MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

Harmful Sexual Behaviour Services for Non-mandated Adults: Service Guidelines

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1. About these Guidelines

What are these Guidelines for?

These Harmful Sexual Behaviour Service Guidelines ("Guidelines") are for providers the Ministry of Social Development ("the Ministry") contracts with to provide harmful sexual behaviour services to non-mandated adults ("HSB services").

Outcome Agreements with providers of HSB services require that they are delivered in accordance with these Guidelines. The Guidelines form part of the Outcome Agreement.

What is the purpose of these Guidelines?

These Guidelines provide:

- a set of practice principles to guide service delivery
- an outline of service delivery and practice
- a resource tool to help providers deliver services consistently
- a resource tool to assist providers in meeting the desired service outcomes
- a way for the Ministry to improve its responsiveness to feedback regarding changes to the service delivery component of the Outcome Agreement.

How should these Guidelines be used?

The Guidelines set the minimum standard for service delivery, from which each provider can develop a service that reflects their philosophical base, incorporating local need and the culture within which they work.

Will these Guidelines be revised?

This is a living document and will be updated over time to take into account provider feedback. Ministry staff will consult with providers on any editions, updates or changes. Feedback on the Guidelines is welcome at any time and can be sent to the Ministry national office using the attached Feedback Form (see **Appendix 2**).

Where can you go for more information?

For further information on these Guidelines, please contact your Contract Manager as identified in your Outcome Agreement.

2. Relationships

Relationship principles

Both parties to the Outcome Agreement shall collaborate to ensure the services are effective and accessible.

Both parties recognise the service is a joint endeavour, in which both parties have a shared goal to achieve positive benefits for the target client group.

Both parties agree to:

- act honestly and in good faith
- communicate openly and in a timely manner
- work in a collaborative and constructive manner and recognise each other's responsibilities
- encourage quality and innovation to achieve positive outcomes.

Both parties shall appoint relationship managers who will be responsible for effectively managing the contract relationship. Details of the relationship managers nominated by both parties are set out in the Outcome Agreement.

Cultural responsiveness

Both parties recognise the needs of all people, including Māori, Pacific, ethnic communities and all other communities, to have services provided in a way that is consistent with their social, economic, political, cultural and spiritual values.

Good practice approach

HSB services are specialist behaviour change interventions. All design and delivery approaches for HSB services must include 'stopping or preventing harmful sexual behaviour' as an ultimate objective.

Both parties support the development of good practice in the delivery of the service. This includes, but is not limited to, the following (see also **6 - Principles of good practice and 7 - Service components**):

- Services are evidence-based: interventions are underpinned by the Risk, Need and Responsivity (RNR) principles, incorporate strengths based approaches, and are designed to address dynamic risk factors.
- Services are responsive: services are easily accessible, appropriate, and can respond (among other things) to people's cultural contexts, language, diversity and personal situations.
- Client-centred approach: interventions are delivered in a client-led and family/whānau focussed way, and providers acknowledge the social and cultural context of the client and their community.
- Quality assurance: service effectiveness is informed by ongoing monitoring, review and evaluation and supported by a specialist and experienced workforce.
- An integrated approach: services are integrated across the social sector, easy to navigate, continuously improved and focused on client outcomes.

3. About harmful sexual behaviour services

What is HSB?

Harmful sexual behaviour (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.

Concerning sexual ideation (CSI) is a descriptor for people who have harmful sexual thoughts or fantasies, but who have not yet acted on them.

What is the history of HSB services

The delivery of community-based harmful sexual behaviour services in New Zealand originated in the 1980s. This was firstly as a response to HSB by adult men and subsequently as a response to concerning sexual behaviour in adolescents in the early 1990s and then to children in the early 2000s.

There is a wide body of research on HSB services and HSB programmes have been evaluated as being effective in the reduction of risk factors associated with HSB perpetration.[1] New Zealand programmes have been shown to align with international good practice.[2]

HSB services are delivered to four population groups, funded through the Department of Corrections, the Ministry of Health, Oranga Tamariki—Ministry for Children (Oranga Tamariki) and the Ministry of Social Development:

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

For the avoidance of doubt, these Guidelines only apply to HSB services purchased by the Ministry and delivered to non-mandated adults.

Why do we purchase HSB services?

The Ministry’s purchases the provision of clinical assessment and intervention places in order to reduce the devastating impact that sexual violence has on people and communities across the country.

The Ministry’s investment strategy in respect to HSB services is to ensure the provision of accessible, sustainable, effective, well-coordinated responses to HSB, available to those who need them, tailored to their level of need and risk.

What are the outcomes we want to achieve?

The provision of HSB services falls within a wider public investment into specialist sexual violence services.

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[1] Lambie, Fortune et al, 2007; See also Lambie, Kryen, Loane and Herald (2014), *Recidivism and risk factors in adolescents with HSB*

[2] HSB Parliamentary Review, 2014

This investment is focussed on delivering the following intermediate outcomes:[3]

- New Zealander's beliefs, attitudes, awareness and knowledge about family violence and sexual violence are improved.
- People who have engaged in family violence or sexual violence access and engage with services that meet their needs.
- People who have engaged in family violence or sexual violence are supported to address their behaviour.
- Victims of family violence or sexual violence access and engage with services that meet their needs.
- People who have been affected by family violence or sexual violence (are supported to lead safe and healthy lives.
- New Zealanders are motivated and supported to act on concerns about family violence or sexual violence.

These longer term outcomes support the Ministry's ultimate goal of supporting adult victims/survivors, addressing perpetrator's behaviour and reducing violent crime.

[3] See the Results Measurement Framework for HSB Services in Appendix 1

4. Service overview

What is the service about?

HSB services are specialist behaviour change interventions. The services are part of a broader suite of sexual violence support services that aim to support adult victims/survivors, address perpetrators' harmful behaviour and reduce violent crime.

Who are the services targeted to?

HSB services are delivered in a community-setting to non-mandated adults (18 years and older) who have engaged in HSB.

Clients are predominately male, although services may be delivered to female clients if a suitable intervention is available. Typically, non-mandated clients:

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

Clients will be prioritised based on risk, need and impact, with a particular focus on those who have engaged in harmful sexual behaviour against children or young people less than 16 years of age. However HSB against people 16 years and over may also be included in the target services.[4]

Who can deliver HSB services?

The provision of HSB services is a specialist field, delivered by clinicians trained and experienced in the assessment and treatment of sexual offenders (see **8 - Workforce capability and support**).

Providers who deliver HSB services are required to meet Level Two, Ministry of Social Development Accreditation Standards. Providers are required to maintain their Accreditation level according to the Ministry's relevant Approval and Accreditation Standards.

Who is involved?

The client

The client is at the centre of all services and will be actively involved in the development of intervention goals and safety plans.

Providers and clinicians will recognise the diversity of clients and types of offending and deliver interventions in a way that is responsive to the needs of the client.

Family/whānau/support person ('support network')

The client's family, whānau, support person ("support network") will be given information on how they can be involved in the process, including in the development of

intervention goals and safety plans, and will be supported to manage any safety risks. This extends to other professionals involved with the client, including the referrer.

HSB providers will prioritise the protection of children, community safety and the rights of victims when developing and implementing services.

The Provider

In addition to carrying out all requirements and responsibilities outlined in their Outcome Agreement and these Guidelines, the role of the Provider is to:

- employ and support specialist and appropriate staff
- operate a viable service which is able to support all staff and professional development, in accordance with Ministry Accreditation Standards and these Guidelines
- ensure appropriate community collaboration and networking links are made to support clients
- actively participate in any regional networking, information sharing and knowledge building activities (to the extent they do not infringe any intellectual property rights)
- develop and maintain effective collaborative working relationships with regional Ministry of Social Development sites
- participate in training and up-skilling activities to keep up to date with development, innovations and best practice in the design, development and delivery of HSB services
- ensure systems and processes are in place to utilise and report on funds in line with the Outcome Agreement and these Guidelines.

The Ministry of Social Development

The role of the Ministry is to:

- approve providers
- monitor the service delivery and financial management of the Provider
- make referrals and provide information, where the service is specifically contracted for referrals from the Ministry
- seek continuous improvement of service delivery, including updating of these Guidelines.

Integration with other services

Providers of HSB services should work closely with government agencies and other community services to ensure people who have committed and experienced HSB get the help they need.

The Provider will build connections, collaborate and maintain effective relationship with other relevant agencies and services that are able to provide complementary support to clients. This may include relationships and memoranda of understanding with iwi services, victims' support services and health services.

The Provider must not enter into sub-contracting arrangements for delivery of HSB services without the express written permission of the Ministry.

5. Service delivery

What do the services focus on?

The focus and goal of HSB services is to reduce clients' risk to engage in HSB and increase their ability to live healthy, non-abusive, and satisfying lives, with the ultimate goal of making communities safer.[5]

Access to services

The Provider will endeavour to reduce any barriers to access to services, including (but not limited to), geographic locations, cultural identity and beliefs, language, age, gender, socio-economic status disability and sexual orientation.

Access issues for Māori and Pacific people must be clearly understood and processes developed to minimise any barriers Māori and Pacific people may experience.

The Provider will be available during standard office hours. However, HSB services - particularly group intervention - may be delivered outside standard office hours to best suit the needs of the client.

Coverage

The Ministry purchases nationwide coverage of HSB services. The Provider will work collaboratively with the Ministry to ensure adequate service coverage of their target areas, having regard to contacted volumes, demand and organisational viability.

Referrals

Referral to an HSB service can come from:

- the individual themself or their family/whānau
- social service/health service providers or community professionals
- government agencies (including Oranga Tamariki, the Department of Internal Affairs and Justice agencies)
- the client's lawyer.

It is up to the discretion of the Provider as to whether they will accept self-referrals into the service.

The Provider will ensure referral pathways into the HSB service are visible and there are documented and accessible referral forms. Providers will collect sufficient and appropriate information about the client to determine their suitability for the service.[6]

The Provider must have processes in place for making referrals to other social service/health service providers or community professionals, including keeping records of referrals.

The Provider should encourage clients to include a support person(s) in assessment and intervention; however, assessment and/or intervention will not be delayed or declined because of the absence of a support person(s).[7]

If a referral is accepted, the Provider will ensure the right clinical team for assessment is available.

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[5] ATSA Adult Practice Guidelines (2014)
[6] See Social Sector Accreditation Standards – Level 2: Client services and programmes
[7] This is provided sufficient collateral information about the client is available, for example, from the referrer.

The client will be given notice of their assessment appointment, along with information about what to expect during the process, including consent processes and collection and storage of personal information.

Referral assessment targets

Suggested performance targets for referral are:[8]

- Time from receipt of referral to response: No more than one week.
- Time from acceptance of referral to commencement of assessment: No more than 14 weeks, provided a Ministry funded assessment place is available. If there is a waitlist, assessment should commence as soon as practicable once a place becomes available.

Prioritising referrals

The Provider may need to prioritise referrals to manage contracted volumes. In this case, the Provider will prioritise adult clients based on risk, need and impact, with a particular focus on those who have offended against children or young people less than 16 years of age.

If waiting lists are used to prioritise access to service, the criteria applied must be transparent and ensure those with greatest need are seen as a priority. Additional information should be gathered if necessary to assist in prioritising referrals.

Initial safety planning

HSB services are part of a wider social services system, focussed on preventing sexual abuse and prioritising the rights of victim and community safety.

The Provider will develop an interim safety plan, after first contact with a new client and advise the referrer and/or any relevant statutory agency of any immediate safety concerns that need to be addressed to manage risk.

Assessment and intervention

As noted above, the Ministry purchase the provision of clinical assessment and intervention places for non-mandated adults who have engaged in HSB. These are funded on the basis of clients assessed (for assessment) and placements available (for intervention).

Assessment and intervention are discussed in detail in **6 – Principles of good practice** and **7 – Service components**.

Client groups and risk level

Where necessary, non-mandated clients may receive intervention together with mandated clients referred from Corrections.

This does not apply to clients ordered to attend a service by the court under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, who receive treatment separately in accordance with Health's Service Specifications and Model of Care for Sexual Offender Treatment Programmes.

The Provider will have documented processes for reducing the risk of contamination where clients of different risk levels may be treated together in group sessions.

[8] These are best practice suggestions. Providers are only required to report on client results and service delivery measures in respect to clinical assessment and intervention.

Service completion and exit

On completing and exiting the service, clients will have a final system review with their clinical team and support person(s).

Where clients exit the service prior to completing an intervention, the Provider will make recommendations to the referrer and the client's support network to support the client's and others safety.

If a client exits intervention for any reason prior to completing their intervention plan, the Provider will make that place available to the next suitable client on the waiting list. A client may re-enter an HSB service through one of the referral pathways.

See **9 – Measuring results and reports** for a list of when a client may be considered closed.

Transfers

The Provider will provide HSB services to all eligible clients within their target area, subject to contract volumes.

If a client moves out of their target area the Provider will endeavour to ensure the prompt transfer of relevant information, including assessment and intervention plans to the new HSB provider, subject to the provisions of the Privacy Act 1993 and any intellectual property rights of the Provider.

Service accountability

In delivering HSB services, the Provider must comply with the following broad service accountability obligations:[9]

- Consent and information management: The provider must obtain the written consent of the client under the Privacy Act 1993 for collection of their personal information before delivering services. The Provider must also tell the client how they can access and make changes to any of their personal information.
- Complaints policy: The Provider must have a documented and available complaints policy. Clients will be told how they can make a complaint and what to expect if they do make a complaint.
- Mandatory reporting: The Provider must have a documented and up-to-date child protection policy as required under the Vulnerable Children Act 2014. In addition, the Provider will understand and fulfil its statutory and/or regulatory obligations in relation to essential notification reporting.
- Incident reporting: The Provider must advise the Ministry (through its relationship manager) of any changes, problems, significant risks or issues that may, or are likely to, materially reduce or affect its ability to deliver the HSB services.
- Health and safety: The Provider will perform its obligations regarding health and safety matters in accordance with the Health and Safety at Work Act 2015 and will have a set of documented policies covering (but not limited to) risk management and staff safety and managing disruptive behaviour.[10]
- Client feedback: The Provider will maintain a formalised client feedback tool for evaluating the success of their service in meeting client needs and outcomes, and for informing on-going improvements in service delivery.

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[9] This section should be read in conjunction with the Ministry's Social Sector Accreditation Standards – Level 2, which contains further detail around staffing, health and safety and resolution of complaints.

[10] Social Sector Accreditation Standards – Level 2

6. Principles of good practice

Providers of HSB services are expected to develop and document interventions based on the following key principles of good practice.

It is the responsibility of the Provider to ensure these principles of good practice are incorporated into service design and delivery and referenced in all programme manuals.

Prioritise safety

All design and delivery approaches for HSB services must include 'stopping or preventing harmful sexual behaviour' as an ultimate objective.

The Provider will prioritise the welfare and safety of the client, their victim and associated family/whānau and community members.

The Provider will have documented policies outlining processes for dealing with allegations of abuse or situations that raise safety concerns, including recording issues of concern and notifications made.[11]

Evidenced model of change

There should be a documented clear model (Theory of Change/Intervention Logic) to explain how the intervention is intended to bring about the relevant change in the client.

The Provider will design and deliver interventions in accordance with the Risk, Need and Responsivity (RNR) principles and utilise cognitive-behavioural and relapse prevention models.

The Provider should also incorporate strengths based approaches (like the Good Lives Model) and (where relevant) appropriate cultural models in intervention.

Intensity of intervention

Clinicians will use structured assessment tools to determine the client's level of risk of future offending/reoffending and their needs and tailor the level of intervention accordingly.

The RNR principles dictate that the level of measured risk determines the intensity of intervention.

If intervention for low risk clients is warranted, it should be less intensive than for medium or high risk clients (research indicates that low risk clients should receive no more than 100 hours of intervention).[12]

Targeting a range of dynamic risk factors

There should be an explanation of how the intervention programme addresses dynamic risk factors, specifically those factors known to be associated with risk and recidivism.

Evidence should also be provided to show that the intervention methods used are likely to have an impact on the targeted risk factors.

Interventions are responsive to the client

Clinicians will tailor intervention approaches with sensitivity to the needs of the client, for example, language, culture, personality style, learning styles, cognitive abilities.

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[11] See Social Sector Accreditation Standards – Level 2

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

Engagement and motivation

Interventions should be structured to support engagement of the client as well as their support network.

Clinicians should engage therapeutically and relationally with the client to sustain and seek to enhance the client's motivation throughout the intervention.

Clinicians must 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.

Skills oriented

There needs to be a strong component of and bias towards skills learning and practice to practically help clients use non-violent respectful behaviours, avoid abusive ones and change cognitions related to HSB.

Maintaining integrity

The Provider should maintain programme fidelity to models that have been shown to be effective.

The Provider will have in-built processes and systems that monitor operations and enable service delivery to be adjusted where necessary, including through the use of internal case reviews and regular system reviews.

Professional and supported workforce

Interventions will be delivered by appropriately qualified, experienced and supported clinicians (see **8 – Workforce capability and support**).

There will be in-built processes governing training, supervision, professional development and support for staff.

Ongoing evaluation

Clear systems must be in place to measure and monitor effectiveness and evaluation of HSB interventions, including through the development of, and response to formal feedback and complaints processes.

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

Client-centred and integrated services

The Provider will acknowledge the social and cultural context of the client and community and deliver intervention in a client-led and whānau focused way.

This includes involving the client and their support network in setting and reviewing intervention targets and goals, and recognising the importance of cultural responsiveness in service delivery.

The Provider will have a clear understanding of their specialist role and work with other services, agencies and communities to provide a collaborative, integrated and holistic response to people who have engaged in HSB.

7. Service components

Clinical assessment

The purpose of the assessment phase is to engage the client and determine, in the form of recommendations, which intervention (if any) is the most appropriate for them.

Assessments are carried out by clinicians and overseen by senior clinicians and/or team leaders (see **8 - Workforce capability and support**).

During assessment the clinician will determine the client's level of risk to formulate an intervention to support the client from engaging in HSB in the future. Assessment also seeks to identify areas of client need, 'human goods' goals and responsivity issues to ensure the proposed intervention addresses both risk and need. This is discussed with the client and their support network. The clinician will also assess what supports may be required for the client's family/whānau.

Assessments will be contextualised using a holistic approach, coupled with the RNR principles, to best determine the appropriate intervention(s), duration and intensity for the client.

Providers will adopt a nested ecological approach to put the risks and needs of the individual in the context of family/whānau, community and the broader society.

- Individual – personal development history and history of offending
- Family/whānau – immediate family environment
- Community – broad community environment
- Society – wider beliefs and values

Throughout the assessment process, the Provider (through its clinicians and support staff) will prioritise and consider the safety of the victim and any potential future victims.

Core components

During assessment, the clinician will conduct assessment interview(s), administer psychometric tools and risk assessments and prepare a written assessment report. At a high level, assessment comprises the following components:

- gather and review background information and collateral reports about the client and keep records of consultation with relevant persons/agencies involved
- employ a motivational interviewing technique designed to increase the client's motivation to participate in intervention
- engage and build rapport with the client's support network in a non-threatening and professional way
- use psychometric assessment tools to assess the client's: static and dynamic risk factors to reach an estimate about the client's overall level of risk and need; and level of protective factors
- develop a working formulation/hypothesis about why the client's HSB occurred
- identify actual or potential risks to safety and well-being, particularly in respect to the client/victim/children
- prepare an assessment report documenting the client's level of risk, as well as needs, strengths and responsivity issues, and the clinician's intervention recommendations as to how those issues can be addressed
- obtain written and informed consent from client and client's support network to the assessment and intervention recommendations

- refer the client to other services if they have outstanding health or social needs that need addressing before assessment and/or intervention can occur
- keep accurate and secure records of all client data, reports and recommendations.

Assessment performance targets

Under the terms of the Ministry's Outcome Agreement for HSB services, performance targets for assessment are:

- Time from referral to commencement of assessment: No more than 14 weeks provided a Ministry funded assessment place is available. If there is a waitlist, assessment should start as soon as practicable from a place becoming available.
- Time from commencement to completion of assessment: No more than 8 weeks.
- Total number of clinician hours for completion of assessment: No more than 30 hours.

See also **9 - Measuring Results and reports** and the **HSB Results Measurement Framework**.

Risk assessment measures

Assessment includes the use of psychometric assessment tools aimed at identifying risk factors (both static and dynamic) that are a good predictor of future HSB. Other psychometric tools are applied to ensure inclusion of assessment of a client's protective factors and strengths.

For the purposes of the Outcome Agreement, the following assessment tools should be used to inform assessment.

The list of assessment tools will be reviewed and updated as required to reflect current research on HSB risk assessment.

Client group	Assessment tools
Female clients	• STABLE-2007 as an aide memoire; and/or • VRS-SO as an aide memoire; • Risk assessment tools appropriate for assessing female offenders; e.g., HCR-20 or LSI-R.
Internet only clients	• STATIC-99R[13] (only if the behaviour involved the creation of child abuse images with a real identifiable child) • STABLE-2007 as an aide memoire; and/or • VRS-SO as an aide memoire.
Clients for whom all HSB was committed below the age of 18	• If currently aged 18 or younger: ERASOR • If currently aged over 18: Static 99R[14] and STABLE 2007 used as an aide memoire to help inform intervention length and intensity

[13] Refer to Page 13 of the Coding Manual (2016) for a description of the limited circumstances in which use of the Static 99R is appropriate for internet offenders. It can only be used with offenders charged or convicted of possession or distribution of child pornography if their behaviour involved the creation of pornography with a real identifiable child.

[14] Refer to page 14 of the Coding Manual (2016) for a description of the limited circumstances in which use of the Static 99R is appropriate for adolescents. It is recommended that even if these circumstances are met, clinicians should use the scale with caution and include appropriate caveats in their reports.

Low cognitive functioning clients (I.Q. >75)	• Static-99R and STABLE-2007 (if they have applicable convictions and/or meet the coding manual criteria) • ARMIDILO-S (includes protective factors).
All other clients	• STABLE-2007 as an aide memoire where conviction history is not applicable to providing nominal risk category; and/or • VRS-SO.
Assessment of protective factors (all clients except low functioning clients)	• SAPROF

Best practice is to use the most up-to-date assessment tool. The Provider must ensure its clinicians are appropriately trained and knowledgeable about the use of these tools and keep up-to-date with evolving research around sex offender risk assessments. Psychometric testing administered as part of assessment must be overseen by a competent supervisor, trained in the use of the particular assessment tool.

Note: The above measures do not apply to clients pre-assessed as low risk due to the difficulty in accurately detecting and measuring change in this client group.

Practice requirements

The description and practice requirements for assessment are listed in Table One below.

Table One: Assessment practice requirements

Description	Requirements
Providers ensure assessments are based on an evidence-informed understanding of risk, need and impact	• Clinicians can articulate the nature and relevance of dynamic and static risk factors in respect to offending / re-offending • Clinicians comply with the requirements in these Guidelines in respect to the risk assessment tools used to assess risk • Clinicians base intervention recommendations on the client’s assessed level of risk and need, with higher risk clients assigned a greater dosage of intervention • Client notes evidence comprehensive and up-to-date risk assessments
Clinicians have a clear understanding of the client’s background and pathway into HSB	• Clinicians conduct interview(s) with client to obtain information about their background, circumstances, the client’s account of their HSB, past offending behaviour, social and sexual /relationships and lifestyle • Clinicians gather and review collateral reports about the client, e.g., police reports, medical reports • Clinicians have regard to multiple data sources for the assessment as relevant
Clinicians engage therapeutically and build a constructive relationship with the client	• Clinicians engage with the client in a relational, non-judgemental and non-stigmatising way • Clinicians employ a client-centred interviewing style to increase the client’s motivation to participate in assessment and intervention • Clinicians are culturally responsive and sensitive to

	the needs of the client • Clinicians must always engage and seek to involve the client's support network in the assessment process
Providers support the assessment process through its operational procedures, facilities and workforce	• Providers have documented procedures covering (but not limited to) informed consent, ethical codes, confidentiality, conflicts of interest, terms of attendance etc. • Providers have safe and suitable facilities for conducting assessment interviews • Clinicians have specialist qualifications, skills and experience in respect to the assessment and treatment of people who have engaged in HSB
Clinicians document all relevant information and intervention recommendations in an assessment report	• The written assessment report should include (at minimum): – the range of information sources used to conduct the assessment – demographic information – the client's developmental, social, psychological history, including patterned behaviour – outline of RNR – baseline information on risk – conclusions and intervention recommendations(s), including if treatment needs would be better met elsewhere • Assessment documentation, risk assessment documents and case notes support the intervention recommendation(s)
Providers maintain quality assurance processes in respect to the completion and storage of the written assessment report	• Processes are in place governing peer review and sign-off of assessment reports • The client and their support network must be involved in the completion of the assessment report and agree that all factual information (e.g., demographic information) is correct • Providers must have robust case management systems in place capable of securing storing all client data and assessment reports
Providers give priority to the safety of victims, their children and the wider community	• Risk assessment identifies actual or potential risks to safety and well-being of the client, victim/children • Clinicians document safety recommendations as part of the assessment process • Safety concerns are responded to without delay and other support services involved where necessary • Clinicians are aware of the risks of collusion and work to address this in their practice • Supervision, peer support and case reviews are used to address risk and safety issues
Providers are familiar with legislative and reporting requirements	• Providers comply with all required notification reporting, particularly in respect to safety

Intervention

The aim of intervention is to reduce or minimise the risk factors linked to the client's HSB and to increase the client's protective factors.

Interventions are delivered by clinicians and overseen by senior clinicians and/or team leaders (see **8 - Workforce capability and support**).

Research indicates that effective interventions for people who have engaged in HSB incorporate the RNR principles and utilise cognitive-behavioural and relapse prevention models. The Provider should also incorporate strengths based approaches, which aim to equip clients with the necessary skills, competencies and values to enable them to lead 'good lives', and (where relevant) appropriate cultural models.

Clinicians will work with the client, and where possible, their referrer, support network and other community supports, to ensure the intervention meets the recommendations contained in the assessment report in respect to goals, duration and intensity of the client's intervention.

As with assessment, during intervention the Provider and clinicians will prioritise and consider the safety of the victim and any potential future victims.

Core components

During intervention, the clinician will undertake intervention planning, deliver intervention and monitor intervention progress and effectiveness. This process includes a number of components, which can be summarised briefly as follows:[15]

Intervention plan

All clients will receive an individual intervention plan (or individual treatment plan).

The plan should cover individual intervention goals and timeframes, identification of proactive interventions and supports, risk assessment and safety planning and intervention completion. The plan will be developed in conjunction with the client and their support network and must be agreed to by the client.

Individual therapy

Clients can undertake weekly individual therapy session(s) with a primary clinician.

Individual therapy enables the clinician to explore the factors that underlie the client's HSB as well as review key concepts introduced in group therapy. Individual therapy may be provided as an 'individual intervention' if the client is not suitable to attend group or group is not available.

Group therapy

Group therapy generally takes place in a weekly or bi-weekly structured session co-facilitated by two clinicians. There may be up to ten clients that are appropriately matched with respect to cognitive, developmental and age levels.

Content (see below) is delivered in modules. Participation in group facilitates the client's experience of a group culture and appropriate peer challenge and support.

Family/whānau work

The clinician will meet with the client and the client's support network (which may include family/whānau) if requested and as appropriate.

The purpose of family work is to help the client's support network understand the dynamics of the client's HSB, explore how the client's HSB has affected the family/whānau and to ensure the safety of any vulnerable family members.

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[15] Note: in all cases a client's intervention will be tailored according to their need and will be made up of all, or some, of the core components as required.

Family work may also address dynamics within the family that may compromise safety and/or condone attitudes and behaviours that are potentially harmful.

Psychosexual educational programmes

As part of all interventions, the Provider will provide information to clients and their support network about the dynamics of HSB, myths and realities of HSB, identifying and responding to risk, expectations of treatment/intervention and the role of a support person.

Case reviews and client system reviews

Each client's progress is reviewed throughout the intervention period by the clinical team working with the client.

Client system reviews (every three months) provide an opportunity for the client and their support network, including the referrer and other professionals/agencies involved with the client, to give feedback on progress, risks, ongoing safety issues and any relevant issues regarding intervention effectiveness. These reviews are generally facilitated and overseen by the Team Leader/Senior Clinician and/or Clinical Manager.

Post-intervention risk assessment

At the end of the intervention period, the clinician will repeat the psychometric assessment tools used during intervention and compare the results against the pre-intervention scores to assess change in identified areas. See **Risk assessment measures** above for a description of the assessment tools used in HSB services.

Completion

Clients are considered to have successfully completed an intervention and exited the service when the goals of the client's intervention plan have been addressed.

On completing the service, clients will have a final system review with the primary clinical team, their support network and any external support agencies involved with the client. Following the final system review, the primary clinical team will prepare a completion report, including:

- a summary of safety strategies
- a summary of engagement/progress made
- the client's most up-to-date risk assessment[16], and
- any recommendations or notes for referrals on.

If a client exits the service prior to completing an intervention providers will use their best efforts to develop other arrangements to ensure the client's and other's safety. This would include relevant Reports of Concern if necessary.

Follow-up/transition session

Further transition or booster session(s) may be offered if recommended and where appropriate to reinforce the intervention strategies. In certain circumstances, a new referral may be necessary. This will depend on the length of time since completion, subsequent HSB and/or change in circumstances.

Intervention content

Intervention addresses the client's treatment needs identified through the clinical assessment. During intervention, clinicians will also:

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[16] Because of changes in dynamic risk factors, conclusions and recommendations based on psychometric risk assessments are only valid for six months

- assess the client’s readiness to change (model of change)
- support the client’s motivation to change (motivational interviewing)
- build on the client’s strengths and supports identified in assessment
- monitor and respond to any significant change that may increase the client’s risk.[17]

Key features of intervention will be tailored to each client’s background and risk factors that led to their HSB, but are likely to include:

- understanding the client’s pathways in to offending and their needs met by HSB
- empathy and victim harm
- relationship issues
- sexuality (healthy and deviant)
- risk factors
- problem solving
- emotional regulation.

Clinicians will also respond dynamically to address the needs of each individual client (for example, self-esteem or coping mechanisms). This work can be reinforced during individual sessions.

During intervention, clinicians will support the client to identify their primary goods, goals and supports and to develop a plan that assists the client to live a pro-social life.[18]

Intervention performance targets

The performance targets for intervention include:

- Time from completion of assessment to start of intervention: No more than 4 weeks provided a Ministry funded intervention place is available. If there is a waitlist, intervention should start as soon as practicable once a place becomes available.
- Time from commencement to completion of intervention: 12 to 18 months for clients assessed as moderate to high risk. Generally 6 months for low risk clients.

If the client does not begin intervention within eight weeks from completion of assessment, the case may be closed and a re-referral may be required.

Intervention will be provided at a length and intensity relative to the client’s risk of re-offending and need. Clients assessed as low-risk will not complete more than 100 hours of intervention.

See also **9 - Measuring Results and Reports**.

Intervention measures and outcomes

Under the terms of the Ministry’s Outcome Agreement for HSB services, intervention measures and outcomes sought are:[19]

- Decrease in risk factors: No less than 80% of clients who complete intervention will show change in risk factors evidenced by stage of change progression on the VRS-SO tool.
- Increase in protective factors: No less than 80% of clients who complete intervention will show change in protective factors evidenced by progression along each of the dynamic item scales on the SAPROF tool.

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[17] For example, through the application of the Acute assessment tool.
[18] See Ward et al, the Good Lives Model
[19] These outcome measures will be reviewed from time to time to ensure they are the most appropriate measures of outcome.

The above measures do not apply to clients assessed as low risk due to the difficulty in accurately detecting and measuring change in this client group. Successful completion of intervention does not, however, indicate that the client's risk of reoffending has been eliminated completely.

Practice requirements

The description and practice requirements for intervention are listed below.

Description	Requirements
Providers ensure interventions are grounded in a research-informed theory of change	• Intervention design is based on empirically-validated research into what works • All interventions must be underpinned by reference to the RNR principles and cognitive-behavioural and relapse prevention models, as well as appropriate strengths-based approaches • Intervention content and delivery is consistent with the theoretical base • Documentation and client notes links design of intervention to the primary objectives of HSB services
Clinicians will work with the client and their support network to set intervention goals (intervention planning)	• Intervention goals are informed by the client's individual needs, deficits and strengths • Intervention goals align with the primary objectives and content requirements for HSB services • The intervention plan covers goals, expectations, resources (staffing), timeframes and planned contact • Clinicians will review and update the client's intervention plan as required
Clinicians take account of dynamic risk factors (those factors that can be changed through intervention) when designing and delivering interventions	• Intervention goals are tailored according to the client's dynamic risk factors and identified areas of need/responsivity • Clinicians will review and adjust the client's safety plans as required • Clinicians can articulate an understanding of high risk situations and respond appropriately
Intervention design and delivery is responsive to the diverse needs of the client	• Interventions demonstrate a tailored response to the individual client's social, cultural and community needs • Case notes and intervention design evidences a match with clients learning style, personality style, literacy and ability
Intervention design and delivery seeks to engage and support the client's support network	• Clinicians will engage the client's support network in the intervention, either actively or by providing information on intervention content • Providers work collaboratively with other services to ensure the safety of any vulnerable family members
Interventions designed and delivered to and for Māori reflect a strengths-based, whānau-centred approach	• Intervention design and delivery acknowledges the mana of local iwi and reflects Māori values • Interventions provided to and for Māori should adopt a whānau-centred approach • Providers must be able to articulate the kawa (structure) and Kaupapa (content) of the intervention • Providers have relationships/networks with iwi services

	and organisations
Interventions designed and delivered to and for Pasifika reflect relevant cultural values	• Intervention frameworks and case notes evidence Pacific culture and values • Providers demonstrate an understanding of cultural frameworks for the Pacific communities it works with • Providers have relationships/networks with Pacific services and organisations
Clinicians build constructive relationships with clients	• Relationships with clients are engaging and constructive but must avoid any collusion with the client • Clinicians use techniques shown to be effective in engaging the client, like modifying pace and delivery • Providers and clinicians comply with all relevant ethical codes, standards or guidelines for their profession
Intervention content and structure complies with the specifications contained in these Guidelines	• Session length and time is within the overall scope of the specified hours • Group participants attend individual sessions to meet particular needs • Providers have documented processes for reducing the risk of contamination where clients are treated together in group sessions
Providers ensure intervention structure and policies encourage accountability and prioritise safety	• Intervention content and sessions provide repeated opportunity for the client's reflection and development • Providers have documented policies covering (but not limited to) the structure of groups, compliance and non-attendance, confidentiality, ethical codes, incident reporting and complaints management • Non-compliance or non-attendance at intervention is reported to the appropriate agency or person
Providers employ evidence-based methods to monitor the client's intervention progress and completion	• Providers conduct regular system reviews (at least every three months) and regular internal case reviews (every three months) • Clinicians will re-administer psychometric and risk assessment tools to measure client risk/level of protective factors at completion of intervention in accordance with these Guidelines • Client and their support network are involved in all system reviews and completion report • Case notes evidence documented measures of progress/outcomes, treatment completion reports, recommendations and notes of any ongoing concerns
Providers ensure service effectiveness through quality recruitment and professional development practices	• Providers employ clinicians that meet the minimum qualification and experience requirements in these Guidelines • Providers have documented procedures governing peer review and supervision of staff • Appropriate professional development and support for staff – particularly around staff burnout and compassion fatigue
Providers offer appropriate referrals to meet additional needs of clients	• Providers make and document referrals to meet client's additional needs • Providers establish effective working relationships with

	other local providers and relevant social services
Reporting and client files reflect the needs of the client and objectives of the service	• Client files will contain evidence of the client's intervention plan, content of sessions, system review minutes, reports, supervision notes, risk assessments, safety planning records or actions, evidence of family/whānau involvement

8. Workforce capability and support

Qualifications and experience

The provision of HSB 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 3 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 face to face experience in the assessment and/or treatment intervention of sexual offenders. All clinicians will undertake assessments and interventions under the supervision of a team leader/supervisor. Psychometric testing administered as part of assessment must be overseen by a competent supervisor, trained in the use of the particular assessment tool.

In addition to clinical staff, the Provider 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 experienced required of clinical staff and social support staff are outlined in the below table.

Table 3: 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: • 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 Indigenous practice models and culturally relevant understanding and perceptions	Social support staff work alongside clinicians and clients to support them in achieving therapeutic outcomes. Social support staff must demonstrate the following: • 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 to develop and sustain relationships with other agencies and key personnel across the social services sector

of HSB • 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 to 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	• 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

Staff recruitment and induction

When recruiting staff, the Provider will ensure prospective employees have the relevant qualifications and skills to be able to work with adults who have engaged in HSB, as well as working with the client's support network and wider community.

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

- have documented human resource policies covering the recruitment 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, Māori, Pacific and CALD people.

Staff safety

Given the context and nature of HSB services, it is important that providers ensure a safe working environment for both its staff and clients.

In meeting this requirement, the Provider must:[21]

- have documented health and safety procedures which align with the Health and Safety at Work Act 2015
- have documented workplace policies covering risk mitigation and management of disruptive clients
- have a documented complaints and escalation policy
- ensure all premises are safe and fit for purpose.

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[20] This section should be read together with the Social Sector Accreditation Standards – Level 2 (Staffing requirements).
[21] This section should be read in conjunction with the Social Sector Accreditation Standards – Level 2 (Health and safety).

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, the Provider should:

- provide an induction period, including core induction, training and mentoring, to all new staff
- 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, as well as relevant clinical training, experience and knowledge.

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

- 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.

Professional development

HSB practice is a specialist area and clinicians and staff working in this area require ongoing professional development. As a matter of good practice, the Provider 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.

9. Measuring results and reporting

How do we know if the services we fund are working?

The Ministry needs to demonstrate the HSB Services it funds demonstrate results for clients, families and whānau. The Ministry will do this by collecting client results data based on a Results Measurement Framework (RMF).

Reporting measures

HSB providers use standardised psychometric assessment tools in determining the effectiveness of the HSB services. These tools provide an assessment of risk against a baseline offender population. Assessment tools can also be used to measure a client's protective factors and strengths.

Providers understand and acknowledge risk is not static and will (at minimum) measure the client's risk level at commencement and completion of intervention. The following assessment tools are used in the delivery of HSB services:

Client group	Assessment tools
Female clients	• STABLE-2007 as an aide memoire; and/or • VRS-SO as an aide memoire; • Risk assessment tools appropriate for assessing female offenders; e.g., HCR-20 or LSI-R.
Internet only clients	• STATIC-99R[22] (only if the behaviour involved the creation of child abuse images with a real identifiable child) • STABLE-2007 as an aide memoire; and/or • VRS-SO as an aide memoire.
Clients for whom all HSB was committed below the age of 18	• If currently aged 18 or younger: ERASOR • If currently aged over 18: Static 99R[23] and STABLE 2007 used as an aide memoire to help inform intervention length and intensity
Low cognitive functioning clients (I.Q. >75)	• Static-99R and STABLE-2007 (if they have applicable convictions and/or meet the coding manual criteria) • ARMIDILO-S (includes protective factors).
All other clients	• STABLE-2007 as an aide memoire where conviction history is not applicable to providing nominal risk category; and/or • VRS-SO.

[22] Refer to Page 13 of the Coding Manual (2016) for a description of the limited circumstances in which use of the Static 99R is appropriate for internet offenders. It can only be used with offenders charged or convicted of possession or distribution of child pornography if their behaviour involved the creation of pornography with a real identifiable child.
[23] Refer to page 14 of the Coding Manual (2016) for a description of the limited circumstances in which use of the Static 99R is appropriate for adolescents. It is recommended that even if these circumstances are met, clinicians should use the scale with caution and include appropriate caveats in their reports.

Assessment of protective factors (all clients except low functioning clients)	• SAPROF

The Provider will also collect and report on client feedback, specifically whether the intervention has supported the client in applying new skills in managing their HSB.

Results measurement framework

The Provider is required to collect data in order to contribute to an evidence base for the effectiveness of HSB services.[24]

To do this, the Ministry has developed a results measurement framework (RMF) for HSB services (see **Appendix 1**). The RMF is a Results-Based Accountability measurement system that links performance measures in Provider Outcome Agreements to the bigger results the Ministry is seeking.

The RMF has two levels – the population level (which covers high level government priorities) and the performance level (which looks at client results). The data is backed up by a narrative report, which forms part of the Outcome Agreement.

More information on RBA can be found at http://www.business.govt.nz/procurement/for-agencies/buying-social-services/results-based-accountabilitytm-rba/

What reports are required by the Ministry?

The Provider will report on the following service results measures, in line with the HSB RMF. Reports must be **submitted quarterly** to the provider's relationship manager, as outlined in the Outcome Agreement.

Type of measure	Measures (during the reporting period)	Information collected through
Service detail	Programme/service name, start date and end date, source of referral	Service detail reporting
Quantity (how much)	Of the total clients reported: • number of clients referred to service for assessment (during the reporting period) • number of clients assessed (during the reporting period) • number of clients referred to service (intervention during the reporting period) • number of clients who started service (intervention during the reporting period) • number of clients who closed (completed the service for intervention during the reporting period) • number of clients who closed prior to completing the service (intervention during the reporting period)	Service result measure reporting
Quality (how well)	Of the clients who closed during the reporting period, how many:	

[24] As at 1 July 2017, providers of HSB Services are exempt from collecting and providing client level data to the Ministry. These Guidelines will be updated as and when this exemption changes.

	• achieved their client results • provided formal 'client satisfaction' feedback Of the clients who provided client satisfaction feedback, how many: • reported they were 'satisfied' or 'very satisfied' with the service	
Result Measures (is anyone better off?)	Of the clients who closed during the reporting period, how many: • did not offend/reoffend while on the programme (based on information available to the Provider) Of the clients who closed (completed the service for intervention during the reporting period), how many showed a: • change in risk factors evidenced by stage of change progression on the VRS-SO tool (excludes non-mandated adults pre-assessed as low risk) • change in protective factors evidenced by progression along each of the dynamic item scales on the SAPROF tool.	
Narrative reporting (to support the data)		
1. What is the 'story behind the data'? (e.g., environmental factors that could affect client results including issues, gaps, overlaps and trends) 2. Of the number of clients recorded as closing prior to completing the service, please record how many were for each of the following reasons: a. Non-attendance/refusal – client b. Unsatisfactory progress c. Unsafe behaviour/endangering others d. Referral to non-HSB service prior to completing intervention e. Police custody/Remand/prison f. Lack of funding pathway g. Incapacitating mental health/medical issues/deceased h. Moved out of region/overseas or un-contactable 3. What are your areas for improvement towards achieving better results for clients (continuous improvement)? 4. In what ways have you worked with social sector agencies to achieve results? 5. What are the barriers (if any) to effective service delivery? 6. Provide examples of strategies or practices used to encourage 'hard to reach' clients to engage 7. Provide an explanation of the variance (if any) between client volumes contracted and client volumes delivered		Service result measure reporting

Units of measure

The contracted volume measure for HSB services is 'clients assessed' for clinical assessment and 'placements available' for intervention. The Outcome Agreement specifies minimum contracted volumes.

A client is defined as 'an individual client (and/or their family/whānau/support person) who agrees to participate, and is actively engaged, in a clinical assessment and planned intervention with the provider.'

'Closed' clients

A client should be recorded as closed when they have completed their intervention plan and have recorded a satisfactory decrease in risk factors and increase in protective factors.

A client may also be recorded as closed for one of the reasons outlined above in 2(a) to 2(k) of the narrative reporting.

Quarterly meetings

Quarterly meetings will occur either by video conference or face to face and will focus on monitoring the deliverables in the Outcome Agreement.

Family Services Directory

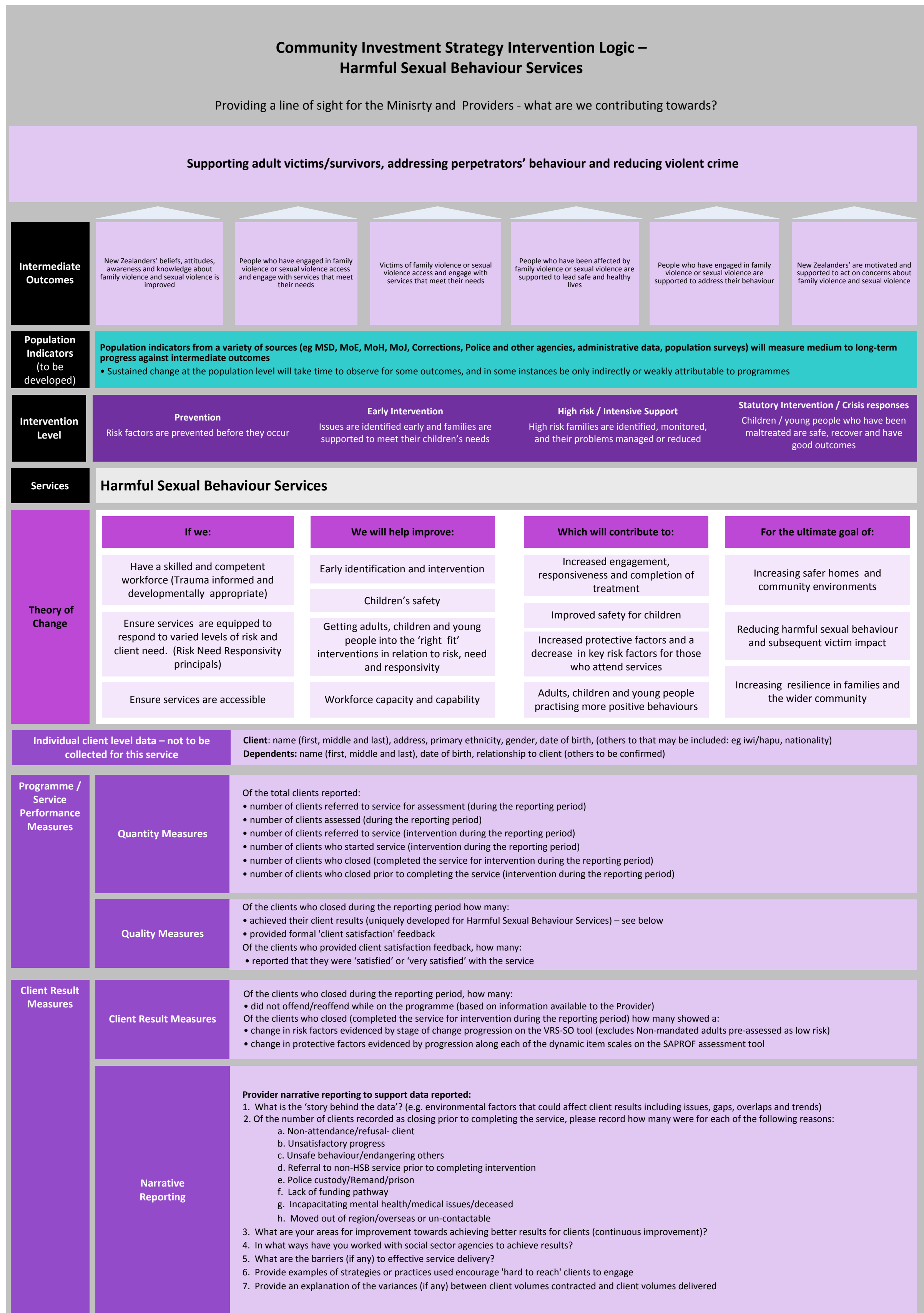
Through the term of the Outcome Agreement with the Ministry, the Provider must ensure their organisation's details are listed and up-to-date on the Ministry's Family Services Directory https://www.familyservices.govt.nz/directory/

Evaluation

The Provider agrees to co-operate with, and participate in, any evaluation of the HSB services that is undertaken by the Ministry or by a third party appointed by the Ministry to facilitate such an evaluation.

The Ministry will discuss any proposed evaluation process in advance with the Provider.

Appendix 1 – Results Measurement Framework



Appendix 2 – Provider Feedback Form

<table>
<tr><th colspan="3">Provider Feedback Form</th></tr>
<tr><td colspan="3">Please email this to your Contract Manager.</td></tr>
<tr><td>Name of service</td><td colspan="2"></td></tr>
<tr><td>Summary of, and reasons, for Suggested change</td><td colspan="2"></td></tr>
<tr><td>Topic</td><td>Reference (section/page)</td><td>Suggested change/description</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="2">Contact Name:</td><td>Position:</td></tr>
<tr><td colspan="3">Provider name:</td></tr>
<tr><td colspan="3">Provider email:</td></tr>
<tr><td colspan="2">Provider phone:</td><td>Date submitted:</td></tr>
</table>

MINISTRY OF SOCIAL DEVELOPMENT

TE MANATŪ WHAKAHIATO ORA