Forensic Fundamentals

Forensic Fundamentals

Training

TaskForce
Where hope finds help.

CARANICHE
Excellence in Psychology

VICTORIA
State Government

Acknowledgement of Country

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

Forensic Fundamentals

Training Outline

Introduction	5 mins
Criminogenic Theory	15 mins
Motivation and Treatment Framing	25 mins
Treatment Interfering Behaviours	35 mins
Boundary Setting	35 mins

BREAK 15 mins

Safety & Managing Aggression	35 mins
Supervision & Reflective Practice	20 mins
Collaborative Practice and Information Sharing	30 mins
Self-Care	15 mins
Summary & Questions	10 mins

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Introductions

- Your name
- Your workplace and role
- Your work background

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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

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Risk-Needs-Responsivity Model of Offender Rehabilitation

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The Risk principle

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

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Responsivity

Tailor Treatment to the Individual Needs of the Client

Internal Factors

- Motivation and Readiness to Change
- Literacy and Communication Skills
- Mental illness
- Personal strengths and Aspirations
- Trauma history
- Cognitive Impairment

External Factors

- Culture and Language
- Childcare needs
- Transport barriers
- Physical disability
- Developmental age
- Work commitments

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Discussion

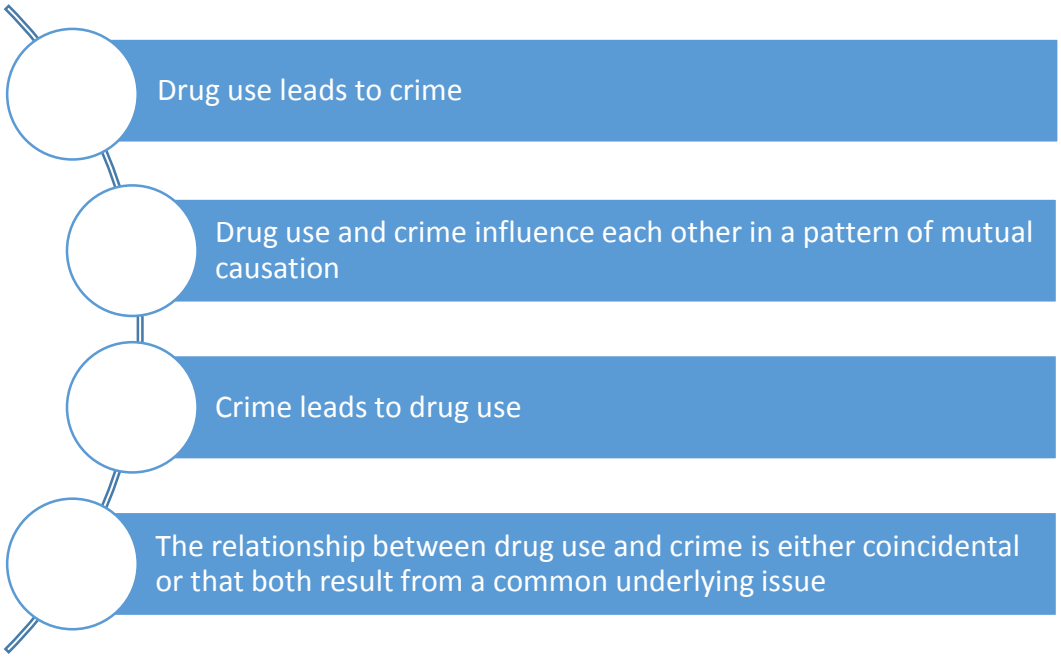
What is your experience (if any) with the application of this model to your clients?

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?

Link Between Drug Use and Crime

The relationship between drug use and crime is complex, and widely debated. Mernard, Mihalic and Huizinga (2001) outline 4 competing theories of this relationship:



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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

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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?

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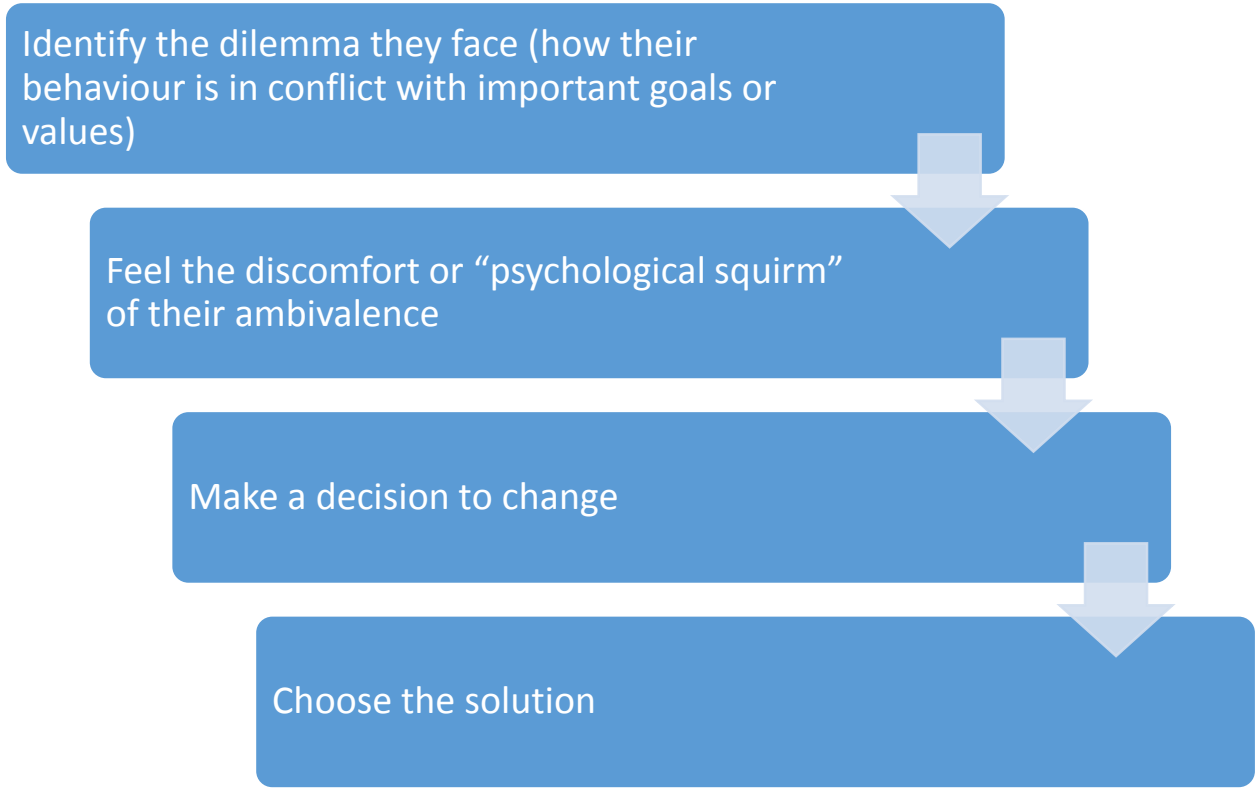
Enhancing the Likelihood of Change

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



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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!

Discussion

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

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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

Stage of Change	Your Goal
Pre-contemplation	To get the person to consider there is an issue
Contemplation	To raise the issue by observation of behaviour. Evaluate choices regarding change options
Planning	To encourage these steps and support change process
Action	To make action plan suggesting, reinforce changes, provide support and guidance
Maintenance	To support continued change and help with relapse prevention

Treatment planning - Goals

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

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Treatment Interfering Behaviours (TIBs)

What are some examples of TIBs you have seen in practice?

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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?

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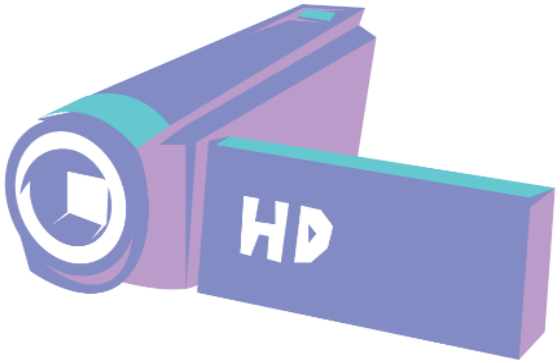
Managing splitting

- 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



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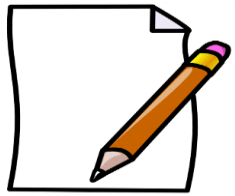
Activity 2- Role Play Managing Splitting & Criticism



- Break into Groups of 3 (clinician, client and observer)
- Role Play Scenario listed under activity 2 in Workbooks

Boundary Breaches

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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

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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.

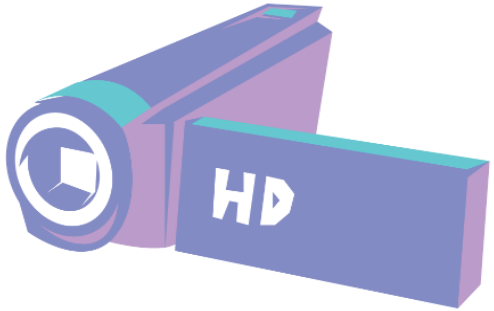
Scenario 2: A client wants to give you a hug after an emotional session.

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…



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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…

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- 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

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Safety

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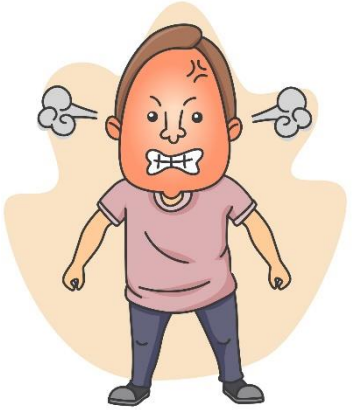
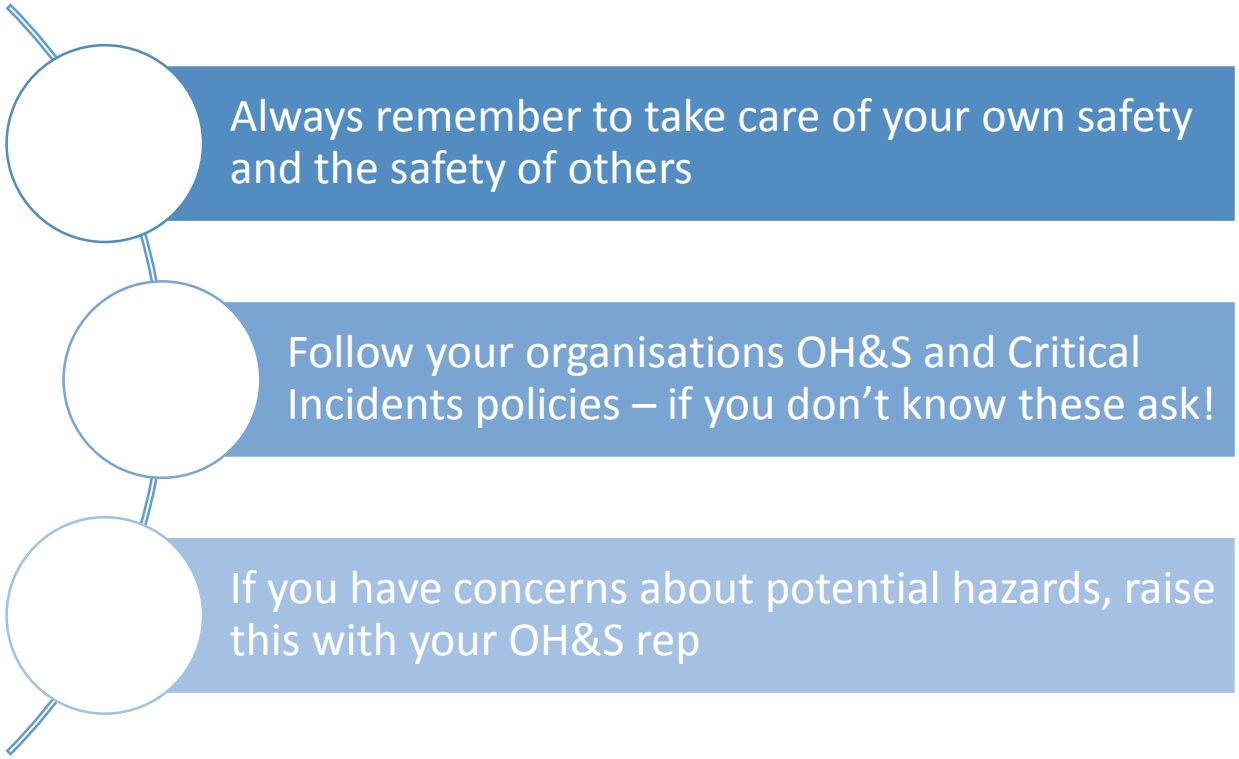
Aggression

- 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!



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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

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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

Danger	• Assess for Risk and Safety
Relocate	• Consider a de-escalation space with low stimulus, no other people, safe, not confined
Listen	• Active listening, empathy, be genuine, affirm
Ask	• Ask about the problem and Ask what they need
Summarise	• State back their thoughts and feelings, validate but don't justify or pass blame
Set out scope	• Explain what you can do and what they can do
Offer options	• Explain 2-3 options and rationale for each

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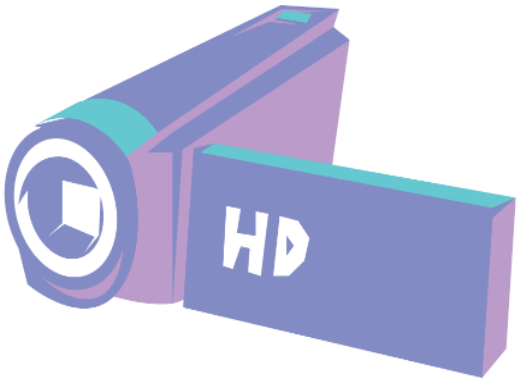
If they continue to escalate – assertive closure

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!

VIDEO – DR LASSO TECHNIQUE



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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

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Discussion – Supervision

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

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Role of Supervision

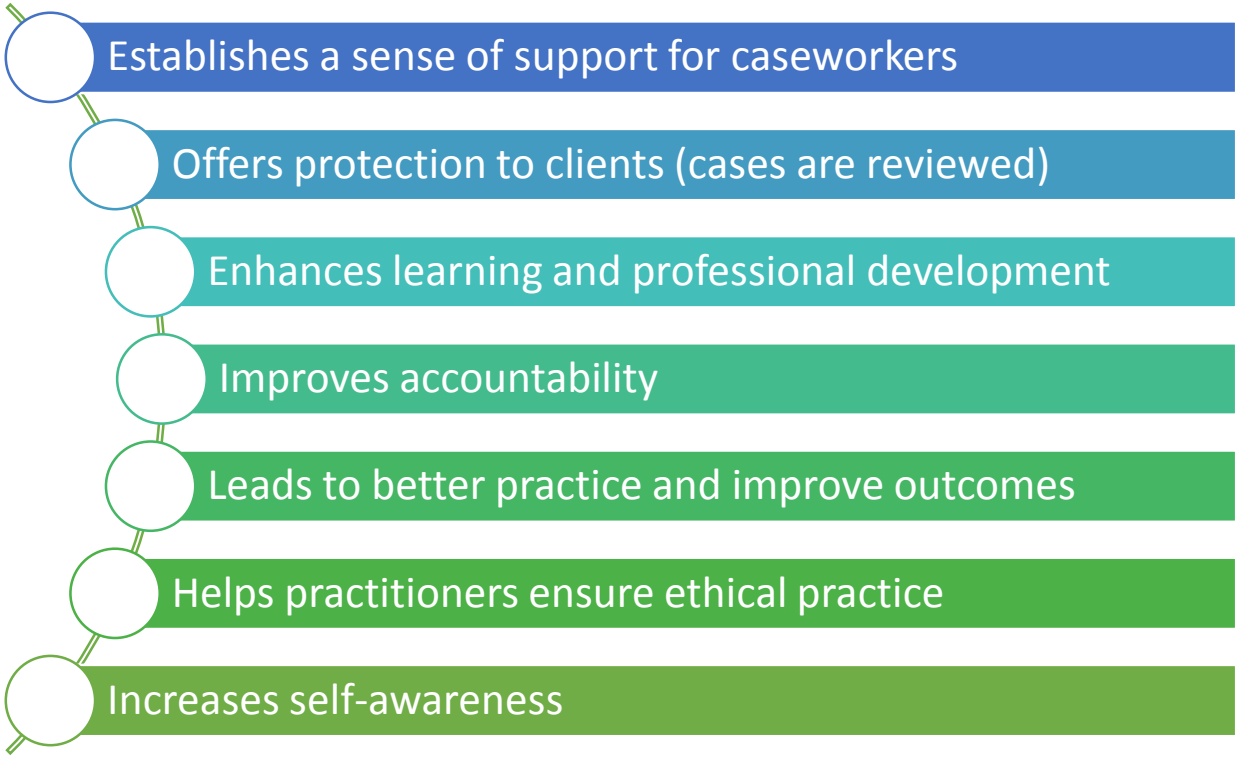
Sometimes, working with forensic AOD clients increases the likelihood of:

- 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



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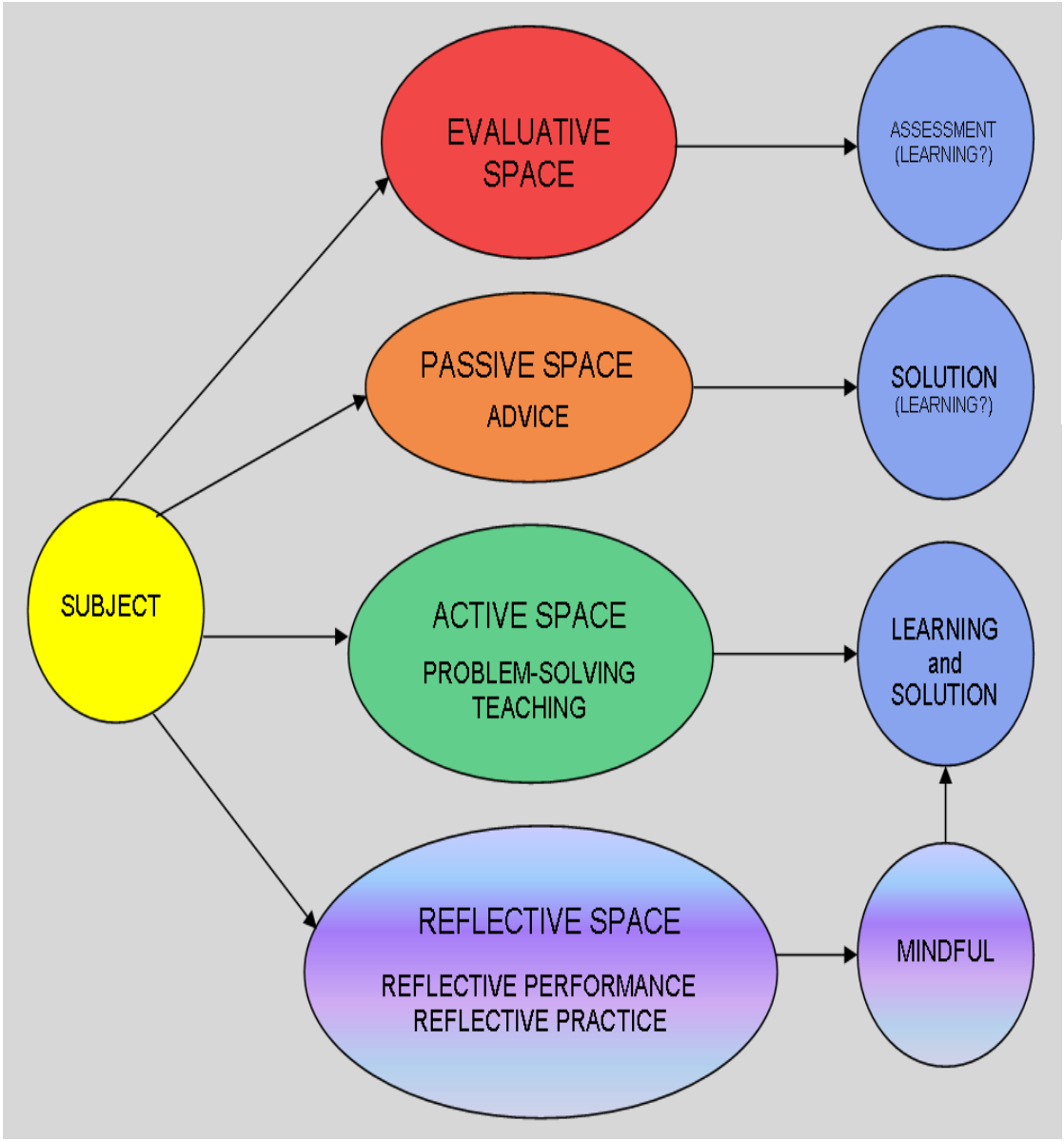

Daphne Hewson,
Reflective Practice Tool Kit,
2012

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)

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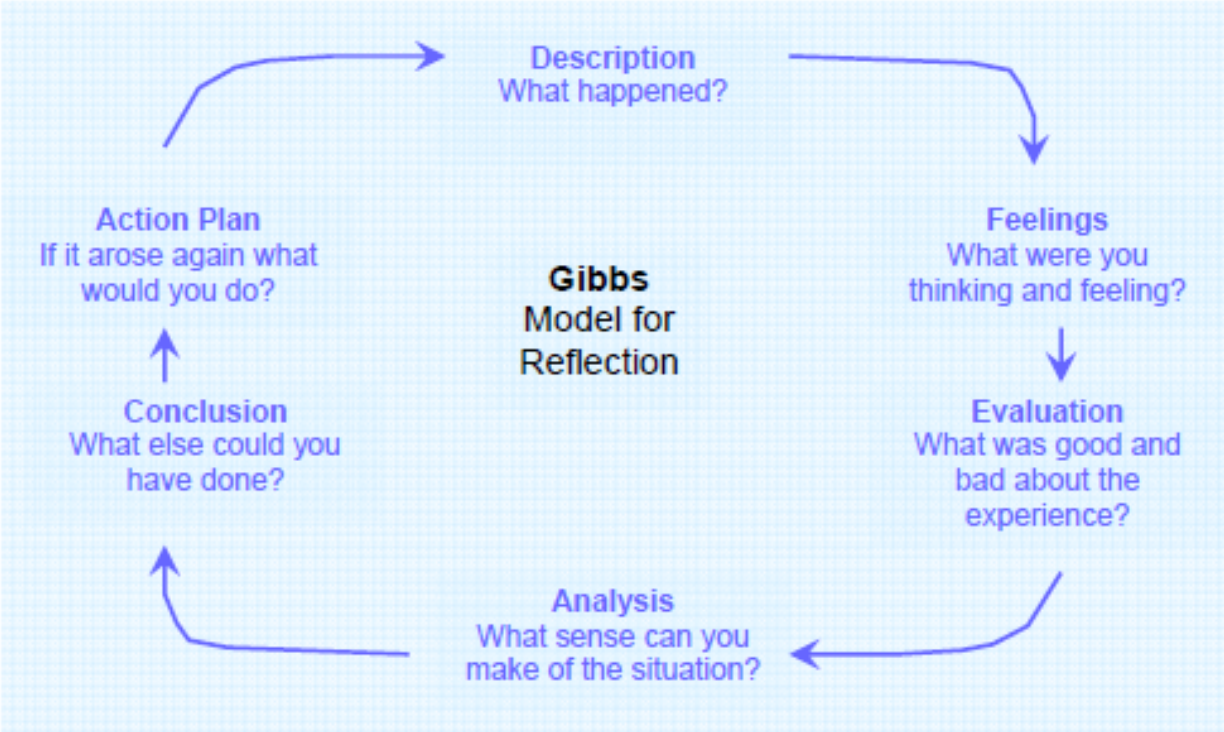
Gibb's Reflective Cycle (1988)



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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?

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Collaborative Practice & Information Sharing

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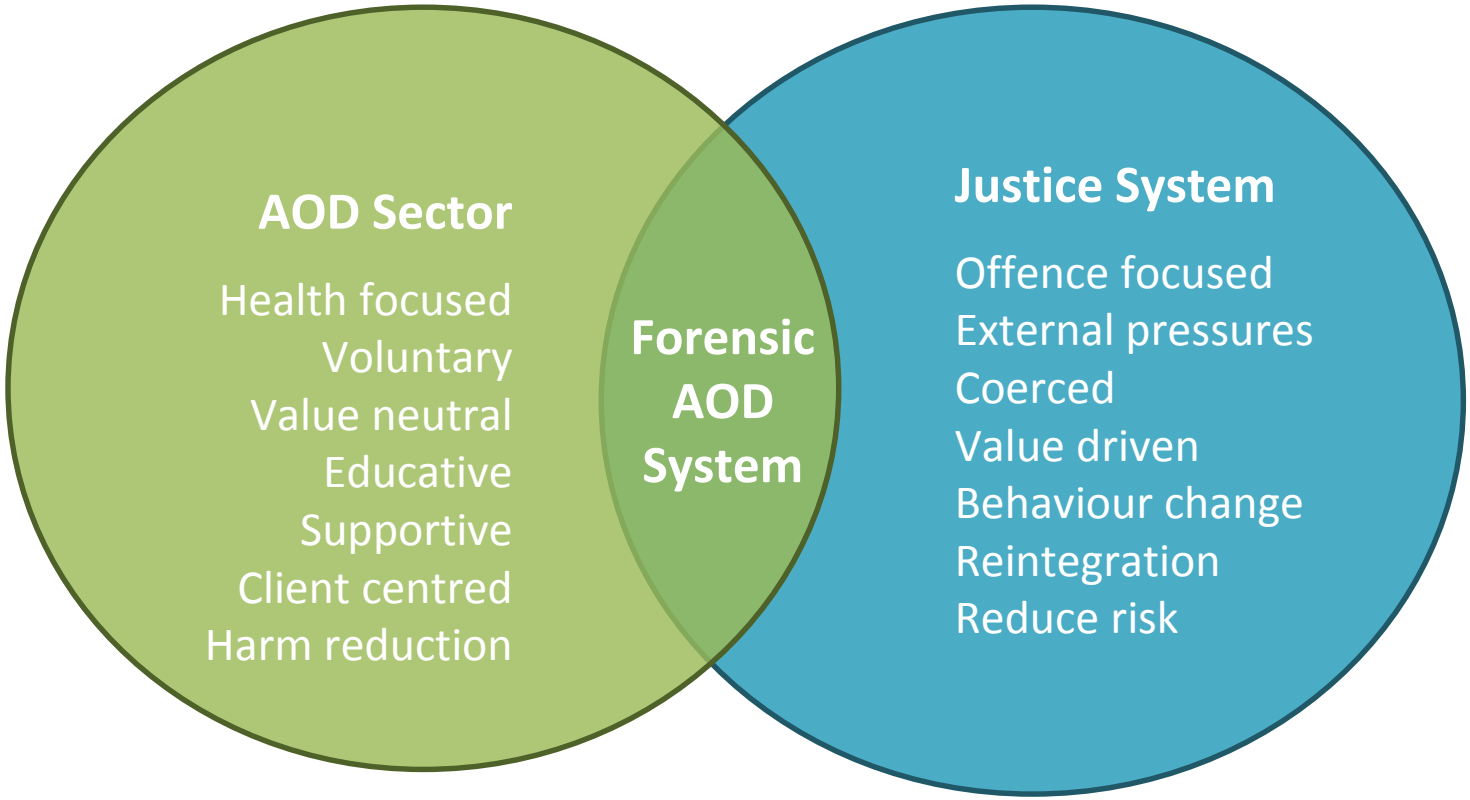

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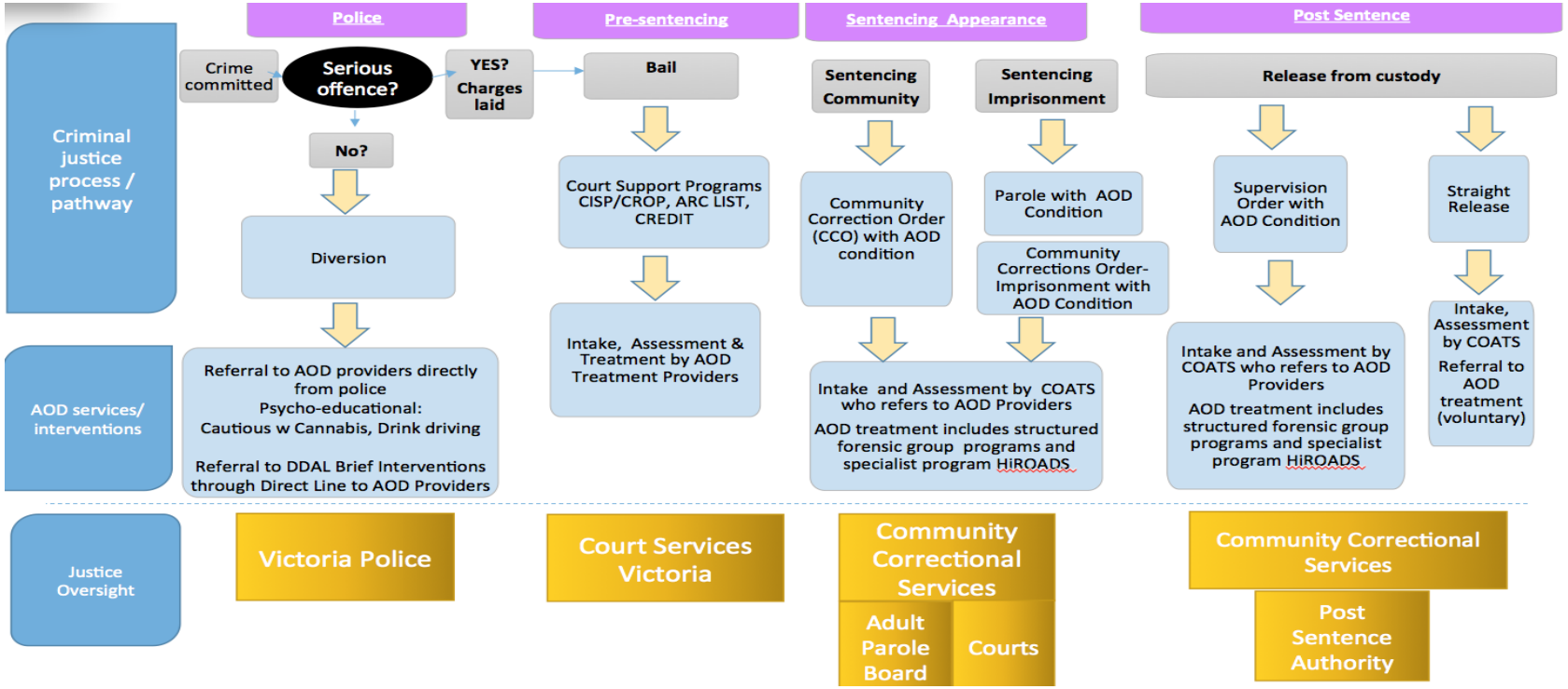

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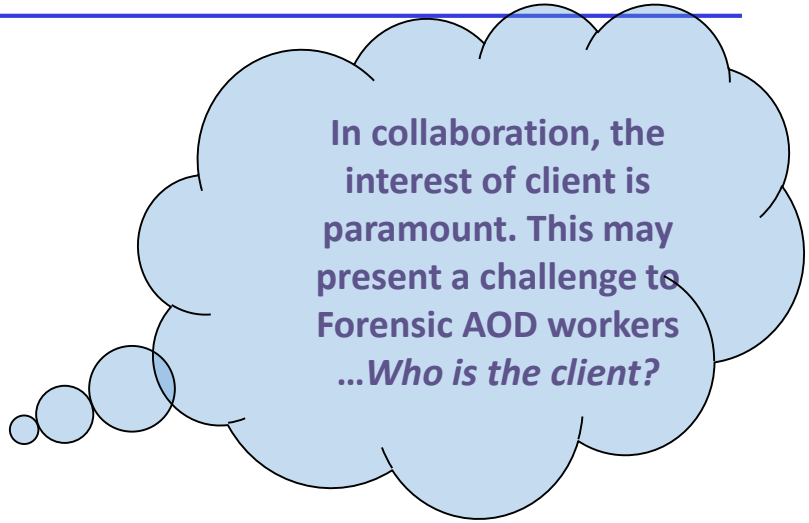
The conditions commonly attached to community corrections orders (CCOs) include the following:

- 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

Collaboration

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).

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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?

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Collaborative Practice

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.

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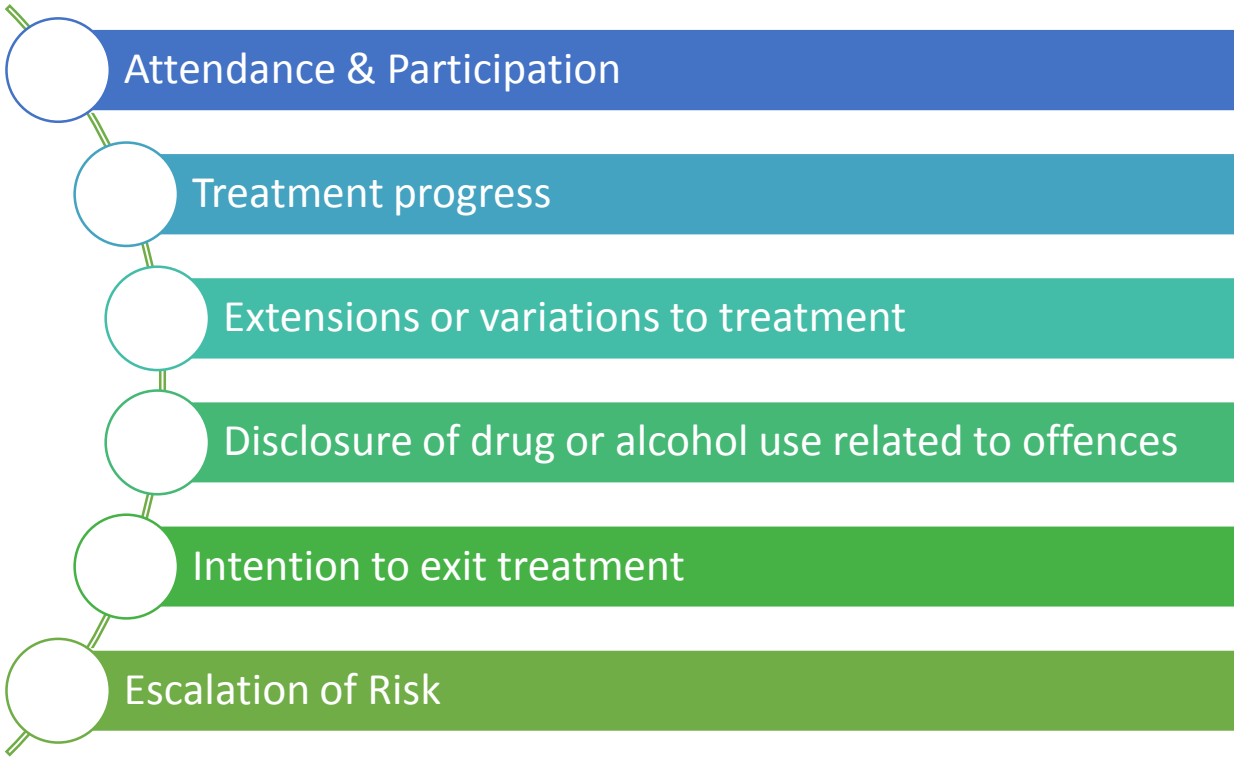
Forensic Alcohol and Other Drugs Treatment Service Delivery Model (FSDM) principles which underpin collaborative practice

- 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



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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
Further offending
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
Any drug or alcohol use for an individual on parole
Family violence victim/ perpetrator concerns
Death/ hospitalisation
Any instances of occupational violence or threat
IVO matters
Contravention and/or incarceration
Family violence victim/ perpetrator concerns
Overdose

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Communicating with other parties e.g. Justice Case Managers

What else you might provide:

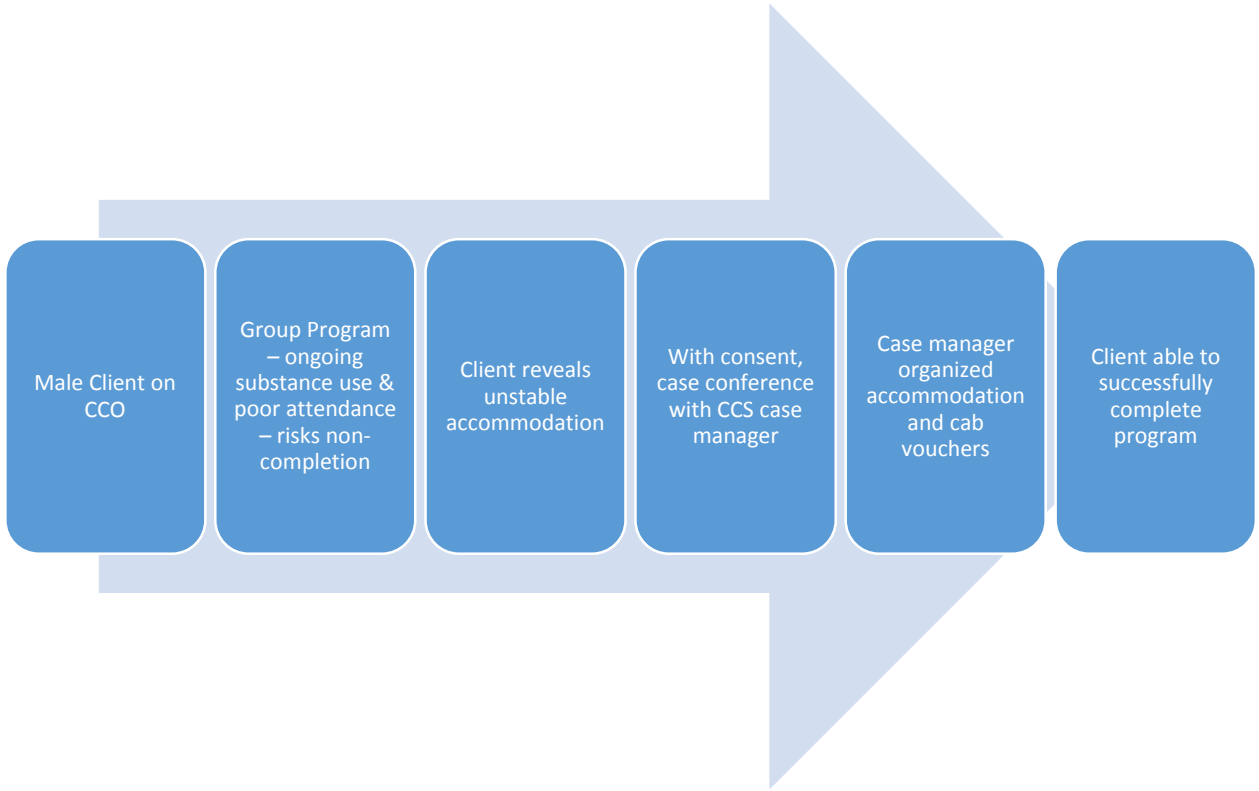
- Change of AOD Counselor
- Referrals made to other services
- Changes of engagement with other services
- Treatment goals (including revisions)
- Changes to AOD treatment (e.g., commencing or terminating OSTP, detox referrals)
- Any key issues that might be relevant in providing support for the client 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



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Collaborative Practice: Family Violence

- 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
- Caraniche clinician attended a Risk Management Review Process, to develop a coordinated response plan. Together, completed a RAMP (Risk Assessment and Management Panel) referral with consent from client.

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

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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

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Build Your Own Collaborative Practice Model

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Self-Care

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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

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Effects at Work

- 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

Unhelpful Coping

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?

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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

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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

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Forensic Foundations Resource Website

Information Sheets	Key Reference Documents	Services for Forensic Clients
Videos	Further Reading	Training Presentation Slides

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Any questions/comments?

Please fill in your evaluation survey before your leave

Thank you for your time

TaskForce
Where hope finds help.

CARANICHE
Excellence in Psychology

VICTORIA
State Government