Forensic Fundamentals

Training
I would like to formally acknowledge the traditional owners and custodians of the land on which we meet here today. I pay my respects to their elders both past, present and emerging and any of those who may be with us here today.
## Training Outline

<table>
<thead>
<tr>
<th>Topic</th>
<th>Time</th>
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<tbody>
<tr>
<td>Introduction</td>
<td>5 mins</td>
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<tr>
<td>Criminogenic Theory</td>
<td>15 mins</td>
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<tr>
<td>Motivation and Treatment Framing</td>
<td>25 mins</td>
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<tr>
<td>Treatment Interfering Behaviours</td>
<td>35 mins</td>
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<tr>
<td>Boundary Setting</td>
<td>35 mins</td>
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<tr>
<td><strong>BREAK</strong></td>
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<tr>
<td>Safety &amp; Managing Aggression</td>
<td>35 mins</td>
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<tr>
<td>Supervision &amp; Reflective Practice</td>
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<tr>
<td>Collaborative Practice and Information Sharing</td>
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<tr>
<td>Self-Care</td>
<td>15 mins</td>
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<tr>
<td>Summary &amp; Questions</td>
<td>10 mins</td>
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*Forensic Fundamentals*
Introductions

- Your name
- Your workplace and role
- Your work background
Challenges of working with (some!) Forensic clients

- balancing health and criminogenic needs
- lower motivation and resistance to treatment
- antisocial personality patterns – including heightened aggression
- pro-criminal attitudes and thinking styles
- denial of offending
- increased risk and safety concerns
- attending appointments while substance-affected
Risk-Needs-Responsivity Model of Offender Rehabilitation
The risk principle contains two elements:

1. Assessing and predicting of risk of reoffending
   - Using static and dynamic factors that are related to offending

2. Matching risk to intensity of treatment
   - Providing treatment that matches the intensity of the risk
   - Higher risk clients need more intensive services
   - Treatment services to low risk offenders should be kept to a minimum
   - Supervision and treatment resources should be prioritised for higher risk clients
7 Criminogenic Needs

- Antisocial Personality Pattern
- Pro-criminal Attitudes
- Social Supports for Crime
- Substance Abuse
- Poor Family and Marital Relationships
- School/Work - Poor performance or satisfaction
- Lack of Pro-social Recreational Activities
# Responsivity

**Tailor Treatment to the Individual Needs of the Client**

<table>
<thead>
<tr>
<th>Internal Factors</th>
<th>External Factors</th>
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<tbody>
<tr>
<td>• Motivation and Readiness to Change</td>
<td>• Culture and Language</td>
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<tr>
<td>• Literacy and Communication Skills</td>
<td>• Childcare needs</td>
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<tr>
<td>• Mental illness</td>
<td>• Transport barriers</td>
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<tr>
<td>• Personal strengths and Aspirations</td>
<td>• Physical disability</td>
</tr>
<tr>
<td>• Trauma history</td>
<td>• Developmental age</td>
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<tr>
<td>• Cognitive Impairment</td>
<td>• Work commitments</td>
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**Forensic Fundamentals**
What is your experience (if any) with the application of this model to your clients?

What responsivity factors might you need to consider for your clients and how might you address these?

How can you address the responsivity principle within the constraints of your role?
The relationship between drug use and crime is complex, and widely debated. Mernard, Mihalic and Huizinga (2001) outline 4 competing theories of this relationship:

1. Drug use leads to crime
2. Drug use and crime influence each other in a pattern of mutual causation
3. Crime leads to drug use
4. The relationship between drug use and crime is either coincidental or that both result from a common underlying issue
Menard and colleagues (2001) conclude:

• “the initiation of drug use typically occurs subsequent to the onset of offending”

• “whilst some crime is caused by drug use and some drug use is caused by crime, both are heavily influenced by a similar set of underlying factors”
Motivation and Treatment Planning
Low Motivation

- Forensic clients can present with lower motivation than voluntary clients.

- This is not always the case however, as some clients are highly motivated to avoid the CJS and cease offending.

- Legally referred clients do not necessarily have poorer treatment outcomes and in some studies showed higher treatment completion rates (e.g. Farabee, Prendergast & Anglin, 1998).

- Motivational interviewing techniques are important to build motivation in forensic clients who have lower internal motivation.
Motivational interviewing (MI)

- What is your current understanding of MI?
- How confident are you using MI?
- What MI techniques are you currently using (or have used) with clients?
Enhancing the Likelihood of Change

Clients are more committed to change when they (not you):

1. Identify the dilemma they face (how their behaviour is in conflict with important goals or values)
2. Feel the discomfort or “psychological squirm” of their ambivalence
3. Make a decision to change
4. Choose the solution
The Spirit of MI (PACE)

- **Partnership (vs. Confrontation):** working with the client, never taking an oppositional viewpoint

- **Acceptance (vs. Judgment):** avoid labelling or judging the client as right or wrong, rather aiming for understanding

- **Compassion (vs. Indifference):** extending the above into feeling for the client’s predicament (empathy)

- **Evocation (vs. Education):** the reasons and motives for change should be coming from within the client
Change Talk

- Any client speech that favours movement in the direction of change
- Provides indicators of motivation
- Must be elicited (or evoked) from the client rather than prescribed by the clinician
- Gives voice to reasons for change that are personally meaningful for the client
- Requires active listening – change talk can be hard to hear

Research has found that change talk is associated with successful outcomes – so we need to evoke and respond to change talk!
What sorts of questions or strategies have you found helpful in evoking “change talk” from your clients?

Remember your aim is to have the client verbalise their own motivation to change
Sample questions for evoking change talk

- “What changes do you want to make?”
- “What skills do you have that will help you succeed?”
- “What are some of the reasons for making change?”
- “On a scale of 0 to 10, how important is it to make change?”
- Follow up with, “Why a ___ and not a 0?”
# Treatment planning

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Your Goal</th>
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<tbody>
<tr>
<td>Pre-contemplation</td>
<td>To get the person to consider there is an issue</td>
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<tr>
<td>Contemplation</td>
<td>To raise the issue by observation of behaviour. Evaluate choices regarding change options</td>
</tr>
<tr>
<td>Planning</td>
<td>To encourage these steps and support change process</td>
</tr>
<tr>
<td>Action</td>
<td>To make action plan suggesting, reinforce changes, provide support and guidance</td>
</tr>
<tr>
<td>Maintenance</td>
<td>To support continued change and help with relapse prevention</td>
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</table>
A number of factors can impact goals in treatment planning:

- Your role
- Stage of client’s navigation through CJS (e.g., on bail, sentenced, parolee)
- Needs of the client e.g. housing, relationships
- Severity of client’s substance use
- Motivation of client
- Insight of client, etc.

Goals might include:

- Harm reduction
- Motivational enhancement towards change
- Reduction/cessation of substance use
- Addressing offending behaviour
- Improving family relationships
- Increased engagement in prosocial activities
Treatment Interfering Behaviours
What are some examples of TIBs you have seen in practice?
Common Client TBIs

- Non-attendance or late arrival
- Limiting the time available for sessions
- Dramatic behaviour or extreme emotion
- Splitting
- Threats of harm (self and others)
- Critical or dismissive of response to therapist’s approach
- Presenting substance affected
- Repeatedly presenting “in crisis” (Crisis orientation)
- Deliberate disruption of therapeutic relationship
- Unhelpful responses (“Dunno” or “I can’t remember” or “I’m not sure”)
- Aggression
- Providing inaccurate information
- Denying problems or refusing treatment
General Strategies for Managing TIBs

- Establish expectations early (through group agreement or treatment contract)
- Refer back to expectations as needed
- Refer to specific behaviour
- Discuss impact behaviour has on treatment
- Explore reasons for behaviour (e.g. avoidance, cognitive deficits etc)
- Identify strategies that could assist with the reasons for this behaviour
- Advise the client of the consequences of continued behaviour
- Seek supervision
- Document actions
Activity 1: Managing TIBs

- Break into small groups

- Review the Scenarios in Workbook “managing TIBs”

- Identify the treatment interfering behaviours displayed and suggest strategies to manage them
Splitting

- Splitting is the conscious tactic employed by clients to pit one entity against another (e.g. CCS case manager vs clinician)

- Splitting is often employed by clients to get what they want

- Splitting may simply be one of the client’s strategies to manipulate and control their situation

- Note: splitting can also refer to the cognitive pattern of seeing things as “all good” or “all bad” – and that is how the client will present the two entities (e.g., good cop vs bad cop)
Splitting

What might be helpful to manage splitting behaviours?
Managing splitting

- Seek to provide a balanced response where the client is not invalidated and you are not placed in an untenable situation
- Consistency and communication with the client and the CJS are vital
- Ensure that everyone dealing with the client responds in a similar way
- Communicate clearly (and unapologetically) that you are unable to get directly involved or ‘take sides’
- Gently encourage client reflection on their interpretations of other people’s actions / motivations
- Never speak negatively about other staff to the client
- Be clear from the beginning about reporting requirements
- Consider holding a case conference with CJS staff to discuss issues together
VIDEO: Managing Criticism and splitting
Activity 2- Role Play Managing Splitting & Criticism

- Break into Groups of 3 (clinician, client and observer)
- Role Play Scenario listed under activity 2 in Workbooks
Boundary Breaches
Boundaries with Forensic Clients

- Forensic AOD clients have a history of violating personal boundaries and social norms, including violations of a sexual nature (inappropriate comments and gestures).

- Given the client population, expect the boundaries of the therapeutic relationship to be challenged and/or crossed at some point.
Ways Clients Challenges Boundries

- Criticising the worker
- Asking personal questions
- Not paying attention, refusing to answer questions
- Asking for favours or special treatment
- Bringing others to sessions
- Overreacting or angry outbursts, aggressive behaviour
- Wandering around the room
- Walking out of sessions
- Complementing the clinician
- Giving the clinician gifts
Some Tips on Managing Boundaries

- Clearly define your role
- Discuss mutual expectations
- Discuss limits to confidentiality
- Advise of your response to breaches (such as lateness, attending substance affected etc)
- Act only within the parameters of your position
- Don’t promise what you can’t deliver; deliver on what you promise

- Maintain consistency
- Avoid disclosing personal information
- Follow correct procedure & document carefully
- Seek supervision
- Defer to organisational hierarchy when the situation requires
- Document what’s happening and your responses in your clinical notes
Discussion – Boundary Breaches

Scenario 1: A client who you’ve been working with for a number of sessions asks you if you’ve ever used drugs.

Scenario 2: A client wants to give you a hug after an emotional session.

How might you respond? Share your responses with the group.
On Self-Disclosure…

- Disclosing too much information can put your safety at risk as people with antisocial personality disorder and/or psychopathy can use this information to manipulate you.
- NEVER disclose specific details such as your home address or phone number.
- Considering the reason for the question is helpful information for your therapeutic work (e.g. avoidance reasons, lack of trust, lack of boundaries or respect for privacy, manipulation, confusion about your role). Seek to explore the reason for the question.
- Find your own way of answering these questions in a way that works for your therapeutic style.
Some Helpful Advice…
Professional Boundary Violations

• Given the intense nature of our roles and client type, our own professional boundaries can be eroded over time.

• Recognise anomalies in your professional behaviours that might indicate boundary violations…
• Believing you’re the only one who can help this client
• Avoiding challenging
• Doing favours for the client
• Not talking to peers/supervisors about the client
• Making excuses for the client
• Revealing personal information

• Excessive joking with the client
• Doing favours or spending extra time with client
• Feeling angry or wanting to punish the client
• Losing hope
• Agreeing with anti-social attitudes (e.g. towards police)
• Stereotyping clients who engage in certain behaviours
Management of Clinician TIBs

- Monitor your level of involvement with clients (e.g. over or under-involvement could indicate personal TIB)

- Recognise that your own TIBs provide information about the client’s presentation and seek supervision accordingly

- Practice reflectively (e.g. be aware of your own vulnerabilities and negative responses and what might be driving them)

- Self care

- *STAY IN ROLE!*
Tea Break
Aggression

• Aggression can be defined as the threat of or actual psychological, physical, sexual, material or social injury to another

• Aggression is a TIB commonly exhibited by forensic clients and can result in serious harm if unmanaged or poorly managed

• Aggression is associated with clinician anxiety, stress and burnout

• Because of its prevalence and effect, it is critical that clinicians are confident they have effective strategies to manage aggression and ensure safety of themselves and others
Make Safety a Priority!

- Always remember to take care of your own safety and the safety of others
- Follow your organisation's OH&S and Critical Incidents policies – if you don’t know these ask!
- If you have concerns about potential hazards, raise this with your OH&S rep
Operational Safety Considerations

- Adhere to your organisational, professional and legislative guidelines regarding duty of care, ethics and confidentiality, and mandatory reporting
- Decrease the possibility of your home address and personal details being obtained by clients
- Inform reception staff in advance if client is known to be aggressive
- Communicate your location to other staff
Responding Safely to Risk in Sessions

- Carry duress or be aware of its location
- Always sit near the door
- Have an escape route
- Be aware of any potential weapons in room or on you (e.g., lanyards, scarves)
- If the client becomes agitated and stands in session, remain seated
- Do not prevent the agitated client from leaving the room
- Use de-escalation strategies
- If there is an imminent threat, inform police
After the Session

- Document your actions thoroughly
- Debrief and seek supervision
- Report back to CJS about risk concerns
Responding to Aggression

- De-escalation can increase safety, whilst also ensuring that there is an opportunity for greater understanding of client’s behaviour

- De-escalate using basic skills:
  - Avoid non-verbal behaviours that could be interpreted as aggressive
  - Maintain appropriate eye contact without staring
  - Try to appear relaxed (reduce your arousal level by focusing on your breathing)
  - Maintain a courteous, calm, quiet but firm demeanour
  - Maintain both theirs and your own personal space
<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>Danger</td>
<td>Assess for Risk and Safety</td>
</tr>
<tr>
<td>Relocate</td>
<td>Consider a de-escalation space with low stimulus, no other people, safe, not confined</td>
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<tr>
<td>Listen</td>
<td>Active listening, empathy, be genuine, affirm</td>
</tr>
<tr>
<td>Ask</td>
<td>Ask about the problem and Ask what they need</td>
</tr>
<tr>
<td>Summarise</td>
<td>State back their thoughts and feelings, validate but don’t justify or pass blame</td>
</tr>
<tr>
<td>Set out scope</td>
<td>Explain what you can do and what they can do</td>
</tr>
<tr>
<td>Offer options</td>
<td>Explain 2-3 options and rationale for each</td>
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</table>
If they continue to escalate – assertive closure

Some people may not calm down.

Then:
• Calmly disrupt
• Explain boundaries
• Remain respectful but assertive
• Offer follow-up
• Try a time out
• Allow them to ‘save face’, don’t ‘put on show’
• Hang up/leave the space
• Debrief!
Activity 3- Managing Aggression - DR LASSO

- Break into Groups of 3 (clinician, client and observer)
- Role Play Scenario listed under activity 3 in Workbook
Supervision
Discussion – Supervision

- What does supervision involve in your workplace?
- What different roles does supervision play?
- What do you see as the benefits of supervision?
Role of Supervision

Sometimes, working with forensic AOD clients increases the likelihood of:

• Adverse outcomes leading to harm to self or others
• The need to account for your decisions and interventions in Court
• Our own personal reactions, assumptions and emotional responses influencing our actions

Supervision provides:

• An opportunity to assess situations and your responses more objectively
• Provide professional guidance to increase ability to work effectively with complex clients
• Ensure duty of care and appropriate actions have been taken
Benefits of Supervision

- Establishes a sense of support for caseworkers
- Offers protection to clients (cases are reviewed)
- Enhances learning and professional development
- Improves accountability
- Leads to better practice and improve outcomes
- Helps practitioners ensure ethical practice
- Increases self-awareness
Daphne Hewson, Reflective Practice Tool Kit, 2012
What is Reflective Practice in Supervision?

- A regular, protected time for facilitated, in-depth reflection on practice
  - (Adapted from Bond and Holland, 1998)

- A working alliance between two professionals where supervisees offer an account of their work, reflect on it, receive feedback and receive guidance, if appropriate
  - (Carroll, 2010)
Gibb’s Reflective Cycle (1988)

- **Description**: What happened?
- **Feelings**: What were you thinking and feeling?
- **Evaluation**: What was good and bad about the experience?
- **Analysis**: What sense can you make of the situation?
- **Conclusion**: What else could you have done?
- **Action Plan**: If it arose again what would you do?
Reflective Practice Exercise

In this activity, you will have an opportunity to reflect on a selected case scenario with your partner.

AOD worker

Identify a case in which you were recently involved which:

- Made a real difference to the client
  OR
- Where the case work did not go as planned
  OR
- It was very ordinary and typical of your case work

Describe the situation and your clinical response to your partner

Supervisor or peer

- Ask reflective questions such as:
  - What happened?
  - What was good/bad about the experience?
  - What could you have done differently?
  - What can you learn from it?
  - What would you do next time?
Collaborative Practice & Information Sharing
AOD Sector
- Health focused
- Voluntary
- Value neutral
- Educative
- Supportive
- Client centred
- Harm reduction

Justice System
- Offence focused
- External pressures
- Coerced
- Value driven
- Behaviour change
- Reintegration
- Reduce risk

Forensic AOD System
The conditions commonly attached to community corrections orders (CCOs) include the following:

- supervision with CCS
- unpaid community work
- treatment and rehabilitation (can be for AOD or psychological/psychiatric treatment)
- curfews
- bans on entering specified areas or places
- bans on entering many licensed premises and bans on drinking alcohol in other licensed premises
- bans on contacting or associating with specific people or groups
- residential restrictions or exclusions relating to the offender’s accommodation
- a bond condition requiring payment of a monetary sum that is liable for forfeiture upon contravention of the CCO
Positive working relationships are critical:

- Builds mutual respect
- Assists in addressing case challenges
- Enhances communication
- Assist in addressing risk to community

Building rapport with third parties is just as important as your rapport with the client.

Collaboration between AOD provider and the CJS staff is essential to role-model pro-social behaviour.

Where possible, always seek buy in from your client about the information to be shared – remember the collaboration should be 3 way (you, client and case manager).
Who’s Involved

Community Correctional Services (CCS)
- Provide case management interventions to support offenders to successfully complete their mandated court or parole orders

ACSO / Community Offender Advice and Treatment Services (COATS)
- Provide assessment and treatment service brokerage for offenders on community-based dispositions with an alcohol or other drug concerns

Alcohol and Other Drug (AOD) Treatment Providers
- Specialist alcohol and other drug treatment services delivered via treatment streams that may include counselling, withdrawal, day and residential rehabilitation

Other Agencies
- That your client is involved with e.g. CISP
What are some of the challenges you have experienced in sharing information or collaborating with other agencies with forensic clients?
What is collaborative practice?
Collaborative care is an evidence based approach to service provision which integrates several services to facilitate positive outcomes. This approach can include care coordination, case management, treatment of presenting issues and progress monitoring.

Why is it needed?
Lack of clarity regarding role definition, information sharing and treatment services for AOD clients. This approach is intended to reduce harms to the community.

Who is it for?
• Community Corrections Services
• COATS
• AOD Treatment Providers
• Any CJS staff e.g. CISP staff, parole officers etc.
Forensic service delivery should be client centred and holistic.

Addressing problematic substance use should contribute to improving order compliance.

A collaborative and integrated forensic system is in the best interests of individuals, the service system and the community.

Conditions and interventions should be sequenced to respond to an offender’s health and wellbeing needs as well as the risk of reoffending.

The forensic system should be underpinned by a skilled and capable workforce.

Mandatory AOD treatment should be as effective as voluntary treatment.

Access to AOD treatment for offenders should be accessible and equitable.

A harm reduction approach is critical to reduce risk to the client, others and the broader community.

Service responses should be founded on high quality and culturally competent approaches.

Treatment interventions should be tailored to the needs and risks of the offender.

Continuity of care is essential.
Information to be provided to CJS during treatment

- Attendance & Participation
- Treatment progress
- Extensions or variations to treatment
- Disclosure of drug or alcohol use related to offences
- Intention to exit treatment
- Escalation of Risk
All information relevant to possible trigger issues:

- Offender has multiple and complex needs
- Engaged with multiple service providers
- Number of changes to dynamic risk factors
- Poor compliance/ missing consecutive appointments
- Refusal to engage
- Treatment variations
- Entry into/ exit for residential rehab
- Consideration of parole cancellation
- Any other matter deemed necessary
Immediate reporting of significant events

- It is the responsibility of all agencies to share information about significant events during treatment.
- Information sharing within 24 hours is a minimum expectation, with written follow up expected.
- Information should be communicated via phone and if no response, via email.
## Immediate Reporting Events

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<thead>
<tr>
<th>Event</th>
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<tr>
<td>Further offending</td>
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<tr>
<td>Significant drug/ alcohol use where the type of drug has a relationship to offending behaviour and could potentially lead to a de-stabilization of the individual</td>
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<tr>
<td>Any drug or alcohol use for an individual on parole</td>
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<tr>
<td>Family violence victim/ perpetrator concerns</td>
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<tr>
<td>Death/ hospitalisation</td>
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<tr>
<td>Any instances of occupational violence or threat</td>
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<tr>
<td>IVO matters</td>
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<tr>
<td>Contravention and/or incarceration</td>
</tr>
<tr>
<td>Family violence victim/ perpetrator concerns</td>
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<tr>
<td>Overdose</td>
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Communicating with other parties e.g. Justice Case Managers

What else you might provide:
• Change of AOD Counselor
• Referrals made to other services
• Changes of engagement with other services
• Treatment goals (including revisions)
• Changes to AOD treatment (e.g., commencing or terminating OSTP, detox referrals)
• Any key issues that might be relevant in providing support for the client and that other workers need to know about

Need to consider appropriateness given setting you work
Confidentiality

• **ALWAYS** discuss confidentiality with clients
• Make sure clients understand the limits of confidentiality – especially in relation to information that will be fed back to Corrections
• Communication with third parties
• With young clients, parental involvement should be considered when explaining confidentiality (with young person’s consent of course)
• There is more information on the resource website about the limits of confidentiality
Collaborative Practice Example

Male Client on CCO

Group Program – ongoing substance use & poor attendance – risks non-completion

Client reveals unstable accommodation

With consent, case conference with CCS case manager

Case manager organized accommodation and cab vouchers

Client able to successfully complete program
31 year old female client on CCO, DHHS involvement, current family violence and substance use

Collaboration with CCS, Child Protection and RAMP to enable joint safety planning and to act as each others supports


Benefits of collaborative approach:

- Shared knowledge about partner’s history of family violence and his attempts to sabotage treatment with treatment providers
- Linking her in to FV support service & police FV liaison
- Increased safety for client and her children
- Support for workers through collaborative decision-making
Activity 4: Collaborative Practice & Information Sharing

Break into small groups

Review scenarios in Activity 4 and discuss how you would respond

Consider:
• Consent threshold/ Collaborative guidelines?
• What would be the purpose of sharing? What risk issues should be considered?
• What would you share? How?

• Feedback responses to larger group
Build Your Own Collaborative Practice Model

1. Develop Collaborative Practice Policies and Procedures
2. Introduce immediate reporting protocols
3. Create flow-charts/visual aids for new staff to assist with collaborative practice
4. Encourage discussion on collaborative practice in team meetings and supervision
5. Host regular morning teas or cross agency staff meetings to allow relationships to develop
6. Update other agencies regularly regarding staff changes, absences and leave arrangements
Self-Care
Why discuss self care?

- Self-care facilitates competency and ethical practice
- Self-care assists in maintaining clarity of judgment
- Self-care sustains practice with a clientele that brings unique challenges to the therapeutic space
  - Constant vigilance for issues of risk
  - Ongoing management of frequent boundary challenges and violations by clients
  - Significant exposure to the pain and suffering that clients have both caused and experienced
Possible Causes of Stress at Work

• Threats to self (real or perceived)
• Challenging client behaviours
• Systematic issues
• Too many demands
• Inadequate time, resources or training
• Exposure to vicarious trauma
• Too much choice, not enough guidance
• Personal stress
• Conflict with colleagues
• Lack of support/ recognition
Acting on feelings, not thinking (reactive)
• Giving less attention to everything
• Efforts to ‘super control’ your environment – not fun for others
• Distancing from clients
• Resisting assistance
• Lateness, leaving early
• Absenteeism
• Presenteeism (being at work but not working)
• Poor performance
• Boundary breaches and enmeshment with clients
• Avoidance reactions such as distancing, withdrawal & denial with clients
Be careful of short term coping:

- Increasing high sugar/salt/fat foods
- Switching from food to coffee
- A few extra wines after work
- Overwork
- “Stiff upper lip”
- Withdrawal
- Complaining
- Sleeping in & sickies
What are some of your self care strategies?

What works?

What doesn’t?
Work Practices

- Talk about it – seek guidance and support
- Communicate effectively
- Develop good time management practices
- Create a relaxing work space - declutter
- Ask for the resources you need
- Take breaks
- Prioritise and utilise supervision
- Monitor caseloads
- Maintain boundaries with clients – stay in work role
Simple Self Care Tips

- Deliberately choose to *leave your work at work*
- Practise reflective writing or keep a diary
- Ensure you get adequate sleep
- Eat healthily and exercise regularly
- Maintain social connections
- Allow yourself to use humor
- Make your personal life a priority
What can team leaders do to reduce work-stress?

- Provide opportunities/space to listen to concerns of their team members
- Find ways to address these concerns
- Support staff to take breaks and leave work at work
- Include relaxation activities as part of the day to day work (walk at lunch-time, yoga/meditation before work)
- Consider walking meetings to get staff away from the office/desk
- Provide regular supervision and peer support
- Keep staff members up to date with any changes in the organisation – communicate regularly
- Encourage team members to generate new ideas for the team to function
- Hold team building days or activities to encourage a supportive workplace for all staff
Summing Up

Use the RNR model as a framework to inform your work

MI techniques are helpful to enhance motivation in forensic clients

Setting expectations early is helpful in managing TIBs and boundary breaches

Follow strategies to maintain safety when working with forensic clients

Supervision and self-care facilitate competent and ethical practice

Collaborative practice is important to support clients and workers

More resources available on accompanying website
Forensic Foundations Resource Website

- Information Sheets
- Key Reference Documents
- Services for Forensic Clients
- Videos
- Further Reading
- Training Presentation Slides
Any questions/comments?

Please fill in your evaluation survey before your leave

Thank you for your time