MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

Harmful sexual behaviour services

Service Development Report

May 2017

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Published
May 2017
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ISBN
ISSN: XXXX-XXXX-XXXX

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1. Introduction

Harmful sexual behaviour services (HSB) are provided to four population groups, funded through the Department of Corrections, the Ministry of Health, the Ministry for Vulnerable Children, Oranga Tamariki (MVCOT) and the Ministry of Social Development (MSD):

- mandated adults (court-ordered, including subject to an Intellectual Disability (Compulsory Care and Rehabilitation) Order)
- non-mandated adults (including ID clients who are not mandated under the IDCCR Act)
- children and young people referred by MVCOT
- children and young people not referred by MVCOT (community/self-referred).

Over the last four years, the state of the specialist sexual violence sector has been the subject of several Government inquiries and reviews. These reviews led to an initial injection of funding in Budget 2014 to stabilise the sector, followed by a more significant investment of $46 million through Budget 2016. Of this $46 million, $3.727 million over three years was appropriated specifically for the development of services for non-mandated adult HSB services.[1]

The focus of the HSB service development work during this funding period is to ensure HSB services for non-mandated adults are effective, accessible and sustainable. To maintain stability and continuation of services while the service development work is ongoing, contracts with providers were extended for 12 months to 30 June 2017 with an increase in the number of assessment and intervention places available to align with the increased funding. Following completion of the service development work, the three existing providers of HSB services were offered new two-year contracts to 30 June 2019.

In addition to the service development work a project is being carried out to determine the level of demand for HSB services across New Zealand. This will feed into future funding and purchasing models. It comprises both a needs-analysis of relevant population indicators and data-sets as well as an evaluation of the providers' client data.

[1] The Ministry for Vulnerable Children, Oranga Tamariki is responsible for funding and purchasing concerning sexual behaviour services for children and young people.

2. Project approach

Background

The purpose of the HSB service development project is to ensure "the provision of accessible, sustainable, effective, well-coordinated responses to concerning and harmful sexual behaviour, available to those who need them, tailored to the level of need and risk."[2]

What did we do?

Engagement and consultation with key HSB stakeholders took place via a 'sprint process'. The three-week sprint ran for 15 non-consecutive days from September to December 2016. Most of the work was completed in October and November with two remaining days in December 2016.

The sprint was facilitated by PwC Digital, and a core sprint team was set up with Usability Experience consultants from PwC Digital and members of MSD's Safe Families team. The core sprint team were co-located at MSD's Wellington Regional Office for the duration of the sprint.

Provider engagement and consultation took place via three full-day workshops and a number of one-on-one interviews. Participants included CEOs and senior clinicians from Safe, WellStop, Stop and Korowai Tumanako, as well as representatives from MSD, the Department of Corrections and the Ministry of Health. Providers who took part were advised there would be no procurement advantage or disadvantage from their participation in the sprint.

The sprint used a human-centred design thinking approach to:

- collaborate with community providers to develop a draft service framework that enables and encourages positive outcomes for clients, their support network and wider community
- identify workforce competencies, capabilities and qualifications required to deliver HSB specialist services
- understand the pathway and key referral process clients take to access interventions
- understand what an integrated service system might look like
- understand service delivery gaps.

What is the purpose of this document?

One of the deliverables of the sprint process was to co-develop a draft service framework that outlines the core components of HSB services. As part of this, we also sought to identify the workforce competencies, capabilities and qualifications required to deliver HSB services. Information and content for the draft service framework was gathered in the workshops and interviews and documented and refined by members of MSD's Safe Families team.

[2] Concerning and Harmful Sexual Behaviour Services – Project Brief (22 July 2016)

This document will be used to inform the development of service guidelines for adult non-mandated HSB services. The new service guidelines, along with robust reporting measures and results, will be included in new contracts going forward from 1 July 2017.

Consultation

The content of this document, specifically the definitions, the harmful sexual behaviour clinical practice section, and the results measurement framework, was developed and tested directly with specialist providers (senior clinicians and CEOs) through the co-development sprint process. The workforce capability section was based on provider comments during the sprint process, along with research around what constitutes good practice in this field.

The overall document was then reviewed by the cross government working group which includes representatives from the Department of Corrections, Ministry of Health, MSD, Police and ACC. Feedback and comments have been incorporated (representatives from the Department of Corrections and the Ministry of Health were also part of the sprint process).

Next steps

This document forms one part of the HSB service development work. Work is also underway to develop new contract specifications and reporting measures, and design, develop and procure new services to fill some of the service delivery gaps identified through provider engagement and consultation.

The new reporting measures will align with the Results Measurement Framework for HSB services, which was developed in consultation with the providers in 2016.

Related policies and documents

This document has also been informed by the following documents:

- Services for individuals with harmful sexual behaviour or displaying concerning sexualised behaviour: service specifications (Child, Youth and Family, 2015)
- Practice guidelines for the assessment, treatment, and management of male adult sexual abusers (Association for the Treatment of Sexual Abusers, 2014)

3. Service overview

This section provides a brief overview of HSB services in New Zealand, including a brief description of services, current contracting arrangements, client make-up and evidence base for effectiveness.

HSB services

HSB providers deliver a broad range of services aimed at reducing the prevalence of HSB, including child and youth services, adapted and special needs groups, and adult services for both mandated and non-mandated clients. There are different formats operated by the providers in relation to separating adult clients by offence type (such as an internet offenders group) or by cultural needs (such as Maori or Pasifika groups). Groups may be made up of referrals from a variety of sources.

The providers operate their programmes on a continuous or rolling basis all year round. As a general rule, intervention takes between six and 12 months (depending on client's level of measured risk and need) with one group session a week, along with periodic individual sessions, systems reviews and family/whānau work and support. The Ministry does not currently specify the duration of intervention. Although, if intervention for low risk clients is warranted, it should be less intensive than for medium or high risk clients (research indicates that low risks clients should receive no more than 100 hours of intervention).[3]

Current state

Over the last four years, the state of the specialist sexual violence sector has been the subject of several Government inquiries and reviews. These reviews led to an initial injection of funding in Budget 2014 to stabilise the sector, followed by a more significant investment of $46 million through Budget 2016. Of this $46 million, $3.727 million over three years for service delivery was appropriated specifically for non-mandated adult HSB services.[4]

The objectives of the HSB service development project are to:[5]

- Review and improve the quality of existing services, and design new services to fill any key identified service gaps.
- Increase the available places in existing non-mandated treatment programmes, thereby clearing current waiting lists and meeting some additional latent demand.
- Improve the geographic coverage and tailoring of services to different population groups.

[3] Wakeling, Mann and Carter (2012), *Do low-risk sexual offenders need treatment*, Howard Journal of Criminal Justice
[4] The Ministry for Vulnerable Children, Oranga Tamariki is responsible for funding and purchasing concerning sexual behaviour services for children and young people.
[5] Concerning and Harmful Sexual Behaviour Services – Project Brief (22 July 2016)

- Define and incorporate good practice recommendations from recent and future research on effective delivery of harmful sexual behaviour assessment and intervention services.
- Develop and implement concerning and harmful sexual behaviour services within an integrated service systems approach.

Client group and demographics

The Ministry funds the providers to deliver HSB services to non-mandated adults (18 years and older). While contracts are not gender-specific, in practice, services are predominantly delivered to male clients. Concerning sexual behaviour services for children and young people are funded separately by MVCOT. Typically, non-mandated clients are those who:[6]

- refer themselves, or are referred by family or other social service/health service providers or community professionals to HSB assessment and intervention services, or
- have been referred through a government agency, including MVCOT, Department of Internal Affairs (for internet offenders) and, to a lesser extent, Justice sector agencies (like the Police, Public Defence Service).

The type and severity demonstrated by the non-mandated adult clients varies considerably, as does the age of the victim/survivor, the nature and severity of the offending i.e., contact/non-contact, and the channel through which abuse is committed, i.e., in person or online. Clients are predominantly male, although individual services to women who have engaged in HSB are accessible in some areas.

Non-mandated adult clients include a spectrum of offender types – from those who present as outwardly high-risk, and who may be socio-economically disadvantaged, socially isolated and/or associated with other criminal activity – to those who are outwardly pro-social, high-functioning, contributing members of society. A large number of offenders may be living within families, or be in a position of power or trust with young or vulnerable people.

Due to the capped number of assessment and intervention places funded by the Ministry, providers prioritise clients based on need, risk and impact, with a particular focus on clients who have offended against children or young people. This is consistent with the approach prescribed in the Department of Corrections and Ministry of Health contracts, although during the consultation process we did hear that some providers will accept referrals for adult-to-adult offending if needed.

Effectiveness

The primary goal of HSB services is to reduce clients' (offenders/perpetrators) risk to engage in sexually abusive behaviour and increase their ability to live healthy, non-abusive, and satisfying lives, with the ultimate goal of making communities safer[7].

[6] PwC Budget Initiatives Summary

[7] ATSA Guidelines (2014)

While the effectiveness of HSB services, particularly in respect to outcomes, is subject to much debate and discussion, there is an increasing body of literature with sufficient weight to suggest that treatment approaches – particularly for child sexual offending – can be effective in reducing recidivism.[8] In terms of programme approach, the literature is clear that HSB programmes based on a cognitive-behavioural approach and which follow the risk, need and responsivity principles are most effective.[9]

[8] Community Child Sexual Offender Treatment Programmes: A review of providers and outcomes (Department of Corrections, 2016), Losel and Schmucker, 2005

[9] Hanson et al, 2009

4.Definitions

Concerning sexual ideation (CSI)

CSI refers to sexual thoughts and fantasies that are harmful in nature and can pre-empt actual HSB. People who identify as having CSI may engage in counterproductive measures to manage their arousal/thinking and subsequently commit HSB.

Harmful sexual behaviour (HSB)

HSB or sexually abusive behaviour is a descriptor for a number of sexual behaviours that involve elements of force, coercion and/or power by one person over another for the purpose of sexual gratification and control. These behaviours can include both contact and non-contact behaviour.

Examples of non-contact behaviour include: stalking, grooming, child sexual abuse material, 'revenge porn', on-line sexual harassment, peeping, stealing underwear and exposure/flashing. Examples of contact behaviour include: non-consensual penetrative sex, oral and/or manual sexual contact, producing objectionable material, sexual contact with someone under 16, sexual contact with animals, physical/verbal sexual harassment, intentional exposure to developmentally detrimental sexual material and or behaviour, child/adult sexual exploitation.

5. Harmful sexual behaviour clinical practice

This section looks at the client's journey through the clinical practice components of HSB services. This journey is illustrated in the Client Pathway diagram (see attached). The way HSB services can integrate with the wider social service system is illustrated in the Integrated Services diagram (see attached).

The chapter looks at the four key practice components, namely: referral, assessment, intervention, and service effectiveness. The four components are structured under the following overarching practice principles:[10]

- People seeking help for HSB receive appropriate and timely support (referral)
- Clients get the right intervention based on their individual risk level and needs (assessment)
- Harmful sexual behaviour interventions are evidence-based and align to good practice (intervention)
- Service effectiveness is informed by ongoing monitoring, review and evaluation (monitoring outcomes)

Evidence-base for HSB

There is a wide body of research on HSB services; this includes international as well as New Zealand specific research and evaluation of interventions.

Harmful sexual behaviour interventions and programmes have been in development nationally since the mid-1980s. While it was previously thought that people (men specifically) exhibiting this behaviour could not be treated,[11] advances in understanding of risk and dynamic factors associated with behaviour change through the Risk, Need, Responsivity Model,[12] along with the development of 'human goods' models such as the Good Lives Model, have meant that HSB services now contribute a significant amount of research and learning to the wider sphere of perpetrator interventions.[13]

HSB programmes have been evaluated as being effective in the reduction of risk factors associated with HSB perpetration,[14] and NZ programmes are seen to align with international good practice, although it is acknowledged that there are gaps in service delivery nationally.[15]

Mandated and non-mandated clients

While the focus of this document and section is on non-mandated adults, we found through our sprint process that both mandated (referred through the Department of Corrections) and non-mandated adults receive intervention together. This is based on measured level of risk rather than mandate, although providers do endeavour to ensure that low and high risk clients do not undertake group intervention together.

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[10] The core workforce capabilities and competencies required as part of good practice HSB services are set out in section 6.
[11] Barber, 1997
[12] Andrews and Bonta, 2007
[13] Marshall, 2006
[14] Lambie, Fortune et al, 2007
[15] HSB Parliamentary Review, 2014

5.1 People seeking help for HSB receive appropriate and timely support

This section looks at how clients are referred into a HSB service, the priority criteria for accepting referrals and the process of accepting and triaging a referral for assessment.

The referral process involves a range of roles and skill-sets, including staff who can respond to initial enquiries and requests for information, through to more specialist clinical staff that gather required information and make a triage determination about whether to refer the client to assessment (see Section 6 – Workforce capability for more detail on this).

The section also looks at current gaps and opportunities in respect to referral as highlighted through the consultation process and recommends areas for further development and research.

Referral pathways

Referrals to an HSB non-mandated service can come from a client's family/whānau, other social service/health service providers, community professionals and government agencies (including MVCOT, Department of Internal Affairs, Justice agencies). Clients may also self-refer to some service providers.

As a matter of good practice, it is expected that providers will work collaboratively with agencies and other services to ensure referral pathways into and out of the HSB service are clear and visible. This may include:

- ensuring information (printed and online) about the provider's service and referral process is available to people/agencies that make referrals
- the development of policies covering confidentiality and information sharing between agencies and providers
- the development of policies governing who or where referrals are accepted from, and, if a referral is declined, what information or advice is given to the referrer about alternative services that may be able to assist.

When discussing the referral pathways, providers noted that while acceptance of referrals is relatively standard across the sector, some providers will accept self-referrals while others require referrals to come through an agency or be accompanied by a support person. Providers who only accept referrals with the involvement of an agency/support person noted it provides for greater support and accountability for the individual in the process and within the community, and it makes it easier to obtain background information about their behaviour. Providers also noted that safety concerns, particularly the need to have someone responsible for monitoring compliance with a safety plan, is a strong reason for requiring agency referrals. Providers will partner with MVCOT if there is a child residing in the same home as a client.

We note further consultation with providers is required around the value of defining referral criteria and entry points.

Referral priority criteria

Research into the HSB sector indicates that demand exceeds supply in respect to funded places, particularly places for non-mandated adults.

Currently, funding agreements for services for non-mandated adults do not specify referral priority criteria. This decision is properly left up to the providers, most of whom prioritise adult clients who have offended against children or young people (this aligns with current Corrections' funding models).

Following consultation with the providers, it was determined that current referral priority criteria involves current need, level of risk and impact, community safety and protection of children and motivation of service user.

Referral practice components

The core practice components of the referral process include:

- receive and respond to a referral (this includes managing enquiries regarding potential referrals)
- acceptance and triage of referrals.

During consultation, discussion noted HSB services are part of a wider social services system, focussed on preventing sexual abuse and prioritising the rights of victim and community safety. Providers will advise the referrer and/or any relevant statutory agency of any immediate safety concerns that may require implementation of a safety plan to manage risk.

Receive and respond to a referral

Clients seeking information and/or intervention for their harmful sexual behaviour should receive appropriate and prompt responses that acknowledge and respond to their particular needs and circumstances. In order to do this, providers must have:

- documented and accessible referral forms, containing agreed minimum information fields required for a referral (such as name, age, ethnicity, living context, contact information, known HSB, client consent)
- procedures governing client consent (consent is a prerequisite for acceptance of a referral), timeframes and receipt of a referral, for example, whether this is required to be in writing or email
- procedures covering collection of additional information from the referrer, this may include reports, case files, criminal history or other information as required
- processes for managing enquiries regarding potential referrals, which may not necessarily require an assessment, including further consultation by a clinical staff member and/or advice as to the right service.

During the consultation process, providers noted the challenge and time involved in obtaining comprehensive referral information from non-mandated clients, particularly non-mandated clients that self-refer. Under the current funding agreements, the Ministry provides contributory funding for assessment and intervention but does not fund the enquiry/referral process.

This was identified as a gap and one which had an impact on the capacity of clinical staff to focus their time on their areas of expertise, namely assessment, intervention and service effectiveness.

Acceptance and triage of referrals

Before a client can be accepted into assessment, providers need to undertake a review and triage of referrals. In doing this, it is expected that providers will:

- have processes governing the decision to accept or decline a referral, which are based on a review of the referral by a clinician
- be able to explain to the client, their family/whānau/support person the consent process, including how information is stored, accessed and amended, and limits to confidentiality (this can also be done at the assessment stage)
- be able to explain to the client, their family/whānau/support person and funding agencies (if required) how the referrals process and waitlists operate
- have processes governing what to do if a referral is not accepted, for example, written notification to the referrer and advice as to the right service
- ensure the right clinical team for assessment is identified, a time for assessment is made and the client is given notification of their assessment appointment along with information about what to expect during the process
- have robust and appropriate case management and file management systems that can record and store referral information, individual client data as well as track data and trends.

Initial safety planning and risk assessment

As discussed previously, harmful sexual behaviour services are delivered within an overarching framework of victim and community safety (see the attached diagram for an illustration of how the integrated service system operates in respect to HSB).

Where applicable, providers will advise the referrer and/or any relevant statutory agency of any immediate safety concerns that may require implementation of a safety plan to manage risk.

Providers also advised that implementation of the safety plan for non-mandated clients may be condition of entry into assessment; however, monitoring of compliance with the safety plan will remain the responsibility of the client, referrer and/or family/whānau/support person. Providers noted this is a gap with current service provision and that there is no funding for safety planning work prior to commencement of assessment.

Service gaps

Throughout the consultation period, providers noted the gap around funding for the referral process (specifically the lack of funding for referrals to a Capacity and Ability to Protect Programme) and the challenges - and time involved - in gathering sufficient referral information from non-mandated clients.

Linked in with this was discussion about geographical accessibility and the need to ensure a wider spread of services for non-mandated adults (geographical, cultural, adult-to-adult etc).

As part of the sprint process, we workshopped the possibility of streamlining or improving the referral process – greater use of technology and centralised hubs were

mentioned – and this is something we will consider further throughout the service development process.

5.2 Clients get the right intervention based on their individual needs and characteristics

This principle covers the clinical assessment process and is focussed on ensuring clients receive interventions that are tailored to their individual risk level and needs.

Assessments are carried out by clinicians and overseen by clinicians and/or team leaders (see Section 6 – Workforce capability for discussion of the requisite skills and experience of clinicians).

The overarching goal of assessment is to determine level of risk, client needs and to frame an intervention to support the prevention of future harmful sexual behaviour from occurring. Recommendations are also made regarding current risk management and safety planning requirements.

This section is divided into three parts:

- Good practice approach: looks at the evidence-base underpinning assessment
- Assessment practice components: outlines what is required in respect to the three core practice components of assessment, namely the assessment interview, psychometric assessment and the written assessment report
- Gaps and opportunities: explores current gaps and opportunities in respect to assessment as highlighted through the consultation process and recommends areas for further development and research.

Good practice approach

There are two key elements to an effective assessment approach: the therapeutic relationship or dynamic between the client and clinician and adherence to evidence-based practice.

Therapeutic relationship

Establishing a positive and effective relationship between the client and clinician is fundamental to the client's overall engagement (responsivity) in the process and their internal motivation to change.

In developing this relationship, it is expected that the clinician will:

- engage with the client in a relational way, ensuring the client is met with non-judgemental and non-stigmatising responses
- employ a client-centred interviewing style, designed to increase the client's motivation to participate in intervention
- strive to meet the unique needs of clients with developmental, learning or physical impairments
- engage and build rapport with the client's family/whānau/support person in a non-threatening and professional way (with their consent)
- comply with all relevant ethical codes, standards or guidelines for their profession, as well as any applicable agency policies, particularly in respect to conflicts of interest and confidentiality.

The workforce capability section outlines the skills and experience required of effective clinicians. This has been informed by the Workforce Capability Framework, developed as part of the Family Violence and Sexual Violence Work Programme.[16]

Evidence-based practice

During the assessment process, clinicians gather background information and collateral reports about the client and frame this information against an assessment of both static and dynamic criminogenic factors to reach an estimate about the client's overall level of risk and need.

Static risk factors are non-changeable (on the whole) life events that relate to risk for sexual recidivism. These include factors like having a history of sexual offences or having offended against a male child. Dynamic risk factors are those factors that can change, like drug and alcohol use, sexual preoccupation, relationship stability and so on. In addition, assessment can identify stable dynamic risk factors. These are best described as factors that can change but are relatively fixed in a person's way of being, for example, character typologies, personality spectrum disorders, mental health diagnosis.

Assessment also seeks to identify areas of client need, 'human goods' goals and responsivity factors to inform a robust intervention that addresses both risk and need.

At a minimum, clinicians conducting assessments will:

- obtain information relating to the client's background, including their past offending behaviour and lifestyle
- have regard to multiple data sources for the assessment as relevant, including psychometric assessment of the impacts of trauma on the client, substance abuse, mental health, personality disorders and intellectual functioning
- have processes for referring the client to other services if they have outstanding health needs that need addressing before assessment and intervention can continue
- understand the nature and relevance of dynamic and static risk factors and how these can help determine the likelihood of future offending/reoffending
- select the most appropriate assessment tool(s) for the client's particular needs and characteristics and be trained to implement these tools (see Psychometric assessment below)
- prepare an assessment report documenting the client's level of risk, needs and strengths and the clinician's intervention recommendations and risk management recommendations
- have processes in place to address and assess both sexual and non-sexual harmful behaviour or offending, and document these in the assessment report
- base intervention recommendations on the client's assessed level of risk, with higher risk clients assigned a greater level of intervention

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[16] The draft Framework has been consulted on and is currently being tested in Integrated Service Response (ISR) pilot sites. Information on the status of the Framework and next steps is at https://www.justice.govt.nz/justice-sector-policy/key-initiatives/reducing-family-and-sexual-violence/work-programme/updates/#consultation

- assess and document the client's strengths and protective factors and have regard to these in preparing the intervention recommendations.

Feedback from consultation with providers suggest that while the evidence-base for risk assessment is well documented and accepted in respect to men who engage in harmful sexual behaviour, there are research gaps around its applicability to female clients. This was identified as a potential area for further research.

Assessment practice components

The core practice components of assessment include:

- assessment interview(s)/collection of collateral information,
- psychometric and risk assessment
- a written assessment report.

Throughout the assessment process, providers will prioritise and consider the safety of the victim and potential future victims.

The assessment process generally takes approximately 30 hours of clinician time over a six to eight week time period (40 working days), and includes the three practice components listed above.

Assessment interview

The purpose of the assessment interview(s) is to gather information to try and understand the client's pathway into HSB (formulation), their potential for engaging in harmful sexual behaviour in the future (recidivism), and to determine what should be done to prevent this from occurring.

In order to do this effectively, providers must:

- have documented assessment procedures or manuals covering (but not limited to) informed consent, ethical codes, confidentiality, conflicts of interest, training and supervision of staff conducting assessment interviews and storage and retention of records.
- ensure staff conducting assessment interviews have the specialist qualifications, training and skills to engage therapeutically with the client (see Therapeutic relationship above) as well as with the client's family/whānau/support person and additional supports/service providers.
- have suitable facilities for conducting assessment interviews, this includes consideration of safety, privacy, space to accommodate the client and their family/whānau/support person.
- have processes governing what happens if the client is assessed as unsuitable for intervention and for referring the client to other services if the client has other needs that need addressing before intervention can commence, or if the client fails to engage.

During service development consultation, there was some discussion around how to respond to clients that continue to either deny or minimise their harmful sexual behaviour and whether these clients should be assessed as suitable for intervention. All providers agreed that they will consider the degree of denial, alongside the factors

driving the denial, on a case by case basis and that this does not automatically rule out access to assessment or intervention. On this, it is worth noting that there are a small number of overseas providers (mainly in the United States of America but also the work developed by Jason Ware in Australia) that have developed intervention programmes specifically for men who continue to deny their behaviour. These may provide a good starting point for service development but would need to be explored further for the New Zealand context.

These challenges are explored further below in Service gaps.

Psychometric assessment

As noted above, assessment includes the use of actuarial assessment tools aimed at identifying risk factors (both static and dynamic) that are a good predictor of future harmful sexual behaviour. These tools provide an assessment of risk against a baseline offender population. Other psychometric tools (SAPROF and Armidilo) are applied to ensure inclusion of assessment of a client's protective factors and strengths. Best practice is to use the most up-to-date measure and ensure staff are trained to use it.

A list of the assessment tools used by HSB providers for the purpose of assessing non-mandated clients will be contained in the Service Guidelines for non-mandated harmful sexual behaviour services.[17]

At a minimum, clinicians and providers using and relying on assessment tools must:

- be knowledgeable about the use of these tools and the evolving research in order to select the most appropriate tool(s) for the client's needs and characteristics
- be appropriately trained, experienced and supervised in order to interpret and analyse the results and incorporate into the assessment report
- where possible, use the same assessment tools within and across agencies in order to improve consistency and information sharing.

Psychometric testing administered as part of assessment must be overseen by a competent supervisor, trained in the use of the particular tool. See also the broad good practice principles outlined above in the Good practice approach.

It is also important to note that risk itself is not static and should be measured post intervention and/or if circumstances change significantly during the course of intervention (see discussion on page 17 – Quality assurance).

During consultation, it was noted that there are no current psychometric assessments that are culturally specific with respect to need and responsivity, although providers are currently looking to embed some cultural measures alongside the ARMIDILO tool.

Written assessment report

Following the assessment interview(s) and psychometric assessments, the clinician will prepare a written assessment report.

The report contains an explanation and understanding of the client's harmful sexual behaviour and their potential for future harm. The report brings together information

[17] The Service Guidelines will be available on the Ministry's website once finalised.

gathered through the assessment interview(s) and psychometric assessment to derive an estimate or judgement of the client's level of risk. The report will also consider broader factors including client needs, motivation to change, engagement, ongoing safety and risk management recommendations.

Depending on the client's assessed level of risk, the clinician will recommend intervention strategies designed to facilitate change. In addition to an intervention plan, recommendations may include supervision, monitoring and victim safety planning. The report will also indicate whether the client is unsuitable for intervention and the reasons why.

In respect to preparation of the assessment report, it is expected that providers will have:

- procedures setting out what the assessment report must contain, including (but not limited to): the range of information sources used to conduct the assessment, demographic information, conclusions and recommendations, notes of any recommended interventions or services that are unavailable
- procedures around who completes the assessment report and peer review processes for reviewing the assessment report
- processes governing discussion of the assessment report with the client and their family/whānau/support person, signed consent, and who receives a copy of the report
- broad guidelines governing timeframes between assessment and commencements of intervention and operation of waitlists
- processes governing what happens if the client is assessed as unsuitable for intervention and for referring the client to other services if the client has other needs that need addressing before intervention can commence, or if the client fails to engage
- robust and appropriate case management and filing systems in place capable of recording all relevant client data and securely storing the assessment report.

During the consultation period, providers noted that some of the reasons a client may be considered unsuitable for intervention include priority clinical needs requiring intervention first, issues with barriers/motivation, funding/contractual agreements and not enough information.

In addition to being unsuitable for intervention, a client's access to a service can be constrained by geographic accessibility of services, cost of treatment for non-mandated/unfunded clients, lack of support people to ensure safe community based intervention and monitoring (although this would not necessarily preclude an individual from intervention), and long waitlists.

At present, there are no formal support mechanisms or follow-up for clients deemed unsuitable for intervention or for family/support people where clients dis-engage or are recommended for non-community based treatment.

Service gaps

As flagged in the above discussion, the key gaps in respect to assessment include the availability of New Zealand research into the assessment and services for clients with

concerning sexual ideation (CSI), assessment tools for historical offences committed during adolescence but not reported until the offender is in adulthood, and understanding static and dynamic risk factors for females who have sexually offended.

Through consultation, we also found there is limited national and international research regarding adult women who engage in sexual harm.

5.3 Harmful sexual behaviour interventions are evidence-based and align to good practice

This principle covers treatment interventions for people who have engaged in harmful sexual behaviour. The aim of intervention is to reduce or minimise the risk factors linked to the client's harmful sexual behaviour and to increase the client's protective factors.

Treatment interventions for people who are at risk of, but have not yet engaged in harmful sexual behaviour, treatment interventions for adult-to-adult offending, and Capacity to Protect programmes and intervention with non-offending partners/family are identified as gap areas below in Service gaps.

Interventions are carried out by clinicians and overseen by clinicians and/or team leaders (see Section 6 – Workforce capability for discussion of the requisite skills and experience of clinicians).

This section is divided into three parts:

- Good practice approach: looks at the evidence-base underpinning intervention.
- Intervention practice components: outlines what is required in respect to the three core practice components of intervention, namely intervention planning, intervention and intervention progress and completion (service effectiveness and monitoring is addressed separately in Section 5.4).
- Gaps and opportunities: explores current gaps and opportunities in respect to intervention as highlighted through the consultation process and recommends areas for further development and research.

Good practice approach

Like assessment, a good practice approach to intervention requires an effective therapeutic relationship between the clinician and client as well as adherence to evidence-based practice and a structured intervention programme tailored to the needs of the individual.

Therapeutic relationship

Establishing a positive therapeutic relationship between the client and clinician is important to the client's internal motivation, overall engagement in the process and completion of the intervention.

In developing this relationship, it is expected that the clinician will:

- be appropriately qualified, trained and supervised, particularly with respect to the social context and research base applicable to HSB
- utilise a style and technique that aligns with research, for example, they are empathic, warm, encouraging, firm but flexible, and relatively directive
- utilise techniques that have been shown to be effective in engaging the client, for example, through modifying pace and delivery as appropriate
- adjust their style to match client's needs, for example, they are gender responsive, developmentally appropriate, culturally sensitive and responsive

- engage and build rapport with the client's family/whānau/support person in a collaborative and professional way
- comply with all relevant ethical codes, standards or guidelines for their profession and agency policies, particularly in respect to conflicts of interest and confidentiality.

The Workforce capability section contains further detail about the skills, experience and personal characteristics required of effective clinicians.

It was clear from the sprint process that further research and exploration is required around the therapeutic relationship and cultural effectiveness and any challenges and gaps.

Evidence-based practice

Research indicates that effective interventions for people who have engaged in harmful sexual behaviour incorporate the principles of risk, need, and responsivity and utilise cognitive-behavioural and relapse prevention models.

At a minimum, clinicians delivering interventions will:

- ensure the level (or dosage) of intervention is tailored to the client's assessed risk level (Risk principle)
- where possible, separate clients undertaking intervention by risk and ensure that low and high risk clients do not undertake group interventions together
- tailor intervention targets according to the client's dynamic risk factors, specifically those factors that can be changed through intervention and that are known to be associated with risk and recidivism (Need principle)
- tailor intervention approaches with sensitivity to the client, for example, language, culture, personality style, anxiety levels, learning styles and cognitive abilities (Responsivity principle)
- utilise a cognitive-behavioural model in delivery of intervention, for example, one that teaches individuals to understand the relationship between their thinking patterns, emotions and actions
- incorporate a strengths based approach, which aims to equip clients with the necessary skills, competencies, value and beliefs to enable them to lead "good lives"
- regularly monitor and re-measure the client's risk level using both internal and external review processes, and adjust interventions based on any changes in dynamic risk factors
- engage the client's family/whānau/support person throughout intervention to help them explore the dynamics of the client's HSB, how the client's HSB has affected them, how to identify and respond to any triggers for the client and to ensure the safety of any family members
- regularly monitor and document intervention progress, or lack of progress, against intervention goals (see Section 5.4 – Service effectiveness is informed by ongoing monitoring, review and evaluation for further detail)
- be able to facilitate and support an integrated service response, through awareness of and links to other relevant services.

Through the consultation, it was evident that providers delivering HSB services to adults prioritise interventions for those adults who have engaged in harmful sexual behaviour towards children or young people (this is consistent with Corrections' funding model). However, providers noted that there is also significant need and demand in the adult to adult sexual harm space, specifically in the 18 – 25 year old age group.

A further gap area is interventions for those who are considering harmful sexual behaviour but who have not yet sexually offended. Interventions in this area may require further research and development and are discussed further below in Service gaps.

Intervention practice components

The core practice components of HSB interventions are:

- intervention planning (also referred to as individual treatment plans)
- intervention
- intervention progress and completion (service effectiveness and monitoring is addressed separately in Section 5.4).

In addition to these three core components, effective interventions include supervision, monitoring and safety planning.

Intervention planning

Before commencing intervention planning, clinicians must ensure that the client's assessment is comprehensive and up-to-date.

The purpose of intervention (or treatment) planning is to work with the client and their family/whānau/support person to set intervention goals and timeframes, and to review and amend the initial safety and risk assessment plans. Intervention goals must be informed and collaborative, based on the client's individual needs, deficits and strengths.

The length of intervention will be tailored to the needs of the client, determined by their risk level and specific needs identified during assessment. Generally, intervention takes place over a six or 12 month period, depending on client risk and intervention needs. If intervention for low risk clients is warranted, it should be less intensive than for medium or high risk clients (research indicates that low risks clients should receive no more than 100 hours of intervention).[18]

When undertaking intervention planning, it is expected that providers will:

- document the client's intervention goals/targets (in an individual intervention plan). These should address the criminogenic factors relevant to the individual client's circumstances and needs and may include (but are not limited to) addressing denial, identifying and managing risk factors, enhancing empathy for victims and developing prosocial skills

[18] Wakeling, Mann and Carter (2012), *Do low-risk sexual offenders need treatment*, Howard Journal of Criminal Justice

- work with the client to tailor the above broad intervention goals to the client's specific needs and characteristics and recommend interventions that are appropriate for a client's assessed level of risk
- review and update the intervention plan as required, based on the client's changing needs
- have documented policies covering, among other things, informed consent, programme attendance and expectations, orientation, roles and responsibilities, confidentiality (and the limits to this)
- work with the client's support network to ensure ongoing adherence to safety, additional accountability and monitoring
- have processes for referring the client to other services if the provider is unable to provide the right intervention for the client or if the client has other needs that need addressing before intervention can commence.

Challenges and service gaps identified through consultation include intervention planning with clients from diverse cultures and planning for adult-to-adult clients, including specific interventions for 18-25 year old clients.

Intervention

In the broadest sense, the goals of intervention are for clients to develop skills and techniques that will prevent them from engaging in harmful sexual behaviour in the future, to enhance protective factors, and to lead productive and prosocial lives.

There are four main types of interventions in HSB clinical practice. Clients generally receive all types of intervention, but this will be tailored to individual client need.

- Individual therapy: Enables the clinician to explore the factors that underlie the client's HSB, any responsivity barriers or therapy interfering behaviours and to develop individualised strategies and plans to manage the client's risk level. Individual therapy also provides an opportunity for the clinician to identify and enhance the client's prosocial skills. Individual therapy may be provided as an 'individual intervention' where the client is not suitable to attend a group intervention or group is not available, or as 'additional individual sessions' to group intervention, where key concepts/work is introduced in group and followed up in additional sessions.
- Group therapy: The purpose of group therapy is to extend the client's understanding of the key intervention themes via peer feedback and exposure to other's learning. It also provides an opportunity for the client to build on new skills.
- Family/whānau work: Clinicians will meet with the client's family/whānau/support person early in the intervention process to explore how the client's HSB has affected the family/whānau and to ensure the safety of any vulnerable family members. Family work may also address dynamics within the family that may compromise safety and/or condone attitudes and behaviours that are potentially harmful. Clinicians will also collaborate with other service providers in respect to safety and support planning for the family/whānau.
- Psychosexual educational programmes: Provision of education to clients and support people. Typically this would include information regarding the dynamics of HSB,

myths and realities of HSB, and expectations of treatment/intervention and the role of a support person. Note that this is part of any intervention.

In delivering interventions, it is expected that providers will have:

- documented programme manuals, as well as processes for reviewing and updating the manuals to ensure programme fidelity
- processes for ensuring that interventions are tailored and sensitive to the diverse needs of the client group, this may include for example, processes to incorporate culturally responsive materials, themes, language and activities
- documented policies covering (but not limited to) compliance and non-attendance, confidentiality, ethical codes, incident reporting and complaints management
- processes governing what happens if a client drops-out of intervention or needs to be referred to another agency or service to address other needs (for example, drug and alcohol or mental health issues) and how they can re-engage with the provider
- a well-developed and resourced professional development strategy for staff, including processes around peer support and review, supervision, compassion fatigue and continuing professional development and research
- systems in place to monitor the client's progress against the intervention goals and to measure the effectiveness of the intervention, both at an individual client level and more broadly (see Section 5.4 – Service effectiveness for further discussion).

See also the broad practice principles outlined above under the Good practice approach.

Themes that emerged through the consultation period in respect to intervention included challenges around mixing risk level, balancing mandated and non-mandated clients (specifically number of referrals and funding requirements), numbers to form a group – which is often due to unpredictability of referrals, and cultural responsiveness.

When considering mandated and non-mandated clients, providers noted a number of practical considerations that go into making up a group. These include ensuring a minimum number of clients, clinician capacity and ensuring wider geographic coverage of service. These considerations frequently necessitate the mixing of clients from different funding contracts.

In respect to mixing risk level, providers noted that, where possible, they will separate clients undertaking intervention by risk – particularly low and high risk clients. We will do further consultation with providers around the practicality and value of requiring separation of risk in their contract specifications.

Intervention progress and completion

As noted above, the overarching goal of intervention is to reduce the client's risk of reoffending and increase their protective and prosocial behaviours. Successful completion of intervention does not, however, indicate that the client's risk of reoffending has been eliminated completely.

Providers will have processes and systems in place in respect to monitoring intervention progress and intervention completion. These processes must be evidence-based and will include (but are not limited to):

- processes governing assessment of intervention progress, this will include roles and responsibilities, the use of structured assessment tools during and at the end of intervention and comparison of results/change
- policies around notification if the client drops out of intervention or does not engage and/or is unresponsive to intervention, for example notification to statutory agencies, the Police, the referrer, family/whānau/support person
- processes to prepare the client for intervention completion, for example, this may include a gradual reduction in the number of sessions, support for the client to practice the skills they have learnt during intervention and to develop and maintain prosocial lifestyles
- a final system review and completion report - this process must involve the client as well as their family/whānau/support person and include a safety-plan and any recommendations for further intervention.

There is further discussion of the processes involved in monitoring service effectiveness in Section 5.4 – Service effectiveness is informed by ongoing monitoring and review.

Challenges and gaps identified during consultation included the difference between mandated and non-mandated clients in respect to supervision and monitoring and the lack of formal supervision and post-intervention follow up for non-mandated clients.

Service gaps

During the consultation period, a number of common themes emerged in respect to the gaps around intervention. Key among these was the lack of funding for post-intervention work/maintenance groups, although providers did acknowledge that post-intervention work and its effectiveness does need to be more widely researched. Other gaps included:

- limited culturally specific and responsive services
- limited services for intellectually disabled clients
- services for adult-to-adult HSB, including specific interventions for 18-25 year old clients
- Capacity to Protect programmes and intervention with non-offending partners/family
- services for clients who are at risk of, but have not yet committed harmful sexual behaviour.

Providers also noted gaps in respect to services for family/whānau/support person where the primary client drops out of treatment and/or fails to engage but the family/whānau/support person require support and education.

5.4 Service effectiveness is informed by ongoing monitoring, review and evaluation

Quality assurance and control is a core foundation of evidence-based HSB practice.

This section looks at what is involved in monitoring and enhancing service effectiveness, including the core practice components. The section also explores current gaps and opportunities in respect to clinical assessment and recommends areas for further development and research.

This section should be read in conjunction with the Government's Results Based Accountability Framework.

Good practice approach

The good practice approach to service effectiveness includes three key elements:

- maintain programme effectiveness to programme models that have been shown to be effective
- measure effectiveness through structured assessment tools
- recruit, train and support a quality workforce.

Practice components

The core practice components of service effectiveness include quality assurance, feedback and evaluation and reporting. Ideally, first line quality assurance happens internally, with second line quality assurance done externally for transparency and consistency.

Programmes should also have an inbuilt evaluation framework to ensure data is being collated to inform short, medium and long-term evaluations.

Quality assurance

In order to maximise service delivery, maintain programme fidelity and enhance continual improvement, providers need to have robust staff training and support processes and quality assurance systems. These include:

- processes for measuring clients' intervention progress, engagement in treatment, internal motivation to change (demonstrated in attitudes/behaviour) and level of risk (demonstrated through reduction in dynamic risk factors and increase in protective factors)
- processes for collecting and evaluating information about the client's intervention progress from other sources, for example, reports from client, Police, family, other agencies
- documented practice and/or intervention manuals, based on evidence of what works in respect to treating clients who have engaged, or are at risk of engaging, in harmful sexual behaviour
- procedures governing peer review and supervision of staff, including: review of use and scoring of assessment tools; review of clinician's motivational interviewing technique; evaluation of interventions; review of case files; and recording group and

individual therapy and robust review processes (see also case reviews under Feedback and evaluation)

- processes around training, professional development and support for staff, particularly around staff burnout and compassion fatigue (see Section 6 – Workforce capability for detail)
- processes for conducting operational reviews, recording and collating feedback and updating manuals, including a review of intervention content and delivery and consideration of how the service could be improved
- policies around review of critical incidents and safety concerns, including procedures governing recording and responding to any critical incidents and incorporating recommended changes into practice and/or intervention manuals.

Feedback and evaluation

Feedback and evaluation feed into the overall programme effectiveness and are particularly important for measuring progress against outcomes and incorporating the client and community's voice into service development.

Effective feedback and evaluation processes include:

- regular internal case reviews (every three months), these may include for example, file audits, clinical supervision and peer-to-peer observation and review
- regular system reviews (at least every three months), which provide opportunity for the client and their family/whānau/support person to give feedback on progress, safety, risks and any issues regarding motivation and intervention effectiveness
- ensuring intervention targets align to outcomes and can be observed, recorded and tracked for effectiveness (see also Reporting below)
- development of formal feedback processes and policies so that clients and others participating in them, whether by way of survey, questionnaire, focus groups or evaluation, are aware of how the information they provide will be used
- the development of open and accessible complaints policy, including documented processes for responding to complaints, escalation, and how to incorporate complaints review and findings into service development.

Providers must also be willing and able to participate in any evaluation of services that is undertaken by the Ministry.

Reporting

Providers are required to collect data in order to contribute to an evidence base for the effectiveness of harmful sexual behaviour services. The data required to be collected will be outlined by respective funding agencies and in providers' governance arrangements.

To meet this requirement, providers must have:

- appropriate and robust information management systems, capable of recording (at minimum) how many clients accessed and completed the service and whether outcomes were achieved
- documented measures of progress/outcomes, including the actual number of hours the client was engaged in intervention, the length of participation, reasons for drop-

out or termination of intervention, treatment completion reports and any ongoing concerns and/or additional recommendations for intervention

- a documented plan or strategy for conducting empirical research, this could include for example, research targets, identifying potential research partners and identifying priority or gap areas that warrant additional research.

For further information about the Ministry's reporting requirements, see the Government's Results Based Accountability Framework at resultsaccountability.com.

Service gaps

Throughout the consultation period, the lack of funding for providers to engage in extensive empirically-based research was a common theme. Providers stated they have a rich body of data around what works for HSB services, but capacity and funding constraints make it difficult to consolidate long term research around intervention effectiveness. The HSB sector within New Zealand is has a particularly rich data collection pool, dating back to nearly 30 years of data.

On this, it is worth noting that the three largest HSB providers in New Zealand have recently developed a shared case management system (due for roll-out across the country in 2017). The use of a shared case management system will increase the HSB evidence-base in New Zealand and make it easier for providers to contribute to evaluations and empirical research.

6. Workforce capability

This section looks at the core workforce competencies and capabilities required of the HSB workforce. It is important to note at the outset that harmful sexual behaviour assessment and intervention is a specialist field of work, and those working in the sector require professional qualifications, extensive experience and specific personal characteristics suited to this type of work.

This section looks at the following components of workforce capability:

- qualifications and experience
- staff recruitment and induction
- staff safety
- peer support and supervision
- professional development.

In addition to qualifications and experience, this section acknowledges that the efficacy of HSB interventions depends highly on the skill of the person delivering them; specifically their ability to relate to and engage clients in the process.

6.1The harmful sexual behaviour workforce is qualified, experienced and supported

This principle looks at the qualifications, experience, professional development and support required for the harmful sexual behaviour workforce.

As previously highlighted, a skilled and well supported workforce - along with adherence to evidence-based practices and ongoing monitoring and quality assurance - are all needed to ensure effective outcomes for clients.

This section has been informed by feedback from providers and relevant research, as well as the Social Sector Accreditation Standards – Level 2[19] and the Family Violence, Sexual Violence, and Violence within Whānau Workforce Capability Framework (Capability Framework).

The Capability Framework was developed in conjunction with the family violence and sexual violence sector to build the workforce and community sector capability to respond safely and respectfully to people experiencing, affected by, and perpetrating family violence, sexual violence and violence within whānau. This section should be read together with the Capability Framework.

Qualifications and experience

The provision of harmful sexual behaviour services is a highly specialist area of work. Clinicians undertaking assessment and treatment interventions must have a recognised qualification in a relevant field (see Table 1 below) as well as the skills and experience necessary to facilitate effective outcomes for their clients.

Senior clinicians/team leader/clinical manager must have at least 2,000 hours of supervised face to face experience in the assessment and/or treatment intervention of sexual offenders. Clinicians with less experience may undertake assessments and interventions under the supervision of a team leader. Psychometric testing administered as part of assessment must be overseen by a competent supervision, trained in the use of the particular assessment tool.

In addition to clinical staff, providers may employ staff (social support staff) to work alongside the clinician, the client, the client's family/whānau/support person, and the wider community to provide support, advocacy and 'system linkages'.

The minimum qualifications and experience required of clinical staff and social support staff are outlined in the below table.

Table 1: Provider staff qualifications, skills and experience

Clinical staff	Social support staff
The core role of clinicians is to undertake assessments and interventions with adult clients who have engaged in harmful sexual behaviour. Clinical staff must have:	Social support staff work alongside clinicians and clients to support them in achieving therapeutic outcomes. Social support staff must demonstrate the following:

[19] Social Sector Accreditation Standards-Level 2

• a recognised qualification in psychotherapy, psychology, social work, counselling or equivalent qualification • current registration/membership with their relevant professional body or in the process of obtaining registration/membership • awareness of HSB, including current research developments, evidence-based practice, pathways into HSB and limitations of intervention • knowledge of the dynamics of HSB, risk factors and safety planning in a community context • the personal characteristics and skills to engage therapeutically with a cross-section of people in order to maximise the effectiveness of the assessment and intervention (for example, the client, their family/whānau/support person) • strong oral and written skills and the ability to write detailed assessment reports and recommendations • a knowledge and understanding of Maori societal and familial structures, including whānau, hapu, iwi and the dynamics of whānaungatanga • the ability to work effectively with clients from ethnically diverse backgrounds and minority groups • an understanding of integrated responses to HSB and the ability develop and sustain relationships with other agencies and key personnel across the social services sector • the ability to deliver HSB services to a wider support network and to engage the client's family/whānau/support person in the intervention process.	• a recognised social work qualification or equivalent skills and experience • knowledge of and adherence to consent and confidentiality protocols, including statutory reporting • knowledge of the dynamics of HSB, risk factors and safety planning in a community context • the personal characteristics and skills to engage with a cross-section of people in order to support the effectiveness of the assessment and intervention (for example, the client, their family/whānau/support person) • a knowledge and understanding of Māori societal and familial structures, including whānau, hapū, iwi and the dynamics of whānaungatanga • the ability to work effectively with clients from ethnically diverse backgrounds and minority groups • an understanding of integrated responses to HSB and the ability develop and sustain relationships with other agencies and key personnel across the social services sector • the ability to liaise with a number of support networks (for example, Marae, Church, community groups) and to engage the client's family/whānau/support person in the intervention process.

It is important to note there are currently no specific HSB qualifications. While clinicians must have a recognised qualification, specialist training takes place 'on the job'. Providers have estimated it takes up to two years for somebody entering this workforce to develop the understanding and skills required to deliver the work across various modes of service delivery (i.e., individual, group and family work).

Staff recruitment and induction

When recruiting staff, the provider will ensure they have the relevant qualifications and skills to be able to work with adults who have engaged in HSB, as well as the client's family/whānau/support person and wider community (see qualifications and experience below).

With respect to recruitment and induction, providers must:[20]

- have documented human resource policies covering the recruiting and vetting of all staff, including processes for recording and responding to criminal history checks
- ensure no applicant is employed if he or she has a conviction for sexual offences or physical violence
- ensure all children's workers meet the safety checking requirements required under the Vulnerable Children Act 2014
- ensure their recruitment processes encourage and enable applicants from a range of backgrounds, including gender, Maori, Pacific and culturally and linguistically diverse people
- have documented induction manuals for all new staff covering, but not limited to, the provider's policies and expectations, legislative responsibilities and obligations, safety, staff support and supervision.

Staff safety

Given the context and nature of harmful sexual behaviour services, it is important that providers prioritise and ensure, to the greatest extent practicable, a safe working environment for both its staff and clients. In meeting this requirement, providers must:[21]

- have documented health and safety policies and procedures in place which align with the Health and Safety at Work Act 2015 and which detail the provider's statutory and/or regulatory obligations in respect to essential notification reporting
- have documented workplace policies and procedures available for staff working with potentially abusive clients covering (but not limited to) options for excluding clients on the basis of risk to staff or other clients
- have a documented complaints and escalation policy
- ensure all premises are safe and fit for purpose, for example, they are well lit and lockable and staff have access to keys, security alarms, panic buttons or personal alarm pendants as required.

Peer support and supervision

Well-developed and ongoing peer support processes are necessary to support the HSB workforce and to improve staff retention. To meet this, providers should:

- provide an induction period, including core induction, training and mentoring, to all new staff

[20] See Social Sector Accreditation Standards-Level 2 – Staffing requirements
[21] See Social Sector Accreditation Standards-Level 2 – Health and Safety requirements

- ensure all staff have professional development plans, which are reviewed and updated annually
- establish clear boundaries and support employees in their efforts to sustain a balance between their personal and professional lives.

HSB providers must also ensure all clinicians and staff that provide a direct service to clients have access to regular professional supervision. The clinical supervisor must have a tertiary qualification in a relevant discipline, preferably psychology, as well as relevant clinical experience and knowledge.

Supervision is delivered across a number of service lines, including group supervision, individual supervision, clinical supervision, peer supervision, cultural supervision/consultation. While the frequency of supervision can vary based on client load, severity of cases and experience in the sector, providers must at a minimum:

- have documented procedures specifying who delivers clinical supervision and the frequency (best practice suggests clinical staff should receive at least one hour per fortnight of formal, one-to-one supervision)
- employ or contract a clinical supervisor and, where possible, employ or contract a cultural supervisor or ensure staff have access to cultural supervision (for example, through developing community networks or relationships with other providers).

Professional development

HSB practice is a specialist area and clinicians and staff working in this area require ongoing professional development. Professional development is particularly important for facilitators, who need the skills to be able to effectively engage clients in interventions.

We also note that all clinicians and staff directly involved in face-to-face service delivery are required to be members of relevant professional associations or working towards membership. These bodies have continuing professional development requirements that their members must adhere to.

As a matter of good practice, providers must:

- ensure clinicians undertake ongoing professional development to build on existing knowledge and maintain an awareness of the current research and practice trends
- foster a culture of continuous professional development and learning and look for opportunities to share knowledge and experience internally.

Gaps and challenges

During the consultation process, providers noted there are gaps around the number of Maori clinicians working in the HSB sector.

Providers noted the lack of specific HSB training opportunities and suggested more effort and funding is put into this area. Joint training events, workshops and conferences were suggested as a good way to share knowledge. Developing a New Zealand HSB accreditation process was mentioned as a way to support safe and effective practice.

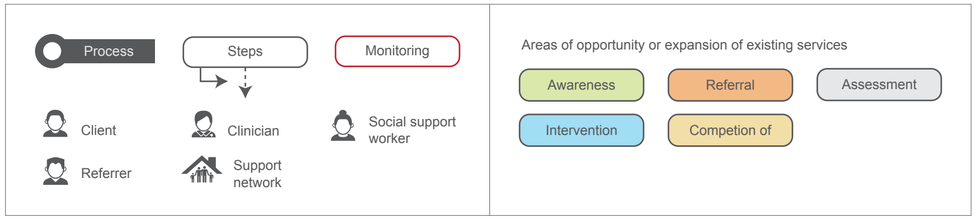
As noted above, at the time of this document there is no specific qualification for those wanting to work in the HSB field.

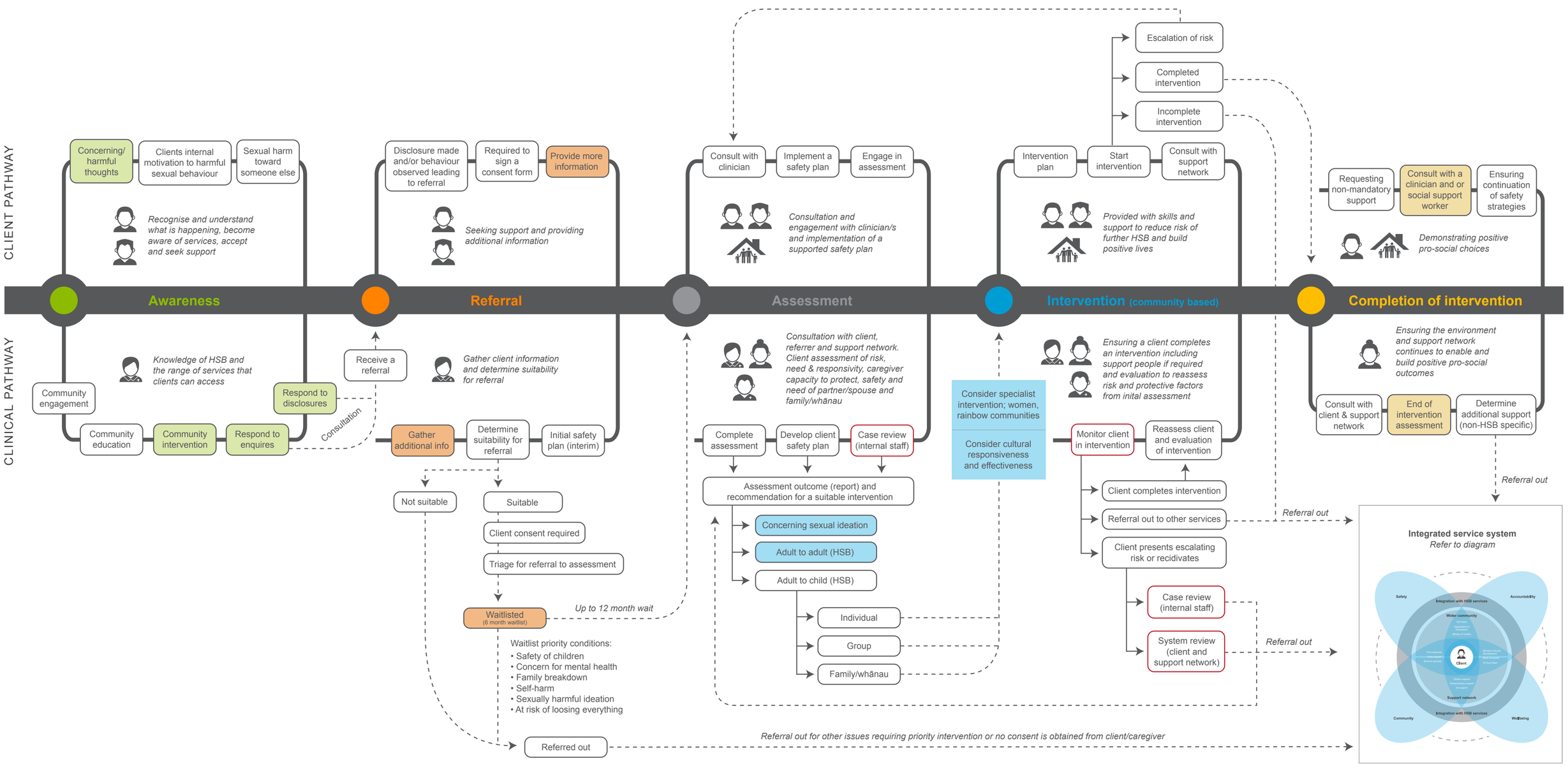
Pathways to intervention

The illustrated pathways demonstrates the high-level process and steps for non-mandated clients accessing harmful sexual behaviour (HSB) services, including highlighted areas of opportunity or expansion of existing services.

Through the sprint process, we recognise that funding for providers currently concentrate on assessment and intervention. Funding needs to consider the complete intervention pathway including preliminary stages such as awareness and referral. Particularly because non-mandated clients can require more time and capacity to gather additional information that is not provided with a referral.

Key





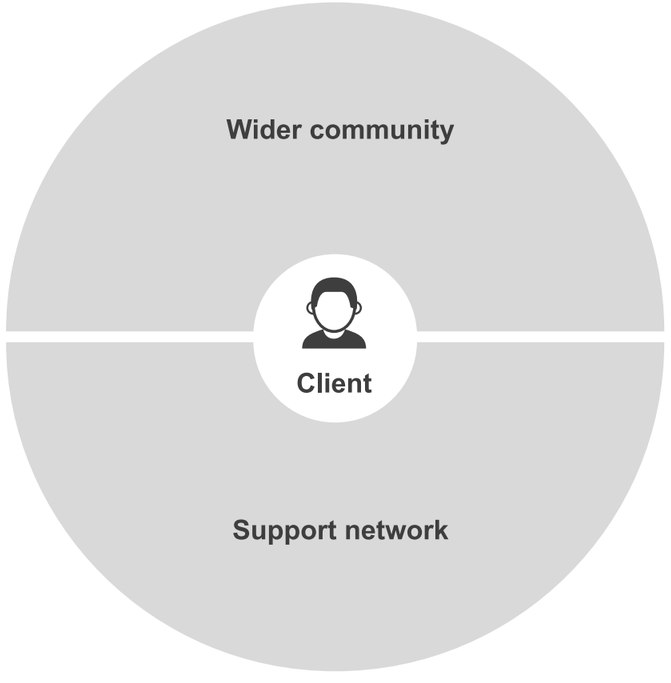
This diagram is a result of [project workstream, project, piece of work, date].

Integration with the wider system

This diagram seeks to demonstrate the integrated response capability required by the HSB sector, acknowledging additional services that are often need in order to address the person's full range of need and to maintain community safety. Services have been delineated into 4 sections, namely: Safety, Accountability, Community and Wellbeing. These sections cross over in the inner circle of wider community support and more personal support networks and reflect both formal and informal care.

The diagram seeks to demonstrate the differing roles and responsibilities of the various agencies involved, and also demonstrate the importance of these services being embedded in the person's immediate social and community environment for best outcomes.

The diagram is purposely client-centric and aspirational. It shows links to both non-specialist support networks (whanau, faith groups, peer support, iwi etc) as well as other community supports and specialist services (mental health, NGO social services etc). Not all of these services and supports will be necessary for all users of HSB services, but all need to be accessible and responsive depending on client need.



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