CHRIS TROTTER

WORKING WITH INVOLUNTARY CLIENTS

A guide to practice

3RD EDITION

ROUTLEDGE

Working with Involuntary Clients

A Guide to Practice

Written by Chris Trotter

Routledge
Taylor & Francis Group
LONDON AND NEW YORK

First published 1999
by SAGE Publications, Inc.

This edition published 2015
by Routledge
2 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN

And by Routledge
711 Third Avenue, New York, NY 10017

Routledge is an imprint of the Taylor & Francis Group, an informa business

British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloging in Publication Data

Trotter, Chris, author.

Working with involuntary clients : a guide to practice / written by Chris Trotter. —Third edition.
p. ; cm.
Includes bibliographical references and index.
ISBN 978-0-415-71564-5 (hardback)—ISBN 978-0-415-71565-2 (pbk.)—ISBN 978-1-315-88058-7 (e-book)
I. Title.

[DNLM: 1. Counseling--methods. 2. Mandatory Programs. 3. Evidence-Based Practice--methods. 4. Social Work--methods. WM 55]

BF636.6
361'.06--dc23 2014033668

Typeset in 10.5/14 pt Caslon 540
by Bookhouse, Sydney

Working with Involuntary Clients 3rd Edition

Many social workers are employed in positions where they deal with involuntary clients. These positions are demanding, and require a specific set of skills. The new edition of this successful book provides an accessible and practical guide for managing difficult and sensitive relationships and communicating with reluctant clients.

The author directly links theory to real-life by adopting a jargon-free and accessible guide to working in partnership with involuntary clients. Written in a lively and engaging style, the book is relevant across the curriculum and richly illustrated with case examples drawn from a variety of service-user groups, such as work with people with addictions, young people who refuse to go to school and mental health patients who refuse treatment, as well as examples from criminal justice and child protection.

The author's integrated and systematic approach promotes prosocial values; emphasises clarifying roles; and deals with issues of authority and goal-setting. Fully revised and updated throughout to reflect contemporary research and practice, the book includes increased emphasis on risk assessment, cognitive behavioural approaches, including manualised intervention programs, and reflective practice.

The result is an invaluable practical guide for social work and social care students and professionals to working with both clients and their families.

Chris Trotter is Associate Professor at Monash University, Australia, where he coordinates the Bachelor of Social Work Honours Programme.

Acknowledgements

The third edition of *Working with Involuntary Clients* continues to be inspired by the late William Reid's work on task-centred casework and by the late Don Andrew's work on pro-social modelling. While they come from different perspectives, their publications have inspired much of my research and the material contained in this book.

In writing the third edition, I remain indebted to those people who assisted me with this edition and the earlier editions, including Michael Clanchy, Jan Mumford and Phillipa Evans, as well as the many other colleagues, students and welfare professionals who provided me with case examples and helped me develop the ideas and practices which are outlined in this book. Thanks also go to Rosemary Sheehan and my colleagues at Monash University, and to Lizzy Walton, Kathryn Knight and Katy McDevitt at Allen & Unwin.

Finally, thank you to Joan, Rebecca and David for your ongoing love and support.

Note: For seminars on working with involuntary clients, Professor Chris Trotter can be contacted via email at chris.trotter@med.monash.edu.au.

Contents

Chapter 1

Introduction

How do you help someone who has no interest in being helped? What can you do with clients in the welfare or justice systems who are not motivated to change? How do you counsel someone who does not even recognise that they have a problem? How do you work with someone who has a totally different set of values from yourself? How can you help someone deal with their problems and at the same time exercise authority over them?

These are questions which workers with involuntary clients face on a daily basis. These workers are asked to help clients who have not chosen to be helped and who may be resistant or even openly antagonistic to the assistance they are offered; to help clients and at the same time collect information which may subsequently be used against them; to testify against clients in court and then to work with them in a helping relationship; and to work in a collaborative manner with clients, yet make authoritative decisions about their lives.

This book aims to help workers with involuntary clients come to terms with these issues.

Who are involuntary clients?

An offender visits a probation officer; a child-protection worker visits a mother following an anonymous report of child abuse; a drug user attends for drug treatment under the direction of a court order; a man who has abused his wife attends domestic violence counselling at the direction of a court; a psychiatric patient who is a danger to herself and others is directed to treatment as an alternative to hospitalisation; a young person living on the streets agrees to go to a refuge with his youth worker, knowing that the alternative is for him to be taken to the police; or a child is placed in a children's home despite the protestations of the parents.

These are examples of involuntary clients. The clients (or recipients of welfare or legal services) in these examples can be described as involuntary because they have not chosen to receive the services they are being given. In fact, these clients might actively be opposed to receiving the service. They might believe that it is unnecessary and intrusive. The clients receive the service either because of a court order or because they are under the threat of some other legal sanction. They are sometimes referred to as *mandated clients* (Ivanoff, Blythe & Tripodi 1994; De Jong & Berg 2001; Rooney 2009).

The clients in these examples are clearly involuntary. In many instances, however, the distinction between voluntary and involuntary clients is not so clear. In the following examples, the clients are not required by a court order—or even the threat of a court order—to receive services. Their participation is motivated by pressures other than their own desire to address their problems: a mother whose child has been removed by child-protection services seeks assistance from a family counselling agency to help get her child back; a drug user seeks rehabilitation counselling before a court appearance; an abusive man seeks anger management counselling in response to his partner's threats to leave; or a pregnant teenager visits a counselling agency at her parents' insistence. These clients are partly voluntary and partly involuntary.

Others who receive services are more obviously voluntary—for example, a student who seeks assistance from a student counsellor; a couple who seek relationship counselling; a parent who seeks assistance with children who are out of control; or an alcoholic who seeks assistance from a drug rehabilitation centre.

There may also be involuntary aspects of work with clients who choose to receive services, as well as voluntary aspects of work with court-ordered clients. For example, a student who seeks the assistance of a student counsellor might feel compelled to do so in order to pass her course; a woman might attend marriage counselling as a result of pressure from her spouse; or a probationer might visit his probation officer on a voluntary basis in order to discuss problems in his personal relationships.

The distinction between voluntary and involuntary clients is therefore not always clear. It is perhaps best viewed on a continuum, with court-ordered clients towards one end, partially voluntary clients in the middle, and clients who seek services on a voluntary basis towards the other end.

This book is about working with clients at the involuntary end of the continuum. Its particular focus is on work in the community with involuntary clients—for example, the work of probation officers (or community corrections officers) and child-protection workers. Few clients in these settings are voluntary or even partially voluntary. Many of the practice principles discussed also apply to work with clients in institutions such as prisons, children's homes and psychiatric hospitals. In many cases, the principles are also relevant to clients who might be described as partially voluntary or even voluntary.

The dual role of workers with involuntary clients

For the most part, workers dealing with involuntary clients work in the welfare or legal systems for government departments or for agencies funded by government departments. They generally have

two roles: a legalistic or surveillance role; and a helping, therapeutic or problem-solving role.

A probation officer, for example, has a responsibility to ensure that a probationer carries out the requirements of the court order. The probation officer is required to take action if a client fails to report or to comply with some other condition of the probation. The probation officer might have to report to a court about the progress of the probationer or undertake a risk assessment, which will influence the level of supervision offered to the client. Simultaneously, the probation officer works towards the rehabilitation of the offender by assisting with problems which may be related to the offending behaviour.

Similarly, a child-protection worker has the dual task of investigating levels of abuse and assessing the risk of further abuse, taking action to protect a child and possibly taking measures leading to prosecution of a perpetrator of abuse; at the same time, they assist the family with the problems that may have led to the abuse.

Reconciling the legalistic and helping roles in work with involuntary clients can be a difficult task. It is difficult for a worker to fulfil a helping role with a probationer when they are also taking action to have a probation order cancelled. Similarly, it can be difficult to fulfil the legal role where a close helping relationship has developed between the worker and client. A child-protection worker who has worked with a family on a voluntary basis for a period of time, for example, may find it difficult if they suddenly have to take action to remove a child.

Coming to terms with this dual role is one of the greatest challenges in work with involuntary clients. Often workers and organisations find it easier to focus on one of the roles to the exclusion of the other. There are examples of workers with involuntary clients who focus almost exclusively on the legalistic role, and other instances where they focus almost exclusively on the helping role (Thorpe 1994; Trotter 1996b, 2004).

This issue is addressed throughout this book, with the aim of helping workers achieve an appropriate balance between the two roles.

Direct practice

The focus of this book is on *direct practice* with involuntary clients. It refers only incidentally to community development, policy development and management. It is about the direct day-to-day work with individuals and families carried out by probation officers and child-protection workers.

As I said earlier, the practice principles discussed here are also relevant to others who work with involuntary clients—for example, workers in psychiatric clinics, drug counsellors, youth workers, school welfare staff, domestic violence counsellors, family support workers, family counsellors and those who work with the aged.

The terminology used to describe direct practice work in welfare and corrections settings has changed over the years. In the 1970s and 1980s, the term 'casework' was popular; then terms such as 'direct practice' or 'clinical practice' began to be used. Today, workers with involuntary clients are commonly described as 'case managers'. To some extent, this change in terminology reflects a change in the way the work is conceptualised and carried out. Case managers tend to have a service-coordination role rather than a direct service or therapeutic role—although, as Gursansky, Harvey and Kennedy (2003) point out, there is a great deal of ambiguity surrounding the term, and the practice of case management may be very different in different settings.

The definition of direct practice workers as case managers rather than caseworkers is seen by some writers as problematic (McMahon 1998; Searing 2003; Turner 2010). They maintain that government department staff are increasingly responsible for case management and case planning, with problem-solving or therapeutic services being left to often under-funded voluntary organisations. They argue that clients are more and more likely to be managed rather than helped.

The following case example in the area of child protection illustrates one way of looking at the differences between case management, problem-solving or therapeutic work and case planning. A case plan involving a direct practice worker is developed, which specifies where and with whom an abused child is to live, how often and in what circumstances that child will have access with family members, and what welfare services will be offered to the child and family members.

Following the development of the case plan, the client or client family is case managed. This involves a case manager coordinating the various professionals involved and ensuring that the case plan is carried out. The case management might be undertaken by a worker involved in the case planning or by another worker. Individual problem-solving work with the client may then be done by another worker. This work might involve, for example, working on problems in the relationship between family members or helping a child to deal with difficulties at school.

Each of these functions—case planning, case management and problem-solving—can be viewed as part of the direct practice process. This book focuses on these three functions as a holistic endeavour, defining direct practice as incorporating each of them. Nevertheless, the framework for effective work with involuntary clients presented here is likely to be useful for those with responsibility for only part of the direct practice process—for example, where the worker has a role exclusively as a case manager or planner, or where the worker has responsibility for therapeutic or problem-solving interventions without a coordination or planning role.

Sources of knowledge in work with involuntary clients

A wide range of *theories* influence welfare work with involuntary clients, including psychoanalytic theory, ego psychology, systems

theory, behaviourist theory, human development theory, labelling theory, feminist theory, critical theory, differential association and modelling theory.

Work with involuntary clients is also influenced by *practice models* originating from a range of theoretical frameworks—for example, task-centred, ecological systems, strengths-based, solution-focused, cognitive behavioural, rational emotive, narrative, motivational interviewing and a number of different family therapy models.

Work with involuntary clients may also be influenced by *research findings*. For example, workers might be aware of research which suggests that peer group influence can impact on young offenders (Akers 1994; Andrews & Bonta 2010) or that client focused problem-solving leads to positive outcomes (Trotter 2004, 2013).

In addition to theories, practice models and research findings, workers' own *values and beliefs* may influence their day-to-day work—for example, a belief that siblings should remain together wherever possible; that women deserve more than they often get in family situations; that marijuana is harmless; that the legal system is unfair; that offenders should be treated more harshly; or that the nuclear family is the best environment in which to raise children.

Particular *life experiences*, both professional and personal, may also influence workers' practices. A case example illustrates this point. A worker in probation confronted a client with what she saw as the reality of his life situation. She said that she believed the client was wasting his life and should be actively seeking work. The client committed suicide shortly afterwards. This experience left the worker very cautious about confrontation with clients.

Workers are also influenced by accumulated life experience, sometimes referred to as *practice wisdom*. A worker may have worked with young homeless people for many years. She may have found that she is able to relate to these young people better if she has supported the young person through a critical incident in which the young person is distressed—for example, following an argument with a family

member. Her experience leads her to try to be available to other young people on such occasions in order to build her relationships with them.

Organisational expectations and norms can affect workers too. An organisation can have a culture which pressures individual workers to behave in a certain way. For example, in one organisation in which I worked, the culture was to see clients as soon as possible, even if they arrived without an appointment. This was viewed as respectful. In another organisation, the culture was to expect clients to make an appointment for another time. This was viewed as helping clients to be responsible.

There are therefore many sources of knowledge for work with involuntary clients. Workers often have difficulty identifying how the different sources guide their work. I have conducted many workshops for direct practice workers over the years, and have consistently been struck by the difficulties workers have in articulating the sources of knowledge on which they base their work. A number of research studies have raised the same problem (Scourfield 2002; Chaffin & Friedrich 2004; Schmuttermaier et al. 2011). This hardly seems surprising given the maze of theories and models, values and beliefs, research findings and organisational expectations which inform every worker's practice.

In work with involuntary clients, where value differences between workers and clients are likely to be accentuated, where the use of authority places particular demands on workers, where client motivation levels are likely to be low and where the development of the worker–client relationship can be problematic, sorting through the conceptual maze of theory and practice can be even more difficult.

Evidence-based practice

In an attempt to make some sense of this conceptual maze of theory and practice, this book outlines a framework for practice based on

the research about what actually works. It presents an *evidence-based practice model.*

What is evidence-based practice (also known as EBP)? Many definitions have been offered. Debbie Plath (2013: 26) refers to evidence-based practice as 'a clinical decision-making process where the practitioner identifies current best evidence, critically appraises this along with knowledge of the client circumstances, and then makes decisions about how best to respond to issues presenting in practice'.

Mark Chaffin and Bill Friedrich (2004: 2) refer to evidence-based practice in child abuse services as 'the competent and high fidelity implementation of practices that have been demonstrated safe and effective usually in randomized control trials'—a rather complex description. However, they also offer a simpler description: 'practice based on scientific knowledge about what works.'

Aron Shlonsky and Leonard Gibbs (2004: 137) talk about the *evidence-based practice process*, which involves 'a well-built practice question, an efficient search for best evidence, a critical appraisal of that evidence and action based on the interchange between client preferences, practice experience and the best evidence'. They point out, however, that some see it as 'anything, which can be done with clients which is linked to an empirical study'.

The definition I favour—and the one utilised in this book—views evidence-based practice simply as *the use of research findings as a primary source of knowledge for practice.* This is not to say that research findings should be the only source of knowledge for practice, or that theories, values or organisational expectations, for example, are not important. It simply maintains that research findings should be viewed as a primary source of knowledge.

Evidence-based practice involves a worker having knowledge of research findings in relation to the various practices in their particular field. For example, a probation officer might take care not to blame or judge a young offender, being aware of research which suggests that when probation officers display these characteristics young