Recovery from Addiction

Residential care for people with
Alcohol and Other Drugs Issues

A Handbook for Training
Addiction Recovery Workers

Volume 1

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Preface

As an educational resource, *Recovery from Addiction* (RFA) is designed to equip you to implement a successful model of treatment as a shift worker, caseworker, shift manager, and later as a senior case manager taking more complex cases. Although it was not the original intention, RFA has to some extent become a how-to manual for establishing recovery services.

This isn't an exercise in classroom theory. It is intended to support you to be trained and assessed on the job. It tells you how to perform the main duties of your role, and gives you enough to start exploring other resources. Wherever possible, I have divided roles into separate skills so that you can learn them more easily and quickly.

So far, students have generally handled the academic aspects very well, but find the practicum requirements more demanding. Even when they can perform their roles, some have difficulties in performing consistently for an extended period across the full range of their responsibilities.

Practicum students need to learn which incidents need to be referred to a supervisor and which they should handle themselves. One of the best signs of being ready for assessment is to be able to accurately discern the difference.

Despite the abundance of Internet information and published texts, I found no other resource that already gives this training, although I found several that suggest various theories in the hope that one of them might work. Some other texts and websites could be very helpful if students have already learned the basics and gained some hands-on experience.

Like most writings in this field, RFA follows a very clear philosophy. It follows the holistic, residential approach to treat-

ing addiction to alcohol and other drugs, and seeks to address best practice and professional competence standards. Unlike most sources, it promotes abstinence from substances of addiction.

The_house

RFA uses the metaphor of a fictitious organization called The_house, although it is based fairly closely on several real facilities. It has enabled me to take a much more "how to" approach than a general textbook that describes theoretical principles. As a reader, you might sometimes find yourself drifting between The_house and your own organization. RFA depends on you to ask the following questions: What can you learn from The_house? Can you do everything in The_house that suits your particular job? What adaptations do you need to make for your situation? How would you improve on the practices of The_house?

The order of contents

The order of contents in Volume 1 is based on the following rationale.

"The basics" is a focussed orientation to what you should know as a new worker coming onto the floor.

The objective of "Starting shifts" is that you'll soon be able to make a valuable contribution to everyday operations in a residential facility. It covers the introductory skills that you can readily learn to become a valuable employee, starting as a shift worker and case worker, and progressing to specializations (advocacy, groups, etc). Later chapters assume that you will be able to learn more advanced skills far more effectively if you already have sound, hands-on experience at this level.

The following stages help you to work with less supervision as a shift manager and case manager, where students learn to oversee the implementation of the holistic, residential approach to treatment. This includes applying current best practice in case-managing residents who have at least one other serious issue that negatively impacts them.

In many US states, addiction recovery counselors are now licensed, and the competency standards1 are a useful reference point. Although this textbook at least touches on all of them, it is deliberately more international and has more emphasis on shift management and case management than on specialist counseling.

Choose the questions and activities that suit your students. I doubt that any instructor or college professor will use all of them for any one cohort of students.

You might not agree with everything that I have written, and that might be a good thing. Think about it and come up with better answers. That especially applies to anything where research has moved on from the time this was written to the time you use it.

RMW

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1
About The_house

Welcome to The_house, a community organization that provides long-term residential recovery for young people suffering from substance abuse and addiction. It is one of the most successful residential programs in the country, with a high long-term retention rate and a very low relapse rate. Our graduates typically excel in employment after the program.

We started small, just a group of friends with a vision and enough money to rent an old house on the edge of town. At first we didn't think of it as organization, so we just called it "the house." The name stuck. Eventually we'd used it for so long that we wouldn't use any other name even if we changed it, except now we write it *The_house*.

We presently now rent several more nearby houses and run our main program in one of them. We depend heavily on volunteers, but our core staff are all employees. Some senior residents also take responsibility for others, but always work under supervision. We don't get institutional government funding.

The_house offers a fairly specific range of treatments. We take people through detox (withdrawal) and provide long-term residential treatment. We only let residents live outside the community if they are older and have satisfactorily completed a substantial period in the residential program.

As a holistic program, we address many needs other than substance abuse. Most residents have backgrounds of other issues such as physical or sexual abuse, homelessness, financial problems, family break-up, crimi-

nality, and unemployment. Some have been in a series of harmful sexual relationships and a few of the older girls have tried prostitution. We often take in pregnant teenagers, and several girls have children. Several residents were professional addicts, cycling through various rehabs, learning to say the right things but never expecting any real change. Almost all substance abuse victims suffer from mental health issues at some stage. Drug-induced psychotic episodes, paranoia, and depression are not uncommon. Some longer-term users suffer from schizophrenia.

Terminology

We call people *residents*. We don't want to call them *patients* because we don't want people to think of The_house as some kind of hospital. We also don't like the word *client*. It would suggest that we were institutionalizing people or selling them a service.

We have other preferences. We prefer the word *recovery* to *rehabilitation*. Some staff prefer the term *substance abuse* to *drug addiction*. Addiction is just that: the medical condition of addiction. But *drugs* tends to connote exclusively illicit drugs, while the term *substance* also includes the abuse of alcohol and prescription medications.

Our preferred industry descriptor is *AR* for *Addiction Recovery*, for example, AR worker, AR agency, AR services. The general acronym for substances of abuse is *AOD* meaning *Alcohol and Other Drugs*.

Meet some people from The_house

You'll find our staff mentioned in incidents later on, so we thought you'd like some background on them.

- **Amanda** is the Director. She was one of the key people in starting and developing The_house.
- **Stewart** is a senior staff member and runs the administration section. He's also been here since we started. Underneath he's very caring and committed, but isn't what you'd call a people person.
- **Rob** is a junior staff member; he's been here for two years and is still learning. Each week, he runs four eight-hour shifts and spends one day on youth activities. He's a really nice guy and is very popular with the residents.
- **Emily** is on senior staff and oversees counseling. Now forty, she lives in and supervises the women's house. She can be tough, but is highly respected.
- **Debra**, a junior staff worker, is twenty-eight. She was a resident and now leads many of the group activities. She was physically abused by her de facto husband and later lived for five years as a homeless per-

son. She has the respect of other staff and residents, and tends to be big sister or adopted Mom for many of the younger girls.

Meet some of our residents, who also show up in incidents later on:

- **Kent** is twenty-four and has now been a resident for four weeks. He was on speed. He doesn't made friends and is usually a loner. He is quite manipulative and erratic, and tries to protect his "rights."
- **Scott** is eighteen and has been a resident for two years. He started drinking when he was fourteen and is now recovering from alcoholism. The_house is his only family; he has no other family that wants to know him. He is usually inseparable from Billy. He's a nice guy and is ordinarily calm and cooperative. Sometimes, however, he loses his temper and staff wonder if he could become violent.
- **Billy** is seventeen and has been a resident for one year. He was a sexual abuse victim until his family broke up. His mother comes for visits, but nobody else. He seems very intelligent but dropped out of high school. He acts tough, and we think it's due to low self-esteem. It has been very difficult to get him to talk about himself and his feelings in any way.
- **Brad**, twenty-one, has now been in The_house for three months. He's here on a court order and has a background of criminal violence. A brooding type who doesn't trust people, he respects Scott but is usually a loner.
- **Andy** is fifteen and has been a resident for about ten weeks. His mother has custody. She comes for visits, but his family has broken up and nobody else does. As the scars up his arms indicate, he has a history of self-harm.
- **Monica**, a university graduate recovering from marijuana addiction, is twenty-four and has been at The_house for six months. She comes from a good family home and her parents regularly come for visits. She is convinced she isn't good at anything and we suspect she has depression. She doesn't make friends easily.
- **Sharyn**, twenty-three, has been a resident for three years. She was a cook in a small hospital in another state and became addicted to morphine. She was fired when she was caught forging prescriptions. She is now highly respected by staff and other residents. She hopes to come onto staff, and already does the cooking.
- **Nina** has been here for only a month, most of which was spent in detox from speed. She's eighteen and starting recovery. We don't know much about her background and she hasn't made any friends

here yet. She behaves erratically and often starts arguments. So far, we haven't yet made any progress getting her to talk about herself.

- **Tanya** is seventeen and has been here for eighteen months, originally on a court order after a conviction for stealing. She's an habitual liar and often manipulative. Very attractive and stylish, she looks much older than she is. Tanya is remarkably sweet and cooperative if it will help her get what she wants. She tends to be a ringleader and can be rebellious.
- **MJ** is twenty-three and has been a resident for three months. She has a history of depression and has been on various medications. Her general health is quite poor; she is thin and weak, and often takes days off sick. She doesn't enjoy healthy food or exercise.

Our goal

The goal is for each resident to build a new, different life that goes in a different direction, without the things that lead to back to substance abuse. Our graduates also aspire to become above average performers to make up for lost time and to be employable in a competitive labor market. The goal of AR is not just that people will get over addiction; we have failed if that is all they do. People shouldn't expect to get "fixed" so they can return to their lives.

In essence, to recover is to become free. Although some consequences of the past linger long, freedom means becoming a different person, no longer bound by one's past or the kind of person one once was.

One of my favorite aspects of life at The_house is that residents can start again with a clean slate when they arrive here. Residents who earn respect will get it, regardless of their past.[1]

About recovery

Our recovery model normally has the following eight stages, each flowing naturally into the next so that the boundaries between them are usually indistinct:

1. Detox
2. Settling in: Adjustment and resocialization
3. Recovery (e.g. groups and homework)
4. Taking responsibility for others at The_house (e.g. leading an activity)
5. Training and education, most often in vocational training but sometimes in a university
6. Integration into work

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1 This book uses the plural forms *they, them* and *their* as non-gender non-specific pronouns, even when they refer as a singular person.

7. Graduation and re-entry: Residents go back into the wider world.
8. Follow-up: The_house maintains supportive long-term relationships with former residents.

It normally takes from eighteen months to three years for a resident to go through the first seven stages, and some take up to five years before they no longer need support. Right now, we're considering ways to get these seven stages below eighteen months, but the risk of relapse goes up sharply with shorter recovery times. The longer residents abstain from their substance of abuse, the more likely it is that they will remain abstinent.[2]

We hold a graduation ceremony when a group of residents is ready to leave. It is a high point in their lives and we make it special. After that, some stay on in the community as volunteers with outside jobs and a few are employed as AR workers at The_house. (Recovered residents become excellent AR workers.) A few groupies are very happy to stay in the community and resist leaving, even when they are ready. Most go on to outside jobs and we try to keep in contact with them through our follow-up system.

Defining best practice

At The_house, we needed to define best practice for several reasons. First, we need to help our residents as effectively as possible. Second, a statement of good practice guides staff when making difficult decisions. Third, a transparent approach helps prevent criticism and misunderstanding. Fourth, we need to be squeaky clean if an allegation of poor practice reaches the press, even if it is completely unfounded. We deal with people who can be difficult, dishonest, and would sometimes seek to cause trouble.

We started by locating several external standards. The state government strategy statement is quite broad and doesn't offer anything specific with which to comply. The state has non-mandatory best practice AR standards, but they are relatively easy to comply with and The_house easily meets them. We also looked at a set of national standards for mental health care, and The_house easily meets them too. The most useful standards are some national competency standards for AR workers, which were very helpful for specific roles and tasks. In many US states, addiction

2 J. Currie, Recovery-focused Drug Treatment Seminar, 21 August, 2010, Perth, Western Australia.

recovery counselors are now licensed, and the competency standards[3] are a useful reference point.

After that, we found other organizations that were similar to us and learned what we could from them.

We also considered how to provide the best services we could to the residents we had at the time, and discussed our ideas in staff meetings. We didn't want something so long and complicated that it wouldn't be helpful, but we did need to get it right.

Then we drafted our own statement of good practice and forwarded it to our Board for its comment and approval. We put the final version into our policy document. It's a work in progress and we'll probably keep tweaking it a little, but right now there's nothing we want to change.

3 Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice Technical Assistance Publication (TAP) Series, No. 21 Substance Abuse and Mental Health Services Administration, 2011. (Rockville, MD), and available from www.samhsa.gov.

The_house
Our philosophy and program standards for recovery from substance abuse

Purpose

1. The purpose of The_house is to promote recovery from addiction to alcohol and other substances for its residents.
2. *Addiction* includes not only physical dependence on a substance, but also its accompanying psychological, social and behavioral effects.
3. *Recovery* is a long-term, holistic change in a resident's life that includes:
    a. Abstinence from the substance of addiction (not just reduced harm), and from medications
    b. Emotional healing
    c. Social readjustment
    d. Behavioral change
    e. Physical health
    f. Moral and spiritual health
    g. A beneficial set of life-goals and the means to achieve them
    h. Developed their teamwork and leadership abilities
    i. Able to make good choices, including avoiding harmful circumstances
    j. Able to take responsibility
    k. Financial health: free of debt, no longer on welfare, saving money
    l. Ready for life after recovery in an uncontrolled environment with minimized risk that they will relapse into former behaviors
    m. Able to gain and maintain employment that suits their abilities and potential.

Our treatment model

1. Because recovery is a holistic change in the resident's life, we believe that:
    a. A medical model of treatment alone is inadequate to promote full recovery.
    b. Full recovery is a long-term process; residents and their families should not expect full recovery in the short term.
    c. Recovery requires a range of services and support, including resocialization, counseling, opportunities to work, and advocacy.
2. We recommend residential care for persons who:
    a. are simultaneously addicted to multiple substances (called *polyaddictive*).
    b. use needles or are otherwise at risk of blood-borne infection.
    c. are at risk of abuse, self-harm, or mental illness.

   d. are in housing arrangements that do not promote recovery, such as being homeless, relationships or environments that do not promote recovery, or where adequate support is not available.
3. Staff provide around-the-clock visual supervision of:
   a. residents during detoxification from addictive substances
   b. residents who show risk of self-harm
   c. residents who pose a danger to other residents.
4. We believe that detoxification practices should use minimal substitute substances.
5. We believe that medication prescribed by a qualified medical practitioner might be necessary for recovery from addiction. The overseeing medical practitioner is entitled to determine any medical intervention.

Acceptance

1. We accept applicants who have been assessed according to the procedure at the time, and
   a. who are within the target population of our services
   b. who have committed themselves to recovery
   c. who agree to comply with the rules for residents.
   d. for whom we have adequate space, resources, and expertise
2. We do not use race, ethnicity or sexual preference as criteria for acceptance, and treat residents of differing racial, ethnic or sexual preference the same as other residents.

Rights and responsibilities of residents

1. Residents have the right:
   a. to be treated with respect as persons
   b. to treatment that is in their best long-term interests.
2. Residents are responsible to:
   a. participate in the program according to the house rules at the time
   b. treat those around them with consideration and respect
   c. be honest and trustworthy
   d. do chores assigned to them
   e. act in ways that promote their long-term recovery.

Behavior

1. We promote habits of positive behavior through:
   a. establishing and reviewing standards of acceptable behavior (the house rules)
   b. informing residents of the house rules

c. reinforcing beneficial behavior
d. discouraging destructive and erratic behavior
e. requiring residents to take responsibility for their behavior.

2. We retain the rights to:
   a. restrict non-essential privileges according to the house rules at the time
   b. allow residents to be physically restrained if staff believe them to be a danger to themselves, to others, or to property
   c. evict residents for seriously unacceptable behavior.

Relationships

1. We promote a safe, supportive environment.
2. We seek to develop positive social habits through:
   a. modeling a caring community
   b. requiring residents to break social ties that are inconsistent with full recovery
   c. helping residents to build positive relationships that are consistent with full recovery
   d. requiring residents to take responsibility for their relationships with others.
3. We promote emotional healing and self-esteem.
4. We practice duty of care that is appropriate to our residents and our services.
5. We require residents to refrain from exclusive intimate or sexual relations while in the program.
6. Where possible, we mediate with estranged family members to foster reconciliation.

Physical health and fitness

1. We develop the physical health and fitness of residents.
2. We encourage a healthy diet.
3. We refer medical problems to medical practitioners.

Education and training

1. We help residents to develop the life-skills they will need in the future.
2. We encourage residents to identify their individual talents and to develop them.
3. We prepare residents educationally and/or vocationally for their lives and employment after recovery.

Accommodation

1. We accept that suitable accommodation is essential in providing recovery services.
2. We accept that residents' accommodation needs normally vary according to their stage of recovery.

Staff

1. All staff are responsible to:
    a. model attitudes that promote recovery in residents
    b. act in the interests of residents' long-term recovery
    c. maintain confidentiality of residents' information
    d. respect the expertise of colleagues in other professions
    e. restrict activities to their own areas of competence
    f. avoid relationships with residents that are exploitative, manipulative, compromised by conflicts of roles or of duties, or are otherwise unethical
    g. keep contemporaneous written records of any incident that has legal or insurance implications.
2. Senior residents may be given staff roles.
3. All staff with duty of care are required to be competent for their roles.
4. Unqualified staff are required to work under supervision.
5. Counselors comply with a recognized statement of professional counseling ethics that is appropriate to the kinds of counseling they provide.

Assignment

1. Explain the philosophy of *your* organization in thirty words or less.
2. Compare The_house's philosophy with that of your organization. What's the same? What's different? What are the reasons for any differences? (E.g. different program goals, different program philosophy, historical development, etc.)

2
About working in addiction recovery

This chapter introduces you to being an addiction recovery worker. You'll meet many of these requirements simply by being a good employee, following your job description, learning what you can from staff meetings, and following procedures.

The_house has procedures for doing most tasks that are part of the job. These are step-by-step instructions, and staff need to follow them correctly. If staff find that they don't work well (e.g. unclear, out of date) then they bring the matter to a staff meeting, which will review them and change them if necessary.

However, procedures don't cover everything. You'll still need to make decisions and solve problems, especially when something doesn't go to plan. You'll be expected to show initiative in responding to challenging situations and individuals. If you have problems following work plans, either re-negotiate your goals or ask for help.

Who does what?

The Director oversees the whole program and the *members of the leadership team* have particular portfolios, such as overseeing group leaders, team leaders, volunteers, and shift managers.

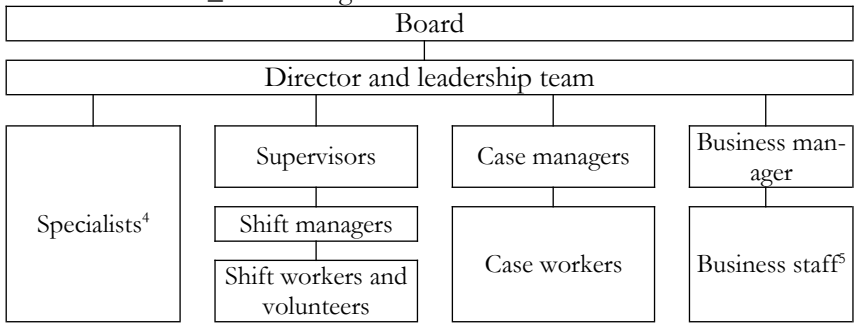
The *program director* arranges all our activities. A *supervisor* is always either present or on call to handle any incident that is beyond the training

of shift managers. Supervisors report to the Director, and some also manage shifts.

Shift managers oversee residents and are residents' first port of call for all incidents and requests for permission. They delegate tasks to shift workers. Together, they receive visitors, answer the phone, help people keep to schedule, oversee chores, and make sure anything necessary gets done. There is always a shift manager on duty, although they may sleep during overnight shifts. In general, their work is covered by The_house's procedures and training. If a situation arises that is outside these, shift managers must refer them to the duty supervisor. They also refer all life-threatening situations and all high risks, such as runaways and incidents with minors. *Shift workers* assist the shift manager.

All shift managers and most shift workers are also case managers or caseworkers, and also have other specific roles: leading activity and recovery groups, overseeing medications, assessing applicants, doing specific advocacy portfolios, and overseeing residents in detox.

Here's The_house's organizational chart



Case managers and *caseworkers* (whom we call "team leaders") are assigned to all residents. They are responsible to make sure that each of their residents gets the range of care that they need. *Group leaders* lead recovery groups and various other kinds of activities. *House leaders* oversee residents' houses. *Counselors* give counseling in cases that are either beyond the expertise of case managers or require larger amounts of time.

4 Activity groups, cook, program manager, doctors, counselors, etc.

5 Bookkeeper, fundraising, heads of businesses, etc.

Reporting and documentation

Our staff report orally to their supervisors, the Director, and to the staff meeting. Shift managers also report orally to the next shift manager at hand-over between shifts.

The Day Book is a simple one-stop-shop where the shift manager records everything that happens during each shift, like a ship's log. It avoids having lots of extra forms and paperwork. Even some quite large organizations use the same system, and the main difference is that some of them use a computer rather than a paper book.

There are pros and cons to having the Day Book on computer. There's little advantage if staff don't have enough computer skills or if they can't type fast enough to make it worthwhile. Besides, IT systems can fail. On the other hand, computerized documents are much easier to search, back up, copy, and place in archives. But right now, all our staff are much more comfortable writing on paper. And when a book is full, we simply archive it in a secure place.

Staff document their work in other ways too. Case managers keep records of case management. Counselors keep their own notes. Staff make incident reports, which record the details of any incident with possible Occupational Health and Safety (OHS), legal, or insurance implications. The staff meeting keeps minutes that record our discussions and decisions.

Other organizations have different systems. One has no Day Book, but staff meet briefly every morning for updates on residents. Then, during the day, they write records of all incidents, which are then all filed in residents' case notes.[6]

In another, shift workers don't write anything; they record voice notes on cellphones and then upload the sound files. Workers can record everything quickly and easily, and staff can search through the recordings later if something specific turns out to be important. However, as it is difficult to scan sound files quickly, it would be better to translate them with voice-to-text software.[7]

Your job description

Your supervisor will meet with you and give you a job description that lists your role, your responsibilities, what you are expected to achieve, and your timeframes for achieving your goals. You'll have to plan your

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6 With thanks to Tina Gunter.

7 It is feasible to create software that enables shift workers to write records as short messages on cellphones that are uploaded to a server. The records could then be displayed either as a Day Book or as case notes on individual residents.

work accordingly. Your supervisor will check that you understand it, and revise it from time to time.

The_house is a community and you will need some time to find your place in it. At first, you'll be given simple tasks, mainly chores and errands, to give you and the residents a chance to get to know each other, and to give your supervisor time to find out what your particular abilities are.

Other parts of this textbook spell out other kinds of requirements that affect you (duty of care, ethics, etc.) If anything is unclear, clarify it with your supervisor.

I'd suggest that the core role of AR work is behavior management, but you have an interesting place in the community services range of professions. Most of your job is much like a social worker (advocacy, casework), some parts of your job are more like a psychiatric nurse (detox, medications), and your role in leading recovery groups is like a clinical psychologist.

The staff meeting will sometimes make decisions that affect either what you do or how you should do it. Many decisions imply a change or improvement of some kind, but some people don't respond well to change. You should speak up and make a contribution to making improvements. Even if you don't really like a particular improvement, you'll be expected to respond positively and support the changes.

The_house needed to change quite a lot as it grew from a small group of friends into a large, well-organized program. A few staff couldn't make the changes and had to leave.

It's about you

Other people will read your attitude, and your work is more about what kind of person you are than what you do. You'll need to figure out what kind of personality, values and attitudes you have and take them into account in your work. They particularly affect your relationships with residents. Your attitudes, value and behavior affects their recovery.

You'll also need to show commitment to treating people equitably. If you're a new worker with a plain, white, middle-class background, you might find it difficult to respect residents with serious difficulties or who come from backgrounds very different from yours. You might find compassion even more difficult.

Before we go any further, it might be good to point out some deadly traps for AR workers:

- The *rescuer* feels a responsibility to somehow "save" people. The attitude is counter-productive.
- The *busybody* wants to help when it is not their role.

- The *advisor* wants to give good advice rather than to listen and support people to make their own decisions.
- The *soft touch* succumbs to the temptation to be people-pleasing and gives in to pushy residents.
- The *gossip* tells anybody anything, even when it should be kept confidential.

Adjustment

If you've ever had any kind of job, you'll remember that your first stage is adjustment. This is probably more demanding in live-in communities because they normally have strong internal cultures. We'll look at it more closely later on, but right now during adjustment, you'll need to figure out the pecking order and your place in it, make friends, and learn the routines. If the organization has a good on-boarding system, you'll be assigned someone to make sure that your adjustment period is a positive experience.

About teamwork

As a shift worker in The_house, you'll need to balance working by yourself and being a team player with other staff. You'll face many situations where you will be alone and need to take initiative. But as a team player, you also need to communicate with each other, and help and rely on each other so that everybody gets their jobs done well. Keep learning about how to help the team perform better.

You'll also need to communicate clearly and effectively. Establish appropriate working relationships with the rest of the team and keep them good. This means supporting them, especially when they are under stress, because stress is a major safety hazard. Besides, one of the major ethical failures is to undermine a colleague in front of others.

Other staff have individual differences from you, such as different temperaments, education, and cultural backgrounds. Be considerate of them. It's normal that you'll get on more easily with some more than others, but you need to prevent tensions within the team. Resolve tensions as soon as possible. If you see a conflict between other team members, or just something that could turn sour, see what you can do to handle it. This doesn't mean you should be a busybody. If you're still new, the best response is probably to report it to your supervisor privately.

Professionalism

As you learn, you'll need to show professionalism in practice and a consistent level of commitment, confidence and skill. Here are some pointers:

- Arrive punctually and be appropriately dressed.
- Don't bring your emotional baggage to work.
- Be polite, friendly, and understanding.
- Give clear instructions and answers.
- Develop a strong work ethic.
- Take responsibility.
- Be consistent.
- Maintain confidentiality.
- Respect the ethos of the organization you work in.
- Keep learning.
- Keep yourself organized. Anticipate requirements and prepare in advance for them.
- Learn to handle diverse demands and deal with multiple stakeholders.
- Be assertive and show initiative when it's your job to make sure things happen.

Communicating with residents

Our work at The_house is mainly working with people, often very closely, so communication is essential to your role. You need to build and maintain relationships with residents based on respect and trust.

As a new worker, start by simply making friends without forcing yourself onto them. Most people want to talk about themselves, so let them. In time, you will develop trust and rapport with different kinds of people. However, while you're new on staff, do not try giving personal advice no matter how much you are tempted. Don't expect to be thanked for what you do. (Some residents even resent being helped.)

You'll need enough emotional intelligence to find the right approach for each person you usually deal with. Respect their needs and rights. For example, if someone is in an emotionally difficult place and is not ready to discuss it with you, they have a right to keep it private until they feel ready.

Gather a basic kit of communication tools. Here are some starters:

1. Be polite and respectful.
2. Be friendly.
3. Listen carefully to understand what people really mean (listen reflectively and actively, be empathetic).
4. Ask questions if you don't know.
5. Ask questions to check that others are okay or know what to do.
6. Encourage people, and tell them when they do well.
7. Apologize when you're wrong.
8. Recognize non-verbal triggers.

9. Clarify the boundaries of your role.
10. Decide about behavior, gestures, and posture.
11. Show respect for other people's views and contributions, even if they are quite different from your own.
12. Do something about any communication barriers if you see them.
13. Choose your words very carefully in sensitive situations.
14. Help people get interpreters or translators if they need them.

At about this point, students often ask how they can earn respect. The answer is not about the residents; it's about you. Set a good example, be consistent and sincere, put others first, and apologize when you're wrong. If you are a person of integrity, respect will come.

You might sometimes have opportunities to coach colleagues and residents in effective communication. As a guideline, keep it low-key and informal.

Conducting interviews will soon become part of your job. We usually try to keep them informal and non-threatening, but you should have either specific goals or a meeting agenda so that it's not just a time-wasting chat.

Our staff meetings sometimes review communication channels to make sure that everybody gets any information they need in a timely way. Your part is to help put effective strategies in place. Observe whether residents and colleagues are communicating effectively and get feedback from people as you go.

Your breadth of view

At first, you'll have a narrow view of what happens. As you learn more roles, observe more, and reflect upon your experience, you'll see a bigger picture of AR and be more able to set your own schedules and goals. You'll see the whole scope of responsibilities rather that picking what you want to do. You'll learn to maintain your attitude and motivation to do a good job. And you'll appreciate the value of the basics; you never grow out of them. (Imagine a baseball batter who starts to think: "I'm so experienced that I don't need a bat any more.")

Keep learning

As a guide to what you need to learn, you can use your Job Description and The_house's objectives.

Keep reviewing what you do and trying to improve. Your supervisor and peers will help you do this so you can learn from your experience. Some of it will be part of your practicum, and some will be part of the normal way of looking after staff.

You need to take initiative in the process too. Ask for constructive feedback on your work, especially when you are not sure how well you did something. When you get feedback, be positive and accept it without being defensive. When you have opportunity, you should also give other staff feedback too. Be predominantly positive.

You will find that some colleagues will naturally be more helpful than others, but beware of any indebtedness that amounts to control. You should also beware of simply following people you like. Someone you don't like so much could also teach you something.

You are quite entitled to ask questions because you need to understand what you are doing. If you are tactful and choose the times carefully, senior staff will normally be very willing to help you as much as they can.

This includes questioning practice. Some practice seems to be based only on authority ('Amanda said so.') tradition ('We've always done it this way.') or local policy ('This is our way of doing it.'). In these cases, you need to find out *why* it is done that way, especially if it differs from your current training and professional reading. There might or might not be good reasons, or there might be good reasons both ways. If your organization's current practice is outdated, your questions might even instigate an improvement.[8]

Professional development

The_house provides most of its staff training through the staff meetings, so you'll do lots of professional development simply by attending and participating. Besides, doing this course might be as much professional development as you can handle right now.

However, you also need to take responsibility for developing your personal skills on an ongoing basis and for staying aware of current issues in community work, and minority group issues. Be curious and try to learn new things. You can even learn from next-door areas of study such as nursing and social work.

You'll need an ongoing system and your first port of call is to ask your supervisor and colleagues for advice. You need to choose one of the options open to you, consult your supervisor, and follow through on it. There are lots of ways:

1. Subscribing to industry periodicals is helpful if you choose the right ones.
2. A personal reading program is a good way to go.

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8 Cf. Tracy Levett-Jones and Sharon Bourgeois. *The Clinical Placement: An essential guide for nurses.* (Sydney: Churchill Livingstone/Elsevier, 2007), p. 58.

3. If you're writing educational materials or giving training courses, you're probably very busy learning.
4. An occasional industry conference can be worthwhile if the topics are good. You often need only one idea that you actually implement to make a conference worthwhile. If you don't implement anything, you've probably wasted your time, even if it's very interesting.

The law

You will find, as I did, that local laws regulate much of what you do but vary greatly between jurisdictions. Your organization needs to check its own legal obligations in your location. Here's a sample of the legal issues that came up:

1. In some states, AR treatment centers need licenses. In another state, they only need licenses if they provide residential care for minors. If your organization needs a license, what do you have to do to meet license requirements?
2. Do residences need to be licensed as boarding houses, lodging houses, or some kind of medical hostel?
3. What is the meaning of "administer medications" in your jurisdiction? Who can administer medications? Do they need particular qualifications?
4. How do you assure that samples for urinalysis are legally valid?
5. Does your organization get government funding? If so, what particular operational conditions do you have to meet?
6. What legal obligations does your organization have if it accepts residents from government departments (courts, justice, child protection)?
    a. Can you physically restrain violent residents? If so, under what conditions?
    b. What can you or your organization be sued for? What can't you be sued for?

The industry

Later on, you'll work with other people in other sectors of the community services industry, mainly youth work, the courts, child protection, family counseling, financial counseling, and mental health. You'll need to show a professional attitude and respect them. Learn about how the interrelationships between them affect your work. In order to give referrals, you'll need to learn about various other community work organizations and what they do.

The sector has its own values and philosophy, and professional ethics is fairly similar across the industry. On the other hand, there are so

many different views on AR that we set our particular version in writing. We expect our staff to show a firm commitment to it and to our particular goals.

Promoting your organization

You will have plenty of opportunities to promote your organization in your meetings with other organizations and professionals, and in our promotional activities. You will be an ambassador. Carry brochures, be positive about your organization, and be accurate when you present its values and philosophy.

You will often be the first point of contact for prospective residents and have opportunity to promote your organization to them. Make sure they understand exactly what services are on offer and their rights, and create options for them. They need informed access so they can select the best available service for their needs. If someone stumps you with an unusual but reasonable-sounding request, ask a senior staff member before you give an answer; you can't promise something that is not actually offered.

The_house gets almost all its new residents though referrals, and does not need to promote its program to prospective residents. Other AR agencies use various strategies to promote participation in their programs, and their promotions obviously need to relate to particular constituencies and the kinds of services offered.

Question 1: Legal clearances

Many governments seek to minimize risk of abuse to clients in human services organizations. In some jurisdictions, new employees need a police clearance as evidence that they have no criminal convictions. In other jurisdictions, the legal check relates specifically to those working with minors.

What legal clearances do you need in your jurisdiction?

Question 2: Professionalism

How should senior staff handle these situations?

1. Rob usually comes to work scruffy and unkempt, even for our casual standard of dress. This morning, he came in wearing a t-shirt with a very offensive slogan written all over the front.
2. When a shift is quiet, Rob sometimes finds a few people he likes and has a long chat with them. While he's talking, he loses track of what is happening around The_house.

3. For the last few months, Emily has been dissatisfied with her role at The_house, and Amanda found out that she has been complaining to volunteers and junior staff.
4. Emily frequently comes in late. She always has a very reasonable excuse, but it now happens so frequently that the real issue seems to be that she is disorganized and undisciplined. It's causing problems at handover time because somebody else has to stay late. It is not only inconvenient and annoying, but they have now started to claim overtime pay.

Assignment 1: How do AR agencies promote themselves?

Do an Internet search on different ways that AR agencies promote their services to prospective clients.

Assignment 2: Staff roles

Look at the various staff roles in your organization and the chain of command. Compare them to those at The_house. What's similar? What's different?

Assignment 3: Follow a supervisor

Follow a supervisor or a shift manager around for a day, and observe what they do and why. As you go, make notes of the schedule for that day, showing the people, the place of each activity, and what they did for that activity. Write down any questions that arise. At the end of the day, discuss your questions with the supervisor. Some words of warning:

- As supervisors are usually very busy, make sure you don't slow them down or distract them from their work.
- You might not be permitted to attend some kinds of meetings.

Assignment 4: Staff meeting observation

Attend weekly staff meetings for one month. Then answer these questions about your observations:

1. What kinds of things were discussed?
2. Which of the decisions affect your role?
3. Do some people talk more or have more influence on decisions? Why?
4. Is there a wide variety of opinion on some topics? Why or why not?
5. How are decisions made? (E.g. the leader makes the final decision, several strong voices push decisions, everyone gets a say, etc.)
6. What can you tell from their body language?

Assignment 5: Incidents

Use the incident form on the next page to describe three interesting incidents on every shift you work. They do not have to be major. As you go, try to describe incidents that are different from those that you have already described.

Your tutor will set a number of weeks and review them every week. At the end of the time, use your notes to make a list of very common incidents, a list of moderately common incidents, and a list of rare or unusual incidents.

	1	2	3
Date of incident			
Briefly describe the incident			
How common is this kind of incident?			
How was it responded to?			
Why this particular response?			
How did you personally feel at at the time?			
What lessons are there for you to learn?			

3
Occupational health and safety

As a new employee at The_house, you must do Occupational Health and Safety (OHS) induction before you can start work. Our OHS system addresses the specific risks, hazards and associated safety practices of the AR sector. Most of what you routinely do is covered in The_house's procedures, so just follow them and stay within your job responsibilities.

Hazards

The main workplace hazards to staff in AR programs are: physical violence from residents, stress and fatigue, blood spills, Post-Traumatic Stress Disorder (inability to work after brief, intense stress), brownout (reduced ability to work after prolonged stress), burnout (inability to work after prolonged stress), and compassion fatigue (reduction of compassion and empathy over time).[9]

Besides physical violence, most other hazards relate to residents' activities, such as sport and chores. Staff systematically oversee residents because safe situations can become dangerous very quickly. While you can

9 AR workers with compassion fatigue tend to make poorer decisions when empathetic understanding is necessary to making good decisions. They might instead prefer to follow procedures rigidly, and become frustrated at residents' personal issues. Compassion fatigue can also cause negative psychological effects.

check OHS in your preparation, your most important role is to observe what people are doing while you have duty of care for them.

Plan your work and work safely

1. Plan your work so that you can work safely. Do your housekeeping in your work area so that it is tidy and free from hazards.
2. Report any incidents or injuries.
3. Support others in working safely. You are responsible to coach less experienced team members to work safely and check their OHS practices. Check that they record incidents accurately and do any other documentation (e.g. insurance reports). Help them if they need it.

OHS meetings

We consult staff about OHS matters in staff meetings. Join in and do your part to improve safety. Raise OHS issues and make a constructive contribution to the discussion.

We occasionally do workplace safety inspections. Cooperate with any OHS representatives and committees and give constructive advice and feedback. And help other staff to make a contribution too.

Spotting hazards, managing risks

Spot hazards as part of planning and doing your work. When you spot a hazard, fix it straight away if you can, before starting work. If there still is any risk, report it. You also have to report hazards that haven't been managed well enough.

You can do a basic inspection by visually checking. It is better if you have a checklist, but you'd still have to add anything dangerous that is not on the list. You also need to be able to identify hazards by examining workplace data (e.g. incident reports).

Spotting hazards is different from assessing risk. As a new staff member, you don't have to do the risk assessment by yourself, but you should be able help a senior staff member to assess and manage risk.

The way to control a hazard is to use the hierarchy of control. All versions work in the same way. The point is that the higher it is on the list, the better it usually is:

1. Eliminate the hazard altogether
2. Substitute it with a lesser hazard
3. Use engineering controls (e.g. failsafe systems, equipment guards)
4. Isolate the hazard from personnel at risk
5. Minimize risk by using personal protective equipment (PPE) such as gloves, etc.

6. Change practices and train staff in how to do it safely (e.g. safe work practices, regular inspections, different procedures, training in First Aid or emergency procedures).

Handling stress and emotional health[10]

Stress is one of the more significant OHS hazards. It's why many AR staff don't last long. You must be able to manage your own stress levels so that you can always work safely. Tell your supervisor if you're really not coping.

Stress follows a pattern. If you compare productivity and stress levels, the lower end is low stress but low productivity. The mid-range is higher stress and peak productivity; this is called eustress, because it's healthy. ("eu-" is the Greek prefix meaning 'good.'). Much higher stress levels, however, are destructive and reduce productivity. People who are very stressed often get very little done but feel extremely busy.

One of the main causes of stress is confrontation with people who are erratic, distressed, aggressive, or non-compliant. Another is grief or loss, such as a resident who is doing well in recovery but then absconds or relapses, especially if they die of an overdose. What about the resident who is progressing well, but is pulled out by parents to be put into an abusive situation? People are at higher risk if they who feel under pressure to live up to the expectations of others, especially if they see them as unrealistic.

It's not just stress; it's total emotional health. Various factors can negatively affect your emotional health, increasing your risk of brownout and burnout:

1. Discouragement.
2. Responsibility for something you cannot control.
3. Interpersonal conflicts with other staff, including the effects of organizational politics.
4. Difficult decisions.
5. Feeling unsuited to tasks given to you ("a square peg in a round hole").
6. Feeling not listened to. "Nobody cares what I think." "I asked for help and nobody noticed." "I think I have some good ideas, but nobody is listening."
7. Feeling drained through supporting people who need lots of empathy.
8. Keeping personal secrets, especially deep secrets.
9. Imposing unrealistic expectations on yourself.

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10 *Passim.* Graham Farmer, Seminar on pastoral self-care, September 18, 2016.

10. Lack of face-to-face communication, including over-dependence on electronic devices for interpersonal communication.

Graham Farmer advocates a simple self-test: How full is your tank? Give yourself a score from 1 to 10:
10: The tank is full: "I love what I do. I can't wait to get out of bed in the morning."
5: The tank is half-full: "I can get out of bed, but I won't cope if anything goes wrong."
0: The tank is empty: "I can't get out of bed at all."

Signs of poor emotional health can include any of the following that are uncharacteristic: bad moods, avoiding decisions, withdrawn or solitary behavior, feelings of disillusionment, and feelings of being ineffective. Other signs are unexplained headaches or stomachaches, lack of sleep, or excessive sleeping.

Another kind of poor emotional health is more subtle. These workers are quite knowledgeable, say all the right things, and do their jobs adequately. However, they just go through the motions of following procedures. Their message, "you can recover" is no longer sincere and they don't really care so much anymore. They are probably deeply disillusioned but don't want to leave.

It might not be any particular incident that seems too much. Stress can be cumulative; workers might cope well for a long time and suddenly find that it is all too hard.

Here's how we tell our staff at The_house to manage stress and emotional health:

1. Leave work at work so that you can relax during leisure time.
2. Have a life and a set of friends outside your work.
3. Don't be at work all the time; have a time and place where you are not at work and not on duty.
4. Keep your key relationships healthy.
5. Support other staff; don't wait for them to ask for help first.
6. You need to have someone to whom you can debrief and who can monitor how you're going. At times, you need to be able to safely offload your feelings and talk them out with someone.
7. If you can't cope, tell someone and ask for help.
8. Don't blame yourself for:
    a. other people's shortcomings.
    b. your mistakes when you did the best you could in the situation.
9. Get enough sleep and exercise, and have a good diet.
10. Take proper vacations and days off.
11. Do something just for fun.

12. Learn how to enjoy the company of pleasant people.
13. Learn your personal limits and work within them.
14. Manage your time, paperwork, and other causes of frustration.
15. Delegate tasks to others and trust them to get on with it.
16. Avoid making destructive responses when you are tense (e.g. inappropriately expressing anger and frustration).

Having a bad day

You'll have days when you're just too drained to do everything in your job. On these days, you still need to be pleasant to people and treat them fairly. For everything else, you can organize your work and set some achievable goals. Choose all tasks that are essential or have deadlines, and then look at all the things you can do. Put them in a workable order and do them one by one. (If you feel under pressure to get them all done immediately, you'll probably feel overwhelmed and get very little done.)

Emergencies

Do your part in handling emergencies. Emergency procedures are designed to keep everybody as safe as possible, even when there is very little time and information to figure out what to do. You will need to recognize the emergency signals and alarms used in The_house, and respond to them appropriately. For example, in case of fire, you need to know how to evacuate the building and go to the assembly point. Follow the procedure correctly without reminders as far as you are trained.

Keep informed

Keep your OHS knowledge up to date for your workplace. Staff meetings will provide information, but you are responsible to take the initiative to get current information, for example, standards, codes of practice, guidance material, and legislation.

Task 1

Describe your current self-care system and evaluate it. Is it working? What improvements could you make?

Task 2

Write a self-evaluation checklist for looking after oneself. Consider questions like: "Am I tired?" "Am I struggling with an issue?" "Does somebody particularly annoy me?"

4
Duty of care

This section gives you some basic training in your legal duty of care for residents. Legislation varies between jurisdictions, so you will need to check yours. Some legal requirements can also be modified by legal precedent and case law.

Summary

1. Develop a culture of identifying hazards, assessing risks, and doing something about anything dangerous.
2. Duty of care doesn't need to be such a big deal, as long as you do it right.
3. Give some basic on-job training to *all* new workers, including volunteers and senior residents with oversight.
4. There are different kinds of OHS risks. Don't limit yourself to only physical dangers relating to the property. Consider other kinds of risks (e.g. counselor burnout, violence).
5. Cover everybody and all off-site activities.
6. Keep up-to-date policies and procedures and make sure everybody follows them.
7. Keep records.
8. Insurance won't necessarily cover everything.

Assignment

Answer the Thirty-Two Questions in writing using the information on the pages afterwards. You will need to check with your supervisor for some items (e.g. insurance).

1. What is "duty of care"?
2. Does duty of care mean that your organization is responsible for everything that goes wrong in its duty of care? Explain your answer.
3. What's the *same* between duty of care under the OHS Act and under the Civil Liability Act?
4. What's *different* between duty of care under the OHS Act and under the Civil Liability Act?
5. How would you answer someone who says, "We have full insurance cover, so it doesn't really matter?"
6. What sort of things *can't* you or your organization be sued for?
7. What kind of incident *must* someone sue your organization for?
8. Who of the following does your organization have duty of care for: staff, residents, children of residents, volunteers, visitors?
9. Does your organization have a duty of care for off-site activities run under its auspices?
10. Who has duty of care for residents when playing basketball at a recreation center?
11. Does your organization have a duty of care for a group of residents who get permission to go out together for a recreational activity? Explain your answer.
12. Does your organization have a duty of care for an adult resident who leaves of her own will? Explain your answer.
13. Does your organization have a duty of care for a fifteen-year-old who has run away? Explain your answer.
14. What duty of care does your organization have for a fifteen-year-old who *wants* to run away? Explain your answer.
15. Does your organization have a duty of care for someone who falls over their own feet and hurts themselves? Explain your answer.
16. Does your organization have a duty of care for someone who falls over a carpet edge and hurts themselves? Explain your answer.
17. Does your organization have a duty of care for people while traveling? Explain your answer.
18. Does your organization have a duty of care for residents in a rented house? Explain your answer.
19. What duty of care does your organization have for residents as counselees? Explain your answer.
20. What duty of care does your organization have for residents in detox? Explain your answer.

21. What duty of care does your organization have if a senior resident is the designated person to oversee residents at the time of an accident? Explain your answer.
22. What duty of care does your organization *not* have for residents' children? Explain your answer.
23. What duty of care does your organization have in this case: Kylie, a resident, has a two-year-old son named Ethan. One evening at the home where they live, which is provided for them by The_house, Ethan climbs a veranda handrail, falls off, and breaks an arm. Explain your answer.
24. What kinds of insurance cover does your organization have?
25. What does it protect you for?
26. What does it *not* protect you for?
27. Make a list of *written* best practice guides and codes of ethics under which you and your organization work. Where do you have access to a copy?
28. Does your current duty of care policy cover *all* legal requirements? Explain your answer.
29. Is your current duty of care policy consistently put into practice? If so, how do you know? Explain your answer.
30. Are you subject to mandatory reporting?
31. Are you legally required to report suspicions of abuse through a contractual arrangement?
32. Explain your duty of care for your particular role.

What is a duty of care?

It is a duty to take reasonable care to avoid acts or omissions that you can reasonably foresee would probably result in injury or harm to somebody. You should have thought about them when doing what you did. However, care doesn't have to be perfect; you don't have to cover all possible problems, because that would be unreasonable.

Here's the "reasonable person" test. It's what a normal, sensible person should be able to foresee. It's not necessarily what *you* think, because you might be unreasonable.

You have a duty of care to those in your care, regardless of their age, but its increased for the vulnerable (e.g. minors). Some relationships (such as student- teacher) have a more demanding duty, called a *non-delegable* duty of care. In schools, this is based on the notion that children are vulnerable and dependent. The school still has a duty of care even if employees and independent contractors do the work.

Consider the following:

1. Is the person especially vulnerable, such as a young child?
2. How serious would the harm/injuries probably be?

3. How likely is it? Can you be reasonably expected to foresee it?
4. How difficult is it to take preventative measures? (Extreme measures would be unreasonably demanding.)

Points 2-4 are covered as part of normal risk management.

Negligence claims

Most legal claims are based on negligence. The employer is responsible for what employees do as part of their employment, so people sue the employer. They can usually only sue employees personally for something done outside their employment. To sue successfully, the plaintiff has to show in court that:

1. the defendant had a duty of care,
2. the plaintiff suffered some kind of damage or loss,
3. the defendant gave a lower standard of care than would be reasonable, and
4. the lack of adequate care resulted in harm (usually injury), even if it wasn't the sole cause of harm.

Occupational Safety and Health (OHS)

OHS law covers things that you can be prosecuted for if you don't comply. Under this law, the incorporated body (e.g. The House Foundation Inc.) has specific duties to provide all employees with a safe workplace and accident insurance, and give adequate supervision. It is liable for anything workers do on its behalf (called *vicarious liability*):

- Employers have a duty of care as far as practicable to provide and maintain a working environment where employees are not exposed to hazards.
- Employees must take reasonable care to ensure their own health and safety, and avoid adversely affecting the health or safety of others through any act or omission.
- All staff have a duty of care to residents.

OHS: What to do

1. First, make sure your OHS system is up to speed. You should have identified hazards, assessed them, and put controls in place. In your buildings, your access and exit ways should be safe. Your instruction and induction training should promote a safety culture in the workplace.
2. Next, differentiate between places that are open to the public and those that are not, and specify any locations that have particular hazards or risks.

3. Allow only authorized people to enter places that are closed to the public. You may allow visitors admission, but should have a duty of care system in place. Train staff to accompany visitors in closed areas.
4. If you have high-risk areas, you would normally restrict visitors from them. Visitors having access to closed areas should go through a procedure for reporting in, and particular staff should be responsible for monitoring entry and accompanying them.

Civil liability

This law covers things that you can be sued for if you don't comply. Even if you are at fault and somebody comes to harm, they can't successfully sue you if they could (or should) have seen the risk and taken precautions, especially considering:

- Would they probably be harmed if they were careful?
- Would the harm probably be serious?
- Is it reasonable to expect them to take precautions?
- "Social utility" is defined in various ways: Is it primarily a social or recreational activity? What was practical and possible in the situation?

In our state, as a health care professional, you can't be successfully sued if you follow competent good practice at the time, even if there are different views of "good practice." You also can't be sued for inflicting mental harm unless it's a recognized psychiatric condition.

The causation section covers recreational activities, contributory negligence, and assumption of risk. For example, injured persons are presumed to be aware of obvious risks, and there is no duty to give warning of obvious risk, and no liability for harm from inherent risk. In other words, if they can see something is dangerous and decide to take the risk, they can't then blame you.

Health care professionals

For the purposes of this Act, an AR worker fits the category of health professional "... any other discipline or profession practicing in the health area which applies a body of learning."

As an AR worker, you can't be successfully sued if you do something (or omit doing something) as long as you follow competent professional practice at the time. This applies even if there are different ideas around on what is "competent professional practice." (However, there are exceptions for pregnant residents.)

But you can be successfully sued if you don't follow competent professional practice at the time.

The mental harm section of the Act basically says you have a duty of care not to put people into a position that would result in a psychiatric illness if you could foresee what would happen. People can't sue you for mental harm without good cause; they can't sue you just because something made them feel bad.

Good Samaritan clause

If you act in good faith to help someone in an emergency, you can't be successfully sued unless you act recklessly or were under the influence of alcohol or other drugs. Many jurisdictions do not have a Good Samaritan clause, so you could be sued for trying to help someone in an emergency.

Volunteers (Protection from Liability)

In our state, people doing voluntary community work can't be successfully sued for their work unless they knew (or should have known) that they were acting outside the scope of the work, act contrary to the organization's instructions, or are significantly impaired by alcohol or drugs.

The community organization that organizes it incurs the liability, and it can't make an agreement with the volunteer to get out of it.

Insurance

Most organizations need insurance cover. [11] In one case, a volunteer was helping at his local church doing some general maintenance. He fell off the roof while cleaning gutters, becoming a paraplegic and incurring huge long-term costs. He was reluctant to sue, but the church encouraged him to do so because it was the only way he could pay his bills and live afterwards as a paraplegic. The insurance company paid the claim in full.

Employers are legally required to have accident insurance for employees. Motor vehicle insurance for personal injury to third parties is obligatory in this state, but it doesn't cover unlicensed drivers or unlicensed vehicles. Public liability insurance and professional indemnity insurance are mandatory in some jurisdictions and often recommended. Public liability insurance covers accidents on your property. Professional indemnity insurance covers the services of professional people (e.g. those giving advice of some kind) in case the service has a defect that results in harm to a client.

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11 Check the laws in your jurisdiction and compare actual policies.

Other forms of insurance are sometimes not obligatory but insurance for vehicle damage is highly recommended. Volunteer insurance is recommended for all organizations that use volunteer help.

Insurance contracts vary widely, and some give much better cover than others. Besides, insurance companies vary in how willing they are to pay claims. Insurance doesn't give much cover if it's your fault or if you are doing something illegal. Insurance companies will spend lots of money investigating a major claim if they think they shouldn't pay.

A small number of reasonable claims often has relatively little effect on your insurance cover, and it is in your organization's best interests to make them.

Major claims or many claims, however can have ongoing consequences for your organization. First, your premiums might go up if they consider you to be higher risk. Second, if they pay out for a series of major claims, they might become unwilling to continue insuring you at all. Third, other insurers will also charge much higher premiums, or even become unwilling to insure you at all.

Even worse, if you go to another insurer and don't disclose a bad insurance history, the policy is void even if you pay the premium. If you have a claim and they check, you have no cover and they don't have to refund your premiums.

Required reporting

Mandatory reporting laws vary greatly between jurisdictions. Mandatory reporting means that one is legally obliged to report abuse to the relevant authority and would be committing a legal offence if they learned of abuse and did not report it.

In this state, mandatory reporters are medical practitioners (doctors), nurses and midwives, teachers (i.e. anybody registered as a teacher), teachers in community kindergartens, teachers in detention centers, and police officers. They must report suspicions of child sexual abuse to the Department for Child Protection if they form this belief, based on reasonable grounds, in the course of your paid or unpaid work.

They should report other forms of abuse (physical, emotional and neglect), but there's no penalty in this state if they don't.

A child is someone under eighteen years of age. If you have no positive evidence of age, a child is a person who appears to be under eighteen years of age. (Some jurisdictions, however, use actual age, regardless of appearances.)

Child sexual abuse includes sexual behavior where:

- the child is the subject of bribery, coercion, threat, exploitation, or violence,

- the child has less power than another person involved, or
- there is a significant disparity in the developmental function or maturity of the child and another person involved in the behavior.

At The_house, we have another kind of required reporting because we often look after people referred by the Department of Justice and the Department of Child Protection. They have their own reporting requirements, for example, what to do if someone absconds.

Questions

1. How do your laws on mandatory reporting differ from those in our state?
2. What kinds of abuse are you required to report?

Categories: Who's at The_house?

At The_house, we have different categories of people, with different duties of care. The list below explains their status. Residents' listed status, however, can be modified by particular court orders that restrict some rights or freedoms. Residents placed by the Department of Justice or the Department of Child Protection are generally under court orders.

1. *Employees* (staff). Their responsibilities are clearly laid out in the OHS Act.
2. *Volunteers*. They have the same responsibilities as employees, but aren't covered by workers' compensation insurance. We have volunteer insurance cover for them.
3. *Senior residents with oversight*. Their responsibilities are the same as employees, even though they always work under supervision. The_house has volunteer insurance cover for them.
4. *Guests*. The_house is responsible for people other than workers while they are in the workplace.
5. *Residents*. The_house is responsible for people other than workers (e.g. residents) while they are in the workplace. The Civil Liabilities Act also requires it to provide a reasonable level of safety on its property, including residences and during its off-site activities. This includes those living with anybody who has an identified tendency to become violent. We have different kinds of residents:

- Adult residents are able to follow instructions and foresee any reasonable risks. They are legally free to leave if they wish.
- Residents who are 16-17 years of age can follow instructions and foresee any reasonable risks. They are legally free to leave if they wish, but must be able to show that they can support themselves. Otherwise, they are under the care of the parent or guardian, or the police.

Some categories are considered vulnerable and deserving of extra care. These include residents who are in detox, sick, or suspected of having a mental health issue, including ideation of suicide, psychosis, etc. Minors are also vulnerable. Some residents' have children, mostly small children of single mothers. Residents under 16 years of age are not free to leave except to the care of a parent or guardian, or to the police.

Location

Residences are both workplaces and private residences. This makes some laws more difficult to interpret.

Main house vs. residences. The main house is clearly a workplace during all program hours. During this time, The_house has full duty of care for everyone on the property. Outside program hours, it is a residence.

Under the Civil Liabilities law, The_house has the same basic duty of care for residences as anybody does for a private home, with some exceptions. The buildings need to be safe. It might be occasionally used as a workplace (e.g. for meetings, counseling). The_house should still consider risks relating to children and other vulnerable people.

Is an off-site activity part of the program? The_house has duty of care for all workers and residents during an off-site activity that is part of its program. However, the duty of care may be shared by another party (e.g. a building owner). It seems that The_house has no particular duty of care at all for residents' children during off-site activities; they are fully in the care of their parents. Otherwise, The_house has no particular duty of care for people during off-site activities that are not part of its program.

Duty of care for minors

This section on duty of care particularly relates to child abuse and neglect. The staff at The_house normally provide enough supervision to prevent any abuse. The most likely kinds of abuse are:

- Physical, emotional or sexual abuse sustained before admission to The_house
- Neglect sustained before admission to The_house
- Peer bullying, both psychological and physical
- Physical abuse of small children due to frustration and anger.

The_house: Child protection procedure

1. Younger children:
    a. Give line-of-sight supervision at all times. Be close enough to intervene if necessary.
    b. Only a parent may be alone with a child in an enclosed space. For other adults, two people should accompany the child. (This

mostly applies to toileting; having two adults prevents allegations of abuse.)

2. Older children and young people:
   a. Give supervision at all times, usually by having at least one staff member on site.
   b. Beware of peer bullying, both physical and psychological.
   c. Notice any signs of harm or neglect, such as abnormal fears, bruises or wounds, lack of proper care, and avoidance or deflection tactics to keep something secret.
3. If you notice signs of harm
   a. Report the matter to your supervisor immediately. You are not authorized to report the matter to any other person or any outside organization without their approval. He/she may decide to take over the reporting at this point.
   b. Keep the matter confidential and do not discuss the matter with anybody else, especially the parent or guardian. (The parent or guardian could be the person inflicting harm.)
   c. Do what you can to eliminate risk of harm to the child.
   d. Record relevant specific and general circumstances in an incident report form. It needs to be accurate and objective enough to cover The_house in case of legal action later on.
   e. Check whether the evidence is firm enough to report the matter to the Department of Child Protection. You might find that the standards of evidence vary between jurisdictions; in some all you might need is a reasonable suspicion, while others might require something more substantial. If the evidence of harm is firm enough and your supervisor approves, report the case to the Department of Child Protection (DCP). If you report it, cooperate with DCP officers so that the report is as effective as possible in protecting the child.

Note

1. Work with your supervisor and don't act outside your responsibilities as shift worker.
2. Take notice of any ethical issues that arise and discuss them with your supervisor.
3. Older children are more likely to manipulate you by translating "I feel bad" into "I am the victim of psychological abuse." In other words, they might be trying to seek attention or to blame someone else for their own feelings.
4. You may need to negotiate your way through some difficult problems at any stage.
5. If you see a colleague acting unethically, report it to your supervisor.

Asking questions

Besides observing, you can also ask non-invasive questions. Use simple, age-appropriate language and show a supportive, non-threatening attitude. You will probably be their only line of support at this stage and they need to feel that they can trust you. They may be afraid that any kind of intervention will make the problem worse, so you need to allay this fear. You can make promises for what you will do, but do not make promises about what others will do; if things don't happen as promised the child will feel increasingly trapped.

Focus on the child and involve them in making any decisions where it is age-appropriate. For example, you only need to get the cooperation of a small child, but a teenager is different; you may be able discuss your plans, ask for their comment, and get their agreement.

Ethically, your first duty is to the child as your primary client. Be fair and objective, and avoid being compromised by personal friendships. Maintain your professional boundaries; you cannot act as if you were the parent, unless of course, the resident is a ward of the state in your care and you are now the legal guardian.

If you believe it is a genuine case, be tolerant and make special allowances to meet the child's needs, for example, you may need to adjust the child's program.

5
Ethics

This chapter is about working within a legal and ethical framework. Recovery programs need to work to a high moral and ethical standard. The humanistic paradigm has helpfully promoted non-discrimination and avoidance of destructive behavior. Some government-funded programs, however, either impose some dubious moral standards or accept any legal behavior, even if it is destructive.

Legal means complying with legislation or court rulings, and *ethical* means complying with conscience or the laws of natural justice. Of course, legislators try to make laws that are ethical. For example, stealing, fraud, assault and killing are illegal as well as unethical.

Professional associations and employers often write up their ethics as codes of practice and require their members and employees to comply. These codes are usually very helpful and often exceed the legal minimum. However, they are not always the same and some codes allow actions that others might consider unethical.

However, being legal and being ethical aren't always the same. Perhaps the best way to see the difference is to look at some examples …

Privacy vs. confidentiality. Privacy laws forbid organizations to release personal information to people who are not authorized to have it, but organizations can generally make the information available to their own staff. Confidentiality rules are often much more stringent; they restrict the way information is made available to staff within the organization.

Unethical but legal relationships. Some relationships are often considered unethical, such as a man and a woman being alone in an enclosed workspace for extended periods, and an older man taking great personal interest in an underage girl.

Ethics and morality

Professional ethics are usually monitored through an organizational or professional code of ethics. Morality relates more to personal standards.

The difference is more of degree than kind; counseling ethics is especially closely related to morality. In a counseling relationship, the counselee is deemed to be vulnerable to exploitation. For example, those who counsel individuals of the opposite gender are at risk of inappropriate relationships. The risk is higher if:

- meetings are frequent, longer, or over a longer period,
- the counselee might appear attractive,
- meetings are held outside professional premises, or
- supervision of the counselor is voluntary and not very intensive.

For obvious reasons, counseling associations normally have long, detailed ethical statements. In doubtful cases of doubt, it is better either to refer the client or, perhaps, for the counselor to have more intensive supervision.

Ethical standards

You also need to comply with the ethical standards of your organization and the community services sector. These specifically include supporting other staff and maintaining appropriate boundaries. You might notice that the word "client" is normal in ethical statements.

General community services ethics

1. *Due diligence* in this context that you need to give due care and attention to your work. In other words, pursue excellence and do your best.
2. The *ability to benefit test* means that you should only accept new residents if you have reason to believe that they can benefit from your treatments. In other words, it is unethical to accept residents if you should know that you can't help them, because you are offering false hope. Under consumer law in some jurisdictions, it is illegal to offer services if you cannot show that they are effective, especially if you are paid for them.
3. Look after yourself and keep your work and life in balance.

4. Keep your skills up to date.
5. *Integrity*. Be honest, fair and trustworthy. Accept responsibility for your actions. Practice what you preach, especially if you are in a leadership position.
6. *Empathy*. Be empathetic and don't judge residents; they spot a superior attitude very quickly. They need to know you care and are working in their best interests.
7. Show that you are aware of your own personal values and attitudes and take into them account to ensure your practices are not judgmental.
8. Put benefit to residents first. Help people get access to services and resources they need. You might often see the terms *client-centered* or *beneficence*. It's not about you; it's about what benefits your residents. This also implies:
    a. At the very least, you need to make sure that you do no harm.
    b. You have a duty to prevent the resident being disadvantaged.
    c. Take a strengths-based approach.
    d. Your role is to empower residents.
9. Actively uphold your resident's rights even when you come up against obstacles.
10. *Conflict of interest*. Avoid conflicts of interest that affect your decisions. Identify and resolve them. For example, you could have a conflict of interest if you are working with family members, or being paid for advice. If you want to recommend the services or a for-profit agency and you hold shares in it, you at least should admit that you are a shareholder.
11. *Undue influences*. The client's family or friends might try to pressure you or the client to make a decision that is not in the client's best interests.
12. You will sometimes need to find a compromise between giving the truth and giving reassurance.
13. Your agency, as well as any agency to which you refer residents, should provide cost-effective services. In other words, it is unethical to put people in a situation where they can be financially exploited.
14. *Due process* means that any complaint should be fairly investigated and considered by a neutral party following a set procedure. In particular, staff may not intervene in order to get an outcome in their favor.
15. Don't solicit or accept bribes or inducements. (Rather obvious, but still needs to be said.)
16. Keep impartial, accurate records. (More about that later.)
17. Advise your supervisor if you find gaps in services available.
18. Support your supervisor and your colleagues.

Questions[12]

1. It's normally considered unethical for a professional person to accept gifts from clients. If you are living together in community, however, people may be as much personal friends as clients. Should you be permitted to accept personal gifts from residents? If so, under what conditions?
2. The new resident was in chapel, clearly wanting to sit on the edge and observe. The chaplain, however, did not give up and continually urged the clearly reluctant resident to participate. Frustrated, the chaplain became increasingly coercive until the resident complied. How could dignity of choice be better applied?
3. Is it unethical to refer residents to services if you know they cannot afford to pay for them? Explain your answer.
4. To find out about incidents with residents, you will often need to ask other residents for information. What is the difference between "listening to gossip" and "collecting information about residents"?

Confidentiality

All applicants to The_house sign a general confidentiality waiver as a condition of admission. This protects us because staff often deal with residents' matters and it is impractical to get a specific waiver for each case.

In practice, however, staff and volunteers must still follow the confidentiality policy and keep residents' information private. Confidential information is available to staff on a strictly need-to-know basis. In the past, all staff had access to all residents' records. But we eventually had so many more staff, volunteers and interns that we had to reduce the risk of inadvertent disclosure.

Anything that a resident tells you in private is to be considered confidential, and may only to passed on to other staff on a need-to-know basis.

Like many organizations, we have a policy on collecting and analyzing information about clients. Usually this kind of information can only be made public in statistics where readers cannot identify individuals. That is, specific information about individuals is still kept private.

Confidentiality has limits in some situations, and your role is to tell residents about those limits. For example, you might refer the resident to another agency and need to pass on information that is normally confidential.

Your organization's rules on confidentiality cannot get you out of obeying the law, so you can be legally required to provide authorities with

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12 Some questions have right answers and some have no easy answers.

information, whether or not you mention it in your confidentiality statement. These vary according to jurisdictions, but as a minimum include mandatory reporting, search warrants, and subpoenaed information. In these situations, failure to comply is an offence that can lead to prosecution.

Your confidentiality rules should include broader exceptions so that you can investigate breaches, or refer them to other authorities for investigation. One of them is breaches of law, even if you are not legally required to give information to authorities. The other is breaches of codes of ethics or conduct, although these breaches are not illegal.

Questions

1. A person tries to bully you into divulging someone's personal information. Their main thrust is, "If you really cared, you'd let me help." How do you respond?
2. You know enough about a particular resident to realize that he could be dangerous to other staff. So how do you tell staff to take precautions without divulging too much information? The problem has two sides:
    a. Your organization has a policy of need-to-know with confidential information. That is, you can't inform other staff of clients' personal affairs unless they are directly involved with the client.
    b. You have a duty of care to give staff enough information for them to keep themselves safe.

Primary client

You have a duty to your primary client. For example, if a young person is your client, you might also work with their parents. Both are clients, but in this case, the young person is your primary client.

Question

Your organization pressures you to act primarily according to its interests rather than those of the resident. In other words, it wants to be the primary client and is exerting undue influence. (This problem is most common in government departments whenever the political concerns of the government of the day might overshadow the interests of clients.) What do you do?

Outside the workplace

Many ethical standards extend outside the workplace and outside work hours. For example, leaking residents' private information is still wrong if you do it in your own time at home. As another example, if you

provide free care to other people outside your work, they are entitled to the same standard of care and confidentiality as if they were paying you for it. Doing something for free doesn't mean you can gossip or be sloppy.

Making promises

Don't make promises you can't keep or to do something that should be the resident's responsibility. Some residents try to manipulate you into a promise by implying that you are doing something wrong if you don't. Don't make promises on behalf of other people.

If you promise something, do it. For example, if you promise to make an appointment for someone, make sure you make the call and get back to the resident about the appointment.

Don't promise applicants or residents anything unless you know you can deliver within our guidelines and current range of services. In particular, don't promise services that your want to offer but aren't yet up and running, or services that are not currently running well. It is also illegal in consumer law to suggest you provide a service if you don't.

Cross-gender relationships

What are the rules for cross-gender relationships? First, displays of affection and/or physical contact between at work staff are usually inappropriate. Second, male and female staff should not be alone in an enclosed workspace for extended periods, including cars. Third, romantic entanglements between staff members should not interfere with workplace relations and need to be kept off-site.

Finally, staff must be seen to avoid romantic involvement with residents. Staff members are usually deemed to be in a position of power over residents, so the relationship would be seen to be exploitative.

Self-disclosure

Define the limits of personal information about yourself that you can appropriately disclose. First, it is always inappropriate to give information that sets a bad example or undermines the recovery program.

Second, confidential information about your personal life is usually inappropriate. In some kinds of recovery groups, however, your personal story may be very appropriate as long as it serves the purpose of the group. For example, you might tell your story of addiction recovery to an addiction recovery group. But you would not disclose other issues that are irrelevant to the purpose.

Working with children

You need particular boundaries for working with children:

1. Respect the authority of parents. Children in your care are not your kids.
2. Never be alone with a child in a private space where no one can see you.
3. Have boundaries for physical contact:
4. Some organizations allow staff to touch a hand to hold a pencil or to tap on the shoulder.
    a. Some organizations allow hugging.
    b. Some organizations allow only side-hugging.
    c. Some organizations do not allow staff to touch children at all.

Questions

1. You have a child as your primary client. The parent is a difficult person with obvious shortcomings, and makes bad decisions that obviously negatively affect the child. If you encourage better decisions, you would undermine the parent's authority. What should you do?
2. The parent is right and the child (who is the client) is wrong. Should you intervene? If you do, will you take the parent's side? How would you avoid alienating yourself from the child?
3. Both parent and child are clearly wrong. You feel you can help. Should you intervene?
4. How can you handle someone who is eighteen years of age (legally an adult) but is developmentally still in early adolescence?

Residents' rights

Residents have a right to your care. A mark of your professionalism is your ability to treat them equitably, giving help where it is most needed. It is easy to give too much attention to residents whom you like, such as the friendly, talkative ones, the naturally attractive ones, and those whose personal values, beliefs, attitudes and culture are similar to yours. It is similarly easy to give inadequate attention to those who are quiet, shy, rude, unattractive, or different from you.

Your organization should have policies and procedures for ensuring client autonomy, that is, their right to make decisions.

You need to recognize when a resident's rights and interests are not being protected and to respond appropriately. For example, be observant and notice any signs of trouble. In making a response, some of your main options are to help the resident to identify and express their concerns, and to refer them to someone who can help them.

Questions

1. How do you handle problems that come from competing value systems?
2. A resident is involved in a particularly negative practice that you and your organization disagree with. Where do you draw the line between the resident's right to a personal opinion and your organization's right to expect certain standards of behavior from residents?

Supporting colleagues

Support your colleagues and don't be party to criticism and gossip. In particular, never undermine another staff member in front of a resident. Undermining colleagues is now viewed with such seriousness that it is called "horizontal bullying."

Questions

1. You see a colleague not doing very well dealing with a difficult resident. You know the resident very well and are sure that you could intervene more effectively, but it would undermine your colleague in front of the client. What should you do?
2. Your subordinate makes a decision and the resident disagrees strongly with it. The resident is actually correct; it is a poor decision. The resident then comes to you and complains. If you make a better decision, you undermine the authority of the worker in front of the resident. Besides, if you take the decision away from the worker, clients will treat his decisions as non-final and want to see you for the "real" decision. What do you do?
3. In a personal discussion with you, a client criticizes one of your colleagues. The criticisms are very accurate, but if you agree, you would undermine your colleague to a client. What should you do?
4. In a personal discussion with you, a resident criticizes another resident. What should you do?
5. You are criticized, unfairly you think. How should you respond?
6. Somebody passes on some gossip to you that a resident has a serious problem. Who do you talk to?
7. When should you report someone to Department of Child Protection? You need a "reasonable suspicion," but where is the boundary between "verbal report" and gossip? And what if your suspicions are not well founded, but later turn out to be correct with serious consequences?

What would be best practice?

Debra was on duty yesterday as shift manager when Brad, a resident, asked permission for something. Debra denied it, following normal procedure.

Brad then asked Amanda for permission, and she gave it. Debra felt that she had been undermined. When asked, Amanda said that she knew of factors in Brad's case of which Debra could not possibly have known.

Look at the dynamics. First, Debra had followed procedure, so she feels she made the right decision. Second, Amanda did not go through the line manager (Debra) with her decision. Without intending to do so, Amanda undermined Debra's role as shift manager and her ability to make decisions. Third, Amanda claimed to know facts about Brad's case that Debra did not. Fourth, Brad had effectively worker-shopped Amanda to get what he wanted. He now knows she can appeal any shift manager's decision to get it overridden.

What would have been best practice in this case for Debra? For Amanda?

Know your limits and refer

It is unethical to take on tasks outside your expertise. This sounds obvious, but residents often ask advice on all sorts of things.

Let's put it this way. You have a brain tumor, and your local medical practitioner says: "Yes, you need surgery. I don't know much about it and I've never done any brain surgery. But I'll do it anyway; I'll just make it up as I go along." Alternatively, he might say: "Yes, you need surgery or you will die. But I'll look after you. Just take two aspirin and go to bed." Either way, he'd lose his medical license very quickly for unethical conduct.

If you are dealing with medical issues, especially as an AR worker, don't play a role of medical practitioner. You have little or no training in other maladies, such as infectious diseases. Refer these cases to a medical practitioner.

Medical practitioners may have good reasons for prescribing or not prescribing medication that you don't know about. For example, they can prescribe higher dosages than the normal maximum for patients in some situations, and might be unwilling to prescribe a very suitable medication if prolonged use results in serious side effects.

At The_house, we've found that it's also easy to fall into other traps. It's easy to give poor career advice when students ask about their futures, and it's easy to take on mental health cases that should be referred to a medical practitioner or clinical psychologist.

There are two exceptions to the principle that you may not take on tasks outside your expertise. First, you can be closely supervised by an ex-

pert, such as when you are learning. Second, you might also need to take on tasks outside your expertise in emergencies when the potential benefits clearly outweigh the potential negative consequences, unless your jurisdiction gives you no legal protection.

General ethical guidelines for referrals are as follows:

1. Refer the resident elsewhere unless you know you have the expertise yourself.
2. You need to be reasonably sure the service to which you refer residents is competent.
3. Inform the resident what you are doing, why, how much it might cost, and give them a chance to ask questions.
4. Get the resident's permission to release any information.
5. You might need a way of following it up, for example, by getting back to them and asking how it went.
6. If you "hand over" the resident, you need to know whether you still have any obligations to them. If you and the other service both have ongoing obligations, you need to know what the boundaries are and what liaison you need.

Question

You are required by law to refer a resident to the Department of Child Protection (DCP) in your state. But you know that DCP in your state is incompetent and will not take action within a reasonable time. A good outcome is nearly impossible if you refer. What should you do?

Whistle-blowing

As part of your role, you are required to report suspected unethical conduct confidentially and promptly, and encourage people to deal with it. This normally applies to staff and senior residents who have been given responsibility. Many ethical contraventions are not illegal, so reporting to external authorities is generally unnecessary.

Going to the police is a more difficult decision. When should you report a staff member or resident to the police for doing something illegal?

What should we do if we find a resident who has sneaked in some illegal drugs for their own use? The policy has varied from time to time. On one hand, the resident has done something clearly illegal. On the other hand, a trip through the justice system might not help him (or her) to recover, so there seems to be no benefit in reporting it to the police unless the case involves other factors.

Right now, we simply take the drugs away from the person and dispose of them. Of course, we follow up the incident by "talking it through" and ground the resident for a substantial period.

If staff fail to comply with standards of ethical conduct, you need a system that allows individuals to report breaches without fear of recrimination or negative consequences.

Questions

1. You get information on drug dealers and illegal practices. Should you report them?
2. When should you whistle-blow a colleague for unethical conduct? And if you should, how do you do it and to whom?
3. What can be done to remedy a colleague's unethical conduct?

Assignment

What are the ramifications of breaches of:

1. duty of care?
2. confidentiality?
3. your organization's ethical guidelines?
4. your association's ethical guidelines?

Vulnerability to psychological damage: The ethics of power and control

Closed communities easily become emotional pressure cans that make residents especially vulnerable to psychological damage. Many have backgrounds of physical and psychological abuse, dysfunctional relationships, and mental health issues.

In the beginning, residents might acutely feel their need of recovery. They are now living closely with many new people, and can find some adjustments to The_house quite traumatic. They are often quite lonely and need friends; some are almost desperate to be accepted and look for someone upon whom they can be emotionally dependent. Others act tough and are defensive about anything they perceive to invade their rights or privacy.

When residents are very vulnerable, they easily feel intense pressure to conform to the group or staff expectations, even if you don't make those demands. In other words, if you treat them as if they were normal, non-vulnerable people, you could still have the effect of abusing them psychologically because you have not considered their vulnerability.

If you're a case manager or counselor, residents' vulnerability puts you in a position of power where you can easily pressure and manipulate them. You can easily give bad advice, make up new rules, interrogate them

and get them to admit to things they didn't do, and even influence what they will write in personal journals. You can restrict their freedom of choice and right to consent. To make matters worse, you can avoid accountability because you decide what you'll write in the case notes, and there's no referee sitting in on your private conversations with residents.

Staff can easily offer the excuse that residents are legally free to go if they don't want to comply with the rules. But it's not that simple. Residents don't necessarily have anywhere to go. If they do, they might already know that it won't help them to recover. Or perhaps they feel they will be branded as failures if they leave the program.

As a result, we started by admitting that case managers and counselors aren't mental health specialists. We then made some decisions. First, we decided that case managers need to follow counselor's ethical guidelines. Second, when residents keep a personal journal, only the case manager and his/her supervisor are allowed to read it. Third, we required case managers to refer cases of significant vulnerability to the medical practitioner or to specialized counselors. We also required counselors to refer mental health cases to a specialist. Other than that, we wondered whether case managers should be supervised in the same way as counselors, but it looks like our training and case conference system should prevent any problems in the future.

How much power should staff have over residents? What are the ethical limits to organizational control? Consider these two fictitious extreme cases:

IJK Community

The IJK Community is a residential rehabilitation home for about thirty residents, whom they call "patients." Staff see their role as the provision of only medical and psychological care.

Patients are free to determine what possessions they have, what they eat, when they go to bed at night, who they sleep with (as long as both are above the age of consent), when they get up in the morning, and what they watch on television. They do not need permission to leave the property, as long as they return for meals and appointments, and are free to leave the community at any time by checking out at the front desk. Staff do not monitor the tone of relationships between patients and may not inspect patients' living quarters for contraband.

Staff do all chores and some of them have become servants for residents. They have unwittingly reinforced their servant role by continued subservience.

The IJK Community also has a set of rules, a list of patients' rights, and a commitment to "the best interests of the patient." Staff interpret them to mean that patients can do almost anything they want. When in doubt, they almost always extend the rights of the patients.

DEF House

DEF House is a rehabilitation home for about twenty-five residents. Staff members have unusually broad power over residents and govern all kinds of behavior. They can determine what possessions residents may have, what they eat, when they go to bed at night, when they get up in the morning, who they may talk to, and what they may watch on television. Residents need staff permission to leave the premises. Staff inspect residents' living quarters and personal property for contraband, conduct random urinalysis tests, and have access to all medical and counseling records.

Staff may use their case management and counseling roles to govern residents' thoughts, emotions, and the minutiae of their likes, dislikes, religious beliefs, and political views. As staff do not personally benefit in any way, they believe they are not exploitative. By asserting that their control leads to recovery, they believe that they are not manipulative. As residents sign a broad confidentiality release when they apply, staff believe they can discuss anything from counseling sessions in staff meetings.

DEF House also has of a set of rules, a statement of residents' rights, and policies based on a commitment to "the best interests of the resident." However, these generally allocate powers to staff rather than set boundaries on them. The Director and staff interpret them to be whatever they want, and the Director is the arbiter of all right and wrong. Individual staff further expand these powers when they work alone and exercise personal judgment in individual cases. Besides, staff write the reports of what happened and interpret incidents as they like.

The DEF House culture also reinforces these powers. To gain the approval of staff and senior residents, residents must show that they are compliant and submissive. Those who voice suspicions that something is wrong are seen to be "challenging authority" or "making unsatisfactory progress in recovery." Younger, more impressionable residents are particularly vulnerable.

All staff and residents reinforce the mindset of control and powerlessness. Even if given the freedom to make their own decisions, they might be fearful of making a decision that would meet the disapproval of their supervisors; they believe that supervisors can overrule any decision. Unfortunately, the leadership reinforces this fear by "guiding the resident to make a better decision."

Residents and junior staff become groupies, dependent on the group for acceptance and support, and dependent on the supervisors to make their major decisions. They are not only unable to leave, they are unwilling to do so.

Despite their legal right to leave, many residents cannot. Some have nowhere else to go, and a few are too sick to go anywhere. Others fear the

personal stigma associated with leaving. Young residents are not free to go; they may only be released into the custody of a legal guardian.

Staff work in a strict line of command, accepting the tight control of their supervisors and enjoying their power to boss subordinates and residents. Every now and then, individual staff and residents become disillusioned when they realize that they have been controlled or exploited. Some simply give up and settle into their roles. Some leave, embittered by their experience and frequently repudiating many of the good lessons they learned. Some very talented staff simply keep their mouths shut, wait until they have a plausible excuse for leaving, and move on.

On one hand, the extreme of cult-like control is obviously quite unethical. Even worse, this kind of power is easily abused. While staff might profess to empower residents and give them greater individual responsibility, they also have the power to decide who is ready for it. Staff can also use their power to circulate residents' private journals to other staff and to discuss interesting tidbits from counseling sessions. They can use this information to manipulate residents' personal decisions, humiliate residents in front of others, and force them to confess deeds they never committed.

On the other hand, absence of control inhibits recovery and tends to precipitate the collapse of the community.

Almost all organizations and staff take a road between these two extremes. As a minimum, all institutions should require a duty of care and basic respect for other people. The hospital-type services treat residents as patients, which is quite appropriate for medically supervised detox treatments. The better long-term residential programs retain enough control to manage behavior and to maintain a sense of community; The_house does not want to lose its right to limit destructive behavior and to deal with negative attitudes.

Clearly, staff need enough ethical guidelines to make decisions consistently and to know when to assert power and when to exercise restraint.

And then it gets more complex

Other than that, the matter is quite complex. First, in the long term, residents are generally happier if there are clear rules that are consistently interpreted and applied.

Second, the closed, controlled nature of the community can exaggerate both harmful and beneficial effects in a way that is usually imperceptible to outsiders.[13]

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13 The movie *One Flew Over The Cuckoo's Nest* was about the abuse of power in a controlled environment.

Third, taking an easy path is no solution; some staff find it easy to take control of anything at all, while others find it easy to ignore everything.

Fourth, residents' issues do not fit into neat, well-defined niches; issues that could hinder recovery can be almost anywhere in their lives.

Fifth, although control is the obvious natural response to perceived chaos, it is not always appropriate. Put another way, the obvious response might be wrong.

Sixth, different residents need different levels of structure. Younger ones, those earlier in recovery, and those with serious behavior problems tend to need much more structure. Age, however, is a gray area, and maturity is a better guide than age. Some thirty-year-olds still act like small children and throw tantrums to get what they want. Older residents generally expect more freedoms, and some are more likely to make unjustified allegations of unreasonable control. In other words, getting it right can look wrong. Then again, those allegations could be well founded.

Consider the case of Cody. To be euphemistic, his behavior was quite challenging. Erratic and moody, he resented being asked to do anything. For no observable reason, he frequently lost his temper and vented his anger at anybody nearby. He then accused staff of releasing his private information and using it to gain unreasonable control. Cody's complaint is probably vexatious, but how do you know? Although unlikely, Cody's complaint might be quite warranted.

Seventh, power and control has a counter-intuitive aspect. Residents normally want more rights and freedoms that they have, so you might appear overly controlling even if you get it exactly right. Even if control is reasonable, the perception of unreasonable control can damage the reputation of the facility and perhaps lead to real consequences. Outsiders cannot know whether or not the perception is accurate. They can ask staff, but the staff can use their power role to easily and rationally justify themselves.

Eighth, confidentiality can hide any reality. Staff base their decisions on their knowledge of residents' personal issues, which they are obliged to keep confidential. Consequently, they can make good decisions but may not disclose the reasons for them. The effect is that good decisions can appear to be arbitrary and capricious. The confidentiality hand, however, plays both ways; it is an easy way for staff to hide the reasons for unjustifiable decisions.

Ninth, staff sometimes make poor decisions by error, even with excellent guidelines and training. Errors usually have consequences.

Tenth, both staff and residents tend to become blind to a practice when it becomes an unconscious norm that is ingrained in their culture and social dynamics. Even if the matter is raised to a conscious level, it is

still difficult to challenge and change that practice and to curb any long-held powers.

The normal approach is to get the matter out of the realm of personal opinion and private judgment and make it more objective. This usually involves identifying and debating the key issues, and then formulating a written guideline or a code of conduct.

In the simplest cases, procedures can prescribe clear-cut responses to specific situations. In other cases, it might be a code of conduct that encompasses a range of factors, although only a few of them ordinarily apply in any one case. The code is then a guide for staff to make informed judgment calls. It probably won't completely settle the matter, but it can reduce confusion and stimulate ongoing discussion and interpretation. If people find mistakes, it is simple to produce a second edition.

If this is starting to look too difficult, let's look at a case study from The_house:

At The_house, we use a system of privileges, which we vary according to residents' stage of recovery. Someone in detox or their first settling-in period has no privileges at all and can't go anywhere on their own. Later on, they can move to an independent house, have their wallets, make phone calls to approved people, and have day visits with their families.

When they are ready, they can do a course of study, have overnight visits with their families, and come home later in the evenings.[14]

The purpose of restricting privileges is to promote recovery and prevent temptations that lead to relapse. Consider the examples of wallets, Internet, cellphones, and visiting rights. By controlling wallets and outside visits, recovering alcoholics cannot easily buy alcohol. By controlling Internet access or cellphones, residents cannot easily contact their suppliers to buy drugs. By controlling visits, residents cannot easily contact old associates whose bad influence would soon reverse any progress made in recovery.

Questions

1. On one hand, your role is to manage residents' behavior, but on the other hand, it is unethical to control their personal lives highly. Between these extremes is a gray area.
   a. Where do you draw the line between ethical and unethical actions?
   b. If you could get the balance correct, how could you implement it consistently and be perceived to be doing so?

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14 With thanks to Kristina Woods.

2. What are emotional blackmail and manipulation, and how can you prevent staff from using them to control residents?
3. Where is the line between encouraging someone to try something new and bullying someone to do something they don't want to do?
4. What would you include in a code of ethics the role of power and control?
5. Which currently controversial ethical views does your agency disagree with? Why?
6. What are the effects on residents *while still resident* of inadequate control? Of excessive control?
7. What are the effects *after leaving* on residents of inadequate control? Of excessive control?

What would be best practice?

Contrast the roles of "sole gate-keeper" and "line manager." It is unethical for one person (the sole gatekeeper) to have complete power over residents, because there is no due process; residents would have no way to complain of unfair treatment. On the other hand, it is usually good management for people to have only one supervisor (the line manager) and for any communication and problems to go through the line manager. This avoids the difficulty of people getting conflicting messages from two supervisors.

How would you resolve the tension between these two positions?

6
Emergencies and crises

As a shift worker, you will often face difficult situations and you need to know how to handle them. In most cases, you'll be able to recognize a developing situation early and avert it. If you do it well, nobody will probably even notice that it could have gone badly. This section specifically looks at AR treatment emergencies.

About frameworks

A framework is a set of general stages that gives staff a strategy to handle unusual, unforeseeable incidents for which there is no set procedure. A framework helps to prevent panic that would make the incident worse. It also helps to prevent staff from "making it up as they go along," which can be very dangerous when the obvious course of action is wrong.

People use response frameworks for other things too. In occupational health and safety, you are probably used to 1. Spot the hazard 2. Assess the risk 3. Fix the problem.

A framework is possible because crises normally follow distinctive stages:

1. Recognize and acknowledge that there is a crisis: Who? What? Where? Why? When? How?
2. Contain and isolate the crisis. Limit it to a particular place and group of people. Isolate it from interference from sympathetic forces both from within and outside the organization.
3. Assess the crisis.

4. Give an appropriate response.
5. Evaluate the progress.
6. Close the crisis: treat Post Traumatic Stress Disorder (PTSD), evaluate the handling of the crisis.

The Framework

The framework below for managing crises was specifically designed for community services work.[15] In this framework, a crisis is any incident that poses danger to people or property and may require an immediate response. This framework might look a little long, but an experienced staff member takes literally less than a second to get through the first three steps.

1. Identify the problem

Recognize and acknowledge that a crisis is starting. Remember that more than one crisis can happen at once.

2. Identify exactly who is involved and what is happening.

At The_house, interpersonal conflicts are the most common kind of crisis. Other kinds of emergencies are:

- Incident requiring first aid and/or medical care
- Psychotic episode
- Fit (e.g. epilepsy)
- Blood spill where blood-borne disease is a risk
- Overdose or suspected overdose.

3. Take charge

If you are the senior staff person on location, you are responsible to take charge of the situation, because somebody must be able to make decisions and give orders to other staff immediately. You can't assume that you have time to get someone from off-site. Other staff need to take orders from the person in charge. You must assume that you have to respond rapidly and that you don't have time to discuss it.

If you hand over to another person to be in charge, make sure you communicate it clearly and get them to confirm that they understand. It must be clear who is in charge.

Don't involve all staff in the incident. Make sure that you leave staff to oversee the residents who are not involved.

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15 Many thanks to Tina Gunter and Rebecca Crook for their advice.

4. Assess the risk

If it looks like no harm will come from it, you probably only need to keep an eye on it. But if it looks dangerous, you need to step in.

- How serious is the risk? How likely is it?
- What kind of harm could come from the incident?
- How serious could the harm be?

5. Avert the crisis

- "Nip it in the bud." Avert the crisis in its early stages before it becomes more serious. You need to minimize the impact. Once the crisis becomes serious, there is no turning back and it becomes more difficult to handle. If you get it early enough, most people won't even know it's happened.
- If you can't avert it, then prevent it getting worse, slow it down, or de-escalate it. In particular, prevent violent behavior from getting worse. You have a duty of care to keep everyone safe.

6. Contain the crisis

- Isolate the problem so it doesn't spread. If possible, move the conflict away from public areas. For example, you might ask an angry resident into a separate office where you can discuss the matter more privately. All other activities can still run normally.
- Keep the number of people involved as small as possible. Ask for help if you need it, but keep unneeded people away from the situation.
- Continue to evaluate the progress of the situation. If the crisis becomes violent, please refer to the violent incident procedure.

7. Follow procedure

If your organization already has a procedure for this kind of incident, then you only need to follow it. Procedures should be written as simple sets of steps that are easy to remember. You should have memorized and practiced them. For example, you should know how to handle accidents requiring first aid or medical help, blood spills, psychotic episodes, and fits.

If there isn't a procedure, your priority is the physical safety of people involved, including yourself. Consider the range of options available and choose the best one.

8. Aftercare

Fill out an incident report form. At The house, we also require staff to inform their duty supervisor as soon as they can.

Make sure you check that everyone is okay, even people not involved in the incident. Debrief the stress. Most people will need to rest and wind down from a suddenly stressful situation, or talk it out with somebody. But don't force people into counseling; it can make the symptoms worse.

Post Traumatic Stress Disorder (PTSD) can affect staff and residents if the incident is serious or unfamiliar. People can appear to be coping well at the time of the incident and immediately afterward, but can still suffer from PTSD later on. They might also fail to realize they have it and even deny it if others recognize it. PTSD can affect people who were not involved in the incident, so check that everyone else is okay as well. You will probably find that a good review will help most people.

9. Review

Discuss the incident response in a staff meeting or with your supervisor. Some of the following questions will be helpful:

1. What was the context? (Where? When, Who?)
2. Exactly what happened leading up to and during the crisis?
3. Why did it happen?
4. What were the personal dynamics involved?
5. How effective was the response? What went well? What didn't?
6. What do we need to learn from this?
7. What other possible responses could have been effective?
8. What can you learn about yourself as a person?
9. What should we do differently next time? Do we need to change procedures or training?

In complex cases, the "Exactly what actually happened?" stage can involve writing a time-line of events leading up to and including incident. It may include events that extend back in time, and not just focus on immediate events. You will probably start making timeline notes fairly early in the discussions, and will have a quite good idea of what happened by the time you get to write the whole timeline. If you find gaps or contradictions, you may have to hold extra discussions or look again at other evidence.

If it's an altercation

Residents who are stressed, angry, dysfunctional, or panicking are likely to feel overwhelmed and act irrationally. They tend to communicate

very unclearly in short, incoherent bursts. They might presume that you already know all about their problem, either because it is so important to them or because they believe you were somehow party to causing it.

The best person to handle the incident is the staff member on duty who has a history of getting on well with the resident. It might be you or a colleague. The crisis might be worse if the resident and staff member have a history of tension. Of course, some residents don't get on very well with anybody, and some situations don't allow you to hand over the incident to someone else.

Your first step is to calm them down so that you can at least communicate. Be careful to contain your own emotional responses. If you start to lose your temper, hand over to someone else straight away and leave the room.

If a person has been threatening to a resident or another staff member, remove the person being threatened from the situation and find someone else to help you instead.

Contain their emotional responses and escalating behavior. You'll need a toolkit of defusing strategies such as tone of voice and positive, assertive language. You can also:

1. use gestures and body language that reduce conflict
2. ask constructive questions and listen reflectively. Get them to explain the problem and make sure they feel you are listening. (Sometimes that is really all they want.)
3. give summarizing and reflective responses
4. divert or defuse verbal aggression.

When they are calmer and more able to communicate, you can get them to explain their complaint clearly step by step. Then identify the source of the issue and do something about it.

You will often have to negotiate. In some cases, you just can't give in; you have to follow the rules. (Some residents at The_house think that "No" is an abbreviation for "Now, let's negotiate.") In many cases, you can and should negotiate. You can make realistic compromises (especially win-win arrangements), or create solutions that they hadn't considered. You might also be able to examine the cause and the effect of their behavior. In any case, it's good practice to encourage them to take responsibility for their behavior and its effects.

Crisis management: Myth and reality

Some things in crisis management are counter-intuitive. The myths might look right but they aren't.

Myth	Reality
"We should discuss how to respond when we understand the problem."	Speed is essential; crises affecting AR workers normally require immediate action.[16] The most senior staff person on site should take charge and give orders. Other staff should obey them instantly. Assume that you don't have time to democratically hold a committee meeting.
"Crisis training is a waste of time because we'll forget it in a crisis."	Training greatly reduces panic and makes responses more effective. It might also reduce Post-Traumatic Stress Disorder.
"Every situation is different so each one needs a unique response."	You need a general strategy and some specific procedures so that you can respond quickly with minimum risk of error. In a crisis, you don't have time to think it through from scratch.
"A serious crisis has major effects."	You should seek to avert the crisis before it becomes serious. Get it early and it might have no effect at all.
"I should find out what is going on."	Unless the person in charge needs help, others should stay away and let them do their job.
"Everyone else should stop what they're doing."	The person in charge should isolate the crisis from other activities, so life stays normal for everybody else.
"The only way you can learn crisis response is through experience."	You can hone your skills through experience and further on-job training. However, you should have training before you are re-

sponsible for crisis response; to do otherwise is very dangerous.

About crisis training

Crisis training should always cover the basic concepts of this framework, and we use all of them at The_house. After that, there is space for variation. Here are the basics:

- The easiest way to give training is through regular staff meetings. Staff evaluate how real cases were handled, review procedures, and consider arguments for and against different approaches.
- Lots of crisis training involves the analysis of scenarios. They may be hypothetical or based on real cases. They may involve discussion of a written story or practiced as if they were real. If crisis responses generally can't be proceduralized, it is best to use a wide range of different scenarios.
- Conflict resolution training often involves getting practice in role-plays, the more realistic, the better.
- In some kinds of crisis preparation, the kinds of incidents are fairly clear (if not predictable), responses must be very fast, and errors are unacceptable. In this case, it is best to provide long, intense periods of practice so that personnel naturally give the correct response very quickly even when they are bored, highly stressed, or very tired. (Military training is a good example.)
- In some kinds of crisis preparation, it is best to manage risks very comprehensively, put good communications systems in place, and give personnel a handbook of instructions about what to do.

Questions

1. What if they threaten legal action of some kind?
2. When should you physically resist?
3. When can you use citizen's arrest?

16 Other kinds of crises are different because they have longer timeframes, such as severe chronic illness, civil unrest, and personal career crises. In those cases, one needs to avoid making decisions too quickly.

7
House leading

At The_house, each residence has someone appointed as its house leader. The role is not particularly difficult, but it does need to be done well.[17] The house leaders' key tasks are to make each residence part of the recovery program, regulate the culture of the group, report any maintenance that needs to be done, and make sure all the bills get paid.

Many decision-making skills are the same as those used in regular shift management. In particular, the house leader needs to observe the group's dynamics and make sure that interactions are beneficial and supportive of recovery, or at least prevent destructive interactions. All the house rules still apply.

The object is to get a mix of residents that works well in terms of age, stage of recovery, personality, etc. You don't always have to move people just because they don't get along, but you do need to split up people who are being bullied. Age has a big role; residents can set up a pecking order, especially if some residents are much younger than others. To make a house work well, look out for the following:

1. Behavior
2. How they respond to each other
3. How they respond to you
4. Doing chores
5. Who's going to be your chore monitor?

17 Many thanks to Kristina Reed for her advice.

6. Who's going to be house leader when you're not there?
7. Protecting people's personal space
8. Clarify which food is shared and which is separate.

You also need to avoid some particular problems such as conflict (especially conflict with the house leader), messy people, people not doing chores, lazy chore monitors, and people not contributing house-keeping money.

The first hint is to have at least one meal together each week and keep it special. The second hint is to designate someone to look after the bills.

What would you do? #1

You are Nina's house leader. She's been here for only a month but has already set a pattern of starting arguments.

It's 3.00 p.m. on Saturday afternoon and you are leading a gardening group. Suddenly you hear raised voices from around the side of the house and you go to investigate.

Nina has started an argument with a neighbor. You can't tell what it's about, but it looks like she hacked down some overgrown plants on the neighbor's side of the fence. Nina is getting louder. The neighbor is up to the task; he is firm and doesn't look like backing down, although he is not irrational.

What do you do?

What would you do? #2

It's 7.00 p.m. on Saturday evening and you're helping wash dishes after the evening meal when you get called to the front door.

A man is waiting nervously, and you get the impression that he is in an agitated state of mind. You recognize him as Kenny, Sharyn's ex-partner. Sharyn, a twenty-three-year old, has been a resident for three years and is now highly respected by staff and other residents.

Kenny got Sharyn's address at The_house from one of her family, although it's hard to understand why they gave it to him. They know that it's against the rules. Kenny has a history of being violent and Sharyn has a restraining order against him. He's not allowed within a half-mile of her or the place where she lives.

He wants to see Sharyn and makes it sound urgent. You explain politely that you can't help and that it would be illegal. Kenny claims that Sharyn owes him money from a bond refund on a house they once rented.

When you don't cave in straight away, Kenny becomes more insistent, and you get the impression that he won't give up easily.

What do you do?

What would you do? #3

It's Friday afternoon and you're overseeing a team on gardening chores. While digging up a dead plant near the men's bedrooms, you find a plastic bag hidden under some soil. It looks like it hasn't been there for long. It's unusually heavy so you look more closely. It contains a handgun and a box of shells.

You suspect Kent because he sometimes does extra gardening. He tends to be a loner and very protective of his "rights." But you have no evidence that it's his handgun.

What do you do?

8
The shift worker's role

The regular shift staff make all the routine things happen as delegated by the shift manager. Shift workers answer the telephone, receive visitors, and oversee daily routines to keep residents on schedule (chores, lunches, etc.). They monitor volunteers, keeping track of what they are supposed to be doing and giving them jobs as needed.

Other roles

At The_house, shift workers also learn various other specialized tasks. They lead activity groups and recovery groups, interview and assess applicants, oversee detox, and supervise medications. They are all caseworkers, and some of them do advocacy roles, helping residents with one of the following: welfare payments, legal and justice system, medical practitioners, mental health system, etc. Each of these specialized tasks is distinctly separate, so new staff at The_house generally learn them one at a time. You also need to keep them separate in practice; for example, if you are managing a shift, you cannot give counseling sessions behind closed doors.

Although they are separate tasks, we ask that staff be good at leading activity groups before they start leading recovery groups. Case management and advocacy are quite closely related, so senior case managers need to learn advocacy. They are covered separately in later chapters.

Being a shift worker

It mind sound odd, but some very basic life skills are essential to recovery:

Go to bed at night.	Going to bed at 2.00 or 3.00 a.m. is *not* normal.
Get up in the morning.	Sleeping until noon is *not* normal.
Get enough exercise.	People need it to be healthy.
Practice personal hygiene.	Wash every day and brush your teeth.[18] Wash your bedsheets.
Be nice to people.	Some residents are confrontational and frequently rude.
Eat healthy food.	Malnutrition is common among new residents. Many have eaten too little or only junk food.
Do your chores.	Some new residents lack skills of how to live in a house.

Shift workers can recognize "normal" resident behaviors and handle them routinely: lying, seeking attention, avoiding responsibility, shifting blame, or being erratic, manipulative, or unmotivated. They need to be emotionally stable and to handle routine emergencies without being emotionally exhausted. They regularly handle problems such as people's emotional instability, disrespect to authority, interpersonal conflicts, anger, self-harm, psychosis and psychotic episodes, and sleepless nights. They ensure duty of care (including in emergencies), and, well, anything else that comes up.

Good shift workers can focus on their responsibilities even when they don't really feel like it, and handle the full range of personalities and situations, even when they are stressful. The main requirement for the job is the ability to walk on water.

As a shift worker, you will need to be able to manage people. It's normal to find that you'll connect better with some residents' personalities better than others. It doesn't really matter if you don't easily connect with some residents, as long as you don't unnecessarily estrange yourself.

Observe your shift managers and learn what you can from their strengths and weaknesses. Like any art form, different shift managers have different styles, and you will also develop your own style when you be-

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18 One fourteen-year-old victim of parental neglect did not know how to brush his teeth, and his house leader had to teach him. Some never wash bedsheets: "They're clean enough. They were clean when I bought them last year."

come more skilled. Michaelangelo, Picasso, Rembrandt, Vermeer and Constable were all great artists, but all had very, very different styles.

Observing everything

A significant part of your shift role is to observe everything that is going on, monitor residents, and identify beforehand what might happen. In fact, the easiest mistake to make as a shift leader is to be distracted and non-observant. It is easy to give noisy, demanding people the most attention and let quiet loners fly under the radar and get inadequate attention. You need to be around the facility enough to know what is going on. For example:

1. What behavior indicates some kind of risk? What OHS hazards could arise?
2. Where are other staff?
3. Are residents doing what they should?
4. What is their demeanor and tone of voice? Are they isolating, distant, aggressive, or hyperactive?
5. How are people forming groups? Is it beneficial?
6. Is someone a loner?
7. Is everybody eating well or not?
8. Is anybody trying to avoid being seen?
9. Are they discussing their pasts?[19]

Question

As your role is to observe everything that goes on, how ethical is it to eavesdrop on conversations? Put another way, which conversations is it ethical for you to hear, and which should you deliberately avoid hearing?

Handover

Between shifts, shift managers go through a handover process. Incoming and outgoing shift managers need an overlap of time for the outgoing shift manager to give a briefing on anything the incoming manager needs to know, and incoming shift managers also need to read the most recent entries in the day book. Not long ago, we started using a simple checklist to make sure that we covered all bases.

When you are the outgoing shift manager, you need to be organized enough to finish your shift on time unless you are handling a genuine emergency. If you stay late, employers who pay overtime are entitled to ask you to justify the time.

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19 At The_house, we try to prevent situations where residents can discuss their past lives. We call it "past-talk" and find that it is very destructive.

Following case plans

Each resident has a specific case plan, which you'll need to follow. A case plan is simply a document that prescribes what The_house will do for each resident. It normally covers particular needs, special rights (or lack of rights), personal goals, how you'll evaluate them, behavior management, resourcing implications, and any contingency plans.

Case plans treat people as individuals, so they can vary greatly. For example, we treat new residents differently from senior residents, and some residents have particular social or medical needs.

You'll need to observe residents and listen to what they say in order to know how well our program is working for each one. It usually works well, but you will find unexpected gaps where The_house can't meet their needs. Report them to your shift leader; we can either redesign our services or refer them to another organization.

You'll be involved in case conferences where we routinely review residents and plan their care. Staff meetings also routinely review the kinds of services we offer and make improvements.

The question arises whether all shift staff should know the full case files of all residents. It seems to depend on the size of the organization. When The_house was small, it was easy and practical for all staff to do so. It is now impossible because we have many more residents and shift managers. Besides, large numbers of staff make confidentiality much more difficult. Our best solution is now:

1. Case managers can brief all shift staff on case plans in staff meetings.
2. Shift managers should do proper shift handovers.
3. All shift managers and workers need to know what's in the Daybook.
4. All shift managers and workers need a copy of residents' care plans at the shift manager's desk and they should know what's in it.

About taking initiative and asking for help

At first, you're still learning how things are supposed to be, so you probably won't even notice many things that need to be done. While you're still new in the role, you should ask for help whenever you don't know what to do. And don't panic; it just makes the problem worse.

As you learn more, it will increasingly be your responsibility to take more of the initiative yourself; you'll have to notice any issues as they come up without waiting for someone to point them out.

You'll eventually have to be able to work alone without much help and without overly depending on the shift manager, and fix your own mistakes quickly without losing composure.

Making decisions

As a shift worker, you will need to become confident and consistent in making effective decisions and managing people. Don't ask your shift manager to make decisions for you. Start by suggesting a course of action and asking your shift manager for permission to go ahead with it. Later on, you'll be encouraged to make the decision yourself and report it to your shift manager afterwards.

Making decisions about people in open-ended situations is one of the most crucial parts of the role. There can be several right responses, some better than others, but other responses can be definitely wrong.

Following a gut instinct is a sure way to make mistakes, so we teach staff to use a particular strategy. After a while, staff can make good decisions very quickly while still going through the steps:

1. Recognize the need (Why are we making this decision?)
2. Identify the factors comprising the situation (people's temperaments, stage of recovery, group dynamics, location, legalities, risk factors, policy, etc.)
3. If there is a suitable specific procedure, follow it.
4. If there isn't a suitable specific procedure, generate a range of solutions that are suitable for the situation.
5. Consider the consequences of each option.
6. Choose the best solution that will work.
7. Implement the solution.
8. Evaluate the decision afterward.

For example, two residents approach you for permission to go into the city on a shopping expedition. It could be a very positive experience that they remember for a long time. They might go into the city, try on lots of clothes, buy something they like, and go somewhere trendy to enjoy coffee and a long talk. On the other hand, it could be a disaster; you might be called to bail them out of jail for shoplifting, or any of many other equally unattractive outcomes. Your answer will depend on:

What is their track record?

- What has been decided about them? Is either one currently grounded?
- How have they been in the week just gone by?
- Have they been honest in the past when asking permission?
- Have they shown in the past that they can behave appropriately?
- Do they have particular health issues? Could they need medication while away?
- Do they have a history of shoplifting?
- Do they have any money?

Would their interaction be beneficial?

- Which one is the stronger personality? Will he/she exert a positive influence on the other?
- Do they have a common past before they came into The_house? If they do, they are more likely to talk about the destructive aspects of their pasts.
- Do they have the same kind of issue? In this case, they will also be likely talk about this harmful aspect of their past.

Will the location be good for them?

- Will it be free of relapse triggers?
- Who might they meet? Will those people be good for them?

What stage of recovery are they?

- Are they still new? (Residents have restricted freedom for the first thirty days.)
- Have they been given extra freedoms? (E.g. older residents living out, senior residents doing outside courses or jobs, etc.)

What legalities?

- Are they still minors? If so, who will have duty of care? What about kids? Is it safe? Who is responsible?
- Are they subject to court orders or parole conditions?

Using emotional intelligence

Even if your decision is within the policies at the time, it can still be emotionally wrong. You need to consider people's individual temperament, mood, and background.

At The_house, we looked at the way nurses give emotionally correct responses to complete strangers. It comes back to the same basic principles: good questioning and listening skills, being non-judgmental, using questions that give people scope to give their own responses, and respecting peoples' responses. Here are several other core principles of getting a response emotionally right:

1. Spend time with people. Many of our teenage girls simply want a Mom to ask: "How was your day?" and bake cookies with them. Even if you're busy, you can still have them close by.
2. Listen carefully to what the resident is actually trying to say, even if they are not very articulate. Simply enforcing rules and controlling behavior does not achieve the desired effect.

3. Make a response at the time. It's almost always a mistake to cut off a call for help, and tell the resident to "See me later." Beside the probability that you might not get back soon enough to be of help, the resident will might interpret it as a personal rejection. Even if you're very busy, it's good to make sure you give adequate attention at the time, even if it's only to have them with you while you're doing something. (It's a point of basic psychology; the sooner that you respond, the more clearly the resident will relate your response to the call for help.)

Examples

1. A resident came to the shift manager with a simple question, who gave a strict by-the-rules response. The resident was greatly upset and exhibited behavior problems until another worker resolved the issue next day. A sensitive answer would have left no mess without being very time-consuming. As the proverb says, "A gentle word turns away anger."
2. You want to motivate two people to achieve a certain goal. You might give one a challenge so they can rise to the occasion. But the other might perceive the same challenge as a message: "You're not good enough and I'm pressuring you to achieve my standard." The second person might be more motivated by gentle encouragement.
3. At our high school program, a teacher's aide came into the Principal's office reporting that one of the students was loudly venting anger, although doing no harm. Instead of closing down the student's behavior, she simply told the aide to give him some space and that she would talk to him later. She knew that the student's parents had split up the night before in a vehement argument, and that his world was in free fall. She realized that an immediate, direct confrontation would probably add to the problem.
4. A resident asked for help from a very positive, enthusiastic shift worker. The busy worker answered quickly and rushed on to the next job. The resident felt crushed and rejected. She felt that the shift worker hadn't really listened and preferred to be preoccupied with other people.

The last example is most interesting. At The_house, some remarkably positive, encouraging staff have enough rapport to prevent most problems, but they still occasionally get it wrong. Being busy and friendly is not always very helpful when people need time and empathy.

Getting the balance

Strike a balance between doing all your work and relating to people. Compare these two shift managers:

- Sam was friendly and fun. She tried hard to make friends of everybody and was usually quite successful. On the other hand, she was often in trouble for failing to write case notes and day book entries, but didn't take much notice. She just couldn't see a problem.
- By contrast, Yenny was extremely task-oriented and usually stayed at the desk to get all her work done very efficiently. Although she was not rude or unfriendly, she never took time to be interested in people. Her demeanor said to residents, "I don't care about you and I am not interested in your life." If asked about it, she says that she gets all her work done, and points to others who have neglected the paperwork.

Guidelines for written notes about residents

Here's The_house's guide on what to put in and what to leave out of written notes about residents:

1. If you find weaknesses in the formats of forms, refer suggested improvements to your staff meeting.[20]
2. Keep each resident's case notes separately filed. Residents have a right to view their own case-notes, but may not view those of other residents.
3. Keep enough notes to enable someone else to take over your caseload at any time.
4. Case notes are confidential, so you can include details that will not be revealed to people who don't have a right to know.
5. You may have to be blunt to be clear. Don't be vague and indirect about a problem to avoid an unpleasant truth; you don't want a replacement staff member to misunderstand your notes.
6. Keep to factual information:
    a. Keep an "objective" tone.
    b. You can include straightforward reports of events and direct quotes from the resident.
    c. Include decisions of what needs to be done, who will do each task, and when they should have it done by.
    d. Include details of referrals.
    e. Include diagnoses and the reasons for them.

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20 Many organizations keep notes on a computer data-base designed for the purpose, and this also applies to computer formats.

7. Include things that may be important later on. You don't want to appear negligent in the future for missing something that turned out to be important, for example:
    a. You may include options for diagnoses that you have ruled out and the reasons for doing so.
    b. You can include avenues of action that you must consider. If you have reason to suspect something may be a problem and needs checking, you should write it down and make a decision to check or monitor it.
8. Do *not* include:
    a. Anything that you wouldn't want the resident to read (e.g. anything that would be seen to be derogatory of them). Under privacy law, residents have a right to view their own files if they wish and can sue you if the notes are evidence of irresponsible or negligent treatment.
    b. Your personal impressions or hunches. If you can't confirm them with some kind of evidence, don't put them in.
    c. Deliberations that lead up to diagnoses or treatment decisions. These generally contain lots of unproven "perhaps" things that would be distressing for the resident to read.
    d. Bureaucratic gobbledygook just to keep the office happy.

Sometimes you still won't know whether to put something into your notes or leave it out, and perhaps it could go either way. Discuss it with your supervisor or in a staff meeting. You might find good reasons for doing one or the other.

Answering the telephone

It's part of your role to respond to inquiries from residents, their families, and from members of the general public. Although this includes people who walk in off the street, the telephone is often the first contact.

New staff members often need to learn to answer the phone according to our standards. It's mainly a matter of having the right attitude, asking what you can do for the caller, and responding promptly. Often it's simply switching the call through to a particular person.

Use a pleasant tone of voice and a polite attitude. Concentrate on the caller—while they are on the phone to you, they are the most important person in your world and you are The_house's ambassador.

Here are our guidelines for answering the telephone:

Telephone procedure

1. Someone will be on duty to answer the phone during all office hours.

a. At the end of office hours, switch the phone to the answering machine.
b. At the beginning of office hours, check the answering machine and follow through on all messages.
c. If you must leave the room for a short period, either take a handset with you or assign someone else to take over from you.
d. If you are busy with a visitor or in a meeting, assign someone else to take any phone calls. It is bad manners to treat visitors as second-class to anyone who phones in.

2. Answer the phone promptly. Within three rings is a good guide.
   a. Give a standard greeting and find out what they want. ("Good, morning/afternoon. This is The_house Foundation. How may I help you?")
   b. Pick up on anything particularly significant (e.g. emergencies, serious problems) and respond appropriately.
   c. Give sensible replies. (People appreciate intelligent answers.)
   d. If the caller is being difficult (demanding, angry, or complaining), sound helpful and switch them through to the best person to answer it.
3. Do …
   a. Apologize for any inconvenience we seem to have caused (e.g. delay, poor telephone connection).
   b. Get feedback from colleagues on how well you handled the more challenging calls.
   c. Close with a polite "Thank you" when you can.
4. Don't …
   a. Don't waste time on telemarketers no matter how good they sound.
   b. Don't release general information unless it's approved to be released to the general public.
   c. Over the phone, don't confirm or deny whether a person is or has been a resident.
   d. Over the phone, don't give the street address of The_house unless the person has a right to know. (Some residents have family members and former friends who might try to harm them.)
   e. No matter what people say, don't release any information on residents unless you have been specifically approved to release it to the other party (e.g. a DCP case officer phones about a resident for whom you are case manager).
   f. Don't make any promises.
   g. Don't admit that The_house has made a mistake in any way that might incur liability or get anyone into trouble.
   h. Don't waste time in idle chatter.

5. If someone can't take the call, don't give the reason unless they are "in a meeting" or "on leave"; it's none of the caller's business. Just say that they aren't available.
    a. Do not put the phone down and wander off looking for someone. It's horrible for the caller to be left hanging. It is better to take a message.
    b. Take a message if the caller wants someone who is unavailable. Write out the whole message neatly. (People won't understand it if it's too brief or if they can't read the writing.) We use pads of printed forms with a duplicate so the original message goes to the person and the original stays in the pad. Each form has places for:
        i. who the message is from
        ii. their phone number
        iii. when they called
        iv. who it's for
        v. who took the message
        vi. the message itself, and
        vii. when you could call back.

Volunteers

You'll often be responsible for other team members and volunteers. For staff, tell them in an appropriate way the standard of work expected of them. This will often involve a training role where you show them what to do and give them as much support as they need.

A couple of words of caution: Some volunteers might do substandard work, and you need ways to handle it. You will learn never to assign some kinds of jobs to particular people, and may need to find tactful ways to discontinue some volunteers.

Be an encouragement to volunteers and help them to enjoy their time at The_house.

They all have different goals and you'll need to figure out the best way to handle them. Some want to come, do a job, and leave. Give them the right kind of job and a schedule. Some want company and need the social interaction. Who you place them with is as important as what they do. Some think of it as a way to learn something new, and may need to be rotated between jobs so they keep learning.

Volunteers drop out for various reasons. For some, their idealistic visions of helping people are shattered in the reality of actual people. For others, the recovery program makes them realize that they have their own problems; they drop out rather than face them. At The_house, we've improved volunteer retention through orientation and a buddy system of coaching.

Questions

1. What would you do if a volunteer:
    a. used their work time as a social occasion only and didn't do any work?
    b. did work of such poor quality that we had to either do it again, fix their mistakes, or pay for repairs?
    c. did good work but was very slow?
    d. set a borderline bad example in speech or relationships?
    e. did good work but ran out of time and left the job unfinished?
    f. had the attitude that "I'm doing it for free so it doesn't really matter if it's substandard?"
    g. was a good person and willing to help, but whose particular abilities weren't those you needed?
    h. did a good job but didn't really enjoy it?
2. How could we further improve volunteer retention? We need to at least retain more than we lose.

Brief interventions

Brief interventions are used in various community health contexts. In essence, they are incidents where you need to respond briefly to someone's problem. They are always one-to-one private discussions where you simply take the opportunity when it comes up. The tone and relationship will vary between cases and incidents. Most interventions will be very routine. Some residents will appreciate your help, but some will be difficult.

The simplest kind of response is to encourage a resident to discuss the matter with their case manager, a supervisor, or the medical practitioner.

If it's more complex, you might need to focus first on encouraging and motivating the resident, giving some emotional support, and de-escalating any tension. Take the opportunity to discuss the matter and be friendly and sensitive.

You then need enough information to be able to respond. Ask the resident what has happened and any necessary follow-up questions. In doing so, you help them think a little more logically and objectively about the problem.

You then need to identify areas of concern and prioritize areas for immediate and longer-term action. In any case, your questions need to help the resident restructure their thinking so they can identify the real problem and head in the direction of a solution.

You can then either give them the help they need straight away and help them to identify what further help they need, or refer them to someone else for more help. You might have opportunity to develop a simple plan and get them to commit to it.

Thoughtful questions, reflective listening and non-confrontational body language will help. Do what you can at the time to reduce harm and risk. You might also need to give them some kinds of factual information so they can make informed decisions.

Brief interventions require you to quickly assess the person's needs and select a next step to recommend. You will generally have to identify their stage of behavior change: pre-contemplation, contemplation, action, or maintenance. If they have satisfactorily maintained a change, they are often in a stage of pre-contemplation for the next change.

Stage	What it means	How to respond
Pre-contemplation	The resident is not yet considering making changes.	Raise awareness of the issue.
Contemplation	The resident recognizes their need and is considering making changes	Conduct brief motivational interview with a resident who is contemplating change.
Action	The resident is ready to make changes.	Support and encourage a resident who has made a change. Explore choices, set goals and identify relapse prevention strategies.
Maintenance	The resident has already made the necessary changes, but needs to prevent relapse.	Identify their current needs and sources of help, and give support as appropriate.

Managing behavior

Behavior management is an essential skill in AR care. We manage behavior by clarifying expectations, having clear boundaries and penalties for infractions, getting people to do their chores, and having a defined schedule. Some residents at The_house have come from highly undisciplined environments where they do not have to go to bed at night, wake up in the morning, eat healthy food, do chores, be told what to do, or (sometimes) even wash regularly. We found that residents give us much fewer problems when the schedule is quite full, even on annual vacations.

Be on watch for different kinds of manipulative ploys. A few of the most common are below although they probably reflect the youthfulness of our residents. An older group might be more sophisticated. With experience, you'll be able to add to this list:

1. Offering plausible explanations that are untrue but difficult to check. That is, they lie.
2. They collude to get a cover story or alibi.
3. Play sweet and innocent. (The younger girls are usually most skillful at this ploy.)
4. Admit to something small (or apologize for something small) to cover something more serious.
5. Get permission for something small and then try to stretch the permission into something much larger. ("Give them and inch and they take a mile.")
6. "Selective hearing" and "Selective memory": Hear or remember only those things that suit their goals. They don't hear or remember anything they don't like.
7. "Selective truth": Tell only those aspects of the truth that suit their goals and conceal everything else.
8. Look for a staff member who will give them what they want. ("Worker-shopping")
9. Use what one worker says to get a more favorable result from another, in the same way that a small child plays off one parent against the other.
10. Single mothers try to use motherhood as leverage to get extra privileges.
11. A person threatens something to get you to respond in a certain way.

Blame-shifting is just as interesting and is often well-hidden. "It's not my fault for being late. It's your fault for not waiting an extra half-hour." "It's not my fault for being disorganized. It's your fault for being inflexible." "Okay, I messed up. But you have to help me fix it." (This actually means, "You are responsible to fix my problem.") "You're judging me." (This actually means, "Perhaps I was wrong, but it's your fault for bringing it up.")

At The_house, we plan how we'll manage each resident's behavior in our case meetings; we probably spend more time discussing behavior management strategies than any other topic. We put our notes in the resident's case plan:

1. Any particular risks of poor behavior. Residents have quite different backgrounds so they have different risks. For example, some are at risk of absconding (which is quite concerning for minors), some are more likely to try to smuggle in contraband, and some are more likely

to be violent or argumentative. Risks usually decrease over the time the resident is with us.
2. Any particular ways of preventing poor behavior.
3. Recommended ways of responding to particular incidents if they happen.
4. The kinds of rewards for good behavior and the kinds of penalties for unacceptable behavior.

Question

How would you handle each of the manipulative ploys listed above?

Difficult people

You'll have to defuse or handle any difficult situations that come up. If your communication breaks down with a resident and you can reconnect, our current procedure is to respond appropriately at the time and refer the matter to another staff member.

Some involuntary residents were placed here by a court or by the Department of Child Protection. Some of them think of themselves as prisoners and avoid communicating. Others have closed or unreceptive attitudes and present different communication challenges. Building relationships with them is one of your most difficult skills, and some staff can even make friends of people who don't want to be made friends of.

If you can, find out their barriers. It could be any one of many things: mistrust, conflict, loss of social skills, misunderstanding of people or organizations, fear, anger, or frustration.

There isn't one basic set of steps that you can use for everybody, so it's better to build up a toolkit of different approaches. (As you keep learning, add more tools to your toolbox, so that you can handle a wider range of situations and people more appropriately.) Try these for starters:

- Be a friend when they need it. Sometimes this is mostly listening.
- Can you identify the cause of the problem and discuss the situation in a way that calms them down?
- Give them time.
- Include other people, especially if you have to resolve disputes.
- Use non-verbal strategies, such as being thoughtful and considerate, and using non-confrontational body language.
- If you need to, refer problems to someone else for conflict resolution and mediation.

Question

One program manager suggested a card system (like soccer) for handling unacceptable behavior. The worker could give a yellow card as a minor caution for unintentional infraction with no penalty, and an orange card as a caution for relatively minor but intentional act. A red card indicates a serious, misbehavior. Besides, we could have a blue card for putting someone in an unsafe situation.[21]

In what kinds of situations would such a system be effective? What kind of penalty would be appropriate for orange and red levels?

Responding to individuals

One part of your role is to respond appropriately to people with different personalities. In practice, this means that you will need to learn how to discern their likes, dislikes and motivations. For example:

- Something that might be a reward for one resident could be a punishment for another; a resident who likes cooking might enjoy an extra round of kitchen chores.
- An approach that appears friendly to some people might overwhelm others and cause them to withdraw.
- A direct approach would benefit some residents but would create resentment and opposition in others.

Don't expect any miracle formulae. Especially while you're learning, the best course of action is to discuss residents' temperaments with other staff and how best to approach them.

Another common way to approach individual characteristics is to look at *personality types*. Although psychologists have many different views on personality types, each different view is like a separate tool in your toolkit, and each can widen your thinking on individual characteristics.

As a starter, many educational courses list four main learning styles. First, *activists* want to do something straight away and see what happens. They get frustrated if asked to carefully think through something before trying to do it. Second, *reflectors* mull it over before taking action. Third, *theorists* think it through and make sure they understand it before they feel ready to do anything. Logical consistency is very important. Fourth, *pragmatists* look for new ideas and try them out to see if they work. They are natural experimenters, and are motivated by the question, "What would happen if I did this?" They ask "What if...?" and "Why not...?".

That's not all; there are others:

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21 With thanks to Sharon Beel.

- *Relaters*. Relating to people is most important. They look at relationships and personalities, and want to learn from other people. They very interested in how people tick but aren't very interested in abstract ideas or books.
- *Visual*. They want to see something such as a diagram or picture. If asked to explain something, their natural first choice is to draw a diagram.
- *Audio*. They like sound. They find a verbal explanation very helpful, and will prefer to explain something orally.
- *Language-oriented*. They think in words, and are sensitive to their meanings, sounds and rhythms. They verbalize concepts, and tell tales and jokes. They might like reading or prefer oral communication.

Another way to look at individual learning differences is in terms of pairs of variables:

- *Concrete or abstract*. Does an individual learn by direct concrete experience (doing, acting, sensing, and feeling) or abstractly by analyzing, observing, and thinking?
- *Right brain or left brain*. Does a student look at the parts, think in sequential linear logic, and try to be analytical and objective? Or are they intuitive and holistic, looking also at the personal feelings and perspectives of the people involved?
- *Social or independent*. Do they want to work with other people and enjoy personal interaction? Or do they like to work and study alone and set their own goals?
- *Creative or pragmatic learners*. Are they imaginative and inventive? Do they like discovery and taking risks? Or are they practical, logical, and systematic?
- *Thinkers or implementers*. Do they want to discover the relevancy or "why" of a situation and reason from information that is detailed, systematic, reasoned and concrete? Or do they want to know how to apply information, look at practical implications, and try it out?
- *Diverges or convergers*. Do they seek to generate many different answers, or do they try to use detailed, systematic, reasoned information to work toward a single preferred answer?

In another approach, Gary Chapman[22] has suggested that people tend to show and receive friendship in five different ways, which he calls "love languages." Different people tend to prefer one way over the others, with a secondary preference for another. However, most people also enjoy

22 Gary Chapman *The Five Love Languages* (1995, Northfield Publishing).

traits of the other non- dominant ways. While not yet validated by experimental methods, you might find it helpful in interpreting relationships.

Words of affirmation. These people like to be told they are doing well, be given compliments, and to hear verbal expressions of friendship. Similarly, negative comments cut deep.

Quality time. These people need time and focussed attention; being with them and listening carefully is meaningful and comforting. On the other hand, they tend to think of you as insincere and hurtful if you are distracted, late to meet as agreed, or a no-show.

Receiving gifts. Some people see gifts as expressions of real friendship. They are not necessarily materialistic, but feel most loved and appreciated with a thoughtful gift, even if it is relatively small.

Acts of service. Do them a favor. Some people see your help as an act of friendship and think that talk is cheap. They might prefer to do something for you than to sit and talk. They strongly dislike broken promises and perceived laziness.

Physical touch. You probably know some huggers. Physical touch, done appropriately, is an essential sign of friendship for some people. They are hurt when they perceive you as avoiding physical contact or physical abusive in any way.

Identifying issues

You need to be able to identify any serious issues affecting the lives of residents, and refer them to someone else for help. For example, you might not have any specific training in mental health but you still need to notice when a resident or applicant has a mental health issue and decide what to do about it.

This skill is essential because you might be the only health care professional in a position to identify a serious need. Without your intervention, someone in serious trouble might never get help. Besides residents, you also need to observe other people, such as assessees and family members.

You need to be able to identify the following issues and refer them for help: mental health, child protection, domestic violence, disability, homelessness, unemployment, alcohol and other drugs, and any other form of crisis. Later chapters discuss them in more detail.

Don't expect residents to ask for help. And if they don't show signs of need, then you can't recognize it so don't blame yourself.

As a general shift worker, you don't have to be able to treat these issues. Except in emergencies, your best option is to refer the resident to someone else for specialized help. Depending on the kind of need, it might be another staff member or it could be an outside organization. Af-

terwards, you should review whether or not it worked. Did the person get effective help? Do you need to make follow-up contact?

Non-English speakers

The_house only accepts applicants who speak English well enough to participate in the program. However, an interpreter may be required for emergencies and for communicating with family members who do not speak English. We usually use telephone interpreters. The_house uses family members as interpreters *only* if it is clear that they can be neutral. Either way, this level of communication usually can't include highly confidential information.

Cultural awareness

A mix of different cultural influences is changing our general culture in terms of personal behavior, interpersonal relationships, beliefs, perceptions, and social expectations of others. Culture keeps generating more change so that social practices and beliefs evolve over time.

Our laws forbid discrimination on the basis of race, age and disability. Besides, equal opportunity laws refer to employing both genders equally. Obeying the letter of the law is easy, but developing non-discriminatory attitudes is much harder. Cultural discrimination is not illegal, but the government has deliberate programs to encourage acceptance of people with non-Anglo cultural backgrounds.

Like everybody else, you carry your own culture and your own preconceptions of other cultures. If you describe something as 'normal,' you unconsciously impose your own values; it excludes other-cultured people by branding their life experiences and situations and somehow abnormal.

When you start to learn about another culture, you experience something unique because you deal with particular individuals and have particular experiences. In other words, what you learn about a culture can be very different from what other people learn about the same culture.

You need to become culturally aware so that you can effectively communicate and cooperate with people from different cultures. This can include all sorts of aspects: youth subculture, ethnicity, language, cultural norms and values, beliefs and customs, family structure, personal history and experience (which may have been traumatic), gender, age, and disability. Be aware that culture affects everything that people do.

Consult with other-cultured people and review your practices. You might need to change the way you work so that you can be culturally appropriate and create a culturally and psychologically safe environment for everybody.

Communicating effectively across cultures

Build relationships based on acceptance of people who are culturally different from you. Try to build mutual trust and confidence. Consequently, you need to show respect for different cultures in the way you communicate with colleagues and residents, families, and others. Figure out ways to deliberately eliminate bias and discrimination. You will find some cultural beliefs and practices that may cause harm, and you should respond respectfully and sensitively to them.

Here's a simple example of intercultural miscommunication. You have a meeting with the Asian parents of a resident. Your culture highly values friendliness, while they highly value politeness. Both sides try very hard to make the meeting successful; you try to be as friendly as possible and they try to be as polite as possible. At the end of the meeting, you think they were cold and unfriendly while they think you were blunt and rude.

You can employ different approaches to resolving intercultural misunderstandings:

1. It's about your attitude. You are probably more prejudiced than you think. White people almost always presume that they are superior and right, and tend to be quite unwilling to learn from people of other cultures. They tend to presume that if someone can't speak English very well, then they aren't as clever. Of course, they don't admit it.

People from other cultures will usually be much better at reading your attitude than you think. They need to feel that you respect them and are trying to help them. Use good manners and show respect. Whatever you do, don't lose your temper. Be willing to give them extra time.

2. Find out what they want. What is their purpose or intent? It is very frustrating for both you and them if they say exactly what they want and you can't understand it. They will be even more frustrated if they think you are not trying to help them. If they lose their temper, they become unhelpable. You have several possible approaches. First, ask questions and talk it around to get to their intent. Second, you may be assuming that they know something that they don't. You need to explain it simply and clearly. Third, remember that they will normally be frustrated by organizational rules that they don't understand.

3. Is this a language problem? A language problem is more difficult and they will be even less clear if they are frustrated or angry. English speakers often have the odd habit of speaking loudly to non-English speakers. Without realizing it, they presume that non-English speakers are a little deaf.

Some will speak English fluently but have a very thick accent. Get them time to speak more slowly and explain it more simply. Some speak broken English. Consider a telephone interpreter. Use simple sentences or

write things down in plain block letters. Speak clearly and more slowly than normal. But don't speak too slowly or use baby talk.

Some will speak fluent English for everyday purposes but lack higher level skills for solving problems and for discussing personal feelings and interpersonal relationships. If at first you don't succeed, give them extra time to talk through it as best as they can. However, an interpreter might still be necessary.

4. Is this an individual trait or a cultural trait? The "quirk" that makes them hard to communicate with might not be cultural. It might simply be a particular personality trait of the individual. You might only be able to tell the difference if you are dealing with lots of people from their culture, or if somebody tells you.

5. Give them a clear course of action. You will often have to help them navigate the system. Don't give people a runaround to other agencies, or use "the rules" as an excuse not to help them. Of course, you can't be a soft touch either, and some people ask for services that don't exist or to which they aren't entitled.

6. Give them the option of follow-up. Don't just send them on their way. If you can, tell them that they can come back if they get stuck. At least tell them who can help them in future and try to link them up. If you are the only professional they can trust for help, they may interpret a lack of follow-up as betrayal and untrustworthiness.

Assignment

Decision-making is an essential part of your role. Below are five different versions of the way a shift worker faced a difficult situation. Compare them and consider which responses were best and which were not. Give reasons for your answers.

Conversation 1

Annie, a shift worker, charged into the reception where Beth was managing the shift, and said desperately in a too-loud voice, "Help! There's a big problem and I don't know what to do. What should I do? Perhaps it's too hard. Perhaps you should do it. What should I do?" She waved her hands in desperation and paced frantically up and down the room.

Beth tried to soothe her and find out what was happening, "Okay Annie, settle down. I'm not sure what's going on. What's the problem?"

Annie didn't make much sense yet. "Well, it's all terrible. It's getting worse. I just don't know what to do …"

Conversation 2

Annie, a shift worker, walked quickly into the reception where Beth was managing the shift. In urgent tones, she said to Beth, "Hi Beth. A man has shown up saying that one of the residents is his daughter and he's going to teach her a lesson. He's getting louder and angrier, and I'm afraid. He looks like he could become violent. What should I do?"

Beth responded, "Hi Annie. Okay. Can you talk to him at all or is he just shouting at you?"

"Well, yes, but he doesn't listen. He just keeps going on and on."

Beth made the decision. "Tell him to leave the property now. If he's still there in a few minutes, call the police."

Conversation 3

Annie, a shift worker, walked quickly into the reception where Beth was managing the shift. In urgent tones, she said to Beth, "Hi Beth. A man has shown up saying that one of the residents is his daughter and he's going to teach her a lesson. He's getting louder and angrier, and I'm afraid. He looks like he could become violent. What should I do?"

Beth focused her attention on Annie and replied, "Hi Annie. Okay. Can you talk to him at all or is he just shouting at you?"

"Well, yes, but he doesn't listen. He just keeps going on and on."

Beth thought about it for a second and asked, "What do you think you should do?"

Annie answered, "Umm. I don't want to let him meet his daughter. It wouldn't help."

Beth asked, "So what do you think you should do?"

Annie didn't take any time to say, "I think I should ask him to leave the property."

"And what if he doesn't?"

"I suppose I'd just have to call the police."

Beth concluded, "That sounds like a good plan. Tell me how it goes."

Conversation 4

Annie, a shift worker, walked quickly into the reception where Beth was managing the shift. In urgent tones, she said to Beth, "Hi Beth. A man has shown up saying that one of the residents is his daughter and he's going to teach her a lesson. He's getting louder and angrier, and I'm afraid. He looks like he could become violent. What should I do?"

"Have we discussed this kind of thing before?"

Annie thought for a moment and replied: "Umm. Yes."

"So do you know what to do?"

Annie didn't even need a short moment, "Umm. Yes."

Beth concluded the conversation, "So go do it."

Conversation 5

Annie, a shift worker, walked into the reception where Beth was managing the shift, and said, "Hi Beth. A man has shown up saying that one of the residents is his daughter and he's going to teach her a lesson. He's getting louder and angrier, and I'm afraid of him. He looks like he could become violent. I think I should ask him to leave the property, and call the police if he doesn't. What do you think?"

Beth concluded, "That sounds like a good plan. Tell me how it goes."

Conversation 6

Annie, a shift worker, walked into the reception where Beth was managing the shift, and reported, "Hi Beth. We had a man here this morning saying that one of the residents is his daughter and he was going to teach her a lesson. He got louder and angrier, and looked like he could become violent. He wasn't listening very much, but I asked him to leave. When he didn't calm down, I just called the police."

"When they talked to him, he decided that it was better to leave than to get arrested. Anyway, it turned out all right. Just thought you'd like to know."

Question

When Nina didn't show up for the morning meeting, Debra went to find out what was wrong. Although awake, Nina wanted everybody to go away so she can go back to sleep. Debra was quite firm but Nina still refused to get out of bed, and looked like she would lose her temper. Nina didn't want to start an argument.

What should Debra do? What are the general principles for handling residents who refuse to do as they are told? Should there be a procedure?

What would you do? #1

It's midmorning in the middle of the summer vacation and everyone else is down at the beach. You are alone looking after the front desk and doing some boring paperwork.

James McNamara, a Senator who lives locally, walks in and asks to see Stewart, the administrator. You explain that Stewart is at the beach and you can't contact him.

Mr. McNamara explains: "Sorry, that I dropped in unannounced. I tried to phone but couldn't get through."

You've been here all day, so the call probably came while you took five minutes to make a coffee.

Mr. McNamara continues, "The_house put in a grant application that mentions me as a referee. The grants committee contacted me for the reference and I'm happy to help with it. But I don't know anything about what the grant is for, so I thought I'd come and ask. Oh, the deadline is noon today, so I'd like to email it off straight away."

You don't know anything about that particular grant application; Stewart's office is locked, and his cellphone is switched off.

What would you do?

What would you do? #2

You are at the front desk and Stewart, the administrator, is away this week. It's an ordinary weekday and you are opening the mail.

One of the letters is addressed to The_house. It's a court order informing The_house that a court official will come the day after tomorrow to see Brad, a resident. You don't know what it's about, but it doesn't look routine. Brad has a background of criminal violence and you are concerned that he could threaten violence if the meeting with the court official goes badly. What would you do?

What would you do? #3

It's halfway through a boring afternoon in summer. You're doing this week's data entry of the finances.

The phone rings and you answer. It's Jason, a former resident. He seems glad that you answered the phone and asks how you are. You're secretly glad that he has contacted The_house; it indicates that he is trying to stay clean and avoid relapse. It crosses your mind that he might need extra support.

You tell him you're doing some routine stuff and it's taking lots of time. The_house is pretty quiet this time of the year. Jason settles in to chat and tells you what he's been doing since he left. You talk about friends and what you've doing lately.

But after ten minutes, you realize that you can't tie up this phone to chat during office hours.

What do you do now?

What would you do? #4

You are alone at the desk on duty. Emily, a senior staff worker, comes in looking rather shaken. She needs to sit down, and then struggles to speak.

She explains that she was driving home from a meeting, and has just had a major crash while turning into our street. It wasn't her fault, but the car is very badly damaged. Perhaps the insurance company will write it off; it was a brand new car that we'd bought with a grant.

She was alert enough to write down the other car's registration plate number and car make, but the driver didn't stay around to give any personal details.

What do you do?

What would you do? #5

It's 11.00 a.m. on Tuesday morning and you're looking after the front desk.

A middle-aged woman comes in the front door and says, "Excuse me, I'd like to talk to the director. I need to see him on something urgent." She obviously doesn't know that the director is a woman.

You ask, "Do you have an appointment?"

"No," she replies. "It's important and I need to see him now."

This is difficult. Amanda is quite flexible and could see someone at no notice if it's a real emergency. However, she usually wants an appointment and would like to know what it's about.

You ask, "Could I ask you what it's about?"

"No. I only want to talk about it with the director." She seems adamant and looks like she might become rude and insistent. You suspect that she's here to make a complaint about something.

What do you do now?

What would you do? #6

You're on shift and the phone rings. You answer and a voice claims to be Andy's mother asking about the results of a recent assessment. You remember that Andy is a minor, his mother has legal custody, and she is entitled to the information. However, you remember the rule about not giving out residents' information over the telephone.

What do you say now?

Task: "How do I …?"

Every time you ask how to do something, write the "how to" in a journal. Your journal is complete when you no longer need to ask your shift manager how to do things that are part of your role.

Task: Developing style

After a while, some shift managers develop their own style. Consider the differences between these three competent shift managers:

"I'm based at the desk. I have people coming to me all the time so they need to know where I am. I also do a lot at the desk, such as medications, checking wallets and purses out, and answering the phone. But I know I also need to get out of the office to know what's going on, where everybody is, and what they are doing."

"My job is to circulate among the residents and to make this place fun and enjoyable. My main job is to be with people and make a positive contribution in their lives. I need to be at the desk for some tasks but I keep it to a minimum. I think it's a mistake to hide behind a desk in the office."

"My job is to keep this place organized. I need to be around the place as much as possible, observing what is going on and making sure that people are doing what they are supposed to be doing. I always have a phone with me, and my assistant always knows where I am and what I'm doing."

1. What is similar between these styles? What is different? Which do you prefer? Why?
2. Describe your own style.

Task: Culture and diversity

1. What kinds of other-culture people do you have as clients? (You may include people from subcultures and people of other races.)
2. What have you learned about their cultures that affects the way you should communicate with them?
3. What kinds of misunderstandings have you noticed that might be due to social diversity issues?
4. What do you do to try to prevent or resolve them?
5. Describe the specific cultural protocols and taboos that you need to observe when working with them.
6. Describe their specific language systems. What do you have to do to adjust to them?

Task: Shift checklist

Write a practical checklist of everything that you normally need to do every time on shift. (For example, shift leaders at the house have to do handover, check food preparation, check for stragglers getting to groups, check chores are done correctly, welcome visitors, answer the phone, and answer residents' questions.)

Task: The practicum student

You have a student coming from a local college to do a two-week practicum. Your task is to give him or her some orientation: show them around, explain how the place works, and explain the shift helper's job. Write a list of what you would include in your orientation.

9
Leading activity groups

Leading activities is one of your main tasks. For example, you might be asked to leading group doing chores, going to the beach, or practicing basketball. Some groups will be quite informal and others will be quite structured.

Plan the group

For some very informal groups in a one-time activity, you don't need to do much planning. Start by asking: Who is in the group? What do they need from the activity? What should be the group's purpose? What kind of activity should we offer (unless it's already obvious)? What human, financial and physical resources will you need?

For more formal groups, you might need to do much more. You can form a planning group from residents, which you will lead. You'll need to learn how to ask questions, and give them enough time and space to express their ideas and wishes. When you get people's contributions and suggestions, do it in a way that encourages them to keep joining in, to feel a sense of ownership, and that they are part of the group. The things you need to cover in your planning group:

1. Ask about the group's needs and expectations
2. List them in order of priority.
3. Negotiate the purpose of activities with the planning group.
4. Define what the group should achieve. Express the purpose of proposed activity as a set of aims and objectives.

5. Find out what effect your values (and the residents values) will have on the way the group functions. Clarify it with the planning group and anybody else who will help you lead the group.
6. Plan ways of handling the group so that it works well. Consider also the specific characteristics of residents who will participate in it.
7. Then make a concrete plan stating:
    a. The kind of activity
    b. Who it's for (the target group)
    c. The purpose of the activity
    d. How often you'll meet and for how long
    e. Outline of the series of sessions
    f. Outlines of each session (if necessary)
    g. Resources: personnel, finance, equipment
    h. Space/location.
    i. Possible problems and what you'd do about them (e.g. safety, miscommunication, scheduling)

Your supervisor will need to approve your plan before you can go ahead. If you don't already have all the resources you need, ask the Director for an allocation of funds, people's time, location, etc. If resources aren't available internally, ask the administrator about making submissions to potential sources of help and resources. If you need to make formal submissions, follow the funder's guidelines. Our procedure at The_house is for the staff member to draft the submission and to have it checked and approved by the Administrator.

Run the group

Follow your plan. As you go, give people opportunities to discuss topics openly and encourage them to actively listen to each other.

Develop and maintain positive relationships. Be sensitive to people in the group and encourage others to be sensitive too. Treat them all equally and fairly. It's your job to resolve any conflicts that might arise in the group. Afterwards, give people the opportunity to debrief with you and to get your support.

Evaluation

After you've finished running the group, do an evaluation of how it went. Did you achieve your aims and objectives? What did people think of the group? Ask for their feedback on the leadership style, the group process, how well it achieved its objectives, any other achievements, and other areas that it could improve on.

Write down your evaluation results and give a copy to the Director. You may be asked to discuss it and answer questions in the "program review" section of a staff meeting.

Assignment 1

Because humans are social beings, a group of people left together will naturally set up social structures where some people are leaders and others are followers. This is called group dynamics, and we'll study it in more depth later. As a group leader, you need to monitor the dynamics of your group.

Describe the dynamics of a group:

1. What kinds of people are in this group?
2. How did they naturally divide in subgroups (e.g. groups of friends, similar backgrounds, age, newness to the group, socio-economics)?
3. What are the rules for each group? (These probably won't be written down.)
4. How is the group changing? Why?
5. Who are the most influential people in it? (They might be ringleaders.)
6. Who are the followers?
7. How do the most influential people use their power?
8. How does it affect how you'd run a group?

Assignment 2

Observe a colleague leading a group and make notes:

1. How much did the leader listen and how much did they speak?
2. How long was the longest monologue by the group *leader*? By a group *member*?
3. How did the group leader control group members who tried to take over the discussion?
4. How did he/she draw out quiet people?
5. How good was the leader's eye contact with the group?
6. Did his/her facial expressions body language and gestures reinforce the point made?

Discuss: What did you learn?

Assignment 3

Groups of any kind naturally evolve over time. For example, Allen went to his first meeting of a new recovery group. He didn't know many people so he stuck with one or two people he knew. Later on, he got to make some new acquaintances and formed a new little group that always sat together and talked afterwards.

1. Describe the stages of evolution of a group you are in. List the stages and the different characteristics of each stage.
2. How do the stages of group development affect how you'd run a group?

What would you do? #1

You're supervising a game of basketball when one of the residents calls you to the changerooms.

Brad went berserk a few minutes ago and is shouting and swearing at everybody. He has started throwing things at people and looks like he might try to attack anybody who gets too close. He's big enough and fit enough to be dangerous. But instead, he throws a chair across the room and punches out a couple of windows; he doesn't even notice that he is cut and bleeding. He is now so irrational that you can't even tell why he is angry.

Brad is twenty-one and has been a resident for three months now. He's here on a court order, with a background of criminal violence.

What will you do?

What would you do? #2

You're overseeing a group and Scott asks permission to go buy a Coke.

A few minutes later, you get a phone call from the shop asking whether you know someone answering Scott's description. You confirm that you do, and they ask you to come immediately.

When you get there, the shopkeeper has a raised voice and is threatening to call the police. He says he caught Scott shoplifting. Scott denies it, starts losing his temper, and becomes loud. Other people in the shop are hurrying out.

While Scott sometimes behaves badly, you wonder if he is right this time. You've never known him to steal before. But his response to the shopkeeper's accusations is certainly not helpful.

What do you do?

10
Starting in casework

The basic idea of case management is very simple. It is a way of systematically ensuring that each client's needs are met over a period of time.

A case manager's job is to track the needs of individual residents and do what needs to be done to help each one. They make sure everything happens, and the buck stops with them. (That's why an organization should appoint only one case manager for each client.) The final effect should be that the resident gets a total care program that is seamless across both their range of needs and the services that meet them. By overseeing the whole case, a case manager can prevent people getting lost in the system, falling between cracks, getting conflicting advice, or being ping-ponged between various officials.

Many industries use case managers, in fact, almost any industry that needs to help clients over a period of time. Case managers work in hospitals, legal firms and AR facilities. They also work as social workers, rehabilitation officers for the disabled and for industry accident victims, commercial dispute mediators, community care supervisors of the elderly, mental health workers, employment officers, and schools with special needs students.

As The_house grew, we decided to differentiate between *case managers* and *case workers*. Case workers do more of the frontline face-to-face work with residents, but generally have less training. They work under the supervision of their case managers, and get coaching through any difficult

decisions, especially dealing with any other organizations outside our normal referral channels. Here are some brief job descriptions:

Case manager

- Oversee case workers
- Oversee complex assessments of residents
- Lead case conferences (more about that later)
- Plan care and write case plans
- Coordinate the range of services that each client needs, and arranges improvements where necessary
- Keep track of progress and assess it regularly
- Check that case records are complete and up to date
- Oversee closure of cases, and
- Evaluate services.

Caseworker

- Liaise with/ report to the case manager
- Follow residents' case plans
- Meet regularly with residents to ensure their needs are being met
- Regularly monitor residents' progress
- Keep routine case records
- Give feedback to case manager.
- Relate to other services as required (advocacy)
- Liaise routinely with resident's families and other relevant parties
- Contributes to the case plan and case reviews

How we've changed as we grew

When The_house was small, we had a system that was effective and adequate at the time. We didn't differentiate between case managers and caseworkers; we were all case managers, but junior staff often sometimes needed help. We'd set and review case plans in staff meetings, which automatically communicated the plan to all shift managers and shift workers. They needed to know because they oversaw implementation.

Now that we're bigger, it's impractical to do it all in a staff meeting.

Case managers attend the case meeting, and later on learn to lead them. Case workers are also invited to attend discussions on their residents. In case meetings, we discuss and compare our observations, gather input from other staff, make decisions, and formalize them by putting key points into the case plan. This process helps us to be fair, objective and

consistent in the way we evaluate behavior and make decisions based on all available evidence.

The case meeting tells shift staff what's in the case plan. Each staff member learns to informally observe and monitor the behavior of residents in their care, and gives feedback to the case worker or case manager.

We occasionally need to ask for specialist advice and make referrals. In many cases, we have the right services within The_house so we don't usually have to refer residents outside.

Starting out

The term *caseworker* sounds a little intimidating, so we use the term *team leader* at The_house. Similarly, the resident in this relationship is called a *team member*. However, we train team leaders to introduce themselves as case workers or case managers when dealing with other agencies, because other service providers understand the terms and their implications.

Further below is a simple job description for a first-time caseworker at The_house. It is successful for several reasons. It highlights the personal relationship with the resident, and matches caseworkers with residents whose personalities are most compatible. By separating the roles of case manager and caseworker, it omits the most complex tasks from the job description and ensures that caseworker has the support of a more senior person.

These all mean that someone with the right attitudes and motives can learn fairly quickly how to be an effective caseworker and, although it looks quite simple, it is very good practice.

At The_house, we appoint an interim caseworker to look after new residents during the initial settling in period. Later on, we choose a caseworker whose personality is most compatible with the resident. Especially as a beginning caseworker, it's more effective to be matched to a resident with whom you can be good friends.

Later on, you'll learn the role of case manager: more advanced counseling, how to use a wider range of helping approaches, how to lead case conferences, and how to work with minimal supervision.

Job description: Team leader

Meet individually with each team member at least once a week:

1. Be an encouraging friend and keep the meeting informal.
2. Discuss any topics your team member wants to talk about (e.g. friendships, housemates, fitting in, family, recovery session topics, homework, and upcoming big decisions).
3. Encourage them to develop positive attitudes and behavior:

a. Motivate them toward rewards and incentives for positive growth.
b. Discourage anything destructive or that would bring penalties or disincentives.
c. Teach any other self-management skills.
d. Resolve conflicts and avert/manage any looming crises (e.g. personal or relational crises).

4. Set goals:
   a. Help your team member set a personal schedule and budget and keep to them.
   b. Help your team member set or review new weekly, monthly and three-monthly goals that are positive and achievable.
   c. Focus on short-term goals if the resident is not coping emotionally.
   d. Monitor your team member's achievement of goals and change them as needed.
5. Fill in a case meeting form and file it.

Other

1. Be an encouraging friend to your team member outside meetings too.
2. Identify any problems they have with other organizations (welfare, courts, bank, medical insurance, etc.), and refer the matter to the assigned staff member. Make sure problems don't fall between the cracks.
3. Make sure your team member gets any other kind of help he/she needs.
4. Sit in on your team member's doctor's appointments if required.
5. Liaise with parents and family, and hold parent meetings:
   a. Develop rapport, and help them maintain a positive outlook about the resident's recovery.
   b. Keep them up to date with the resident's progress.
   c. Refer them for counseling, police assistance, etc. if they need it and are willing.
   d. Answer any questions.
6. Although the resident might rely on you, don't let them become emotionally dependent.
7. Join in case meetings and contribute to the case plan.
8. Ask your supervisor for help if you get stuck.
9. If it's not working or helping, tell your supervisor.

Starting out with a new resident

Start by putting the resident at ease and building some rapport and trust. Your role will be easier if you can make a friend early, so do something about any communication barriers you see.

Discuss what you will do and how often you expect to meet. Explain the case management process with the client. You should also discuss the complaint and appeal processes; it will probably be your job to help your resident make them.

Be a good listener

I can't teach essential listening skills by writing words, but at least I can list some of them:

- *Genuine care* is something that you shouldn't try to fake. This is much more about your attitude than about anything happening to the resident.
- *Listening skills* are a large part of empathy. They include not only listening, but also your body language and your comments.
- *Empathy* means that you listen enough to feel what they feel. It's not just information that matters. Besides, you can understand people much better if you listen empathetically than only by processing information.

Avoiding these deadly traps:

- The *rescuer* feels a responsibility to somehow "save" people. The attitude is counter-productive.[23]
- The *busybody* wants to help even when it is not really their role to do so.
- The *advisor* wants to give good advice rather than to listen and support people to make their own decisions.

People-helping is really about being a friend. Give your resident enough time to tell their stories. Listen carefully and don't rush in with advice; they need to feel that their stories are heard and that you understand. Most people find it easy to talk about themselves. Offloading their story to someone who listens carefully gives a sense of release, known as catharsis. Listening is all you need to do for some people; they don't want you to give solutions.

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23 A resident's chances of recovery are much lower if they have come from a recuer-run environment, such as a co-dependent counselor. (Rebecca Crook).

At first, they will normally avoid anything that casts them in a bad light and test whether you are a trustworthy listener. They won't go further until they know that they can trust you.

In other cases, you might take them further. You can ask probing questions, as long as you are gentle and keep listening. Help them to explore and unpack the issues they raise and identify individual issues. You need to get a read on what is happening in the interaction without being judgmental.

As you go, check that you're not getting out of your depth. If you start to feel out of your depth, discuss the situation with your supervising case manager. Don't try to be a professional counselor.

A couple of cases deserve special attention. First, in cases of sudden grief, the resident might be unable to speak at all, and nothing you could say will help. But they still need you there. Later, they need you to listen as they go through a range of extreme emotions. Second, teenagers are different from adults. They tend to be less aware of their own emotions, less able to articulate their needs, have more mood swings, and less aware of why they act as they do, and more inclined to expect instant gratification.

Questions

1. Describe a "trustworthy listener."
2. Consider these two opposing positions below and suggest a suitable solution.
    a. You cannot possibly understand some people without empathy.
    b. Empathy is a trap; you could use it to justify nearly any behavior, no matter how bad. "It's easy to understand how Tony turned out like that, surrounded by what's left of a dysfunctional family since he was a baby, and most of his friends involved in criminal behavior since he was in elementary school."

About calls for help

Be alert for emotional messages. If you notice them, discuss them with your supervising case manager. Consider these ways in which people find it difficult to ask for help.

Unable to speak. Desperate people might feel quite unable to speak, so they wait for you to ask how they are. Even if you ask, they might be too afraid to speak and will sometimes deflect your question.

The vicious cycle. The resident might start asking for help by giving deliberate hints and seeking attention. If you don't notice them, they feel rejected and become more desperate. Their next call for help might be more subtle and harder to notice, but takes more courage because they

have to overcome the increasing fear of rejection. This can trigger a vicious cycle where the more they need help and the more desperate their cry for help, the more oblique their hints might be and the more unlikely they are to get attention. The louder they try to cry for help, the softer their voice becomes. The moral of the story is that you need to be sensitive to deliberate but veiled calls for help.

Questions

1. How can you respond most helpfully to residents who are unable to speak?
2. How do you respond to calls for help without pandering to attention-seeking behavior?

About goal-setting and planning

Help residents to feel ownership in writing their goals. It needs to reflect their understanding of their current situation and to address what they feel are their needs. Have another look at the The_house's job description for team leaders above.

As you go, you can empower your residents to help themselves. Build on their strengths and abilities. Involve them as much as possible in making decisions and setting goals. Find out their preferred way to address their goals and needs; talk them through the range of options available. Consider their views and perspectives in interpreting problems and resolving them. Give them the power to address and resolve problems, and to have a sense of ownership of what they do.

Put the plan in the resident's own words. They need to feel that it is their plan, and will soon abandon it if they feel that you have imposed it on them. Finally, help them to take responsibility and leadership so that you can eventually hand over responsibility.

Their goals in the plan will normally involve other services, including in-house services. If a specific service is not available, find an alternative. Clearly list all tasks and who is responsible for doing them. As you write, explain their role, their rights and responsibilities, and what all service providers will do. Make sure they are all written clearly into the plan.

You can be proactive, as long as it is still the resident's plan, not yours. First, you might be able to suggest a course of action to address issues, as long as you ask for their agreement and protect their dignity and do not suggest that you have the whole answer. Second, you can also express your own view and explore how it affects the communication. Third, help your resident to weigh up the good and bad motivations for an action.

Fourth, help them check that they have set realistic goals for little steps of progress. Fifth, encourage them to achieve their goals. It's a lot about being positive and motivating. Sixth, residents can easily stagnate at a particular stage of recovery, so check that their goals will actually result in progress. Take notice of any stagnation and set goals that push the resident on to the next stage.

About monitoring

Monitor whether they reach their goals, and give them the best opportunity you can to achieve them. Even when residents don't make their goals, it's progress that matters.

Some residents have erratic moods, and might easily change their minds about their goals and their plans. Your role is to bring them back to focus on their recovery goals.

Monitor the implementation of everything else in the plan, such as their use of other services. Keep the resident informed of anything new and give encouraging feedback when you can. At The_house, we usually discuss how each kind of service is going with both the resident and the service provider. If both sides are satisfied, it is probably okay, and we don't check as often. If either or both sides are dissatisfied, then we find out what has happened and make a decision, even if it is only to monitor more often.

Plans aren't perfect. If a change is necessary, put it in writing and inform everybody who needs to know.

Preparation for referrals

As a case worker, you'll need an up-to-date list of all the community services to which your organization normally refers people with instructions on how refer to each one.

At The_house, we keep a list of other service providers to which we normally refer residents and general enquirers for specific kinds of help. We also do our best to keep it up to date. It's at the shift manager's desk where any staff member can easily see it, even in an emergency. However, we make sure that *only* staff can see it; places like women's refuges keep their addresses confidential to prevent visits from potentially violent relatives of clients. Besides, most staff also keep their own lists of contacts.

The main list has contact details and any particular rules for accessing each service:

1. What services does each one provide? What can't they do? Are the services open to anybody in the general public, or only to certain groups of people? (e.g. ethnic communities, unemployed, etc.)

2. Do you need to ask for anyone in particular? Are appointments necessary? If so, how far in advance?
3. What hours are they open?
4. What is the referral procedure? For many services, a phone call referral is enough, especially if you have a continuing relationship. Some will need a letter of referral, perhaps from a medical practitioner or government agency. Can the resident self refer? If so, how?
5. You can also record how are their services paid for.

Our full list includes ambulance, police, General Practitioner, mental health, pediatrician, domestic violence, emergency accommodation, emergency accommodation, employment and job adviser, disability, financial counselor, child care, child protection, family and relationship and counseling. For example, here are several entries in our list:

Name	URBAN Women's Refuge	Dr Bones	Crisis Counseling Inc.
Service	Domestic violence	Medical doctor (GP)	Mental health
Phone no.	91234567	9555 1234	98980765
Hours	Anytime	Office hours	Anytime
Who to talk to	Sally Goodwin	Receptionist (make appointment)	Whoever answers
Referral procedure	Phone call	Phone call	Phone call
Address	789 Jane St. Littletown	123 John St. Littletown	21 Lame St, Littletown

Giving referrals

Referrals can be internal, that is, to or from someone else inside your organization. In a small community, internal referrals are usually very simple ("Go and talk to Beth"). Even in a large organization, internal referrals are seldom more than a phone call and a form.

Giving external referrals is a little more complicated. First, find the particular service that the resident needs. Second, check with your supervisor; you probably need some kind of approval, especially if it is to a ser-

vice to which your organization has never yet given a referral. Third, if it is approved, tell the resident about it. Consider what kinds of fears they might they have, and look for a way to avert or minimize them. Discuss fees. Make sure they feel they have some choice in the referral and get their consent. Although they need to make the final decision themselves, in practice they usually need your advice and recommendation. Tell them their rights and responsibilities and help them feel in control. Check that they understand and give them an opportunity to ask questions.

For many referrals to other organizations, you will need to issue a referral document or fill out a form.

You cannot presume that they will connect up well without you, so help them to avoid falling between the cracks. Some residents manufacture excuses to avoid attending an outside appointment. You will need to work at both ends of the relationship to make it work. For example, if there's an appointment, you may need you to go with them for the first time, or at least set it up and then check that it went well. As for the persons or agencies to whom you refer, liaise with them and report any assessment results that they need for their role.

Some residents are afraid to speak up. Encourage them to advocate for themselves to get what they need from those services, for example, speak up, navigate the system.

You should consider whether they need an advocate. Ideally, you'd encourage residents to advocate for themselves; for example, to speak up and fill in any forms. But they will probably need help. For example, most residents need someone to accompany them and to navigate the system. They might even need specialized advocacy services to get the specific kinds of services. (For more, see Chapter 10 on advocacy.)

If necessary, work out contracts with external service providers and get agreement on them. You'll probably start with a phone call, and you should make a written note of whom you spoke to and what they said. If it gets any more complicated, you need to see their written information and see what you can negotiate. Cost and scheduling can be awkward, so be careful to get them right.

Amanda said: "Internal referrals are very easy. The only difficult thing is referring residents to other agencies. Getting appointments is sometimes tricky, especially if the other organization wants to cancel or change times. Besides, a staff member has to go with the resident to the appointment, so we're usually down at least a quarter day of staff time for every outside resident appointment. Usually a half day. And paying for it can be messy too."

Assignment 2

Describe these principles and their application to case management: 1. Beneficence 2. Non-malfeasance 3. Social justice 4. Autonomy.

What would you do? #1

It's an ordinary day and Carole comes in to see you for the second time this week. She was a resident her for over a year and you were her team leader. She has since moved on but she obviously feels a bond to the people she knows.

Carole is in trouble again. She tells you all about how she broke up with her boyfriend and about an argument last week with her brother. Then she talks about her job and wonders how long she'll stay at it. (She's feeling miserable and dumping her emotions on you.)

You want to support her and don't want to cut her off, and she is obviously treating you like her confidante. But she might go on for hours. And she's not giving you opportunity to say anything.

What would you do now?

What would you do? #2

It's 10.00 on Wednesday morning and you're looking after the front desk.

The phone rings and you answer. A young voice tells you that her name is Ashleigh and she needs help. She's broke and can't pay her credit card debt. If she doesn't get her act together, she might be evicted from her rented apartment. She asks for some financial counseling.

She sounds like she's really in trouble and needs help. But The_-house doesn't actually give financial counseling.

What would you do now?

What would you do? #3

Sharyn is twenty-three years old and has been your team member for over a year. In the last few days, you have noticed a dramatic change of mood and are now become very concerned for her. Usually a bright happy person, she has become morose, short-tempered, and withdrawn. She has not been mixing with other residents.

What would you do now?

What would you do? #5

As a case worker, you are starting to feel that you are umpiring a game where everybody thinks *his or her* role is the most important. For example, a resident might have a medical practitioner, a lawyer, a parole officer, a bank manager (to handle debts), a family court case deciding on cus-

tody of children, a psychologist, a counselor, and family members. Some charge high fees for missed appointments, and voluntary workers might quit if they feel unappreciated. A court might give a default decision against them. The family might pull the resident out if they feel undervalued and the resident is a minor.

How can you handle these competing interests?

Weekly progress report **The_house**
(Team leader and resident)

Instructions
Follow guidelines regarding language.

Follow up goals or issues discussed.
File form in resident's case file when finished

Resident's name	
Date of meeting	
Team leader	
How is the resident progressing with homework for group sessions?	
How is the resident's relationship with housemates?	
How is the resident progressing with counseling?	
How is the resident going with work/volunteer work?	
How is the resident's personal budget and schedule?	
How is the resident progressing with weekly, monthly and quarterly goals?	
10. Are any other issues causing concern?	
11. Recommendations: (e.g. treatments, assigned tasks, etc.)	
12. Matters referred to staff meeting, other staff, etc.	
13. Notes:	

Next review	
Signed (team leader)	

Case Meeting Record The_house

Instructions
Use this form for routine reviews.
Inform all persons of assigned tasks.
Follow guidelines regarding language
File form in resident's case file when finished.

Resident's name	
Date of meeting	
Team leader	

Names and roles of persons present:

General description of case at present

Indications of issues causing concern

Specific risk factors

Indications of progress or change

Further action (e.g. goals for next meeting, recommendations, treatments, referrals, etc.)

Date of next meeting

	Name	Signed
Case manager/ Case worker		

11

Being an advocate

Advocacy is representing people who can't act on their own behalf. People need advocates for various reasons:

1. They find the rules too complicated.
2. They have had a bad experience of a particular official or organization.
3. A disability makes them physically or mentally unable to speak for themselves.
4. They are unaware of their rights.
5. They feel powerless.
6. They don't speak English well enough.
7. They come from another culture.
8. They don't have citizenship.

Example#1: Brett, in a halfway house

Brett is in a halfway house after coming out of prison. He is unemployed and has no skills that could lead to a job of any kind. He doesn't believe that government agencies would help him and is highly reluctant to get advice from the welfare office.

Mark, his case officer, offers to make an appointment and go with him to the interview. Brett needs to sign a letter authorizing it. During the interview, the welfare officer asks many questions that Brett can't answer and asks for many documents that Brett probably doesn't have. But Mark helps Brett to answer questions and gather documents, and gives advice about what documents he can sign.

Example #3: Yanina, a single mother

Yanina, a single mother with a drug addiction, has two small children. After she was convicted of drug dealing, the Department of Child Protection obtained a court order putting her children in the care of her mother. Yanina has since become estranged from her mother, who has moved to an unknown address.

Yanina has been a resident at The_house for a year and has made such good progress in recovery that, Naomi, her case officer, believes she now needs to be reconciled with her mother and her children.

Naomi plans to approach the Department of Child Protection and Yanina's mother so that Yanina can see her children and to start the reconciliation process.

Example #3: Matt, facing court

Matt faced a court hearing next week. He had a lawyer from legal aid, but still wasn't sure whether it would work out. The press got hold of the story and the arrest, and made a big deal out of it. Mom was too upset to speak about it and Dad was angry most of the time.

A friend had referred Matt to Jim's organization and said that they could help him. Matt was nervous and put off phoning. But next day the problem looked even worse. He was still really stuck and now he'd lost a day.

Now Matt just had to make the call, and he was glad he did. Jim sounded really friendly. He seemed to understand the problem and it didn't seem to worry him at all. But he said it would be easier if Matt came around and met him personally.

Good meeting. After some more introductions, they found a table that didn't have papers all over it. Jim said he could make sure they covered everything if they went through a form. So they chatted about the questions and Jim made a few notes here and there.

Then Jim said: "This is what I suggest. Sometime in the next few days, I'll phone your lawyer and make sure he knows my role. You'll have to meet with your lawyer again before the hearing, and I can be there if you like."

"On the day, I'll pick you up in the morning, take you to court, and sit in the public area of the courtroom. In this kind of case, I'll be able to see you after the hearing. I'll get you through the media pack so you don't have to worry about being on tonight's TV news. Just do what I tell you and you'll be okay. Perhaps then would be a good time to go for a coffee, see how you think it went, and see what plans we need to make for any follow up. Then I can drop you off back here. Or, if you like, I could take you home and speak to your Mom and Dad.

"I can't promise it'll be the best day of your life, but it'll probably a lot easier. How's that sound?

Advocacy and social justice

Advocacy is based on social justice principles. This is the idea that everybody in a society should be treated fairly and should have the same basic rights. That is, if some people are given rights under certain conditions (e.g. to a pension) then other people should have the same rights under the same conditions. The idea is easy to abuse, because people often label something they want as a right.

At The_house, we often deal with:

1. Medical practitioners and dentists
2. The legal and justice systems (courts, lawyers, prisons, parole officers), for those on bail, charges, or parole
3. Fines payment offices, for those with outstanding fines
4. The welfare office, for welfare payments, and occasionally repayment of debt
5. Banks, for residents who have debts, such as credit cards
6. Family court, for divorce proceedings or children with unresolved custody
7. Department of Child Protection, for wards of the state and for children with unresolved custody
8. Tax office, for those with taxation debts or who need to submit annual tax reports
9. Hospitals, especially mental health hospitals
10. Department of motor vehicles, for those who need to get driver's licenses.

We recommend that you specialize in only one or two of these and learn their procedures thoroughly. It is usually impractical to try to learn them all, especially as some agencies frequently change their procedures. In time, you will probably get to know people in other organizations whom you deal with regularly, and learn how their systems work.

You might also need to advocate for residents to your supervisors, other staff, or the resident's family. This is usually a personal discussion.

In most outside cases, the task is quite simple; you help them to figure out what is required, fill out forms correctly, get supporting documents, and lodge them on time.

If it's an outside appointment, start by encouraging residents to make the effort, because they might manufacture various excuses not to go. Check that they are correctly dressed, have all relevant documents, have the right attitude, and that the appointment is confirmed. Make sure that they have a clear idea of the purpose of the meeting, which usually involves making a list of questions, issues, or expected outcomes for the

meeting. Then get them to the appointment on time, and debrief them afterwards.

Over time, you'll also learn to prepare residents for the more challenging meetings (including meetings by telephone), perhaps telling them what *not* to say. You can sit in on meetings and ask pertinent questions when the resident overlooks significant points or is too afraid to ask. As residents sometimes forget or misunderstand important points, you can take notes, either during the meeting or immediately afterwards, and provide another interpretation of what was said.

Resolving disputes

Besides being an advocate, you might take the role of a conciliator or mediator. For privacy reasons, outside agencies will often ask the resident to agree to your presence and your access to the resident's personal information. Some will expect a written authorization. Here's a list of different kinds of dispute resolution:

1. *Individual advocacy*: acting on behalf of the interests of individuals who are unable to speak for themselves.
2. *Negotiation*: A meeting where the disputing parties discuss ways of reaching a compromise.
3. *Conciliation*: The conciliator is a neutral third party who meets separately with both parties to resolve a dispute.
4. *Mediation*: A mediator is a neutral third party who meets with both parties together to resolve a dispute.

A procedural approach

The steps below are the basis for The_house's procedures. Some of it is useful as is, while you might need to adapt other parts for specific needs, such as courts, child protection, banks, etc.

1. Identify residents' rights and needs

What does the resident need? What are their rights? These will vary but generally include their legal entitlements, freedom of choice, access to services, personal safety and security, and access to legal solutions. Check that your information is still correct, complete and relevant.

2. Inform the resident

Inform your resident of their rights and responsibilities, and check whether their rights are being infringed and whether their needs are being met. Make sure you do so in time for the information to be useful.

3. Can the resident speak up for him/herself?

Assess whether or not they can. You can get input from other staff and the resident's significant others to find out. If the resident can speak up for themselves, tell them about the available options and help them to choose one. Then help them to contact the relevant organization and negotiate to get the services they need.

The list of relevant organizations and contact details is kept on the board near the Shift Leader's desk.

4. Make a strategy

You should advocate on behalf of residents if they ask you to or if you assess that they need your help.

Take the initiative. Start by negotiating a strategy with them. Unless it's very simple, you should write it down as a list of things to do with deadlines for each one, and keep a copy. For example, you might ask the following questions:

1. What are we trying to achieve?
2. Precisely what will we have to do?
3. Who are the best people or organizations to get help from?
4. Do we have different options? If so, what are they? Which is best?
5. What are the rules?
6. Will we need any particular documents? If so, which ones? Do you have them?
7. How much will it cost? Do you have the money?
8. What compromises might we have to make? What compromises can't we make?
9. What kinds of things might go wrong?
10. How long could it take? When do we have to have it done by? Are there deadlines?

5. Implement the strategy

Contact the people or organizations and present the resident's point of view, then negotiate to get the best possible result. Follow through to get the kind of help your resident needs. As you go:

1. Keep in consultation with the resident. Discuss your progress and results with them and support their reasonable expectations.
2. Maintain documentation and file it in the resident's personal file, e.g. invoices, receipts, copies of all forms and letters, records of significant telephone conversations, and records of significant discussions in meetings.
3. Consult with your supervisor if necessary.
4. Mediate or conciliate when needed.

5. Deal with any intercultural issues.
6. Identify any potential conflicts of interest and resolve them.
7. Keep information confidential unless you are authorized to release it.

Individual advocacy and system advocacy

So far, we've looked at *individual advocacy* and representing specific individuals or small groups who are unable to act on their own behalf.

Systems advocacy is quite different; it is lobbying for policy change. You'll probably be familiar with leading figures who have advocated for people's rights: Martin Luther King, Mahatma Ghandi, Rosa Parks, and Nelson Mandela. *Systems advocacy* refers to advocacy for the rights and needs of a group of people in the context of the broader rights and needs of the general community. It often seeks a change in legislation or government policy, and often involves participating in decision-making forums to advance specific views and influence public decisions.

Assignment

1. Make a list of organizations with which you do advocacy. For each one:
   a. What is the procedure for referring a resident to it?
   b. What can it do for residents?
   c. What legal rights do clients have to its services? (This usually applies only to government agencies.)
   d. What are the limitations on what it can do?
2. Explain how social justice principles apply to your role.
3. What is the difference between negotiation, advocacy, mediation and conciliation?

What would you do? #1

You are the advocate for all matters relating to the Department of Child Protection. You are having a day off when you get a phone call from Rob, a junior staff worker. He tells you that he just opened the mail and there's a formal complaint from Department of Child Protection alleging that The_house has been negligent in its duty of care.

You think it's most likely a disgruntled former resident who is using a complaint as a way to get revenge for being evicted. On the other hand, it could be a justifiable allegation about an incident that you don't know anything about. What do you tell Rob?

What would you do? #2

Gavin, a new worker from the Department of Child Protection, has been doing routine interviews with the wards of the state for most of the morning. He is quite young and appears to be quite inexperienced.

Gavin shows up in your office looking quite frustrated and exasperated. He appears to panic and says he wants to withdraw all DCP residents from your care. You ask why and he doesn't really want to talk about it.

What would you do?

12

Networking

At The_house, our staff have networks of workers in other AR organizations. Through their contacts, they gather all sorts of information, forge links and promote activities.

Some networks are very established and are very easy to join. Many organizations have like-minded people, such as counseling organizations, Christian AR organizations, charities, and helping professions. If they hold conferences, it is easy to establish a personal network and gain support from within the sector.

Kinds of networks

A network is a group of people from whom you can learn and share experiences. Networks come in many different kinds, and many industries have competing associations. Each might have its own characteristics, and you should find out why they arose separately.

Professional and industry associations usually have standards for membership, and often have different kinds of memberships for individuals working in the profession (often in different categories), organizations in the profession, and students. Some have only one kind of member, some have two, and a few have all three. Many associations charge membership fees, but some have special rates for students. Some services are available to the general public, often at a higher price than to members.

Their services vary greatly. Some offer only meetings for discussions and an email newsletter, while others offer information, Professional Development, government liaison, and sometimes professional certification. Most services are designed to raise funds, enhance the image of the profession, or enhance the value of membership.

Most associations are run by their members. A few, however, are simply private businesses that generate a profit for their owners; "members" are actually only consumers and have little or no say in governance.

Government consultation groups give advice on policy that specifically affects that industry. You might also join in giving industry advice to government.

Online forums, such as those on LinkedIn, have new discussion topics coming up all the time.

Groups of friends are quite informal. Most professionals have good networking skills and build their own personal networks over time: friends from college, former colleagues, and friends of friends. In fact, they often do it without even thinking of it as a network. They usually find this kind of network most useful because they know key people personally and can solve difficult problems quickly and easily just by phoning a friend.

What do you need to get of a network?

You should consider what you need to get of a network. At first, you might not know what you need or what is on offer. Consider these kinds of benefits:

1. *Keep up with changes in government policy*. This is especially important when policy changes frequently, your organization has lots of interactions with government, or community services are heavily regulated in your jurisdiction. You get forewarned of new policies, and might also have opportunity to contribute to new policies.
2. *Best practice*. Ideas on best practice change from time to time, and you and your organization need to know the current view. It is not always as easy as it looks. In some cases, current best practice is just a new fad in political correctness, but it still might have something useful. Best practice is essential if your organization could be sued for failing to follow current best practice.
3. *Keep up with changes in industry*. When an agency works alone without a network, its workers can easily tend to think that, "We're the only ones facing these problems." Workers find it quite refreshing to find that other agencies face the same challenges.
4. *Changes in substance abuse*. In AR, the most likely changes are those relating to trends in usage of addictive substances. For example, you will want to know which drugs are increasing or decreasing in usage and the demographics. In particular, one interesting trend in alcohol consumption has been the rise of teenage binge drinking. You might learn of interesting patterns of co-occurrence, such as addiction, crime, poverty or wealth, prostitution, imprisonment, and family breakdown.

5. *Solutions to problems*. If you face a problem, you'd probably like to be able to phone someone you trust for an answer.
6. Ideas for improvements. Most professionals are looking for ideas on how to work more effectively and efficiently, especially when their budgets are tight.
7. *Opportunities*. Networks offer information about sources of funding and other resourcing, opportunities to start new kinds of services, and professional development. Staff recruitment is interesting; most new jobs come up through the network and are not advertised.
8. *Referrals*. You can get and give referrals. When workers have a client that they can't help, they can refer the person to another agency that is a better fit for the client. If someone needs a computing specialist (or some other kind of outsourcing), it's easy to ask someone in the network for a referral.

Finding and choosing a network

Start by clarifying what you want to get out of a network. In other words, what will help you and your organization give better services to your clients? Give higher priority to your clients' most important needs.

Find the networks available to you that are relevant to your particular job, your organization's priorities, and your target groups. Start by asking colleagues and friends. You will easily find some on LinkedIn, and an Internet search might be helpful. In some cases, you might not directly find the network, but will find contacts who can direct you. Choose networks that suit your role and find out what you can do to join.

Don't just look for people who are like you or think the way you do. Learn to appreciate people of different ages, cultures and views; it's often the differences that stretch you to think more widely and view the profession differently. You don't have to change your beliefs, but you can understand them better and your reasons for them.

In some meetings, you might be authorized to represent your organization and in others you won't; you'll attend as a private person. Many meetings are not held in normal office hours, but those that depend on professional staff normally are, and you would need to either be paid to attend or get time off work.

How to participate effectively

If you are a student or still very new to AR, start by taking the place of a learner and only observe and listen at first. If you have questions, ask someone privately afterwards. Observe the culture of the group. Who runs it? What do other people expect to get out of it? How is it evolving? What topics keep coming up?

When you have a better understanding of the group, you can start contributing. You can give comments when you have something to say, but welcome the comments of others and be polite, constructive, and positive. Abrasive people tend to become marginalized.

When people are quite different from you, try to understand their reasons. They might have good ideas and come from a very different set of background experiences from you. Use what you know about their values, beliefs and perspectives to communicate more effectively.

Online forums are easy. Read as much as you can, and ask questions when things are unclear. Be polite and positive; discussion moderators often shut people out if they become negative.

Face-to-face meetings require more caution. You will need to be able to ask questions, listen carefully, and get people to clarify things that are unclear to you. You can explore issues and ask for solutions to problems, but try to differentiate between facts and opinions.

You will need to decide how open you can be about your organization and your work. I prefer to be more open, but some guidelines apply:

1. Maintain the confidentiality of your clients' personal information.
2. It is often inappropriate to discuss your organization's internal politics, and always inappropriate if it will embarrass a colleague.
3. Do not divulge any organizational information that would put your organization at legal risk. You might not be allowed to divulge some other kinds of internal organizational knowledge.
4. In a relationship with another organization, you might be both a collaborator and a competitor. Be careful not to disadvantage your own organization.

As you go, monitor the benefits of the network to you, your organization, and your clients. For example, some meetings are mostly a waste of time, but have one news item that is so valuable that it justifies being there the whole time.

Hints and tips

1. Help other people. Don't just take from the group. It will build your relationships and give you more opportunities to learn.
2. Thank other people when they help you.
3. Get on email lists.
4. Follow through quickly on referrals.
5. Attend Professional Development sessions.
6. When you make new friends, visit them and learn about what they do.
7. Keep a directory of your contacts.
8. Some network discussions need to be kept confidential.

9. Keep notes of anything helpful. Later on, you should report outcomes to your own organization.

How to form a new network

Start with a small group of people you know, such as friends from your current workplace, college friends, and others you know in other AR organizations. Give them a convincing reason for forming a new network. Most people will ask, "Will I get more out than the time and effort I put in?" You can usually offer more by pool your knowledge.

Start informally. When you meet, get people to introduce themselves and help people to work well together, especially when they have very different personalities, organizational cultures, or philosophies of AR. Create a positive, purposeful atmosphere. Most people will probably have mixed emotions of hope and apprehension. They might be reluctant to say what they hope for from the group, but will expect you to offer something that addresses their expectations.

You can start inviting new people to join the network when the members are comfortable with each other, the purpose is clear, and you have some clarity about how it will work. Then go meet people. It's easy if you attend industry events, conferences, and product launches. Make friends, keep their business cards, and follow them up afterwards. Get agreement on how you will keep in contact.

Questions: About networks

1. Explain each of these different kinds of networks and collaboration:
   a. Organizational
   b. Individual
   c. Virtual
2. What is different between formal and informal networks?
3. How should you respond to differences in values between organizations?
4. How does the structure of the AR industry affect relationships between different organizations, both public and private? (E.g. Relationships will be different between a primarily government-owned industry and a network of scattered private organizations.)
5. Describe an established AR network:
   a. key stakeholders,
   b. vision and purpose,
   c. opportunities for participation.
   d. its power structure. (Who runs it: a small group of local people, a distant central office, or everybody in it?)

Questions: Joining a network

1. What networks do you have in the AR industry? Describe them.
2. How can you know what kinds of help and support a network provides?
3. What are the benefits of networking and collaboration:
    a. for clients?
    b. for your organization?
    c. for you as a worker?
4. What can you do to take the initiative and make new contacts?
5. How can you make a network effective in supporting our job?
6. What kinds of risks does an AR worker take when joining a network?
7. How could you do to maintain your networks over the long term?
8. Explain your top five principles for each of the following:
    a. using networks to help you in your job.
    b. communicating in a professional network.
9. What criteria can you use to give some contacts higher priority over others?
10. How do resource constraints affect your ability to network?
11. What are the limitations of your network? That is, what kinds of things can't it do?

Questions: Collaboration

1. What legal and ethical considerations and constraints affect collaborative practice, e.g.:
    a. copyright and intellectual property?
    b. privacy, confidentiality and disclosure?
2. What kinds of collaboration and partnerships can it foster?
3. Explain your top five principles for successful collaboration.

13

Assessment and admission

At The_house, we assess incoming residents through an initial interview following a proforma. We also assess the applicant's family situation, although this varies greatly according to the applicant's relationship with them. Later on, after an extended observation during the settling in period, we do a comprehensive assessment, and then ongoing assessments by observation, in counseling sessions with the team leader, and in case reviews with other staff members.

The assessment is presented below as a step-by-step procedure. Besides being good organizational practice, it simplifies what could be an overly complex task.

If you are a case worker, you might not be approved to fly solo for the whole assessment, especially for very complex cases. Stay within the procedures and ask for help from colleagues and experts if it might be needed.

Setting it up

Start by checking that the applicant is suitable for assessment. In your first contact, get the applicant to introduce themselves and say why they would like to come into The_house. It might be unwise to press the matter too hard if they are evasive, but you should know enough about them to be able to can go ahead with the assessment. If they are referred to you, the person giving the referral will normally give you a reason for going ahead with the assessment. If you find that you should not give an assessment, you can refer the applicant to another agency.

You should normally give some kind of specific encouragement at this early stage. For example, you should allay any fears and might help them to build on their strengths and to function adequately in the meantime.

Organize an appropriate time and place for the assessment with the applicant. Explain that it is normally necessary for them to come in to The_house; we always try to do assessments on site so we can show people around and explain the program. It also it saves staff time and travel. In some cases, you need to visit applicants in their surroundings, and you have no choice if the person in still in prison or in hospital. You might do the assessment in their home if the person is reluctant, or has no transportation.

Decide on suitable assessment tools and procedures. We always follow our set procedures, but we might need something extra if we know in advance of a special situation.

Check other kinds of information or resources that you might need for the assessment. For example, you might need information packs of specialized information or contact details of specialized services to which you might want to refer applicants or their significant others.

You should consider the range of issues that might be affecting the applicant. Ask for any other information you need from specialists and other sources check that you are adequately informed.

Ethnic minorities

Navigating the sensitivities of people from ethnic minorities can be quite difficult because you cannot see yourself as they do. For example, you might be perceived to be a bureaucrat who uses forms and rules to prevent people getting help, even if you treat people the same as you would anybody else. Unfortunately, this perception is quite accurate for some agencies.

In other words, being equitable and non-discriminatory is not necessarily enough; you need to be culturally appropriate if you want to build their trust and confidence to work with mainstream services. In some cases, it is helpful to build relationships with ethnic community organizations and multicultural organizations, and to involve their representatives in the assessment.

Before your assessment interview with the applicant, check whether an interpreter is necessary to communicate with family members. If so, make sure one is available and has been briefed. Interpreters can be interpreters of culture, not just language. Cultural interpretation is especially important when:

- hidden cultural factors prevent people from being understood or speaking freely.
- non-acceptance would cause shame in the family.
- the family believes that admission to The_house is a family decision, not a decision of the applicant. The applicant might be unwilling but

forced to comply with family wishes. Or the applicant might urgently need residential care but the family might be unwilling.

Observation

This interview asks for considerable detail, but the answers to questions are not the only facet. One of the main skills in assessment is to notice any observable signs of issues needing attention. For example, homeless people might not want to admit to homelessness; they might evade giving a home address by giving some other kind of address.

Look for non-verbal cues such as body language. If the talk doesn't match the body language, they might be lying or trying to impress you. Some make light of their problems while others exaggerate them.

Look through the discussion of particular issues listed in the chapters on social and medical aspects of treatment and risk factors. They list not only most of the issues that applicants face, but also their observable signs.

Other issues will probably surface later but that doesn't necessarily mean that your assessment was at fault in any way. It might simply mean that no signs were observable during the assessment. Besides, applicants frequently lie during the application interview, so interviews are not definitive.

Welcome

Welcome the applicant and put them at ease. Make them feel as comfortable as possible, because they will probably be nervous and might be defensive. Show respect and a non-judgmental attitude. Communicate in a way they easily understand, and avoid any jargon or technical language.

They may have brought a significant other, such as a parent, guardian, spouse, carer, or another kind of natural support person. If so, their input might be might be helpful but beware of any tensions between them. Their stories might be inconsistent, and one will probably be more interested than the other in the applicant coming into The_house. Similarly, some are sent to you by order of a court or a government department. In other words, the applicant might be the dragged and someone else is the dragger.

Show them around, explain the program, give them the orientation booklet, and explain the following:

1. The purpose of the assessment is to decide whether they can be admitted.
2. The assessment has several parts:
    a. The interview with the applicant.

   b. The interview with the applicant's significant other (if applicable).
3. The interview follows a procedure, but it still gives people the freedom to talk about anything important that arises in the conversation. It is quite detailed and might feel intrusive, but everything in it is necessary.
4. Confidentiality:
   a. Assessment results are confidential, and are only given to others if they agree.
   b. We aren't subject to mandatory reporting.
   c. Applicants may view their file by appointment at the office.
   d. Explain that records are kept in the office.
5. Your duty of care
6. The interviewer will make a recommendation, but a senior staff member will make the final decision about acceptance. There is no right of appeal.
7. The outcome of the interview will be a recommendation to:
   a. Accept immediately as a resident
   b. Accept immediately for detox
   c. Defer and re-interview
   d. Put on the waiting list
   e. Refer to another organization
   f. Not accepted nor referred.
8. Answer any questions.

The orientation booklet includes this information in writing, but you can't presume that people will read it and understand it straight away. Your duty of disclosure means that you need to talk people through it as well.

Be aware that some applicants are not fully alert at the interview and later can't remember much of what was said or what they signed. They may have been in emotional trauma or suffering the effects of drugs. Some are a little overwhelmed by a new experience in unfamiliar surroundings. A few will mis-remember what happened. For that reason, it is good practice to refresh their minds later on. It is also good practice to have a sign-off record for each element of the interview just in case it is questioned later. You don't want a court case based on, "But you never told me" or "But I thought you said …"

Ask them if they would like to apply and be assessed. If they want to go ahead, confirm that they would like to go straight to the interview.

Families and "significant other" interviews

It is good practice to informally assess the family as well as the applicant. We don't do it formally because we don't provide them with ser-

vices as primary clients. Others might be involved such as carers, existing case managers, medical practitioners, and natural supports.[24]

In some cases, a family member comes in with the applicant, and we offer them some time in an informal discussion. It's helpful to find out how they are coping too, and sometimes it's not very well. It gives us a brief picture of the kind of person they are, their family situation, and how they view the applicants' issues. We put them at ease with what's happening and tell them how we assess applicants.

If they don't want a meeting, we still need permission from a parent or guardian for a minor to be in the program (and any other decisions later on), so we normally meet someone at least briefly.

If the applicant agrees, you can involve the significant other in the assessment by interviewing them separately without the applicant present. At The_house, our policy is that the other person should not be in the same meeting with the applicant. For example, both a girl and her mother have come for the assessment. If you asked the girl in front of her mother, "Is it okay if your mother sits in the assessment?" the girl might feel under duress to agree. Even if she willingly agreed, she would probably change some of her answers. (How many people want do discuss their drug habits or sexual encounters in front of their mothers?)

If you interview the significant other, you need their full name, contact details, and their side of the story. This will give another view of the applicant, but it could also be very biased. If the other person is a spouse and not separated, The_house's policy is that husband and wife should both apply to come into The_house unless they have a compelling reason otherwise.

About families

We try to find out who the family members are and how to contact them, and we usually try to speak to them as soon as possible. To get the applicant's cooperation, we usually explain that we won't disclose their personal information and that they don't have to meet with the family if they don't want to.

It's a bigger step to find out what is going on in the family because applicants' families vary. Some families care very much and want to be told what is going on, and some have gone through considerable tension

24 In some kinds of community services, such as care of the aged and disabled, assessments should include other stakeholders, such as carers and family members. Their input is helpful, and can be essential. They can have rights in the assessment and in making decisions, and are entitled to an assessment of their own needs.

as a result of the applicant's substance abuse. It's easier to assess caring families and offer liaison. Focus the assessment on the relationship and seek to strengthen the relationship between them; it is better than treating the individual in isolation.

Other families are not so straightforward. A few applicants are under family court orders, and we can deal with only one parent but not the other. A few are so dysfunctional that there's little we can do. We have to avoid contact with estranged partners who can be dangerous.

Consider these other kinds of complicated cases:

- The single mother's new boyfriend didn't like her sixteen-year-old son. The mother had to choose between them, and decided to evict her son.
- The applicant's husband is working away and you cannot get a message to him.
- The applicant has impaired cognitive function and a nearby brother makes all his decisions. However, the mother, who lives in another state, disagrees with the proposed treatment.
- The resident is a fifteen-year-old boy. The parents have separated and the family court has not yet decided on custody. They disagree strongly on the kinds of treatment he should have, and the mother authorized admission to The_house. The father, a violent alcoholic, wants to move interstate and take the son with him.

Applicant interview

Write notes by hand to maintain personal eye contact and conversation. Using a computer is only good interviewing practice when it does not interrupt personal contact, that is, when you are clicking on multiple choice answers.

You can fill in the interview form as you go. Make rough notes of the more complex discussion items and use them later on to fill in the longer sections of the form. This will help you to maintain personal eye contact and conversation. The full report will also be easier to understand, and not a collection of random phrases and short sentences. (File your rough notes as well because they are a contemporaneous record of the interview.)

Some interviewers like to be as relaxed and informal as possible. They talk the applicant through all the topics of necessary information, then treat the form as "doing the paperwork." Others like to be all business and treat the interview as a form to be filled in, and then go into the applicant's personal story where they relax, listen, and explore.

Either way, people usually enjoy talking about themselves as long as you are interested and willing to ask questions.

The interview is more than just filling in the boxes on the form; it is a basis for exploring, and you might need to adapt your communication styles to meet specific needs:

- Listen actively and empathetically.
- Ask how they heard about The_house. This might indicate a helpful connection. Our public relations people also want to know where we get applicants from.
- If there is a referral or other documentation relevant in the assessment, check what it says, for example, who gave the referral and the reasons for giving it.
- If you see the interviewee omitting anything important, you can ask extra questions. You'll often need to ask good follow-up questions to get useful answers. As a result, you will sometimes get necessary information for which there isn't a box to fill in. Write it down somewhere.
- You might need to go through some topics more than once to get enough information. But don't make people feel interrogated; you might want to leave an inadequate answer and come back to it later.
- The applicant might bring up unexpected topics that you want to explore to get more background. The interview might turn into a brief intervention.
- Answer their questions.
- Discuss with the applicant and those with them (e.g. family member or carers) the applicant's goals and needs, their priority, and any risk factors.
- Give encouragement, but try not to appear pushy.
- In your written record, follow the same protocols for other kinds of written case and incident information. Include facts, actions, behaviors, and statements, but don't include your personal feelings or any speculation.
- As you go, assess any risks. If they are serious, handle them in the best interests of the applicant.

Payment can be a sensitive topic. The financial form gives a range of options, and the circumstances of the individual determine the most suitable option. At The_house, the overriding criteria for acceptance are the applicant's need and commitment to recovery, not guarantee of payment. In many other organizations, however, confirmation of payment is required for acceptance.

Give the applicant freedom to identify their own needs and risks and put them in order of priority. (You don't have to agree, but you need to know what the applicant thinks.)

Our current list of questions goes through the following specific risk factors: family, education and training, medical background, tobacco and alcohol, finances, and legal. It then becomes open-ended so that applicants can tell their own stories and give their own reasons for applying.

At the end of the interview, ask the applicant whether they are ready to commit to entering The_house. Make sure it is their own decision and avoid talking them into it; they could blame you if they become unhappy later on for some reason. It is good practice to tell the applicant your understanding of their needs, the kind of services that will help them, and the priorities you should set. Check that the applicant understands, and, if possible, agrees with your view.

Make sure you have the full range of relevant information about the applicant's needs. If you need more information, you should consult a specialist.

Question

What kinds of risks can arise during an assessment?

Interpreting the assessment

One of the main purposes of this stage is to decide what needs and risks are of highest priority (sometimes called establishing a risk hierarchy).

During the assessment, you have identified and clarified the needs of not only the applicant but also those with them (e.g. family member or carers). It is also good practice to list the risks facing the applicant. For example, they might be at risk of losing their job, overdose, being beaten up or raped, or homelessness.

You should also check for any health and safety risks associated with providing services and resources. (These risks are fairly uncommon, but it's good to check.)

When you have decided on the priority needs and risks, you are ready to progress to the next stage.

Making a decision

Discuss your findings with a colleague. When assessing an applicant, the key question is whether the applicant will benefit from the program. Do you provide the kinds of services that they need? Would they be better off in another agency that could better address their areas of strength?

It might sound harsh to reject needy people, but you should not accept applicants if you cannot reasonably expect them to recover. In fact, it is probably unethical to accept them because you cannot provide the ser-

vice as agreed. Their place would be better given to a more deserving applicant.

Look through the applicant's issues, which are normally complex, multiple and interrelated. What are the most urgent needs? Are they eligible for our program? What are the risks to our service delivery if we accept this applicant?

One of the biggest questions is: "Is this applicant willing to commit to recovery?" Although some have hit rock bottom, they don't need to have bottomed out to be good candidates for recovery; they simply need to realize they need help and to commit to recovery. The two best signs are:

- *Asking for help.* For some people, simply recognizing that they have a problem and asking for help is a major step toward recovery. For a person with an addiction issue, the decision to admit they need help and ask for it can be more a significant indicator of recovery success than the kind of help they get.[25]
- *Desire to become a different person*. The most significant sign of a successful attempt to recover is a desire to become a different kind of person and have a different life. They might look at the kind of person they have been and compare it to the kind of person they want to become. This usually happens over an extended period.[26] Later on, making the change of personal identity is one of the most important aspects of recovery.

Accepting new residents always has an element of risk. Even if they make a clear commitment to recovery, most still have some desire to go back to their old life or at least to enjoy again the pleasurable effects of their substance of abuse. In fact, part of recovery is to change their thinking from seeing their substance of abuse as pleasurable to seeing it as destructive.[27]

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25 Brewer, Colin. 2011. Conference paper given at "Recovery-orientated drug treatment: the evidence" at the University of Western Australia. July 8.

26 It could be a growing realization or it could be a sudden realization with significant preceding and post-event contemplation. McKeganey, Neil. 2011. Conference paper given at "Recovery-orientated drug treatment: the evidence" at the University of Western Australia. July 8.

27 McKeganey, Neil. 2011. Conference paper given at "Recovery-orientated drug treatment: the evidence" at the University of Western Australia. July 8.

Write your report

Write the assessment outcomes according to your organization's procedure and store it according to confidentiality requirements.

Inform the applicant

Inform the applicant and support them to make their own decision about what they will do. If necessary, encourage them to advocate on their own behalf to access services elsewhere. Your main options are:

Unsuitable for admission

- Explain your reasons (e.g. not within the range of needs The_house can address,[28] not committed to recovery, just looking for accommodation, not willing to follow the rules).
- Recommend a course of action.
- Create a way of keeping in contact.
- The appointment is ended. Bring it to a congenial close and check that they have suitable transport.

Better referred to another agency

- Recommend them to other agency and give your reasons.
- Ask the applicant's consent to forward their information to the other agency (i.e. according to confidentiality requirements).
- Give the referral
- Create a way of keeping in contact.
- The appointment is ended. Bring it to a congenial close and check that they have suitable transport.

Defer and re-interview

- Explain your reasons.
- Recommend a course of action (e.g. a timeframe).
- Create a way of keeping in contact.
- The appointment is ended. Bring it to a congenial close and check that they have suitable transport.

Suitable for immediate admission (with or without detox)

- Explain your reasons.
- Tell them what you recommend.

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28 The_house is unable to treat mental health issues that are not drug-induced.

- Get them to fill out and sign the application form and the confidentiality clearance.
- Ask them to wait.

Put on waiting list

- Explain your reasons.
- Tell them what you recommend.
- Fill out the application form and get them to sign it.
- Establish a way of keeping in contact.
- The appointment is ended. Bring it to a congenial close and check that they have suitable transport.

If you recommend immediate admission, ask them to wait and submit the application to the Director, or the supervisor on duty for a decision. If approved for immediate admission, get a room and help them move in. Then arrange for a check with the medical practitioner. If the resident is found to be unable to work, they can get a medical certificate and apply for a disability pension.

Then introduce them to their interim case manager and make sure they are comfortable with the process. The interim case manager will usually ask a senior resident to be buddy the new resident.

Evaluate your assessment

Reflect on your performance and ask for feedback about assessment processes from your colleagues and through other networks.

Is the assessment system working? Monitor the processes and outcomes. Ask questions such as:

1. Is the assessment system successful in meeting applicants' needs?
2. Do we get good enough information to make good decisions?
3. Do we accept the right applicants?
4. Are the risks we take in accepting people reasonable?
5. What questions are most helpful?
6. What questions should we add?
7. What questions can we delete?

Staff meetings are usually the best place to discuss ways of improving the system. Use the feedback you get and your own evaluation as a basis for suggesting improved processes.

Validity

Validating your conclusions uses the same basic principles of validating (or "moderating" an academic assessment. It involves conferring to

attain the same understanding of the situation, comparing and evaluating your information, checking that your conclusions are correct, and finding ways to improve the quality and consistency of your decision-making.[29]

Should agencies allow smoking?

Smoking is often an issue for applicants. Some agencies allow smoking because a ban is a major barrier to smokers who apply. Some of their most notable graduates came in as smokers and only gave it up later, and most of their residents quit during their time in recovery. There are rules: residents must lodge cigarettes with the shift manager in the office and may smoke only in the smokers' area. They must leave the program if they quit and then relapse. Quitting is also a condition of graduation.

Other agencies require applicants to become non-smokers when they are admitted. Their reasons are, first, smoking is an addiction to nicotine, and a major purpose of recovery is to become free of addiction. Second, the kind of talk that goes on in the smoker's corner is seldom conducive to recovery. Third, if applicants are really committed to recovery, they have enough commitment to quit smoking. Fourth, smokers use cigarettes as an escape from facing the challenges of recovery. (In fact, some agencies now ban coffee and sugar for the same reasons.)

Evaluate these two positions and defend one or the other. Which reasons are only assumptions and are not based on evidence?

Questions

1. What different types of assessment are there? Explain how each is used and the appropriate contexts for each.
2. In your organization's assessment process:
    a. What are the roles and responsibilities of different people involved in assessment?
    b. What is the impact of the setting on the assessment?
    c. What different kinds of assessment tools does your organization have? When would you most appropriately use each one?
3. Explain three different ways of collecting information to be used in an assessment.
4. In community services assessment, what is validity? What requirements does your organization have for validity?
5. In community services assessment, what is reliability? What requirements does your organization have for reliability?
    a. How do you ensure the validity and reliability requirements?

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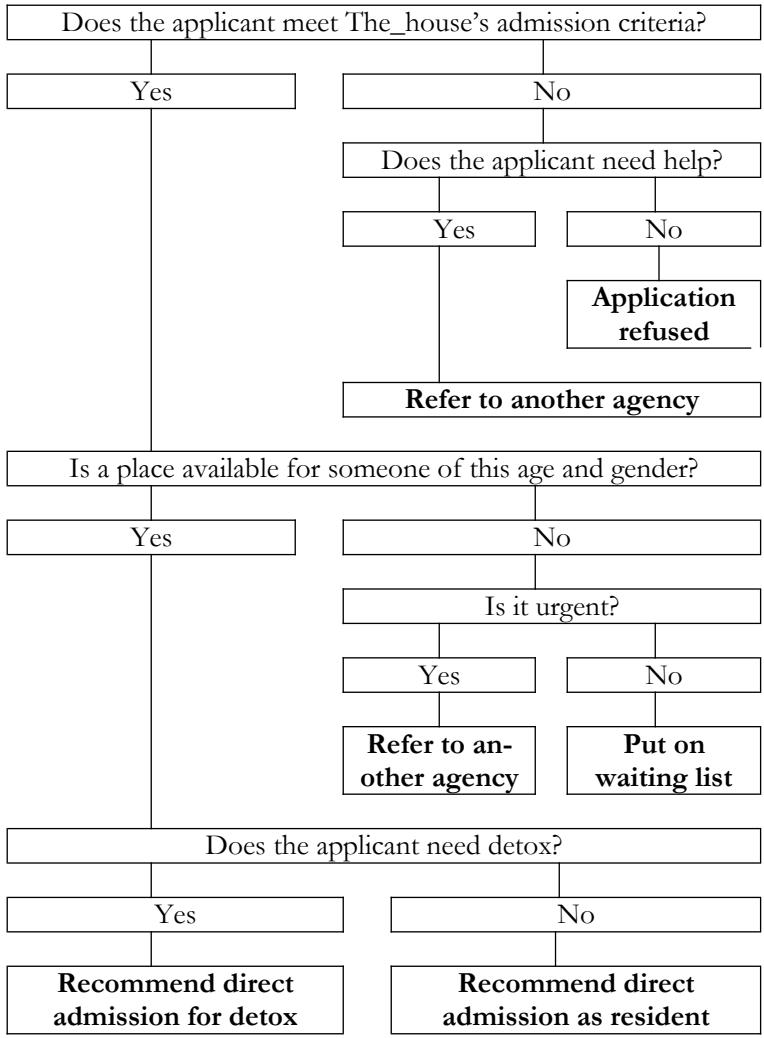
29 While useful, this view does not have the same rigor as validity in experimental design and research evidence.

   b. Explain your organization's reporting requirements and format.
6. Client groups face the effects of various kinds of problems or limitations. Explain each of the following and their effects:
   a. mental health
   b. addiction
   c. imprisonment
   d. child abuse
   e. family violence
   f. homelessness
   g. poverty
   h. health
   i. age
   j. disability
   k. behaviors of concern
   l. employment culture
   m. religion.
7. Of those problems and limitations, explain the potential interrelationships between them.
8. Community services organizations offer various kinds of services. Explain how services for each of the following works and the usual basic features:
   a. employment
   b. physical and mental health
   c. housing
   d. community support
   e. social inclusion
   f. education and training
   g. financial support.
9. What other services do clients of your organization need? Explain their basic features.
10. What networks and specialist services are available to you in -house? Through external providers?
11. Relating to assessments, what the legal and ethical considerations relating to:
   a. privacy, confidentiality and disclosure.
   b. duty of care.
   c. informed consent.
12. What other legal and ethical considerations relate to assessments?



A flowchart of The_house's procedure for making recommendations after an assessment interview
The end-points are bold-faced.

Strictly confidential

Application form

Applicant's name	
Date	

The_house

Note: Make this application form in two identical copies and give one copy to the applicant or the applicant's parent/guardian.

Applicant's full name	
Address	
Date of birth	

1. I hereby apply for admission to The House Inc. ("The_house") to be a resident.
2. I have received a copy of the orientation handbook and understand it to my satisfaction.
3. I have asked any questions I wished and have had them answered to my satisfaction.
4. I agree to abide by the rules of The_house, and understand that they are changed from time to time.
5. If I leave The_house for any reason, leave behind property and do not collect it within thirty days, then I fully relinquish ownership of that property and it shall become absolutely the property of The_house.
6. If this application is accepted, I agree that The_house may liaise with any other relevant agencies for purpose of case management.

Signed,

Applicant		Parent Parent/guardian (if applicant is under 18 years of age)	
Date		Date	

Parent/guardian's full name	
Address	
Telephone no.	
Email	
Any other relevant contact information	

Strictly confidential

Applicant interview form

The_house

Applicant's name	
Date	

Ver 2.0

Procedure

- Fill out this form and file it in "Current applications."
- Do *not* give a copy the applicant or the parent/guardian.
- The form remains the property of The_house, but the applicant or parent/guardian is entitled to view it if they wish.

Applicant's full name	
Usually called	
Date of birth	
Current address	
Best way of contacting	

Marital status

❑ Single	❑ Separated	❑ Other:
❑ Married	❑ Widowed	
❑ Divorced	❑ De facto	_____

Spouse/de facto

Name	
Phone no.	
Address	

Children

Children's names and dates of birth	
Any other dependants?	

Closest family member/significant other

Name	
Kind of relationship	
Address	
Phone no.	
How do you get on with your family?	
Have you discussed coming into The_house with your family/ significant others?	

Highest education or training achieved

Qualification	Institution	Year

Recent employment

Dates	Employer	Position

Referral

How did you hear about The_house?	
Did someone refer you to The_house? If so, who?	

Medical

Do you currently have a regular doctor?	
Are you currently under medical treatment or taking medication?	
Are you pregnant?	Yes/No/Possibly
If pregnant, how many weeks?	

Tobacco and alcohol

Do you smoke tobacco?	
If yes, how many per day?	
Do you drink alcohol?	
Do you drink every day?	
Do you drink within an hour of waking up in the morning?	

Finance

What is your current source of income?	
Are you currently on welfare or other benefits?	
Are you in debt?	
Do you have any ongoing cause of debt? (e.g. car, child support, alimony, loan repayments)	
Do you have health insurance?	

Legal

Citizenship	
Do you have a criminal record?	Yes/no

Do you currently have any of the following obligations or court orders?

- ❑ Ward of state
- ❑ Parole

- ❑ Binding contracts
- ❑ Run a business or company
- ❑ Tax debt
- ❑ Arrest warrant
- ❑ Bail
- ❑ Summons
- ❑ Writ/being sued
- ❑ Restraining order
- ❑ Outstanding fine
- ❑ Under investigation

Applicant's background ("Tell me your story")
Attach separate sheet.

Why do you want to come into The_house?	
What do you hope to achieve while in The_house?	
In your view, what are your greatest needs right now?	
If you come into The_house, how will it affect your family and significant others?	

End of interview

Observation

Does the applicant have any visible signs of poor physical or mental health?
If so, please describe them

Injuries?	No/Yes	.
Poor physical or mental health?	No/Yes	

Issues arising

What issues appear to need treatment at The_house?	
Do any outstanding issues or information need verification?	
Are there any high-risk issues needing immediate attention?	
Are there any outstanding barriers to admission?*	

*E.g. approval of parent/guardian, legal issues, payment arrangements, etc.

Assessor's recommendation

❑ Immediate admission as resident	❑ Not to be accepted or referred
❑ Immediate admission for detox	❑ Referral to another organization:
❑ Put on waiting list	

Reasons for recommendation:

Signed			
Name		Date	

Final approval

❑ Immediate admission as resident	❑ Not accepted or referred
❑ Immediate admission for detox	❑ Referred to another organization:
❑ Put on waiting list	

Signed			
Name		Date	

14

Detoxification

The_house generally uses a cold turkey approach to detox (detoxification, also known as withdrawal), with support from medical practitioners.

The exception is high-risk detox. Medical oversight and pharmacotherapy is essential for detox from benzodiazepines ("benzos"), alcohol, and barbiturates. In these cases, cold turkey detox is dangerous and can be life-threatening. Alcohol withdrawal delirium can be serious. Benzodiazepine withdrawal is similar; it causes seizures and there is a possibility of suicide. Withdrawal from barbiturates can cause dangerous changes in blood pressure and pulse.

The overseeing medical practitioners will usually prescribe medication to reduce the impact of withdrawal syndromes, such as antipsychotics and painkillers, and give them something to help them sleep.

Besides issues of drug-induced psychosis, you should be aware that detox can trigger latent psychosis that is not drug-induced and might continue after detox.

It is the medical practitioner's role to assess the risks when prescribing medication, and one of the main risks is that residents might have lied about the substances they have taken. Consequently, many medications can be unsafe because of their potential for adverse side effects. Nevertheless, you might have to handle a medical emergency if a resident reacts badly to a medication on your watch.

Below is our procedure at The_house for supporting people through detox from one or more addictive drugs. It includes some guidelines regarding the varieties of physiological changes in residents during detox.

The_house: Procedure for overseeing detox[30]

General

1. You must have a current first aid certificate.
2. You may detox only live-in residents.
3. We normally allow from three weeks to one month for detox.
4. Follow the instructions of the medical practitioner.
5. The_house's policy is that residents will completely abstain from their substance of addiction.
6. Ensure the personal safety of the resident, yourself, and others at all times.
7. Legally, The_house simply provides a residence and a carer (you). You minimize or eliminate legal liability for The_house and yourself by:
   a. carefully following the medical practitioner's instructions,
   b. calling an ambulance if you need to, and
   c. following this procedure.

Your attitude

- Be positive, calm and reassuring.
- Resolve conflicts. You will need to be assertive at times, but make sure you don't lose your temper or vent frustration. Tell your supervisor if you get stressed and unable to cope.

Your assessment of the resident

1. Check that a supervisor or the administrator has approved the resident's admission so you know that they meet The_house's admission criteria.
2. Even though the incoming resident might say they want to detox, they also need to make the commitment, and usually need lots of ongoing reassurance.
3. Ask the resident about what substance (or substances) they have been using, for how long, their average daily intake, when they took their last dose, how big their last dose was, and how the drug/s was administered. This will help you find out the level of care they need. They might tell you something different from what was recorded on the assessment form at the initial assessment for admission.
4. If you notice any behavior or physical status that is inconsistent with reported or known substance use, report it to the supervisor, e.g. signs of physical illness, injury, or mental illness.

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30 Many thanks to Tina Gunter.

About alcohol, benzodiazepines and barbiturates

Residents are at higher risk if they have been using alcohol, benzodiazepines, or barbiturates, especially if they have been using excessively or for a long time. These residents normally need more care. These residents must not have a cold turkey detox and the medical practitioner will normally adjust the detox medications. You must follow his/her advice.

Starting detox

- Assign a room to the new resident and show them around the house. Introduce them to other people living in the building.
- Check the resident's belongings to make sure they haven't smuggled in anything that is not permitted.
- The resident cannot be left alone during detox. Ensure that someone will always be within line of sight of the resident. During your shift, this will be you. You may sleep during overnight shifts, but you need to be able to wake up and do anything necessary.

Medical check

Unless approved otherwise, use the medical practitioner recommended by The_house. Not all medical practitioners have the expertise to oversee withdrawal and treat addiction, and some have beliefs that are incompatible with practices of The_house (e.g. using addictive substitutes). Get the medical practitioner to check the resident as soon as possible and attend the appointment with the resident.

1. Inform him/her of the resident's background e.g. general health and well being, drug consumption, whether the resident is eating and drinking fluids or vomiting.
2. The medical practitioner might prescribe medication. It is your job to know what it is and administer it according to The_house's procedure and the medical practitioner's instructions.
3. Discuss the level of care required with him/her. Ask whether you need to check pulse and blood pressure regularly, and what particular problems to watch for.

During detox

The acute phase of detox lasts from several days to a week. The post-acute stage lasts up to a few weeks and people differ widely. Symptoms can start to show as early as the first six hours, depending on the substance of addiction. The resident will be very sick and mentally stressed, and at risk of malnutrition and dehydration.

It is likely that they will often be manipulative or erratic, and might sometimes be aggressive. They might feel they can't go through with it

and might try to get a hit of their substance of addiction. They may even suffer drug-induced psychosis and psychotic episodes, during which they can be dangerous to themselves and to others.

1. Regularly monitor the resident's general physical state to keep them healthy and safe. Check that the resident is alert, drinking fluids and (when possible) eating, resting as much as they need, and bathing regularly.
2. Administer all medications according to the medical practitioner's instructions and The_house's procedure.
3. Get an ambulance for medical emergencies.
4. Inform the medical practitioner *immediately* of any significant changes in the resident's condition or symptoms and inform the supervisor on duty.
5. Make regular appointments with the medical practitioner and attend them with the resident.
6. Oversee the residents' room. Check that the resident is comfortable and that the room is comfortable e.g. not too cold or stuffy. Keep bedding clean and change it regularly.
7. Keep entries in the Day Book, including any other services you give the resident.
8. In consultation with your supervisor, review the care plan *daily* for the first week and *twice weekly* for the next three weeks. Consult the medical practitioner if necessary.

Evaluate the detox afterward

- Discuss the detox outcomes with the resident and the supervisor, and document them in a Case Meeting form.
- By the end of detox, the resident should be free of chemical dependence, even though they will still be tempted to relapse. They still need to go through the recovery program where they can build new lives, re-socialize, and learn new behavior.

Give follow-up to help residents stay clean

- You are responsible to make sure that residents make a good transition from detox into the recovery program and become part of the residential community.
- Help the resident to get the help available in The_house, such as group sessions, their team leader, the medical practitioner, and any other counselors or mentors they have.
- Give them up-to-date information on AR and related issues, and discuss how to stay clean.

Your practical assessment

Detox two residents following the above procedure. Apply your organization's restrictions on residents, such as contact with family and friends, curfews, and contraband. The assessor will also consider your workplace documents (Case meeting notes, Day Book entries, etc.) and your supervisors' observations during detoxes.

- Identify the signs and symptoms of withdrawal, including stages of withdrawal, and respond correctly to each stage.
- Access the services of the medical practitioner and any other relevant services. You should know where the list of contacts is and know how to contact each one.

In an interview afterwards, you will be asked to explain your range of strategies for protecting yourself and for dealing with aggressive residents. You will also be asked to explain the information you give to residents on AOD and AR. It may be oral, relating to particular situations, or it may be a set of brochures or handouts.

Assignment

1. Do an Internet search on concurrent medical illnesses that can mimic or mask withdrawal, and write a 300-word guide that you could use to train an AR worker to oversee detox:
    a. Give a list of the illnesses and describe simply the mimicking or masking symptoms.
    b. Present your work typed neatly on a word processor.
2. Track the withdrawals of three residents. What would you add or change to the procedure above?
3. Compare and contrast Opiod Withdrawal Syndrome and Amphetamine Withdrawal Syndrome.
4. Describe the differences between acute and post-acute withdrawal symptoms.
5. What physiological changes do you need to monitor during withdrawal? Which don't you need to monitor? Consider the following:
    a. pain
    b. blood sugar levels
    c. dehydration/fluid retention
    d. heart rate and circulation
    e. body temperature
    f. blood pressure
    g. appetite and digestive system
    h. oxygen levels
    i. adrenaline

j. rapid change in amount of body fat

What would you do?

Eighteen-year-old Nina has been at The_house for a month, and has recently finished detox from amphetamine. She has been on several kinds of prescribed medication since she arrived.

This morning while the girls were out, Debra, a junior staff worker, found a collection of prescribed medications in her room. It seems Nina has been hoarding them for at least a couple of weeks. Debra asks you to handle it.

15
Managing shifts

If you have been asked to manage shifts, your supervisors believe that you have the necessary qualities to take this next step in leadership and responsibility. One of our goals at The_house is to train leaders, and this role gives you some solid experience in leading others. In fact, you've probably already done a few shifts as an ad hoc shift manager.

All the essential skills you learnt as a shift worker are just as necessary to managing shifts: people skills, communication, negotiation, delegation and maintaining the community ethos.

At The_house, we like the principle that if you oversee people, then you should be proficient at their jobs. This doesn't always work for practical reasons because we need more shift managers than recovery group leaders and medication supervisors. But the principle is still helpful and we prefer our staff to be competent in First Aid and all specific shift worker tasks before they become shift managers:

- Leading activity and recovery groups
- Team leader (caseworker or case manager)
- Advocacy in at least one area
- House leader
- Assessing applicants
- Overseeing detox
- Overseeing medications

Working at two levels

The shift manager's job looks easy, and this helps to make the role accessible for staff in training. But it is much more than being on duty, following some procedures, monitoring what happens, and keeping people to schedule.

At another level, shift managers play a significant role in implementing therapy. They oversee work, manage behavior, monitor social relationships, implement the cultural environment, and act as the first line of personal support. Of course, as we have seen, handling difficult behavior and emergencies makes some aspects of the role quite complex.

The_house: Shift Manager's job description

1. At beginning of shift:
    a. Do handover from previous shift manager.
    b. Check high priority cases.
    c. Read the Daybook.
2. Keep Daybook and any other documentation.
3. Know the locations of all residents at all times.
4. Handle routine inquiries, problems, incidents and crises.
5. Make final crisis decisions (e.g. admitting residents to hospital, calling police).
6. Always support and encourage residents.
7. Ensure medications are given out.
8. Ensure telephones are answered.
9. Train shift workers on the job.
10. Delegate tasks to shift staff and supervise them.
11. Handle petty cash
12. Oversee scheduled chores (kitchen, cleaning etc.) and assign chores to residents with nothing to do.
13. Ensure residents' activities keep to schedule.
14. Refer non-routine problems to the duty supervisor, and suggest a solution if possible.
15. Do handover at end of shift to the next shift manager:
    a. Clarify the location of all residents
    b. Clarify any particular concerns (e.g. ongoing incidents, messages to be forwarded, anticipated visitors)
    c. Hand over keys
16. Incoming shift manager:
    a. Read the Day Book
    b. Check medications
    c. Fill out a handover checklist.

Training your staff

Much of your role will be training your staff on the job. The formal training component is done in staff meetings and separate classes, but your staff need practical experience for the theory to be useful.

Learning one new task at a time is enough for anybody. We don't want them to get swamped with new information.

Build a relationship with your staff to develop trust, confidence and rapport. Listen carefully to them and figure out what kinds of tasks they do best and not so well. Share your personal experiences and knowledge with them to help them learn from you.

At The_house, we write our procedures as sets of instructions that we can use to train staff. To train someone in a procedure, follow these steps:

1. Explain the procedures step-by-step.
2. Show them what to do.
3. Answer their questions.
4. Tell them what can go wrong and what to do.
5. Give them some practice while you observe.
6. Monitor them closely for a while and give constructive feedback.
7. When they are proficient in the basic procedure, discuss the difficult or complex cases.
8. When they can satisfactorily handle all normal cases, you can let them work more independently.

After you've trained them, it's good practice to periodically take time to discuss how they feel they are doing and to answer their questions. Mistakes are normal, so be patient when they try something new for the first time. You should also debrief the most critical incidents—how they felt, what they did well, and what they'd do differently if they were to face the same situation again.

Teaching initiative

To get ahead, and especially to become leaders, your staff need to learn to take initiative. Yet it is notoriously difficult to teach—even some experienced instructors give up and call it a character trait that is caught rather than taught. So how do you teach people to take initiative?

If initiative is "recognizing and doing what needs to be done before being asked,"[31] then it comprises two elements: (1) Understanding what to do without being told, and (2) Willing to respond without being asked.

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31 "Teaching Your Kids About the Character Trait of Initiative" Gayleen Rabukkuk, www.metrofamilymagazine.com/ March-2011/Teaching-Your-Kids-About-the-Character-Trait-of-Initiative/ viewed 2 June, 2011.

Perhaps we should specify that we also want staff to get it right. Those who act brashly or presumptuously might be taking initiative, but they are not getting it right.

Understanding what to do

It's easier for staff to take initiative in a task where they are already proficient. They know what to do. To some extent, proficiency implies that they can already confidently solve problems and take initiative. Nevertheless, knowing how to do the job well is basic to taking initiative.

But there's more. You can't fix a problem if you don't notice it. Staff need enough experience to be familiar with the usual, the routine, and how things should be.

Last week, someone told me about a program for training autistic children. The little boy had to remember to say goodbye to his mother when she dropped him off at school. Rather than explicitly reminding the child, the teacher said: "You have to do something now. What is it?" The child then had to think about it until he came up with the answer. It's like initiative—the staff member has to notice what to do without someone else pointing it out.

Big-picture purpose

Another factor is an understanding of the big-picture purpose. You've probably heard the story of the traveler in Europe during the middle ages who came across the construction site of a very large project that would still take many decades to complete. He noticed two stonemasons at work and asked the first one what he was doing. The stonemason looked up and answered, "I'm hewing a stone." Unsatisfied, the traveler walked over to the other and asked what he was doing. "I'm building a cathedral," he replied. Only the second stonemason saw the big picture.

In order to identify something that needs to be done, staff need to understand the big picture, that is, the overall purpose of the activity and the processes used to achieve it. Two characters, called John and David, illustrate my point:

John worked at a factory making shoelaces. He came to work every day, went to his machine, and made all sorts of shoelaces exactly as the order book said. Then he put them on the conveyor belt to the next room where another machine put them in shoes. When his machine broke down, he told his supervisor.

Dave also worked at a factory making shoelaces, which all went to the next room just like John's. But Dave was different. When his machine broke down, he didn't just fix his machine. (He already knew what he was allowed to fix and how to fix it.) He also told the people in the next room

to expect a one-hour delay, helped them deal with the people at the earlier stage (who would be flooded with shoes), and checked for possible dispatch delays.

What's the difference? John knew only his job. But Dave thought of the bigger picture: making shoes to dispatch to buyers. People are more likely to be able to show initiative when they see the overall purpose of the activity.

Seeing the big-picture purpose also helps people to generate creative ways of achieving it. Here's an example:

The_house is a few hours drive from a well-known tourist beach. When a public holiday was going to be unpleasantly hot, Stewart decided to take the bus for a full day out. When nearly there, the bus broke down on a lonely stretch of shoreline.

Stewart learned that repairs would take a couple of hours. He didn't like the prospect of overseeing a large group of complaining teenagers waiting for two hours in the hot sun with nothing to do.

Stewart quickly got everybody organized to pack drinks and swimsuits and hike down to the shoreline. They soon found a perfect secluded beach, and liked it so much they decided to spend the whole day there.

The overall purpose of the beach trip was to have a positive experience on a boring, hot day when people had nothing to do. So what if they didn't get to the place they'd planned? The place they found was a good alternative.

Building positive attitudes about taking initiative

The main factors for instilling positive initiative-taking attitudes are:

- Talk about it. Keep it on the front burner. Look at cases of initiative-taking so that people keep thinking about it.
- Put people with those who model initiative.
- Provide a supportive environment that gives them freedom to experiment and make mistakes.
- Use mistakes as learning experiences.
- Build their confidence by affirming and rewarding good attempts.

Making decisions

As you probably realize by now, making decisions is a significant part of the roles of both shift worker and shift manager. For yourself, you need to make effective, timely decisions. At The_house, we tell our shift managers, "You can always call a supervisor for help, but don't expect your supervisor to run your shift by telephone. Make your own decisions."

At The_house, teaching our staff to make their own decisions goes against the grain because they naturally tend to ask for help more often

than they should. The reasons vary. In the beginning, new staff honestly don't know what to do, so it's right for them to ask. Others easily panic and don't stop to think. And some are paralyzed with fear of making a mistake or of going outside what they have already been told.

Don't always make their decisions for them; it would only train them to get decisions from you. They don't learn to make decisions themselves, they don't learn responsibility or leadership, and they don't grow in confidence.

Training them to make their own decisions has lots of benefits. They become more confident and less dependent on you, and they learn responsibility and leadership. You'll be better placed to evaluate their potential and differentiate between what they can and cannot do.

If you keep training them to make decisions, most of them will gradually gain the confidence to do so without you. After a while, when they still come to you with simpler decisions, you can simply tell them that it's their decision to make. You can also use the same approach to guide them to make bigger decisions without your help.

Two recommended approaches

The first approach is to ask them questions that lead them step by step to make their own decisions, although you might first need to soothe the panic so they can be rational.

More often than you expect, people know what to do but are afraid to make the decision, or even to say what they really think. You need you to draw it out of them. Others have all the information to make the decision but haven't put it together logically.

The three main questions are: "What do you think is the problem?" "What do you think needs to be done?" and "Why would you choose that course of action?"

Other useful questions are:

- "What other solutions should you consider?"
- "What would you do about … [relevant factors]"
- "How do you think [name] will take that?"
- "What sorts of things could go wrong? What could you do about them?"

It's seldom a case of simply choosing the right solution. In any one situation, there might be multiple good solutions, some of them better than others, as well as a variety of incorrect options. A good solution is enough for someone who is learning, even if you could have done better.

If you've learned all the roles so far in this book and this seems familiar, it's similar to the approach that you used as a case manager to help residents to make decisions.

In the second recommended approach, the staff member suggests a course of action for your approval. It's a matter of "Don't come to me with a problem. Come to me with a solution." As a set of instructions for your staff, this approach looks like this:

1. Don't panic.
2. Describe the problem briefly and clearly.
3. Suggest what you think needs to be done and give your reasons.
4. Expect your supervisor to ask you relevant questions.
5. Get approval or non-approval.

The role of scenario training

When staff face a problem, they need the analytical ability to comprehend it, its causes, what can be done about it at the time, and whether their role allows them to do something about it. Even if they can't solve the problem, they should be able to take the next step toward a solution.

This is usually taught by analyzing scenarios and debriefing critical incidents. When staff get accustomed to analyzing new situations and proposing responses, they develop the analytical skills to understand other new situations and to generate solutions.

Besides, they are even better prepared for real situations (and less likely to panic) if they have practiced in simulations and role-plays. Build their confidence by getting them accustomed to making decisions rather than being told what to do. Then debrief their decisions in a constructive, supportive way. With practice, they eventually learn to think quickly and act spontaneously. By the way, you are teaching something as a cognitive and applied skill but, without saying so, you are also developing new attitudes.

In some complex fields of decision-making, this needs to be done in a separate course. However, the best organizations use their regular staff meetings to give this kind of training; they analyze their decisions and look at what worked, what didn't, and why.

By evaluating many particular cases, each staff member builds up their own large, complex picture of what to do:

- They notice themes that arise often, identify general principles and rules of thumb, and find the special cases where the normal rules don't apply.
- They also build a holistic mental flowchart of what to do. In many cases, reality is often too complex for one single flowchart to include all possibilities. Staff get accustomed to handling a huge number of

variables that might be relevant, and identifying those that are relevant to a particular situation.

Procedures and flowcharts

You can express parts of your mental flowchart as relatively simple written flowcharts or procedures. You'll then find it easy to teach some skills that would otherwise be very complex. In management, it is known as proceduralization, that is, converting a complex task into a fixed set of steps to simplify training and accountability and to ensure consistent quality.

Some procedures require a flowchart that is too complex to teach in one stage. You can make one flowchart of the outline of the whole procedure, and smaller flowcharts of each part. Teach the outline first, then go through the smaller charts one-by-one. The other alternative is to separate the easy cases from the difficult cases and teach the simple ones first. Treat the difficult cases as requiring a separate, different procedure. They will show as a separate pathway on your flowchart.

Many skills are so complex that they are best expressed in several different flowcharts, which might even conflict with each other. These are usually cases where the skill cannot be expressed as a procedure and staff must learn to exercise independent judgment. Get staff to compare the different flowcharts and draw conclusions about the circumstances where one is better than the other.

Debriefing

Debrief decisions afterwards because people don't necessarily learn anything from unreflected experience. In some cases, you might discuss them individually, and in others you might refer it to a staff meeting or training session. Your core debrief questions are:

- "What was the decision you made?"
- "What alternatives did you face?"
- "Why did you choose that alternative?"
- "How effective was your decision? Did it work?"
- "Do you think you made the right decision? Why?"
- "What would you do if you were to face the same situation again? Why?"

Some staff learn lessons quite quickly when faced with the consequences of their own decisions. ("It worked! That was great!" "Oh no. I'll never do that again.") A few staff will have confidence-destroying disasters. Perhaps it wasn't even their fault. Or perhaps it was a difficult situation with no perfect answers and they made the best decision they could

in the circumstances. Encourage them through; don't let a negative experience set them back.

Here are several tips. First, it's more constructive to emphasize the positive lessons rather than the negative. Second, debriefings work the same way as scenarios and case conferences.

How long does it take?

Like learning anything else, people don't all learn initiative and decision-making at the same rate, and some might never be good at it. Some learn quickly, especially if they have positive experiences. Some staff need more time to develop and we can't expect them to get it right straight away.

A few people thrive on new situations and are naturally inclined to take initiative; they have temperaments that make them more willing to act than others. Some brashly take risks, and you might send need to teach them to stop and think about their decisions.

And consider learning styles. People who tend to have a theorist style want to postpone any action until they are sure they understand, while activists want to act as soon as possible.

Task

Proceduralization is the translation of difficult, complex tasks into procedures, that is, making complex tasks into sets of easy-to-follow steps with ready-made decisions. Franchising businesses, especially fast-food outlets, use proceduralization to create efficient systems that new franchisees can easily reproduce.

Many tasks and decisions in AR can be expressed in procedures. Others need guidelines, but also require judgment. Others depend completely on the professional judgment of trained professionals.

Make a table with three columns, headed: Procedures, Guidelines, and Individual judgment. Under each heading, list tasks and decisions that fit into that particular category. Bring your answers to class and be able to explain why you listed each item under its heading.

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On leadership

You have been learning to be a leader of people from the time you started as a shift worker. If you went straight from recovery to shift helping, you have skipped the kind of mediocrity in which most people dwell and gone straight to learning to take leadership of people and to think like a manager. You are quite accustomed to getting a group of people to do a range of tasks to achieve a particular set of goals, which is essentially the task of a manager.

If you take another look at the chapters on shift helping and this chapter, you will see that they are as much about leadership as about AR: your attitude, teamwork, motivating others, communication, trying to improve, ensuring the safety of others, professional ethics, managing crises, making decisions, and leading groups. You'll be ahead of the pack if you move on to any other role, because you'll approach problems by thinking like a manager and a leader rather than an employee and a follower.

Questions

1. Think about what can you learn from the shift managers who supervised you as a shift worker. What were they good at? What weren't they? Did each one have a unique personal style? (Incidentally, you'll eventually develop your own style.)
2. Compare the two recommended ways to teach decision-making. What's similar between them? What's different?

3. How can you systematically monitor people's decision-making skills so that you evaluate their progress?

On leadership

For all the lists of characteristics, the experts haven't found a perfect definition of leadership and haven't made a list of characteristics that all leaders have. Without a definition, we might only describe it as "the personal qualities of a person that make others want to follow them."

Why do people emerge as leaders? First, some appear only because they are needed; they may not want leadership but they're the right person for the role in a time of need. This is especially the case where leaders are in short supply. Second, people need leaders to help them get what they cannot get for themselves. People look to a leader for the next step when they don't know what to do, and want someone to speak on their behalf when they feel powerless. Whatever the kind of leadership, people don't work together very effectively without it.

Third, others emerge as leaders because they see an opportunity, start heading in the right direction, and others follow. Fourth, when many people are jostling for leadership positions, the winner is the best person (or the toughest or nastiest). In these cases, it's possible that many good leaders are bypassed.

Before going too far, you might have noticed that evil people sometimes become leaders and get others to follow them. Some are simply bullies, and some are shrewd political operators. Some are deceptive, manipulative, or clever. So when I discuss leadership, I mean developing good qualities.

How to become a leader: Step 1

Thousands of books have been written on this, so I won't write them all again here. There is no simple procedure to follow. Except for the first step.

The first step is to learn personal integrity. Integrity, in this sense, is all the personal qualities that people respect. It includes things like your personal example, trustworthiness, credibility, reliability, honesty, willingness to take responsibility, and willingness to work hard. It is the most decisive factor, and nobody will be in long-term leadership without it.

Leadership is first of all about you as a person and your example. It is not primarily about the followers, power, or authority. Leadership is not just what you do. Some cultures give respect on the basis of position, but others expect you to earn respect. Consider these quotes:

- "Leadership is a combination of character and strategy. And if you must be without one, be without strategy." (Attributed to Gen. Norman Schwartzkopf.)
- "Respect has to be sought and won every day. It is not a given." (Gen. Peter Cosgrove, ABC radio interview, 2006.)
- "Young students come to me and ask, 'People don't respect me as a leader. How do I command more respect?' So I tell them, 'You can't control how much they respect you. But you can set a good example, and respect will follow.'" (Jeff Gulleson.)
- Respect is slow to win but you can lose it in seconds. You can blow away three months of respect-building by losing your temper just once for a moment.

Ask these leading questions. If you can answer them well, you will probably write your own set of principles for becoming a leader.

1. Why should people trust you as a person?
2. Think of someone you respect. What personal characteristics do they have that engenders your respect?
3. Think of someone you don't respect. What personal characteristics detract from your respect?
4. What should be your goals to become a leader?
5. What is the difference between leading people and bossing people?

Other qualities of leadership

Everybody has their own pet theory on this, so let's go though the basics. Our current theories of leadership probably reflect our current culture. Some are generally about taking control of one's circumstances, and one view is that leadership is the ability to influence others.

After integrity, there's a daunting list of other leadership qualities. It's not fashionable in leadership studies to make a list, but it can still be helpful. People tend to follow those who:

- Can make good decisions quickly
- Build effective teams
- Work to their strengths, and use the strengths of other team members
- Are competent
- Show assertiveness
- Tend to be proactive rather than reactive
- Have foresight and insight
- Have a clear sense of purpose and how to get there
- Are clearly committed to shared goals
- Learn fast and keep learning

- Will stand by them in a difficult situation
- Empower them
- Show resilience in adversity
- Take responsibility
- Care about individuals and their interests
- Work sensitively with subordinates and help them to do better.

No matter which theory of leadership you prefer, you probably need some of them in particular to last as a leader.

Be decisive. You need to be able to make decisions and act quickly. In a tight spot, people look to you to make a decision. You won't be showing leadership if you don't, and the mess will be difficult to fix. Even if it's a decision to wait, that can still be the right decision. That means you need to keep on top of your role, understand what is happening, and see emergent trends.

Gather a team. If nobody follows, you're not a leader. To be a good leader, surround yourself with people who are better at what they do than you are. Draw on their particular insights and skills and help them to complement each other. Rod Thomson wisely pointed out that leadership is not a technique or even a person. It is only defined in relation to a group of followers, a community. You need to be the right person for the people you lead.

Have a clear sense of purpose and how to get there. Here's a simple test: A group of people is sitting around contemplating a problem that is too hard for them. The leader is the first person who knows where to go and how to get there. (It's often the first person to speak, but not always.) The others need him or her.

Meet a need. The leader offers something that people can't do themselves. In most cases, sadly, it is little more than self-interest (e.g. more money). In non-profit organizations, the leader offers a way to achieve something good that the followers believe in.

Treat each person uniquely. The best leaders work with the unique characteristics of different people to get the best response from each one. Good leaders can steer a clear path through their different personalities, motivations, attitudes, responses, strengths and weaknesses, to get the support and best performance from each one while minimizing the effects of their weaknesses. (The current term *emotional intelligence* refers to the way one handles and responds to their emotional predispositions and reactions.)

Work to your strengths. Nobody does everything well. (A few appear to do so until you look more closely.) Find what you like and do well, and

develop in your area of strength. It is where you will be most valuable and make your best contribution.

Be assertive. Assertiveness is the ability to state your view clearly when necessary. It can be done tactfully and thoughtfully. One way to look at it is to say what it is not:

- being bossy or pushy to get your own way,
- being afraid of stating your view through avoidance,
- unreasonably compromising your view through fear or,
- being thoughtless, manipulative, argumentative, or inconsiderate.

Questions

1. Do you think there are other essential factors for all leaders?
2. Some sources suggest that leaders should maintain some distance from followers because "familiarity breeds contempt." Others suggest that leaders should become personally close to followers in order to mentor and coach them. Which view is best? Why?

About temperament

Leadership research once assumed that leadership was one set of qualities. More recently, attention has turned to variety of leadership styles.

People are all a little different, and so are leaders. Your temperament affects how you lead, so it's good to know your temperament. To some extent, it reflects your strengths and limitations. The benefits are many:

- To be the leader of the group, you need to appreciate them all and get the best contribution from each person according to their area of strength.
- You usually need all (or most) temperaments to make an excellent team.
- You will be a better leader if you know which one you are, and can better appreciate where others can complement you.
- If people clash because they have different temperaments, perhaps they could also complement each other.
- You will be a better leader if you develop at least minimal skills in your areas of weakness.

Both the Disc model and the team model of leadership include two basic orientations in temperament. People-oriented leaders tend to want to support and train their personnel, and tend to give lots of consideration to the personal needs of individuals.

The list of leadership styles below is more comprehensive.[32] Don't think of them as stereotypes, just as tendencies.

The visionary

"I have a strong sense of purpose and progress, and see one of my top priorities is to draw people to the vision. That's what makes me enthusiastic. If you can't communicate, you can't do anything.

"I like to see the big picture, and what will happen in the future. I think it's important to look at the future, get around to speak to groups, promote a public image, and keep staff motivated.

"I delegate implementation easily because it's the big picture and purpose that count. I don't need to bother with details, and I only do paperwork when I can't get out of it.

"Paradox is just a normal part of reality, so don't worry about being too consistent.

Observations from his team members:

- "Not always very good at one-to-one communication."
- "Without him we'd be sunk. He makes us keep our eye on the ball."
- "He's very persuasive."
- "He naturally does very well in the number one position, but needs lots of implementers around to translate vision into reality."
- "Definitely not a details person. Doesn't worry about small mistakes, even when they are important."
- "Leaders like him do well in the limelight so they can appear egotistical, no matter how humble or insecure they really are."
- "Tends to interpret problems as lack of passion for the vision."

The pastoral carer

"Leadership is really about personal relationships. People are individuals and you have to approach each one differently.

"I think it's important to give team members some pastoral care when I see they need it. After all, they are people. Most of the time, I don't have to offer it; they come to me. That's the kind of person I am, I guess.

"Building consensus is really important. I want to know that everybody is supportive when it comes to making a decision.

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32 Based on those given by Stewart Dinnen of WEC International.

"I try to be sensitive to the dynamics in the team and I try to build team unity. I might not always succeed, but I am very respectful of people's feelings, even in business and public meetings.

"Our organization's problems are really people's personal problems. Fixing them is sometimes very difficult; it would be easy to create bad feelings in the team. But we've made a lot of progress and I think we have a very good team.

Observations from her team members:

- "She seems to know everyone. She's a good networker. No, an excellent networker, the best we have."
- "She sees people's victories as personal victories."
- "Good at encouraging people. She even nurtures people, especially the young ones coming up or those going through tough times."
- "She interprets problems as people's personal problems."
- "She leads by personal influence."
- "I noticed that she finds our procedures and admin stuff quite easy to follow. Perhaps she focuses on the job and the people, and thinks that rules are a bit of a distraction."
- "She sees the institution's goals as mainly the sum of people's goals. Other than that, she doesn't have a strong institutional vision or a sense of progress. She places the main value on the personal development of team members."
- "She's convinced that money doesn't fix problems."
- "Committed to training. Sees it as a way for people to develop."
- "She has excellent personal skills and many of the staff ask her advice. She's willing to be their personal confidante."
- "Perhaps she estranges some people who don't adjust to the personal style. Cliques could be a problem."
- "I wonder if the emotional tension and pressure get her down sometimes. Perhaps she could burn out easily."

The laissez faire leader

"I just give people the job and let them get on with it. They are all good at what they do. They'll figure out their own style and I don't interfere unless I have to.

"They can still ask me for help if they get stuck; that's what I'm here for. All I need to do is touch base with them and check that they're still okay.

"The organization is the sum of its individual people.

Observations from her team members:

- "She gets on with her job and so do we. Works well."
- "Good at letting us get on with the job."
- "Often doesn't notice if we get stuck."
- "Easy to skip out or pass the buck. But she still makes sure the job gets done."
- "Doesn't give a lot of direction. Sometimes I don't know what I'm supposed to do."

The accountant

"I usually measure success and failure in terms of money value.

"When I see problems, I see them as something that will cost money to fix. You can allocate money to fix the problem. Despite all the touchy-feely stuff, you can't fix problems without resources. Even when money isn't an incentive for people, lack of money is usually a strong disincentive.

"Sure, lots of other things are important, but after all, it's about the money, and the goal is to be financially healthy. No matter how good you are, you're not doing it any more if you go broke. The budget is the plan.

Observations from his team members:

- "He also tries to use money to motivate people and control the organization."
- "He's best when problems are about money."
- "Not very good with people's problems; he gives the impression he doesn't care."
- "Looks like we're expendable when his figures don't add up."
- "Everybody resents him if he uses money to control people."

The publicist

"When people suggest new ideas, my first question is always: 'What impressions will we give and what will people think?'

"Our clients are our focus; our resources are simply a means to make them satisfied with what we do. We should be looking at everything from their viewpoint first.

Comments from her team members:

- "Very persuasive. Brilliant at putting thoughts together to make people think whatever she wants them to think."
- "Remarkable ability to predict what clients will think."

- "Creates a good impression. Not sure that she's always so strong on substance."
- "Easy to make promises. Harder to deliver the goods."
- "Professional spin doctor. Tries too hard to please people when she should stick by her guns."
- "Doesn't it matter what we think? Or are clients the only ones what are important?"

The implementer

"I like to get the details right and make plans work on the ground. I think I'm fairly pragmatic; I like to look at what works. What happens on the ground is what's important. I work hard to get all the systems working effectively, although my friends say I might be a bit of a perfectionist.

"The big picture stuff is a bit too vague to be helpful. I think I have a strong sense of purpose, but I don't think I'm all that good at communicating it.

Comments from his team members:

- "Carries more than his share of the load when it comes to getting things done."
- "Brilliant at finding and fixing little mistakes. Saved us from lots of disastrous consequences."
- "Focuses narrowly on getting the job done at any cost."
- "Wants to maintain a strict sequence, so isn't good at tasks needing flexibility."
- "Doesn't notice people's feelings too well. He's not nasty, he just doesn't even see them."
- "Can be a bit technocratic. He values information and ability, and might use it to control what happens."
- "Doesn't easily delegate. Tends to see 'getting things done' as lots of work for him. And when he delegates, he sometimes micro-manages."

The autocrat

"All major decisions have to go through me. With our structure, it's always my head on the chopping block, and the current group of staff are very young and inexperienced. So I've had to become more autocratic in my style. I don't mind admitting it.

"Besides, leadership is about making decisions quickly. If we wasted time in making decisions, we'd lose lots of opportunities.

Observations from his team members:

- "Everyone knows where we're going and what we're supposed to be doing."
- "Tends to make clear decisions very quickly."
- "Best person to have in a crisis."
- "Wants total authority and expects to make all major decisions. Doesn't even realize it when he's undermining a colleague who should be making the decision."
- "Tends to micromanage rather than delegate."
- "Frustrates creative employees. Either their creativity dies or they get fed up and leave."
- "Often lacks empathy. Doesn't listen all that well."

The democrat

"I try to listen very carefully to the views of the team, even though I usually make the final decision. I find that team members contribute ideas that I haven't thought of, so our team meetings are very helpful.

"Sometimes we even come to decisions that I wouldn't have originally agreed with, or perhaps even thought of. It really works well when I can get everybody to contribute their strengths.

Observations from her team members:

- "Can't make decisions quickly. Not very good in a crisis where she must make decisions alone and quickly."
- "Good at drawing out people's ideas and strengths."
- "Everybody in the team is very supportive of our decisions."
- "Tends to interpret problems as lack of shared understanding."
- "She's good at navigating grumpy personalities."

The administrator

"I'm an implementer and a details person. In fact, I'm a lot like an implementer.

"My job here is basically to say, 'Get with the program.' I just have to follow a set of policies and procedures, and they are already there. I guess I'm not very creative, especially when it comes to handling quirky problems. When a problem comes up, I tend to look for something in the system to guide me.

Comments from her team members:

- "She's a bureaucrat, pure and simple. But she makes it work for her specific job; she fits in where she does. She couldn't do some other jobs. Just doesn't have it."
- "She finds safety in the system."
- "Tends to interpret problems as procedural problems."
- "Good at details, especially when working with systems."
- "She isn't very creative, or if she is, it doesn't show in her role here. I don't think she has much initiative in handling issues not addressed by the system."

Questions: Leadership styles

1. Explain five different styles of leadership.
    a. What are the strengths and weaknesses of each style?
    b. What do you think is your particular style? Why?
    c. How have you arranged your work so that your particular style is effective for you?

Training leaders: Four strategies

There are at least four main strategies for training people to become leaders.

First, training leaders is about developing integrity. In this view, the way to develop leaders is to challenge and mentor prospective leaders to develop integrity. It's really about the individual as a person.

Second, training leaders is about teaching skills. In this view, leadership is a range of skills that can be learnt, such as communication, motivation, negotiation, team-building, strategizing, etc. Educational programs tend to follow this approach because it reduces leadership to something that students can learn in a course and get a qualification.

Third, training leaders is about giving people opportunities to prove themselves in small things and give them an advancement pathway to take on bigger things later on. In this view, the way to become a leader is to learn the lesser tasks well and gradually increase in responsibility. Different people have different sets of steps, but they all are all about a gradual process. Some excellent organizations only put people in leadership if they have proven themselves in lesser roles, and follow a principle, "If you can't do it, you can't lead it."

This works well, especially for any kind of on-job learning, but I have to qualify it. First, everybody does some things better than others, and will probably have some failures. A few people with leadership talent only do their best work in a leadership position. But later in leadership,

you and those you lead will be very glad that you know what it's like at the coalface.

Fourth, developing as a leader is about reflecting on experiences and learning from them. In this view, the way to train leaders is to help people evaluate what they have done and identify how they'd do it differently in the future. It's also better to learn in a group so that emergent leaders can gain the insights of others.

This view is normally holistic; reality is not divided into a variety of disconnected academic subjects. It combines both personal integrity and skills, and conceives of leadership development as maturation and personal growth. The learning process may be emotionally very difficult, but avoidable.

Questions

1. Some of the leadership literature differentiates leadership from management, although managers are now generally expected to also show leadership. What is different and similar between them?
2. "Most leaders are best suited to the second-in-charge position, and few do their best work in the top role." Do you agree or disagree? Why?
3. What are the main lessons you had to learn in leadership?
4. If you were training a new person in leadership, what would be the top five principles that you would want them to learn? Explain each of your five principles.
5. Name three instances where you have taken leadership and made decisions that led to positive changes in the workplace.
6. How do you handle your mistakes?

Common mistakes in leadership

Whether you think of leaders or managers, you can avoid some of the common mistakes more easily that fixing them afterwards.

Build the organization to reflect your personal strengths and weaknesses. If you are erratic and disorganized, your organization can easily become erratic and disorganized, and attract only people who are similarly erratic and disorganized. You can't see it, and you like the fit with how you think. The way to avoid it is to listen to constructive criticism so you can think more widely, and deliberately recruit people who think differently from you.

Queen Bee syndrome. The Queen Bee holds absolute power because she believes that all goodness and light flows from her.

Move into reactive mode. If you lose a proactive attitude, you set yourself up to be a victim of circumstances.

Distance. The more physical distance you have from people, the more difficult it is to communicate well and to have effective managerial controls. It is easier to have misunderstandings and to misinterpret motives.

Working hard? Most people feel they are working harder than they are. When people feel the load of responsibility, they feel they are working very hard even if they have nothing to actually do.

Terminations. Terminations are difficult and messy, no matter how necessary they are.

Talented people. Some managers present the image that they want to recruit and promote talented, creative people with leadership potential. In reality, however, they feel threatened by upcoming leaders, and hold them back. Many upcoming leaders either give up or become quiet, frustrated, compliant and uncreative. Others leave the organization and rise through the ranks of another organization.

Volunteers. Charities often use volunteer labor inefficiently. Workflows would change radically if they had to pay full wages.

Too much change. Even when changes are improvements, changes can destabilize the organization if there are too many of them, too frequent, or too erratic. "Too" implies a tipping point; it occurs when the work involved in implementing the changes outweighs the benefits of the changes.

Poor delegation. The reason for poor delegation, other than deliberately holding people back, is that supervisors don't ease people into new tasks through ordered stages.

Poor delegation takes two quite different forms. In one form, managers under-supervise. Subordinates don't learn their job properly, and perform poorly with a higher risk of serious errors. If these subordinates do a bad job, nobody knows until it's too late. In another form, micromanagers control every aspect of what a subordinate does. In the worst cases, subordinates can't do their jobs at all. In other cases, they don't develop a personal style, don't learn much, and don't exercise abilities where they could do a better job than the supervisor. They don't feel free to take initiative, even if the consequences of non-initiative are disastrous. A few people accept their role and lose any creativity and initiative. Good people tend to move on as soon as they get an opportunity.

Forcing square pegs into round holes. If a manager has one peg and one hole, it's convenient to ignore the fact that the peg is square and the hole is round. It's then easy to force the square peg into the round hole. Pushing people into roles for which they are clearly unsuited, however, ruins them both; the person is frustrated and the job is done poorly.

In the worst cases, the person gets so frustrated at being sacrificed that they develop a bad attitude and the supervisor forces them out of the

organization. The supervisor then justifies him/herself by saying: "Lousy attitude; they had to go." but doesn't realize that he/she caused the problem.

Whip a willing horse. The worker is willing to take on a load that is more than their fair share, and carry it for a long time. It can result in the worker eventually burning out and needing to leave. In the worst cases, the person realizes that they are being exploited and becomes bitter. The supervisor forces them out of the organization, with the justification: "Lousy attitude; they had to go." but, again, doesn't realize that he/she caused the problem.

Contributing weaknesses rather than strengths. In this kind of sick team, everybody contributes their weaknesses rather than their strengths. This has two variations, and your nightmare is to have both occurring together. In the first, everybody in the team is assigned jobs to which they are poorly suited, so they contribute mistakes rather than good performance. In the second, the oppressive atmosphere makes people want to complain, so each person contributes negative attitudes.

In too deep in a mistake. You realize that you have made a mistake in a decision and are now committed to a course of action, but you are now too far down the path to call a halt. How do you get out or change direction without losing face? You might fear that backing down would tarnish your reputation, or that the change process would be too difficult to reverse.

Task

Express each of these common mistakes in leadership in a positive form that would be good advice to people learning leadership.

Maintaining standards: Questions

1. Explain your organization's key values.
2. How can a person identify an organization's standards and values when they are not stated, but only implied?
3. Outline your organization's process for raising questions about standards and values.
4. What are your organization's general expectations of team member behavior?
5. Give examples of behaviors and performance that would typically be considered damaging to an organization.
6. How can you get advice to ensure that your team is focused and on track?
7. How should you handle team members who perform poorly (e.g. unproductive, not getting their work done, not meeting targets)?

Team-building: Questions

Explain how to build a team. In your answer, cover at least the following:

- How to monitor team relationships
- How to build positive relationships
- How to strengthen communication
- How to build trust and confidence between team members

Appendix A: Physical restraint

Physical restraint is one of the most difficult topics in AR. Nobody likes to use it and it's always a last resort. But the truth is that many AR agencies need to use it from time to time. It is legally quite tricky: go overboard and you commit assault, but ignore it and you may be guilty of negligence.

Besides, the laws vary from state to state. What is good practice in one jurisdiction might be classified as assault in another. Some states allow restraint only when people are in danger, while other states also explicitly allow restraint to protect property.

Some organizations try to opt out by not offering training. However, that could be negligent if there is clearly an ongoing risk of violent behavior that requires physical restraint.

At The_house, we don't use physical restraint nowadays because we have very few incidents of violent behavior, and because it does not promote good relationships with residents. If we have a violent incident, our current policy is to call the police and inform the supervisor on duty.

Some agencies, however, really need to be able to restrain violent residents. So here's their policy basis ...

Instructions

1. Call the police for immediate help in the case of residents who are physically dangerous to you or to other people:
   - physical attacks on staff or others
   - threats with weapons, including improvised weapons
   - erratic behavior endangering others.
2. You are entitled to restrain residents in some situations, but it might be preferable to call police You don't have to restrain a resident if you'd be in danger, and you are responsible to keep yourself safe. These situations include, for example:
   - attempted self-harm
   - self-harm through erratic behavior

- fights.

3. Use physical restraint as a last resort.
    a. You should only use it when you can't use normal conflict resolution.
    b. You don't have to try conflict resolution first in an emergency where you need to physically restrain someone immediately.
4. If you believe you are in danger, you have the right to use reasonable force to defend yourself.
5. The way you restrain residents should minimize risk of harm to both yourself and the resident.
6. The person in charge may decide to call police if a criminal offense is committed or if it is too dangerous for you to control.
7. Try to leave the incident if you start losing your temper.
8. Be especially careful when restraining people who have never been restrained before. They are likely to be especially violent and to prolong the struggle. They are likely to believe that they can successfully defend themselves or escape. They might also feel threatened and in danger because you have superior force. People who have been restrained a number of times realize that it is all over as soon as they are firmly held.
9. Use only a "reasonable" level of force. That is, use the minimum level of force to restrain the resident satisfactorily and safely.
    a. As a general principle, you need at least three staff members to restrain one person if everyone involved is of similar physical size and fitness and the resident has no weapons (including improvised weapons).
    b. Use force for only as long as you need to.
10. The level of force is unreasonable if:
    a. it is clearly more than you need to satisfactorily and safely restrain the resident,
    b. it inflicts unnecessary physical pain and suffering on the resident, especially if it includes deliberately harmful actions (e.g. punching, kicking, biting, using weapons, restricting breathing),
    c. is maintained for longer than necessary, or
    d. if you deliberately humiliate or degrade the person.
11. A reasonable level of force can still result in extreme discomfort for the resident. It could also result in minor injury that is necessary to the restraint, unintended, or results from minimum risk. For example, people who strenuously resist might thrash around and bruise themselves on the floor or knock their heads. But that doesn't mean it's your fault.
12. Follow your training.

a. Your training should include physical practice and you should do regular refresher courses.
b. You should be trained in safe holds for immobilizing residents. (Arms pinned behind their backs, or pinned face down on the floor for a short period.) Consider safe zones; you can be so close to the resident that they can't hit you, and too far away to be hit. In between, they can hit you very effectively.

13. It is your duty to physically restrain a resident if:
    a. there is a clear need,
    b. you are appropriately trained, and
    c. you are able to do so safely according to the guidelines.
14. If you refuse to do so when you clearly should and can do so safely, and somebody is hurt, you could be charged with neglecting your duty of care.
15. Fill in an incident report after every time you physically restrain a resident. It helps protect you if the resident or his/her parents decide to make a formal complaint or tries to take legal action later on, or if your organization gets adverse publicity.
16. Look after yourself. Major incidents can bring on Post Traumatic Stress Disorder. Properly debriefing the incident afterwards may help. Get counseling if you need it.

Legal aspects

1. You have a duty of care for yourself, your residents and anybody else on the premises.
2. You can't be successfully sued for following standard best practice as health care professionals.
3. You can't use a mechanical devise or apparatus to restrain someone
4. Police should not arrest you if you can show that the use of restraint was justified. If they do, you will probably be released because you have no case to answer.
5. You can still be arrested for assault if you attack a resident. That is, physical restraint is not an excuse for violence.
6. You meet the requirements of the Children's and Community Services Act if you restrain a minor in such a way that it protects them from harm or restrain someone else to protect a minor from harm. One of its main purposes of is to protect the child from harm.

Risks

1. Restraining people the wrong way can cause injury or death.

2. A person being restrained by being held face-down on the floor for long periods cannot breathe freely and is at risk of suffocating. The risk is increased if:
   a. they are obese,
   b. they have a history of respiratory problems,
   c. they resist vigorously for a prolonged time, or
   d. the staff member kneels on them or puts weight on them some other way.
3. The person being restrained is also at risk if:
   a. they have a history of cardiac problems,
   b. they are drunk,
   c. they use illicit drugs,
   d. they have psychosis, including drug-induced psychosis,
   e. the restrainer holds something around their neck,
   f. they could hit solid objects (furniture, walls) by vigorously resisting.
4. Staff members face a risk of muscle damage caused by transition from rest to sudden strenuous physical activity. (Warm-up exercise would normally prevent this kind of injury.)

Summary

- The overriding principle is your responsibility to work safely and to keep other people safe while they are in your duty of care.
- Fill in an incident report after every time you physically restrain a resident.
- When should you physically restrain a resident? Here's a guideline:

You *should not* if:	You can still talk to the resident (conflict resolution), *or* you have not been trained, *or* it is too dangerous.
You *may* if:	The resident is clearly dangerous to him/herself or others, *and* you have been trained, *and* you think you can do so safely.
You *should* if:	The resident is clearly dangerous to him/herself or others, *and* you have been trained, *and* you can *clearly* do so safely.

Appendix B: Websites

The Internet is an excellent source of information on AR treatment. It is in governments' best interests to make information publicly available to promote abuse prevention, early identification, and responsible treatment. The opportunity to commercialize is limited; technical information primarily benefits addiction researchers, the not-for-profit sector, and medical service providers.

Broadly speaking, Internet sources tend to fall into two main categories. The largest comprises information for the general public, whether to promote a particular service, prevent abuse, explain how medications work, encourage persons with addiction issues to seek help, or to inform families how to cope. The other category is information for professionals, including current practice standards, technical explanations of medications, and research.

It is more difficult to assess the value of the information. One of the main weaknesses is the influence of the harm reduction lobby group, and particularly methadone advocates who do not seek to get people free of addiction. The second main weakness is that so much research has been devoted to careful description of problems and so little to effective recovery.