Section four: Skills of engagement

Purpose

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

Objectives

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

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

4.1 Introduction: Engagement

Brief reflection:

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

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

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

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

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

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

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

**Some research findings**

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

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

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

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

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

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

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

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

Exercise

Brainstorm

• What are the skills and processes of effective engagement?
• What do you need to take into account when engaging with people?
• What gets in the way of effective engagement?

Skills and processes of effective engagement:

Engagement considerations and barriers:
As you look at the points you have written, ask yourself the following questions.

• What do you see as the main themes emerging?
• How important is it to value the culture of the person?
• Are there particular issues that are specific to engaging people sent for treatment by Justice?
• What attitudes promote engagement?
• How useful is self-disclosure in the process of engagement, and what are the limits of self-disclosure?

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

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

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

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

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

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

What does ‘ambivalent’ or ‘ambivalence’ mean?

Ambivalence can be defined as:

• A conflict of ideas or attitudes; the presence of two opposing ideas, attitudes, or emotions at the same time
• uncertainty; a feeling of uncertainty about something due to a mental conflict.
Feeling two ways about something or someone is a common experience – feeling 100 per cent clear about something that is important is probably more exceptional than normal.

Ambivalence should be seen as the norm rather than as an exception. This means that working with uncertainty and internal conflict is a ‘normal’ part of the engagement and treatment process with people, not just people from Justice. Ambivalence is often a prominent feature of a range of psychological difficulties. A person who experiences agoraphobia, for example, may say; “I want to go out, but I’m terrified that I will lose control.” So, too, a person who is socially isolated, unhappy and depressed may express ambivalence; “I want to be with people and make closer friendships, but I don’t feel like an attractive or worthwhile person.”

With certain problems the part played by ambivalence is even more central. A person who is having an affair can swing between partner and lover in an intensely emotional ambivalence. Someone who compulsively washes their hands or needs to check things may desperately want to avoid going through this disabling ritual time and time again, yet may feel driven to it by anxiety and fear.

Such approach-avoidance conflict is characteristic of addictive behaviours as well. People who are struggling with a substance use, an eating, or a gambling disorder often recognise the risks, costs and harms involved with their behaviour. Yet for a variety of reasons they are also quite attached and attracted to the addictive behaviour. They want to drink (inject, smoke, purge, or gamble), and at the same time they don’t want to. They want to change and at the same time they don’t want to change.

It is easy to misinterpret such ambivalent internal conflict as pathological – to conclude that there is something wrong with the person’s motivation, judgement, knowledge base or mental state.

“We regard ambivalence to be a normal aspect of human nature; indeed, passing through ambivalence is a natural phase in the process of change. It is when people get stuck in ambivalence that problems can persist and intensify.” (Miller and Rollnick, 2002)

4.3 Exploring ambivalence

“I don’t want to!”

Exercise

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

• What were your thoughts at the time?
• What were your feelings at the time?
• What were your actions and/or reactions at the time?
• What were your thoughts a week later?
• What were your feelings a week later?
• What were your actions and/or reactions a week later?
• What sort of thoughts did you have?
• What feelings did it arouse in you?
• What behaviour did you engage in as a result of the situation and your thoughts and feelings?
• What happened to those thoughts and feelings over the course of time?
• What impact did this situation have on your relationship with the person involved?
When we feel externally compelled to do something we may react in various ways, but what sits behind these reactions?

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

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

When you think about people who are mandated to attend treatment, what might be similar for them to your reactions of being forced to do something? What might be different?

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

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

- verbal aggression
- intimidation or threats
- self-harming behaviour (or threats to do so)
- physical aggression and/or violence
- passivity and/or withdrawal – superficial compliance
- non-compliance or silence
• changing the subject
• helplessness
• bragging about drug use and behaviour
• arguing
• putting forward rational arguments (e.g. “yes, but…”)
• complaints
• lying
• consistently pushing the boundaries of the working relationship.

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

Possible reasons for behaviour

- Shame, helplessness, fear, confusion, frustration, anger, boredom
- Effects of alcohol and drug use
- Individual issues such as learning disabilities, immaturity, TBIs, intellectual disability
- Previous negative experience of treatment and/or health providers
- Community factors such as isolation, lack of resources or recreational activities and opportunities
- Mental health problems
- Societal factors such as acculturation, poor housing, lack of support, lack of education

Behaviour
Discord and relationships

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

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

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

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

Discord within the relationship can be expressed in different ways.

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

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

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

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

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Behaviours:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Squaring off – statements:

________________________________________________________________________

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Behaviours:

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**Interrupting – behaviours:**

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**Disengagement – behaviours:**

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

**Defending – helps/does not help:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Interrupting – helps/does not help:


Disengagement – helps/does not help:


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

- How easy is it to recognise different ways discord is expressed?
- What are the benefits of being able to recognise different signs of discord?
- In the past, have you fallen into the trap of doing one of the things you identified as not helpful?
- Which behaviours, or signs of discord, would you find the most challenging to deal with?
- From this exercise, what are you left thinking about in terms of your practice, and if necessary, what resources do you have that could increase your skills and confidence?

Remember

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

Style

Often motivation is viewed more like a fixed trait (particularly in the justice field). Therefore if the person displays little motivation (often expressed as lots of challenging behaviour) the temptation is to attempt to break through the denial, rationalisations, cognitive distortions and excuses: for example “you've got a problem”, “you have to change” or “you'd better change or else.”

But think back to the exercise above when you had to do something you didn't want to do. What kind of thoughts did you have about it? What were you feeling? What behaviour did you engage in? Think about the effect on your relationship with the person involved. Perhaps you might be thinking – “who do you think you are to tell me what to do?” while feeling angry and resentful.
Research (Miller and Rollnick, 2002) with people experiencing problematic alcohol use found that a directive-confrontational style of intervention produced twice the resistance, as they referred to it at that time, and only half as many positive behaviours as did a supportive, person-centred approach. The researchers concluded that the more workers confronted them the more the people drank at twelve-month follow up.

This demonstrated that a change in intervention style can directly affect the level of discord in a therapeutic relationship, driving it upward or downward. This means that it is not fixed and that there is something you can do about it. It is obviously desirable to decrease discord because less discord is associated with long-term change.

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

Practise

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

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

To debrief the person who played the worker in your scenario you can identify something they did well first (very important) and then one thing where they think they could do with more practice. The worker playing the person in treatment can offer feedback from their experience, commenting on something they thought their partner did well, and one thing they could develop further. If you can use motivational approaches the opportunity to learn from this experience will be useful for both of you.

Now answer the following questions for yourself.

- What worked well?
- What was particularly challenging?
- What have you learnt that you can take back into your practice?

Reflective practice

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

- What is my level of investment in the person making a change?
- How able am I to let the person make their own choices (even when I think the choice is less than wise)?
• What kind of challenging behaviours or signs of discord do I react to?
• What am I doing to influence the discord?
• What is the discord telling me about myself and about the other person?

4.4 Engagement

Now that you have had a chance to work through some of the differences you may encounter with people mandated to treatment and working with discord, we will revisit some of the knowledge and skills around general skills of engagement, and attitudes to be aware of during engagement. There are a number of general counselling and therapy skills which can be revisited here and also some things to be aware of which will assist with engagement and the building of trust in the helping relationship. We should also be thinking about cultural considerations such as protocols, communication styles and values.

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

Principles for engagement

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

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

First contact

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

The initial engagement with a person is therefore critical, remembering that engagement does not just happen during the first part of forming a relationship, but also occurs each time you meet with that person. Also remember that, in the context of working with people sent by Justice, you are working with people whose attendance is usually involuntary. We often take it for granted, but attending to the rituals of encounter can affect the development of a therapeutic alliance.
With many Māori the use of Māori therapeutic paradigms that contribute to whānau ora, such as mihi mihi, karakia, whakawatea and whakamana, ensures the person is given a shared space to express themselves, and a process that honours their mana while also allowing for challenge and guidance. To some degree these will be enacted every time there is a meeting (for further information see section two).

For some people initial engagement may involve exploring the reasons they came and their expectations. This will be particularly important for those referred by the justice system and/or who are mandated to attend. For others it might be an engagement process that includes families, whānau or referrers. Ongoing engagement is about development of a relationship with a person, not a diagnosis or a legal status.

**What to cover in the initial meeting with a person to build engagement**

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

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

Find out their expectations of your time together, your role and their role. Again, ask the person their understanding rather than you doing all the talking before clarifying or explaining your role and their role, including what is negotiable and what is not. Find out from them what they understand the bottom line is in terms of what is not negotiable, especially if there are any special conditions attached to their attendance. Again, fill in the gaps in the person’s understanding.

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

**Person-centred care**

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

Rogers believed that the most important factor in successful therapy was not the therapist’s skill or training, but rather his or her attitude. Three interrelated attitudes on the part of the therapist are central to the success of person-centred therapy: congruence; unconditional positive regard; and empathy.
**Congruence** refers to the therapist’s openness and genuineness – the willingness to relate to people without hiding behind a professional façade.

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

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

A primary way of conveying empathy is by **active listening** that shows careful and perceptive attention to what the person is saying. Person-centred practitioners employ a technique called **reflection**, which consists of paraphrasing and/or summarising what a person has just said. This technique shows that the therapist is listening carefully and accurately, and gives a person an added opportunity to examine their own thoughts and feelings as they hear them repeated by another person. Generally people respond by elaborating further on the thoughts they have just expressed.

According to Rogers, when these three attitudes (congruence, unconditional positive regard, and empathy) are conveyed the practitioner provides a climate in which people can freely engage in focused, in-depth self-exploration.

Outcome studies of talking therapies in general and person-centred therapy in particular indicate that people who have been treated with these approaches maintain stable changes over extended periods of time; that they change substantially compared to untreated persons; and that the changes are roughly comparable to the changes in people who have been treated by other types of therapy. Talking therapies appear to be particularly effective for people experiencing depression or relationship issues.

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

**Skills of engagement**

- Are you fully present – are there distractions/barriers to this (time/preoccupation)?
- Attending – ways to be present with person physically and psychologically (open posture, eye contact, relaxed, leaning forward slightly – shows interest)
- Listening – capturing the persons communications accurately – verbal, non-verbal, clear or vague, listening for change talk
- Be aware of the person’s affect – the underlying emotions that are associated with experiences, behaviours, stated goals and achievements (and expressions of motivation).
These points relate to the way the worker interacts with the person, both physically (including body language) and verbally (including content, as well as tone, rate, and volume), as well as the need to focus on the person, without having your thoughts or concerns somewhere else; highlighting the importance of being person-centred and having good attending and listening skills.

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

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

**Engagement (from Rogerian counselling)**

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

**Potential barriers**

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

**Exercise in pairs (if possible)**

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

Use your own experience or your work with people as a resource for discussion.
**Family and whānau inclusive practice**

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

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

**Reflection**

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


Notes page

What has been my key learning in relation to this module?
1
2
3
4
5

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

What gaps in my knowledge or practice have I identified?

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

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