opportunity to examine their own thoughts and feelings as they hear them repeated by another person. Generally people 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 provides a climate in which people can freely engage in focused, in-depth self-exploration.

Outcome studies of talking 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 people who have been treated by other types of therapy. Talking therapies appear to be particularly effective for people experiencing depression or relationship issues.

Although practitioners may consider themselves capable of developing a good person-centred relationship with almost anyone, there are likely to be instances where their reactions (conscious and unconscious) to aspects of people's issues or attitudes, values or beliefs, or even personalities, are picked up by the person and vice-versa. It is helpful to reflect on this when the engagement doesn't go well, and supervision may help to resolve these issues.

Skills of engagement

- Are you fully present – are there distractions/barriers to this (time/preoccupation)?
- Attending – ways to be present with person physically and psychologically (open posture, eye contact, relaxed, leaning forward slightly – shows interest)
- Listening – capturing the persons communications accurately – verbal, non-verbal, clear or vague, listening for change talk
- Be aware of the person's affect – the underlying emotions that are associated with experiences, behaviours, stated goals and achievements (and expressions of motivation).

These points relate to the way the worker interacts with the person, 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 person, without having your thoughts or concerns somewhere else; highlighting the importance of being person-centred and having good attending and listening skills.

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

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

Engagement (from Rogerian counselling)

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

Potential barriers

- Over-familiarity.
- Gender/cultural issues.
- Large discrepancy between age/values.
- Emotive issues/problems, e.g. trauma/sexual abuse/violence.
- Person's prior negative experience/attitude to counselling; consider how your verbal and non-verbal messages come across to the person and vice-versa.
- Prioritising agency expectations or following set assessment processes.

Exercise in pairs (if possible)

Referring to the principle of unconditional positive regard, discuss with your colleague or supervisor how important this is in regard to building trust and being able to work with people who have addiction and/or mental health problems and/or are in the justice system.

Use your own experience or your work with people as a resource for discussion.

Family and whānau inclusive practice

A variety of workforces that have contact with individuals, families and whānau have the opportunity to help realise family and whānau potential. This is certainly true for mental health and addiction practitioners and those who work with people involved in the justice system. The person you may be working with is likely to have family members, wider whānau and perhaps children that it will be important to ask about. Family and whānau are likely to be concerned about their family member and an initial discussion (with the permission of the person you are working with) can help engage family and whānau in the process and elicit their support for the person you are working with.

You may also be able to further support the wider family and whānau by talking to them about what supports they may require to deal with and support their whānau member. If the person you are working with has children it is a priority you make sure that the children are safe and not at risk in any way. Mental health and addiction challenges are not incompatible with being a good parent, however extra support may be required to support parenting and caring responsibilities, which helps build child, family and whānau resilience.

Reflection

Do you think it is important to involve family and whānau in the work you do with people?

4.5 References

Ardito, R. B., and Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements and prospects for research. *Frontiers in Psychology, 2*. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3198542/

Dearing, R. L., Barrick, C., Dermen, K. H., and Walitzer, K. S. (2005). Indicators of client engagement: Influences on alcohol treatment satisfaction and outcomes. *Psychology of Addictive Behaviors, 19*: 71-78.

Farrall, M. (2001). *The use of motivational interviewing techniques in offending behaviour group work. Motivational Interviewing Newsletter: Updates, Education and Training 8(1)*. Available online at www.motivationalinterview.org/mint/MINT8_1.PDF

Miller, W., and Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change (2nd edition).* New York: Guildford Press.

Miller, W., and Rollnick, S. (2013). *Motivational Interviewing: Helping People Change (3rd edition).* New York: Guildford Press.

Robinson, M. (2009). *Personal Communication.* Trainer, Hall McMaster and Associates.

Te Pou. (2011). *Principles for Engagement*. Te Pou o Te Whakaaro Nui. Retrieved from www.tepou.co.nz/library/tepou/principles-for-engagement

Wild, C., Cunningham, J., and Ryan, R. (2006). Social pressure, coercion, and client engagement at treatment entry: A self-determination theory perspective. *Addictive Behaviors 31(10)*:1858-1872.

Notes page

What has been my key learning in relation to this module?

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What level of knowledge or skills about this section did I have before I read it?

What gaps in my knowledge or practice have I identified?

What do I plan to do from here to increase my level of skill or knowledge? (supervision, support, cultural advice/support, further training).

Section five: Working with people in the justice sector who have cognitive impairment

Purpose

This section introduces the issue of cognitive impairment as an area of special relevance to people who are in the justice system and in mental health and/or addiction treatment as part of sentence management.

Objectives

By the end of the section you will have an introduction to:

- the range of issues that contribute to cognitive impairment
- the prevalence of cognitive impairment in treatment populations
- the possible links between cognitive impairment and mental health, addiction and/or offending
- screening for cognitive impairment
- strategies to enhance engagement and treatment effectiveness with people who have cognitive impairment.

5.1 Terminology and prevalence

The term cognitive impairment is used in this context to describe the impact on functioning of a range of congenital disorders and acquired brain injuries (ABI) that people may present to a service with. This can include a broad spectrum of intellectual disabilities (including learning difficulties and AD/HD), traumatic brain injuries (TBI) and substance related brain injuries.

Many people who access help from mental health and/or addiction services have a history of head injuries, many having multiple injuries over their lifetime. Sustaining a TBI in childhood or adolescence is linked to a two-fold increased risk of developing mental disorders in adulthood (Timonen et al., 2002). In acute mental health inpatient settings almost one in three are likely to have some form of acquired brain injury (McGuire et al., 1998 in March et al., 2013). In one study (Koponen et al., 2002) which found a prevalence of mental health problems after TBI of 48.3 per cent, the most common new disorders after TBI were:

- major depression (26.7 per cent)
- alcohol abuse or dependence (11.7 per cent)
- panic disorder (8.3 per cent)
- specific phobia (8.3 per cent)
- psychotic disorders (6.7 per cent).

TBI has also been observed to be significantly related to later mental disorder with coexisting criminality in males (Timonen et al., 2002).

The relationship between cognitive impairment and offending is complex, especially in the case of traumatic brain injuries. The consequences of having a TBI can include:

- aggression
- impulsivity
- disinhibition
- lethargy
- apathy
- diminished insight
- impaired cognitive functioning.

These effects may predispose people with TBIs to offending (Jackson and Hardy, 2010). It has also been observed that people who have personalities characterised by high impulsivity and low harm avoidance are more likely to receive head injuries in childhood and/or use substances at an earlier stage of life. When people with this personality structure have cognitive impairments, especially frontal and temporal lobe damage, and also use substances (especially alcohol) they may be more sensitive to the disinhibiting effects of the substance and more likely to act impulsively and without thought for the consequences – and therefore be involved with impulsive and/or reactive offending.

Within prison populations a recent study in Victoria found that over 30 per cent of female prisoners and 40 per cent of male prisoners had ABI (Jackson and Hardy, 2010). Studies that have also included loss of consciousness and mild TBI have reported prevalence rates of between 60 and 90 per cent in prison populations (Riches et al., 2006) and a recent meta-analysis of studies to date estimated the prevalence of TBI in the overall offender population as being 60.25 per cent (Shiroma et al., 2010). An early study (Barnfield and Leathem, 1998) of the incidence of TBI within an Aotearoa New Zealand prison population observed that 86.4 per cent of the population studied had sustained a TBI, with 56.7 per cent reporting more than one TBI, and that Māori prisoners reported 12 per cent more TBI.

Intellectual ability, or IQ, also has an impact on offending and this is particularly notable among people with borderline intellectual disabilities, i.e. an IQ between 71 and 80. This is possibly because greater resources are in place to support people with significant intellectual disabilities, i.e. an IQ below 70. Within the Australian justice system it has been observed that 21-30 per cent of people going through a regional group of courts had an IQ below 80, with 46 per cent of this group also having a mental illness (Vanny et al., 2009). Another study identified that 11 per cent of young men an Australian prison had borderline intellectual disabilities (Herrington, 2009). It has been reported in the literature that significantly below-average intellectual ability is an independent predictor of future offending (Holland et al., 2003) and further, that people with mild intellectual disability who offend report greater use of substances than their non-offending counterparts and many report they were under the influence of alcohol or other substances at the time of the offending (McGillivray and Moore, 2001).

5.2 Screening for cognitive impairment

A starting point to investigate whether a person has cognitive impairment is to, as part of a comprehensive assessment process, ask them about their history of head injuries and any evidence of learning difficulties when at school. The latter indicates the possibility of some form of congenital impairment and/or AD/HD. As multiple relatively minor head injuries, i.e. those with no evidence of loss of consciousness or concussion, can contribute to cumulative damage, it is important to get a full history of the incidence of brain injury due to: accidents, fights, sports and substance use, including history of overdose, blackouts and/or inhalant use.

A history and/or evidence of learning difficulties and/or ABI should indicate to practitioners a need to respond to the person in ways that take into account difficulties they may have with processing and integrating new information. Using appropriate strategies will help to engage people with cognitive impairment in person-centred treatment that is responsive to their individual needs and is more likely to result in positive treatment outcomes.

When people do not, or are not able to, report a history of learning difficulties and/or ABI but then display some difficulties, as are described above, either engaging or participating fully in treatment, then formal screening for cognitive impairment can help to clarify whether this is an issue that needs to be taken into account when providing treatment. The Montreal Cognitive Assessment (MoCA) is a straightforward screening tool that is freely available for clinical use and requires minimal training. The MoCA is particularly sensitive to frontal lobe damage and this makes it a useful tool to use in mental health and addiction settings with people who are involved with the justice sector because of impulsive behaviour, possibly due to disinhibition or poor decision-making. The MoCA and the instructions for use are available from: www.mocatest.org/default.asp.

No screening tool can replace a formal neuropsychological assessment as these provide a significantly more in-depth assessment of a person's type and degree of impairment. Where it is clear that a person is struggling significantly or when screening results indicate that impairment is severe, a neuropsychological assessment will provide valuable indicators of specific deficits and how these could potentially be managed both by the practitioner and the person.

5.3 Working with people with cognitive impairment/acquired brain injuries

Based on *Looking Forward Acquired Brain Injury* (arbias, 2011, www.arbias.org.au)

5.3.1 Difficulties people with ABI may have in treatment

People with cognitive impairment may struggle with standard therapeutic approaches to treatment. When someone appears not to engage with treatment, or appears to not act on stated intentions to change behaviours, this can possibly be due to unacknowledged or undiagnosed borderline low IQ and/or ABIs. Indicators that a person may have some degree of cognitive impairment include problems with:

- keeping up with the pace of sessions
- remembering what was discussed
- carrying information through from session to session
- coming up with ideas and alternatives

- thinking abstractly, complex thinking, linking ideas and seeing patterns
- structuring information and ideas – they may be less organised and goal focused
- setting realistic goals
- applying what they have learned – they may be good at verbalising their difficulties, but lacking in the ability to move beyond intellectualising to acting
- monitoring behaviour and conversation – for example, excessive talking or difficulty staying on a topic
- switching between ideas – people may become easily stuck on one idea and be unable to move on unaided
- lack of self-awareness and insight (particularly with regard to their cognitive impairment) which may mean people rationalise their problems.

Often it is easier for people to accept psychological or emotional causes for their problems, rather than their cognitive impairment, and there may be a tendency to focus on discussion of life stressors as the cause of problems. This can be a trap for practitioners who are used to responding to the problems people present with.

Think about someone you have worked with in the past month who appeared to have one or several of these difficulties.

Which of the above difficulties did the person appear to have?

What did you think the reason was that the person was behaving like that?

Does the person have a history of learning difficulties or acquired brain injury?

If the person has a known history of cognitive impairment what could you do to engage them in effective treatment?

5.3.2 Practical strategies to engage people with cognitive impairment in treatment

Considering the prevalence of cognitive impairment in people who are involved with the justice sector and mental health and addiction services, it is worth taking into consideration that someone who you are meeting for the first time may have some form of cognitive impairment. Taking this into account and using the strategies below, while provided to help with engaging people known to have cognitive impairment, may be helpful with initial and ongoing engagement.

- Choose a time of day when the person is alert but relaxed, if possible.
- Where culturally appropriate, obtain eye contact and/or the person's attention before beginning the conversation.
- Begin the conversation with information that orientates the person to the situation.
- Identify yourself and call the person by their name.
- Use familiar language. Avoid the use of jargon or technical terms.
- Match language and conceptual difficulty to the person's level of understanding.
- Repeat important points or write them down.
- Use a calm, respectful manner at all times. Avoid a condescending, patronising, or overly sympathetic manner.
- Ask people to repeat or paraphrase important points to ensure they are encoded into memory.

Exercise

Where you are able to, with a colleague or supervisor spend five minutes consciously using each of these strategies, taking the role of the worker. At the end of the five minutes discuss how it felt from both perspectives. In particular be aware of the use of jargon and coming across as being condescending.

What worked?

What did you have difficulty with?

What can you do for the use of these strategies to become more natural?

5.3.3 Strategies to use to enhance treatment for people who have cognitive impairment

The strategies provided below can help ensure people who have any form of cognitive impairment are able to focus their attention on their treatment and avoid the feeling of being overloaded by new information or expectations. Difficulties with self-monitoring and tangentiality often mean a worker has to be more assertive, repetitive and directive in their interactions than they would normally be. People with cognitive impairment may need constant prompting to stay on track during sessions.

- Break down information and present one idea at a time. When breaking information down ensure relevant information is grouped together.
- Discuss one point at a time – ensure the point being discussed is understood (especially if it's an important piece of information) before moving on to the next point.
- Tackle one problem at a time, one step at a time. Allow the person to focus solely on the issue at hand. Once achieved, move on to the next step.
- Allow sufficient time for people to work at their own pace. Don't expect the person to process the information at the same speed as you. Allow the information to be processed and a response to be generated.
- Minimise distractions and stressors in the environment. For the best results an environment where the person's attention is solely on the task at hand is ideal. Turn off televisions, radios, move away from a noisy office etc.
- Allow frequent breaks or rest periods; avoid the person becoming fatigued.
- Use a logbook or diary to record what is discussed in sessions.
- Generate ideas and alternatives. Write them down so the person has a visual cue to refer back to.
- Develop a plan of action to tackle problems. Once again put them in writing so if the person gets off track there is a document to refer them back to.
- Set concrete, realistic goals. Break them down into well-defined steps and tackle one at a time. Provide a written outline of the goals and steps and refer to it constantly.
- Prioritise steps. Putting the steps in a sequential order allows the person to see each step and also to have a cue for when each step is complete (i.e. encourage them to cross out completed steps).

- Follow through with plans by prompting people at each step.
- Provide encouragement and reinforcement at each stage.
- Reinforce steps that have already been completed.
- Help the person focus on the discussion by redirecting their attention if they become stuck on an idea or re-focus them if their conversation becomes tangential.
- Frequent summing up during a session helps to organise new information for memory.

5.4 References

arbias Limited. (2011). *Looking Forward Acquired Brain Injury.* arbias Limited.

Barnfield, T. V., and Leathem, J. M. (1998). Incidence and outcomes of traumatic brain injury and substance abuse in a New Zealand prison population. *Brain Inj.* Jun;12(6):455-66.

Brown, S., and Kelly, G. (2012). *Issues and inequities in facing people with acquired brain injury in the criminal justice system.* Victorian Coalition Of ABI Service Providers Inc. (VCASP).

Herrington, V. (2009). Assessing the prevalence of intellectual disability among young male prisoners. *Journal of Intellectual Disability Research.* Volume 53, Issue 5, May: 397-410.

Holland, T., Clare, I. C. H., and Mukhopadhyay, T. (2002). Prevalence of 'criminal offending' by men and women with intellectual disability and the characteristics of 'offenders': implications for research and service development. *Journal of Intellectual Disability Research.* Volume 46, Issue Supplement 1, May: 6-20.

Jackson, M., and Hardy, G. (2010). *Acquired Brain Injury. Screening, identification and Validation in the Victorian Correctional System.* arbias Limited and La Trobe University.

Koponen, S., Taiminen, T., Portin, R., Himanen, L., Isoniemi, H., Heinonen, H., Hinkka, S., and Tenovuo, O. (2002). Axis I and II psychiatric disorders after traumatic brain injury: a 30-year follow-up study. *American Journal of Psychiatry.* Aug;159(8):1315-21.

McGillivray, J. A., and Moore, M. R. (2001). Substance use by offenders with mild intellectual disability. *Journal of Intellectual and Developmental Disability.* Vol. 26, No. 4: 297-310.

March, E., Salzberg, M., and Hopwood, H. (2013). Acquired brain injury needs to be acknowledged at the national mental health policy level. *Australian and New Zealand Journal of Psychiatry* 47: 212.

Riches, V. C., Parmenter, T. R., Wiese, M., and Stancliffe, R. J. (2006). Intellectual disability and mental illness in the NSW criminal justice system. *International Journal of Law and Psychiatry.* Volume 29, Issue 5, September–October: 386–396.

Shiroma, E. J., Ferguson, P. L, and Pickelsimer, E. E. J. (2010). Prevalence of Traumatic Brain Injury in an Offender Population: A Meta-Analysis. *Correct Health Care.* Apr;16(2):147-59.

Timonen, M., Miettunen, J., Hakko, H., Zitting, P., Veijola, J., von Wendt, L., and Räsänen, P. (2002). The association of preceding traumatic brain injury with mental disorders, alcoholism and criminality: the Northern Finland 1966 Birth Cohort Study. *Psychiatry Research.* 113: 217–226.

Vanny, K. A., Levy, M. H., Greenberg, D. M., and Hayes, S. C. (2009). Mental illness and intellectual disability in Magistrates Courts in New South Wales, Australia. *Journal of Intellectual Disability Research.* Volume 53, Issue 5, May: 289-97.

Notes page

What has been my key learning in relation to this module?

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What level of knowledge or skills about this section did I have before I read it?

What gaps in my knowledge or practice have I identified?

What do I plan to do from here to increase my level of skill or knowledge? (supervision, support, cultural advice/support, further training).

Section six: The justice context

Purpose

This section introduces the systems and processes that operate in the justice system for people who may be referred for mental health and/or addiction treatment as part of sentence management.

Objectives

At the end of the section you will have:

- an overview and understanding of court processes
- an understanding of the care and control contexts of working with people who are involved with the justice sector
- had an opportunity to reflect on your own attitudes to the justice system
- developed an understanding of the role and tasks of a probation officer in relation to assessing mental health and addiction issues
- an understanding about the links between risk, need and responsivity in relation to assessment and case planning.

As a starting point, we will provide an overview of the justice process in order to understand the pathway people have taken to get to be seen at a service, as well as who is involved in that pathway. We are particularly interested in the role of probation officers and our work with people who have been referred to mental health and/or addiction treatment as part of their sentence conditions.

Before we start, take a minute and reflect on the following.

What do you know already about the justice system and processes, and in particular what do you know about a person's experience from the time of their arrest to their conviction and sentence?

6.1 The justice process

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 180,000 criminal trials a year. See www.courtsofnz.govt.nz/from/statistics/annual-statistics/june-2013/district-courts/district-courts-national-workload-statistics-for-the-12-months-ending-30-June-2013.

The majority (95 per cent) 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, more serious 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 though the court system in a number of ways.

Criminal cases begin when the police or another prosecuting authority file a charging document with the court. A charging document is the formal method of accusing someone of breaking the law. 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 (Category 1 offences, which have a maximum penalty of fines only and Category 2 offences which have a maximum penalty of less than two years imprisonment) are conducted in the District Court by a judge alone, while more serious charges (Category 3 which have a potential penalty of more than two years imprisonment) are conducted in the District Court unless the defendant chooses to be heard before a judge and jury. Category 4 offences are the more serious Schedule 1 offences that must be heard in the High Court.

6.2 Sentencing

The purpose of sentencing

Over 2012/13 the Department of Corrections managed 8,587 prison-based and 54,561 community-based sentences and orders. Community work and supervision make up the bulk of community-based sentences with much of the rest being community-based orders for offenders released from prison.

Imposing sentences is one of the most demanding 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 combination of the following to:

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

Sentencing options

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 one year 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 their rehabilitation and reintegration.

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 high risk child and adult sex offenders and very high risk violent offenders for up to 10 years at a time after their release from prison, or on completion of parole or release conditions. Extended supervision orders are used to impose conditions on eligible 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 per cent 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 this.

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 Parole Board considers offenders who are eligible for parole at hearings and decides at what point in their sentence they will be released.

Release on conditions

Offenders who are sentenced to less than two years imprisonment are automatically released from prison once they have served half of their sentence. The other half of their sentence is served in the community subject to release conditions, unless the sentencing judge has stated specifically that there are no conditions of release. However, most offenders have special conditions, set at the time of sentencing, to attend rehabilitative programmes.

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 two different types of report. A written report, called a Provision of Advice to Court (PAC), uses a standard template to provide the District Court a concise pre-sentence report. Full reports are produced after a more in-depth assessment for the High Court.

Navigating the justice system

Navigating the 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 to demonstrate the 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.

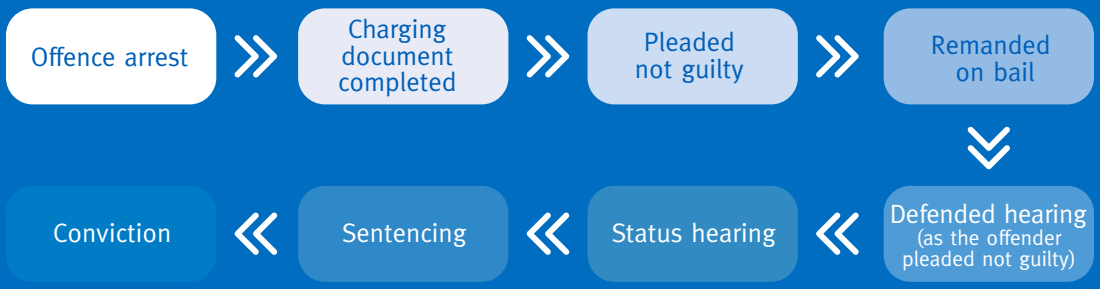
- What happens at each point?
- Who is involved at each point?
- What do they do at each point?

Pay particular attention to the role of the probation officer at the pre-sentence step in the assessment of risk and needs related to offending to assist 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 non-prescribed benzodiazepines and dangerous driving.

Pathway of the process:

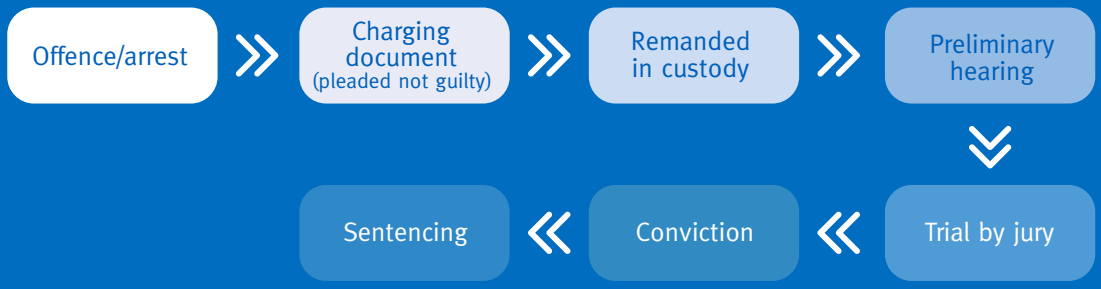


In this example, the sentence is a concurrent one of supervision and 100 hours community work. Karen has a special condition to attend addiction treatment. Reporting to a probation officer within 72 hours of sentencing is standard practice. A probation officer would then be responsible for inducting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

Example 2: John

Offences – dealing in a Class C drug, resisting arrest.

Pathway of the process:



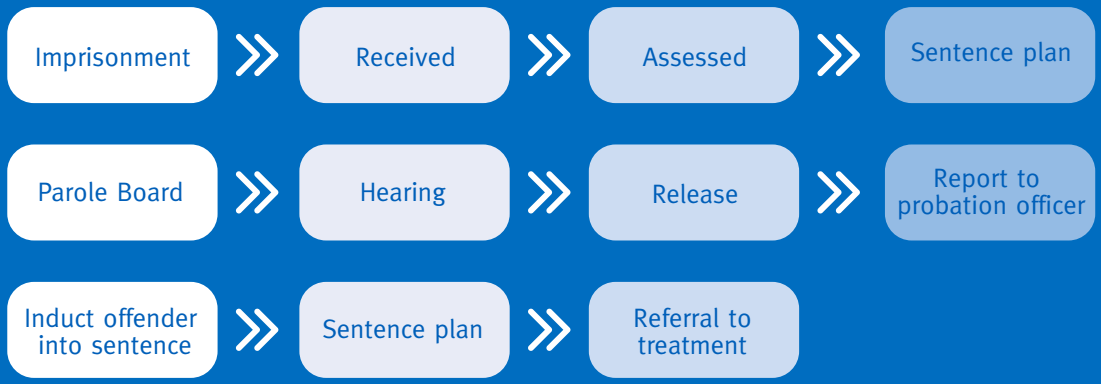
Because these offences carry a potential penalty of more than two years imprisonment (i.e. Category 3) the offender can elect trial by jury (rather than a defended hearing). In our example John elects trial by jury and is remanded in custody. In our example there is enough evidence so the case goes to trial and he is found guilty.

Sentencing is the next step, and the defendant (John) is sentenced to a term of two years imprisonment.

John would be received into prison, assessed (in the Assessment Unit) and a sentence plan developed.

He is eligible for possible release on parole after serving one third of his sentence.

In this example, John is released on parole after eight months, with standard conditions and a special condition to attend mental health and addiction treatment, significant mood issues having emerged in custody. 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.



Questions

Referring to the above examples consider the following questions and come up with at least two points that each of the questions raise.

Remember that people's experience of the justice system affects their level of motivation to engage in treatment post-sentence, which in turn influences the engagement processes with the mental health and addiction worker.

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

The person:

The worker:

What additional issues might a person who has been in prison bring to:

Treatment:

The working/therapeutic relationship:

What issues might you need to work through with someone who potentially sees you (the health practitioner) as just another part of the justice system? How might this affect your engagement with him or her?

If a person 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 worker?

With people referred from Justice, how might their views on the justice system impact on treatment? How might this impact on you (the worker)?

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

6.3 Post-sentence

Sentence management

Most sentences and orders are managed in Community Corrections according to Standards of Practice, previously referred to as Mandatory Standards. The standards of practice are the same for all sentences, however higher tier sentences and the offender's assessed risk of future offending and harm, determines differences in timeframes to complete certain activities. The minimum level of reporting by the offender and monitoring by the probation officer depends on the sentence or order they are subject to.

Offenders are usually required to report in to a Community Corrections office within 72 hours once they have been sentenced to a community-based sentence. Offenders subject to Community Detention must report within 24 hours. At this point, the probation officer will induct the offender into their sentence.

The purpose of initial induction is to:

- explain the requirements of the sentence and any orders, and the consequences of non-compliance
- engage offenders in their sentence/order
- provide offenders with accurate and comprehensive information about their sentence/order, rights and complaints procedures
- identify, assess and manage offenders who may be at immediate risk of self-harm and/or 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 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.

The information shared between the probation officer and offender includes:

- 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 Parole Board monitoring.

The sentence plan

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

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 to probation and 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:

- that the main purpose of the offender plan, which is to help the offender meet the requirements of the sentence, is to help identify and address the offender's goals to 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 to how these requirements will be met – not whether they will be met. Any failure or refusal to meet the requirements of the sentence or 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 offender's 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 and the offender signs both, keeping one copy while the other is kept on file.

Planning special conditions

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

The probation officer is responsible for:

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

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

- risk and responsivity (see section 6.7)
- sentence length
- programme availability
- unmanaged mental health and/or addiction issues, i.e. these should be addressed before making a programme and/or counselling referral
- offender employment, i.e. where possible attempts are made to manage special conditions around the offender's employment.

A probation officer has to make a referral for each special condition outlined in the offender's sentence plan.

If the plan does not specify the intervention the probation officer needs to match the offender to an appropriate agency or treatment provider. They have to provide the offender with information about the agency or provider requirements.

The probation officer also has a responsibility to explore and identify any barriers to the offender participating in internal programmes or external programmes and/or counselling and, where necessary, work with the offender to develop strategies to overcome barriers.

Exercise

Let's consider briefly what happens for offenders post-sentence, as they bring their experiences of the justice system with them when they come for treatment. For the purposes of this exercise, we are going to focus on the offender's experience of probation post-sentence.

Remember our examples of Karen and John.

Your task is to put yourself in their shoes and imagine that they have to report to the local Community Corrections office within the 72-hour report in period. Record your key ideas in relation to the following two questions.

- What would you expect from your first meeting with a probation officer?
- What would you need to know to ensure you did what you were supposed to do for your sentence?

Karen:

John:

6.4 Balancing care and control

The Department of Corrections is charged with improving public safety and to do this 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.

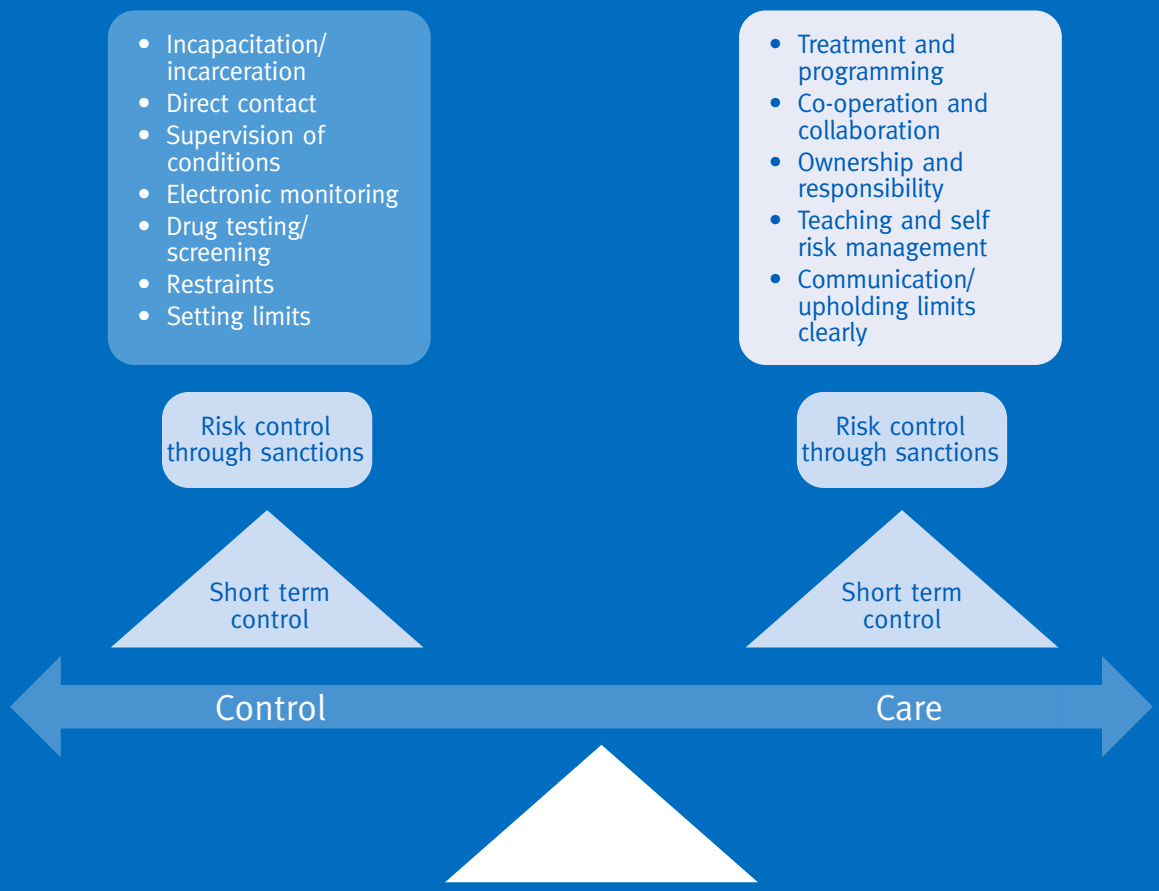
Balancing care and control is a central aspect of casework. Managing the control aspects of a sentence does not mean that the care or rehabilitative aspects of the sentence need to be ignored.

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 in the short term, they do not usually bring about lasting change.

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

Control versus care



Adapted from Effective Interventions training (ABACUS and HMA 2008)

6.5 Care and control

As we know, the probation officer is a key player in the justice process and the worker in the justice system that you are likely to deal with the most as they are expected to improve public safety through their monitoring role. If a parolee, for example, fails to report, the community (i.e. potential victim) could be at risk.

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 mental health and addiction practitioners. Consider the two case studies below from the probation officer's perspective and answer the questions.

- What were the risk issues you identified?
- How might they affect your work with the person?
- How do these risk factors influence your work with the person?
- 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?

Scenario one

Peter is a 36-year-old man who has been referred to you by his probation officer for an assessment. He is serving concurrent sentences of supervision and 200 hours community work. He has a special condition to attend mental health and addiction treatment including 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 both his alcohol use and depression, 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 the probation officer between care (rehabilitation) and control (compliance)?

How may this be different from a health worker's focus?

Scenario two

Liz is a 27-year-old and has been using a variety of substances since she was 14, at which stage she had been admitted into a youth mental health facility following a self-harm episode. She has an extensive offending history including shop lifting, 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. While in prison she disclosed a history of abuse and was provisionally diagnosed with Post Traumatic Stress Disorder. She has been released on conditions which specify regular reporting to Community Corrections, where she can live and who she can't associate with. She has a special condition to participate in addiction and mental health treatment and has been doing this for six weeks.

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

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

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

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

How may this be different from the mental health and addiction worker's focus?

6.6 Reflection on attitudes to the justice system

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

What are my beliefs about and attitudes toward the justice system?

Where have these beliefs and attitudes come from?

What aspects of my attitude might I need to reappraise and/or reconsider?

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

What useful attitudes can I 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 justice system and/or workers in the justice system have shifted?

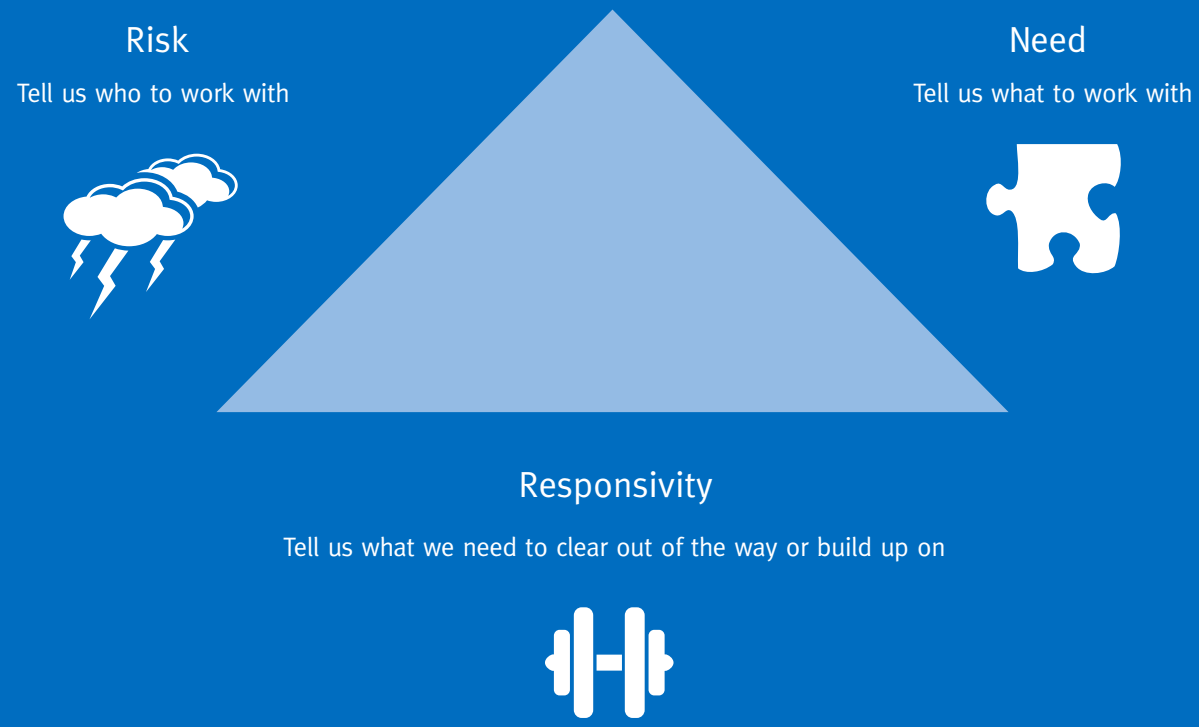
- If so, in what way?
- If not then why not?
- Have you gained a new or different appreciation for the work of probation officers?
- Have you been able to identify the influence your beliefs and attitudes have on your work?
- What sort of influence do those beliefs and attitudes have?

6.7 Assessment of 'risk, need and responsivity'

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

The mainstream corrections approach to the rehabilitation of adult offenders is based on the work of Andrews and Bonta (*The Psychology of Criminal Conduct,* 1994). They developed 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. While health workers and others might critique this approach (Workman, 2012) due to its deficit focus, it is the dominant model used by the Department of Corrections.

The risk, need and responsivity pyramid



Adapted from Effective Interventions training (ABACUS and HMA 2008)

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 x Risk of Imprisonment) which was developed in New Zealand. This type of risk assessment uses an approach based on research with large samples of offenders, where specific characteristics of individual offenders are correlated with outcomes.

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 five years, e.g. an offender with a .15 risk rating has a 15 per cent likelihood of reoffending, whereas an offender with a .73 risk rating has a 73 per cent likelihood of reoffending and is therefore at greater risk.

General prison populations in New Zealand tend to divide up approximately as:

- 10-15 per cent of inmates assessed as low risk
- 35-50 per cent as medium risk
- 50 per cent as high risk.

Within Community Probation, approximate figures are:

- 30-40 per cent low risk
- 30-35 per cent medium risk
- 30-35 per cent 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 access to 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) 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." (p. 176).

Within the Department of Corrections, criminogenic needs are assessed to inform rehabilitative needs. Factors are described as either static or dynamic factors, depending on circumstances. For example static factors include age at first arrest, history of arrests, sex and current age. These are things that cannot be changed and are static. Dynamic factors can include problematic substance use, educational achievement, unemployment or mental health challenges, all of which have the potential to be changed or worked with to improve outcomes for people. Within correctional models of working the focus is on these more dynamic criminogenic factors.

Responsivity
The risk principle helps in deciding who might profit most from intensive programmes, while the need principle suggests appropriate targets for programmes. 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.

Essentially, it is ensuring that we apply appropriate individual treatment matching principles to get the best possible outcome.

People who have offended, 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 substance use. External barriers include such things as unavailability of suitable programmes, transport, childcare, etc.

Cultural congruence can be both a positive and negative responsivity factor as working with someone who understands features of culture and/or ethnicity can enhance engagement and/or treatment. Understanding the principles behind both cultural safety and cultural competence is important when considering responsivity.

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, though some obstacles have 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.

6.8 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 needs of the community to know about the offender, either to:

- help the offender, or
- protect the community.

6.9 References

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

Workman, K. (2012). *How should we reintegrate prisoners?* Rethinking Crime and Punishment. Retrieved from www.rethinking.org.nz/assets/Newsletter_PDF/Issue_104/07%20Paper%200n%20Prisoner%20Rentegration.pdf

Notes page

What has been my key learning in relation to this module?

1

2

3

4

5

What level of knowledge or skills about this section did I have before I read it?

What gaps in my knowledge or practice have I identified?

What do I plan to do from here to increase my level of skill or knowledge? (supervision, support, cultural advice/support, further training).

Section seven: The mental health and addiction justice context

Purpose

This section describes the legislation and processes relevant to mental health and addiction services and practitioners which directly interface with the justice sector.

Objectives

At the end of this section you will have an understanding of:

- police involvement with a person experiencing mental health problems and the Mental Health Act (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act)
- police involvement with a person experiencing addiction problems and the Alcoholism and Drug Addiction Act 1966
- what may happen when a person experiencing mental health and/or addiction problems appears to have committed a crime
- what may happen when a person experiencing mental health and/or addiction problems is charged with committing a crime and has been ordered to appear in court
- what may happen when a person experiencing mental health and/or addiction problems is charged with committing a crime and appears in court.

There are a variety of circumstances when people experiencing mental health and/or addiction problems may become involved with the justice system. Each situation may involve different processes and people and enact different legislation. In many circumstances the issues of concern may be resolved without going through a court process and therefore do not lead to the person being sentenced or convicted for a criminal offence.

The Police may end up involved with people who have mental health and/or addiction issues unrelated to offending behaviour. However, because of the presence of the police that person may feel like they have done something wrong. For this reason the first part of this section articulates the role police have with a person who may have a mental health and/or addiction problem but who has not been charged with committing an offence.

7.1 Police involvement with a person experiencing mental health challenges and the Mental Health Act

Police may become involved with a person experiencing mental health problems as they have a statutory role within the Mental Health Act.

The importance of health and justice working together is highlighted by a memorandum of understanding (MOU) between New Zealand Police and the Ministry of Health at a cross government sector level. The MOU provides guidance to police and health professionals administering the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act). In addition there are MOUs between the New Zealand Police and local district health boards.

There are four main areas in regard to use of the Mental Health Act where a person experiencing mental health problems may have contact with police.

1. If a person appears to be experiencing mental health challenges in a public place and there is concern about their behaviour the police have powers under the Mental Health Act in relation to a person appearing to be mentally disordered in a public place. The police may take that person to a police station, hospital, or surgery, or to some other appropriate place and arrange for a medical practitioner to examine the person at that place as soon as practicable. This process should be within a six hour time frame.
2. If a person is going through the initial processes of being assessed under the Mental Health Act a duly authorised officer (DAO – who is a health professional) may request police assistance to enable them to undertake an initial assessment and/or to transport a person to a medical practitioner for the purposes of a medical examination.
3. Police may also assist a medical practitioner to administer medication to a person if required during the initial stages of the use of the Mental Health Act.
4. In some circumstances police have the authority to return patients to hospital if they leave without permission or fail to return from leave.

For more information refer to the *Guidelines to the Mental Health (Compulsory Assessment and Treatment)* Act 1992 which is available at: www.health.govt.nz/publication/guidelines-mental-health-compulsory-assessment-and-treatment-act-1992.

7.2 Police involvement with a person experiencing addiction problems and the Alcoholism and Drug Addiction Act 1966

Police are often the first point of contact for people with addiction problems, e.g. intoxicated people being taken into police custody for the night to provide a safe place for them to sober up. They are also regularly called to incidents in which intoxication and/or gambling has played a part in offending. When a person is arrested or sentenced to a term of imprisonment, the person is likely to be detained for some time in police custody, either until they are bailed to appear in court (for sentencing) or until there is transport to prison (after sentencing). As a consequence police and other staff working in the police custody suites need to be able to recognise and respond to acute substance withdrawal.

The statutory responsibilities of the police as far as the Alcoholism and Drug Addiction Act 1966, currently under review,[2] are clear but rarely well understood or even called upon.

When someone is being assessed and/or detained under the Alcoholism and Drug Addiction Act the police can be called on to:

1. ensure the person being assessed under the act appears in court
2. detain a person assessed by a judge as being at risk to themselves or others due to their addiction problems in a police station
3. transport the person to a psychiatric hospital and/or certified treatment provider
4. return people to the treatment provider if they leave without permission.

See www.legislation.govt.nz/act/public/1966/0097/latest/DLM380085.html.

Reflection

What values and attitudes to mental health and/or addiction problems could be barriers to police fulfilling these roles?

How could you and/or your service support police to respond appropriately to people with mental health and/or addiction problems?

7.3 When a person experiencing mental health problems appears to have committed a crime

This section explains what may happen when a person who may be experiencing mental health problems also appears to have committed a crime. Circumstances are unique and not all court systems and personnel are exactly the same. General scenarios are provided to explain what may happen in some circumstances when a person you are working with may have committed a crime.

The mental health of a person who has, or has apparently, committed a crime is considered from the outset. One of the fundamental precepts of common law is that "no person can be tried for a crime unless in a mental state to defend himself or herself" (Broodbanks and Simpson, 2007, p. 157).

2 - At time of writing this workbook the Alcoholism and Drug Addiction Act 1966 is under review and any changes are likely to mean substantial differences to this legislation and how it is used.

When a person commits a crime and the police have concerns for that person's mental health they may contact local mental health services for assistance. In most cases this will be a crisis assessment team.

Some police in New Zealand also have access to watch-house nurses who work in the police stations. They are employed to:

> "assess and assist in the clinical management of detainees who are experiencing drug, alcohol and mental health related problems while in police custody; reduce the risks of harm to detainees in police custody and custodial staff through the appropriate clinical management of intoxication, withdrawal and mental health disorders; liaise with other service providers, and make referrals of detainees to treatment providers; and provide ongoing education to the police regarding the identification and management of mental health and addiction disorders" (New Zealand Police, 2010, p. 19).

At this time, if the person is engaged with a mental health and/or addiction service, the service may be contacted to provide relevant information. In services where there are electronic clinical records the crisis assessment team may access the necessary information online to inform decision-making.

If a decision is made that the person needs mental health care steps are taken to assess the person's state of mental health. This may include initiating the Mental Health Act. This does not however mean police automatically withdraw the charges against the person.

If a decision is made that the person does not require acute mental health care they may be placed on bail by police and/ordered to appear in court. Some people may be remanded in police custody until they appear in court.

7.4 When a person involved with a mental health and/or addiction service has been ordered to appear in court

Once a person has been charged with committing a crime they will be ordered to appear in court. Appearing in court may be a stressful time for any person and perhaps more so if this is their first court appearance. This is likely to be a time when the person may need extra support.

Some health professionals may not be aware that a person they are working with is appearing in court. The person may choose not to inform their health care team. However once you become aware it is useful to ascertain what the person needs to support them through the court process.

It is not about determining whether or not you think the person committed the crime, it is about supporting the person. Sometimes the nature of the crime may generate some unease for a health professional or raise some other issues for them which could impact on the therapeutic relationship. Accessing your professional supervisor or increasing the frequency of supervision may be useful at this time.

As appearing in court is very stressful, working with a person to enhance their natural supports is useful. If a person experiences any deterioration in their mental health or exacerbation of addiction problems they may require a review of their treatment plan. This may also be a time to reassess a person's risk to themselves or others and take action to reduce or mitigate any risk.

This period may also be very stressful for the person's family or whānau. Therefore, identifying the supports available to family and whānau members is useful.

Adults will initially appear in the District Court. Depending on the seriousness of the crime some people may need to appear in the High Court during the later stages of the court process.

Information for the person you are working with about what to expect during the court process is helpful at this time. This information is available from the court or the person's legal representative.

While a person may be assigned a duty lawyer on the day they appear in court they may not want to wait for this or would prefer to choose their own legal representation. However, they may not know how to do this and you may need to support them through the process of finding a lawyer.

Most courts in New Zealand have a mental health court liaison role in place. In most instances these roles are held by experienced mental health nurses, often referred to as forensic nurses. Their primary role is to provide a service to the courts but they are also a point of contact for health professionals who are working with people who appear in court. The central focus of this role is "to detect people with mental health problems who are in the criminal justice system in order for appropriate referral or diversion into mental health services to take place" (Broodbanks and Simpson, 2007, p. 451). Health professionals working in these roles need to have competence and confidence in their ability to undertake mental health assessments and screen for alcohol or drug use; a sound knowledge of the mental health related legislation and court process; and the ability to build and sustain relationships with justice and mental health and addiction workers (Te Pou, 2013).

> "The person in this role can be caught between police who want to make a conviction, the defence lawyers who want charges averted and the judge who wants advice on the mental health status of the defendant and guidance as to where they should be placed" (Broodbanks and Simpson, 2007, p. 460).

Many courts in New Zealand also have experienced addiction practitioners working in a forensic role, providing brief assessments and acting as a liaison with local and national addiction services. Their primary role is to arrange access to pre-sentence comprehensive assessments and to provide advice to judges about the impact of substance use on offending and also possible treatment options and pathways as an alternative to, or as part of, sentencing.

The forensic nurse or addiction practitioner may be contacted if you have any questions prior to the person going to court. Remember, at this stage of the process it is only alleged that they have committed the crime. A person may need to appear in court more than once in relation to the same charges until a decision is made. This really depends on the seriousness of the offence and on how they plead in relation to the offence.

Prior to a person appearing in court you may be contacted by the forensic nurse or addiction practitioner to provide information about the service you were or are providing to the person. This will enable the nurse or addiction practitioner to present relevant information about the person's contact and engagement with mental health and/or addiction services to the judge when they first appear in court.

You may be invited by the person to attend court with them. In some cases it is possible that the judge may ask you to comment on the services you are providing to the person.

If you are aware that the person is appearing in court and you are not attending, you could contact the forensic nurse or addiction practitioner and they may make contact with and, if needed, support that person when they appear in court.

Reflection

What do you think are some of the specific attitudes, knowledge and skills needed to be a forensic nurse or addiction practitioner in this setting?

What information would be useful to share with a forensic nurse or addiction practitioner if you have been working with the person they are seeing?

7.5 When a person experiencing mental health problems is charged with committing a crime and appears in court

As mentioned previously, the circumstances of a person who has offended are unique and not all court systems and personnel are exactly the same. Generalised scenarios are provided to explain what may happen in some circumstances if a person you are working with has been ordered to appear in court.

The legislation that relates to this scenario is the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP Act). In addition sections of the CPMIP Act, which are applied by the judge, may also interface with the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act), the Intellectual Disability Compulsory Care and Rehabilitation Act 2003 (IDCCR Act) and the Crimes Act 1961.

Forensic nurses will have an in-depth knowledge about how these Acts interface and can advise health professionals supporting a person who is appearing in court.

7.5.1 Legal definitions related to a person's state of mental health

What is important to note is that there are different legal definitions that describe mental health problems which are not clinical diagnoses. Reports from psychiatrists and psychologists can be ordered by the Judge to provide information about the persons' mental health from a clinical perspective.

The Mental Health Act (Ministry of Health, 2012, p.14) states that mental disorder

> "...in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it (a) poses a serious danger to the health or safety of that person or of others; or (b) seriously diminishes the capacity of that person to take care of himself or herself".

The Crimes Act 1961 (Section 23) provides a legal definition for insanity.

1. Everyone shall be presumed to be sane at the time of doing or omitting any act until the contrary is proved.
2. No person shall be convicted of an offence by reason of an act done or omitted by him or her when labouring under natural imbecility or disease of the mind to such an extent as to render him or her incapable —
    a. of understanding the nature and quality of the act or omission; or
    b. of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.
3. Insanity before or after the time when he or she did or omitted the act, and insane delusions, though only partial, may be evidence that the offender was, at the time when he or she did or omitted the act, in such a condition of mind as to render him or her irresponsible for the act or omission.

See www.legislation.govt.nz/act/public/1961/0043/latest/DLM328219.html.

In essence, being assessed as being insane either before or after offending is considered grounds for not being convicted because the person was unable to understand what they were doing or what was wrong about their actions or inactions.

7.5.2 Identifying mental health issues that impact on the person's ability to follow the court process

The focus at this stage is to identify whether there are any mental health issues that impact on the person's ability to follow the court process or which relate to the offending.

Prior to appearing before the judge a forensic nurse, who may have been approached by the lawyer or police, may have interviewed the person to assess their mental health.

The forensic nurse may also be instructed by the judge to assess the state of the person's mental health if they have concerns about the person's fitness to plead. Remember, the judge is gathering information from many sources to inform his or her decision about what is the best course of action to take.

During this stage of the process if a person appears to have an addiction problem, or the offending is clearly related to substance use or gambling, the judge may request an addiction practitioner who is based in the court (if available in that area) to do an initial assessment. The forensic court liaison nurse may have also identified this as an area requiring further assessment and may liaise with the addiction practitioner.

7.5.3 When the judge finds there are no mental health issues related to the offending

If the judge is satisfied the person has no mental health issues related to the offending they are likely to proceed with the court process. Outcomes can vary and can include the person being discharged without conviction, being convicted and discharged with or without a fine and convicted and sentenced. The person may receive a community sentence as discussed in section six of this workbook.

If a person receives a prison sentence, prison staff will be advised by the forensic nurse or addiction practitioner that the person has mental health and/or addiction problems and what if any services are in involved with that person's care. Prisoners are also screened for mental health and addiction problems on their arrival at prison. Acute problems such as substance withdrawal and mood disorders that are identified at this stage are usually managed by prison health staff. If the person is on medication, including opioid substitution treatment, their medication regime may be reviewed and can be maintained to support the person with their recovery while in prison.

As a health professional you may be contacted for information about the person by prison nurses or forensic prison liaison health professionals who may provide support while they are in prison.

Once a person has been sentenced to prison, if they have previously been under the Mental Health Act, this no longer applies. A prisoner's engagement with mental health services therefore becomes voluntary. There are, however, provisions in the Mental Health Act for a prisoner to be transferred to a secure mental health facility for care and treatment if they become acutely unwell in prison.

When a judge is satisfied there are mental health issues that impact on the persons' ability to follow the court process or which relate to their offending they can order a court report from a psychiatrist or psychologist. This assessment can happen in the community or in prison if the person is remanded in custody.

During this stage of the process if a person appears to have an addiction problem a judge may request an addiction practitioner to do a comprehensive assessment in order to ascertain whether their substance use or gambling was related to their offending.

You may be approached to provide information to the health professional completing these court reports. What is important here is that the person fully understands the purpose of any assessment of their mental health and/or addiction problems. It is the responsibility of the assessor to advise the person being assessed of the purpose of any assessment carried out.

The judge will be guided by the outcomes of these reports in determining the next course of action. This may include issuing a community treatment order under the Criminal Procedure (Mentally Impaired Person) Act 2003 or a person being found not guilty of a crime by reason of insanity as defined under the Crimes Act 1961.

The subsequent processes are outside the scope of this workbook. For information please refer to *Psychiatry and the Law* (Broodbanks and Simpson, 2007). While significant mental health problems may be considered adequate reason for a person to be considered unfit to plead or not guilty due to insanity this is not the case for addiction problems.

Reflection

How can mental health and/or addiction problems contribute to offending?

Considering these factors and the stages of the court process above, what information could you provide a judge or other health professional that could help explain a person's offending?

What risks are you aware of for people with mental health and/or addiction problems who are sent to prison?

How could these risks be managed?

7.6 References

Brookbanks, W. J., and Simpson, A. I. F. (2007). *Psychiatry and the Law.* LexisNexis: Wellington.

Ministry of Health. (2012). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health. Retrieved from www.health.govt.nz/publication/guidelines-mental-health-compulsory-assessment-and-treatment-act-1992

New Zealand Police. (2010). *Evaluation of the Mental Health/Alcohol and Other Drug Watch-house Nurse. Wellington:* New Zealand Police. Retrieved from www.police.govt.nz/sites/default/files/publications/evaluation-watch-house-nurse-pilot-initiative-2010.pdf

Te Pou. (2013). *Handover, 23*. Retrieved from www.tepou.co.nz/library/tepou/handover-issue-23---autumn-2013

Wexler, D. B. (1996). Therapeutic jurisprudence in clinical practice. *American Journal of Psychiatry, 153*(4), 453-455.

Notes page

What has been my key learning in relation to this module?

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What level of knowledge or skills about this section did I have before I read it?

What gaps in my knowledge or practice have I identified?

What do I plan to do from here to increase my level of skill or knowledge? (supervision, support, cultural advice/support, further training).

Section eight: Working across systems

Purpose

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

Objectives

At the end of the section you will:

- 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.

8.1 Working as part of a team

We are all used to working as a team at some level and organisations usually have several different teams depending on the focus of their work. Various teams within an organisation work together towards the goals of the organisation, for example, clinical teams working with administration and management teams for the benefit of people. What we discuss here is working across different sectors and agencies who are all working with the same person, which in our context would be mental health and/or addiction services and justice services (as well as others who may be involved with the person and their family and whānau).

Let's imagine for a moment that a probation officer has referred a person to you because they have a special condition to attend treatment. Think through your answers to the following questions.

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

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

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. 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 working as part of a team – what is required of me?" Enter these ideas in the bottom right quadrant:

Risks to person when workers are not working as an effective team	**Mitigations**
Factors that make a good team	**What it means for me**

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. 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 you work for.

Risks to person when workers are not working as an effective team

- lack of communication about the person's, experiences and previous interventions
- lack of communication around challenges and progress for the person, in terms of positive steps or risks, which needs to be understood within the wider context of their sentence
- the person feeling unsupported
- misdirection of casework and treatment (i.e. 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 service and Corrections
- lack of credibility
- splitting – telling one story to one provider and another to other providers.

Mitigations

- talking to each other
- regular updates and/or conversations with the probation officer
- putting effort and time 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 person's progress and giving suggestions on how the probation officer can support the person's treatment and 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
- common overarching goals.

What it means for me

(Adapted from Christensen, Todahl, and Barrett, 1999)

8.2 Collaborative working relationships

Many case managers or probation officers may be reluctant to talk to mental health and addiction professionals about treatment and/or therapeutic outcomes, possibly considering it to be out of their area of expertise.

Mental health and addiction workers should not assume that because a case manager or probation officer does not ask about treatment that they do not care, as they may care a great deal but are too respectful to invade the worker's turf.

It is therefore helpful for the worker, with permission from the person they are working with, to extend an invitation to the case manager or probation officer to discuss the person, and the family and whānau as relevant, asking questions that elicit useful answers that will help the worker to organise information about the person.

Talk early and often

It is critical for case managers, probation officers and treatment providers to have contact at the time of referral and regularly thereafter, resisting the assumption that no news is good news.

No news is almost always bad because it means the team members are not communicating about what they are doing, any progress, any setbacks and lapses, and not reminding themselves about what the original outcomes and objectives were.

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

Time itself 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 agreed treatment plan is critical. Sharing progress and difficulties in a specific and timely manner is best done with specific reference to the particular tasks that were supposed to occur in the person's plans.

If a person is having difficulty documenting his or her efforts around a specific task the partnership should consider that difficulty as a lapse back into risky behaviour, and the issue should trigger contact between team members. This timely response to a lapse into the old pattern is in contrast to the practice of waiting to contact other team members until a relapse has occurred. The latter tendency to wait until there is a problem is reactive versus preventative and results in a need for more intrusive responses. When a person is working steadily on their issues most treatment providers, case managers and probation officers assume there is nothing to contact each other about. However, from a wellbeing and recovery perspective, it would be helpful to acknowledge exactly those times.

This is a possible list of issues for a person in treatment that probation officers and treatment providers can discuss at any time.

- How engaged is the person in treatment?
- 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, feelings or behaviours that warn them that they are escalating?

- What have they decided to do in order to avoid high-risk issues and/or 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 relapse prevention plan?
- What have their successes been?

Benefits and challenges of shared casework/treatment goals

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

Balancing care and control needs for mental health and addiction services and justice:

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

- Incapacitation and/or incarceration
- direct contact
- supervision of conditions
- electronic monitoring
- drug testing and screening
- restraints
- setting limits.

Care aspects (Mental Health and Addiction) – long-term change and risk reduction through intervention:

- treatment and programming
- co-operation and collaboration
- challenging choice
- ownership and responsibility
- teaching and supporting self-risk management
- communication and upholding limits clearly.

Consider the following.

- What crossover is there between the rehabilitative focus and the concern for public safety?
- Is the voice of the person who offended usually in the justice sentence plan?

Benefits and challenges of shared casework goals

	Benefits of shared casework goals	Challenges of shared casework goals
Agencies (Mental Health, Addiction and Justice)		
People they work with		

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

Having meaningful conversations with probation officers

The points of contact that a probation officer should be initiating and having with a mental health and addiction provider include:

- at referral
- at regular intervals during the programme
- at programme termination.

The probation officer may also have contact with the treatment provider pre-sentence when canvassing sentencing options.

The points of contact a treatment provider could initiate with a person'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.

Exercise

Think about a typical person who is likely to be referred to you as part of their special conditions or who you are aware is under supervision. Your task is to think about the points throughout the treatment 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 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 treatment providers need to let the probation officer know. Think about this in terms of both progress towards change and risk identification and management. It would be best practice for the person you are working with to also be in attendance, if appropriate.

8.3 Probation referrals

Building local relationships

This section provides the opportunity for you to consider your local relationships with the Community Corrections service and to begin planning how to build, develop or strengthen those relationships.

What would best practice look like for relationships between Community Corrections services and mental health and addiction treatment services?

Are there any specific issues for us to consider from a Māori or Pasifika 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.

Here are some questions to consider in your planning.

- 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)?
- What is it that we want to achieve? (Describing it is one step closer to it happening).
- 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 to the people who use the services. Mental health and addiction services might consider negotiating with their local Community Corrections service about processes and protocols to be used in any referral system. These agreed processes and protocols can set out clear pathways and timeframes for access to treatment services and ongoing contact.

Some possibilities may be:

- identifying liaison people in both services who could be contact points for each service
- checking the limits of confidentiality for people when referred from justice services, and establishing what the needs of probation officers are which don't conflict with these
- designing confidentiality forms, consistent with boundaries, that are appropriate to the needs above so that people feel confident about their rights and services (have their signatures on file acknowledging this)
- visiting each service (reciprocal) with presentations and information in order to build relationships and understand each other's needs
- creating opportunities to share perspectives on people's progress in treatment (review) which benefits the person without compromising confidentiality and may include the person themselves
- with people who have complex co-existing problems, having 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 relevant to the nature of your services and to 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 people easier and has positive benefits for people who, over time, are likely to appear in various clinical and social services as well as the justice system.

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 and/or counselling.

The type and frequency of contact a probation officer has with a treatment provider will depend on the nature of the treatment or intervention being undertaken.

In terms of frequency, minimum contact should be monthly depending on the intensity of the intervention and the requirements of the sentence. For offenders subject to home and community detention, or those on parole with residential restrictions, contact should follow each session to confirm attendance.

While in treatment the person who has offended needs to continue their scheduled reporting to their probation officer. If treatment is residential the person who has offended may report to the probation officer at agreed times at the residential facility.

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 and/or counselling. Create your own list using some suggestions below:

What do you need to know?
This might include:

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

What do you need to share?
This might include:

- criteria for attending
- length and/or nature of your treatment (residential, inpatient or outpatient)
- medication needs and effects including negative or side effects, for their information (for example, opioid substitution treatment or antipsychotic medication)
- other identified treatment needs (co-existing problems etc., if not already known)
- whether the person 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.

8.4 References

Building local relationships

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

Notes page

What has been my key learning in relation to this module?

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Matua Raki

National Addiction Workforce Development