Psychology of Substance Use – Special Interest Group

First Quarter 2012 **Issue 1**

Welcome.

Here it is May (I have typed March – that was way too ambitious a timeframe for me, and April) and my first ever newsletter!

I thought this would be easy. Ask some people to write some articles, cut and paste them into a document and ta da ...newsletter done. Not quite like that. Sourcing contributions was the easy part, and I thank those who willingly and readily provided articles for this edition. The cut and paste into a newsletter format ...oh, what skills ... I don't have those skills!

I am excited to have this opportunity and look forward to working with you all to build, what I envision to be, an interesting resource for people to explore issues that surround the use of substances for the individual, family, community, and broader Australian society.

The theme that was selected for this publication is 'working with mandated clients within the context of substance use'. Exploration of this theme is through a reflection from experience around working with mandated youth, a discussion of considerations, such as who is the client? And what is the motivation? When working with mandated clients, and an article that explores some ethical considerations when working within the substance use population.

I hope you enjoy the read and welcome your thoughts on this topic, along with your thoughts and ideas for the newsletter.

I hope to be able to include, in future newsletters, a section for ongoing discussion around the explored themes. Also, if you have a particular theme you would like explore through this medium please feel welcome to contact me.

Ciao,
Nicola

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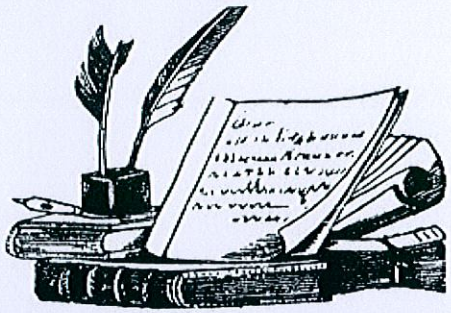
THEME:

'WORKING WITH MANDATED CLIENTS'



Writers & Contributors

Introductions ...

Tom Stylli is a psychologist that has worked in the field of Alcohol and Other Drugs for 14 years. Tom has worked as a clinician, supervisor, and manager within the context of voluntary, statutory, and mandated systems with young people and adults within the context of a variety of settings such as community health, welfare, and AOD specific services.

Melissa Kent has experience as a clinical psychologist working in fields like adult custodial corrections; community corrections; community-based AOD treatment; juvenile detention; & a hospital-based clinic for adolescent sexual offenders. Work involved assessments, treatment, and facilitating specialist intervention programs. Currently taking time off with her two young children, she maintains currency of knowledge by teaching the Graduate Certificate in AOD Studies with the University of Southern Queensland.

And Kate Crawley has been a practising Forensic Psychologist for over 10 years working extensively in the area of criminal risk assessment in Vancouver Canada, Wellington NZ, South Australia, and the Northern Territory providing treatment for forensic patients within inpatient and outpatient settings, prison, and community corrections settings. Also with AOD services working with patients experiencing addictions and chronic pain and is currently working in Court Diversions. Kate is the Chair of NT Branch of APS, President of the NT Branch of ANZAPPL and is a member of the NT AOD Tribunal.

I thank you for your contribution, without your participation a newsletter it would not be!

Working with mandated youth around substance abuse issues is a complex story ~ Tom Stylli

A Reflection

A clinician who works with mandated clients is required to have an extra level of skills and knowledge that a general clinician who works with voluntary clients is not required to possess. A clinician who works with mandated clients is required to understand the forensic system, legal obligations for themself and their clients, while also understanding that the motivation for attending treatment is often fuelled by avoiding an incarceration and not necessarily seeking treatment. This is in addition to the clinical skills they should possess.

The field of substance abuse and addiction is considered to be a complex field of intervention and health services, however, when clients are mandated into services the level of complexity increases.
This is true for adult clients; however, the complexity intensifies when a professional works with a young person, (a young person here refers to an individual who is under the age of 18 and can be referred to as a minor or youth).

When working with a young person, it is critical that a clinician has a thorough understanding of childhood and adolescent development prior to commencing any work with a young person. If a clinician transitions from working with adults to working with young people and has not undergone any further training and supervision to up skill, then their interventions will not be client centered, focused or sensitive to their client needs. Depending on the stage of development that the young person is in, it will greatly impact on a that young person's level of insight into their issues and the clinician will need to be able to assess what treatment options will be suitable, how their peers influence their behaviours and what the legal obligations of the clinician has. A clinician needs to be able to understand these factors prior to even considering engaging with a young person around their issues or attempting to intervene around addiction.
Thus, if the clinician is not aware of these issues and has not received specific training around adolescent issues, then the exposure to treatment will be a negative experience for the young person.

It is known that young people in general do not engage actively with traditional methods of counselling and therapy, the office based "hour" is too confronting and exposing for them. Hence traditional treatment options for adults need to be adapted to meet the needs of the young person. The other factor that many young people struggle with is that of trust, in particular with addiction. While the concepts of privacy and confidentiality appear to be understood, they are complicated by age, culture and family dynamics. Many young people resist seeking treatment based on not trusting all information will be fed back to their parents/carers. Whilst sharing of information is essential in some circumstances, the clinician needs to be aware of their own values, professional's standards and their legal obligations. This seems simple, however needs to be reviewed and assessed per case and consulted with a supervisor when in doubt.

These 'matter of fact' statements of working with young people are compounded when the young person is mandated to come for treatment for their substance abuse. A young person is mandated as a result of a police diversion or a court order that has resulted in involvement with Youth Justice. Whilst the wider system can recognise that their crimes are most likely related to their substance use, the young person does not see the connection in most cases. They may have agreed with their solicitor that they committed the crime under the influence of substances; in spite of this they rarely see their substance use as a problem. This can be further observed with the motivation for treatment; rarely do all parties share the same motivation for treatment, let alone agree on treatment goals.

Most young people mandated into treatment do not see their substance use as problematic let alone that they need to cease their use. The police, the courts, youth justice and potentially child protection would all prioritise abstinence as the goal of referral into treatment. The young person sees continuation as their goal, while the clinician will often be working from a harm minimisation model of treatment which can be seen by other services as being condoning of drug use. The clinician will never condone drug use, however recognises that working from a model of forcing abstinence as a goal, this will result in the young person disengaging and thus not allow for assessment of risk, psycho-social education or engagement them with treatment if required.

Letters

As mentioned previously, when working with a young person you need to be family sensitive and systemic with your practice. However, within the mandated system the clinician will always be required to work in a systemic framework. All young people come to an AOD service with a family and peer network, but once they are mandated, the system expands dramatically causing further stress on a young person's life. A mandated young person with an AOD clinician will also have a Youth Justice Worker, often a Youth Justice Support Worker, potentially Adolescent Forensic Health Clinician, often are also involved with Child Protection – thus an additional worker, if they have issues around education or employment (which most do) they will have a vocational worker. This is not including the solicitor that supported them in court or the general practitioner that they may also be connected with. Thus an AOD Clinician working with mandated youth needs to think and work systemically, be able to provide secondary consultation, have clear professional boundaries, have the capacity to attend Care Team Meetings, have an understanding of the legal obligations of other professionals and further Acts (e.g. Children's Wellbeing Act) and be prepared to write regular reports.

Overall these reflections are not to focus on the presentation of the young person, rather to increase the awareness of the clinician and the skill-base and knowledge base they will be required to have, with the potential areas of ethical dilemmas. Working with mandated youth is for the clinician who can work with difficult to engage individuals while working systemically and creatively.

Letters from you ...

No letters for publication have yet been received. Please send any letter to:

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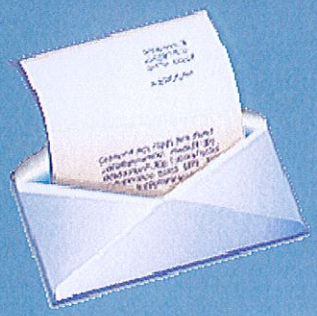

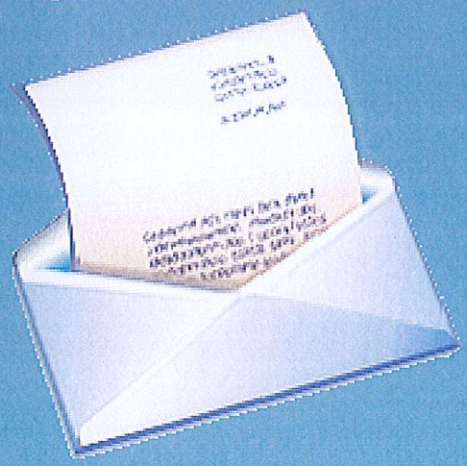

Ethical considerations when working with substance using populations
By Melissa Kent MAPS

I have a long history of working with substance using clients, both mandated and non-mandated. I have found that the approaches taken to these two groups of clients, while on the surface are similar – for example, as a Psychologist I abide by ethical guidelines, I follow the process of assessment-to-intervention – the approaches are also quite different, albeit in subtle ways. In my experience, working with mandated clients tended to involve much more frequent consideration of ethical considerations and guidelines. The constant issue for me was "who is my client? The person in front of me, or the referring/governing agency? How do I abide by the rules and regulations of my governing body/agency but also behave ethically towards the person in front of me?". These considerations were not always easily resolved and required constant thought and discussion, usually in the form of colleague discussion or professional supervision. The answer to these questions was often different, depending on the issues at hand. There was never an easy or obvious answer.

There were also a number of other ethical considerations that arose regularly, such as the issues of informed consent, managing disclosure, and obtaining collateral information. In my experience, these ethical considerations were not unique to mandated substance using clients – rather, they were applicable to substance using clients in general. However, when the substance using client was mandated, it tended to add another layer of complexity. I will summarise these ethical considerations below, using my experience as examples. I am by no means claiming to be an expert on working with substance using clients, or managing ethical issues; rather, I am a practitioner who thought it might be worthwhile to share my point of view and stimulate thought and discussion with my colleagues out there.

Informed consent

The Australian Psychological Society's (APS; 2011) Code of Ethics General Principle A.3 deals with informed consent. It states:

> *"Psychologists fully inform clients regarding the psychological services they intend to provide, unless explicit exception has been agreed upon in advance, or it is not reasonably possible to obtain informed consent"* (p13).

This is all well and good. But alcohol and other drug users' present issues that complicate the informed consent process (McCrady & Bux, 1999). In the context of AOD assessment, informed consent refers to the client's ability to consent to undertaking assessment and all of the implications of that process. A variety of concerns have been raised with regards to AOD clients being able to give informed consent, including the degree to which a substance using individual can fully comprehend the implications of the assessment process, the degree to which an individual's capacity to make informed choices is impaired, and the care given to the informed consent process. In particular, AOD using clients may have an impaired ability to comprehend the implications of the assessment process, perhaps due to cognitive impairments due to their substance use, or impaired judgement due to organic brain damage; clients may have limited educational attainment, particularly early onset users. Further, clients' abilities to make informed choices may be impaired at the time of the assessment – they may be under the influence of substances, withdrawing from substances, substances may have negatively affected their cognitive capacity. All of these issues need to be borne in mind when obtaining consent, to undertake assessment with a client. For example, if a client is clearly under the influence of alcohol when they are scheduled to undertake the assessment, perhaps reschedule the assessment and discuss the importance of being sober for sessions. Of course, each situation is different and you need to use your professional ethical judgement.

Informed consent

There are a number of suggestions for procedures to try and ensure clients can provide informed consent and are unimpaired when giving consent to participate in assessment. Consent should be obtained at the beginning of an assessment interview, and preferably in written form. It is suggested that a written consent form includes basic information about the information that will be obtained during the assessment and what will be done with it (e.g. where files will be stored, who will be informed of information etc.), how long the assessment is expected to take, and avenues for complaint. Many organisations will have standard consent forms that are used routinely with clients.

However, it is not enough to simply present a consent form to a client and have them sign it. Many clients may not have the literacy skills needed to read the form, or the cognitive capacity to comprehend it; they may be overly compliant and sign it without actually understanding it. Some suggestions put forward by McCrady and Bux (1999) to try and ensure consent forms are understood and therefore consent is given, include soliciting questions from the client about the process outlined in the consent form, reviewing the form with the client and explaining it in your own words or words the client will understand, or reading it verbatim to the client.

Managing disclosure

The nature of the population of substance using clients means that as a practitioner in the field, you are more likely to be given information about issues that, in many cases, need to be disclosed to other parties. Such examples include suicidal ideation, homicidal ideation, child abuse or neglect, and criminal activity. In many cases, the particular organisation you are working for will also have policies and procedures regarding disclosure of certain information. This is especially the case when working with mandated clients, such as those in a correctional setting.

It is important to know what your duty of disclosure is regarding the issues mentioned above; it is just as important to know what to do if such information is disclosed to you, so that you are behaving ethically by your client. Will you tell the client that you need to disclose the information they have just given you? Will you tell them who you are disclosing it to and when? Your response to disclosure may be prescribed by your professional body and/or your place of work, and it is suggested that the response for managing disclosure is documented in your written consent form that you present to your client, so they are aware of it prior to commencing assessment.

Obtaining collateral information

Obtaining collateral information about a client with substance use issues is, in my opinion, essential. Information from other treatment providers, treatment facilities, government agencies (especially if mandated) and friends and family members can help you to put together the puzzle of the client's issues, connect it to the pieces the client has given you, and the overall picture that is made (hopefully) means your assessment and treatment plans are going to be far more comprehensive and suitable for the client, and therefore ultimately more effective.

When working with a mandated substance using population, obtaining collateral information is also useful as clients are more likely to have reason to neglect to mention previous diagnoses or treatments, or to try and present a particular image, depending on their source of referral. An example is a mandated client who is wanting to minimise his or her history of drug use in order to present a favourable impression for a forensic assessment, or parents who are undertaking treatment under order of a government child protection agency and are trying to regain custody of their children.

From an ethical perspective, it is important to ensure that you obtain consent from a client to contact their previous or current treatment providers and to obtain information from them. It is preferable that this consent is given in written form. It is also important that you inform the client of the purpose of obtaining collateral information and what it will be used for. Your specific organisation may have policies and procedures relating to obtaining collateral information and it is important you are aware of them.

References

Australian Psychological Society. (2011). *Code of ethics.* Melbourne, Victoria: The Australian Psychological Society Ltd.

McCrady, B. & Bux, D. (1999). Ethical issues in informed consent with substance abusers. *Journal of Consulting and Clinical Psychology, 67*(2), 186-193.

Working with Mandated Clients: some considerations

By Kate Crawley. Forensic Psychologist.

Question: How many psychologists does it take to change a light bulb?
Answer: Only one – but the light bulb must want to change.

The old joke reflects the traditional wisdom that dictates the client must accept his or her "problem" or "illness" and be willing to accept treatment otherwise treatment will not be effective. In contrast however, it is widely acknowledged that many individuals who seek treatment do so because someone (e.g. an employer, partner, and parent) is exerting pressure.

In the case of mandated clients the pressure is generally in the form of an employer, correctional body (prison, community corrections) or judicial system (such as a drug court).

For a therapist working with the mandated client – there is much to consider. For example:

- Who is the client – the mandated person in front of you or the judicial / correctional system?
- What are your reporting responsibilities in terms of breaches?
- What is the nature of the client – therapist confidentiality?
- What are the relevant State / Territory laws on FOI and record keeping?
- What does your professional body (e.g. APS) advise regarding the above.

Lack of sufficient knowledge in these areas can lead the therapist into problems both ethically and legally and in some instances – personally.

In addition to the above ethical areas there are also the unique aspects of the setting or clients themselves which make working with them sometimes challenging. These include:

- The client may not in fact, construe his or her behaviour as a problem. This viewpoint may be countered by re-framing the client's disorder to fit a problem-orientated approach rather than using an illness model in which the goal of treatment is to 'cure' the client.
- Related to the above issue is the question of motivation and consent to treatment. There are many issues to contend with and take into account, for example;
  - Family and societal pressures placed on the offender to take part in therapy.
  - Undertaking therapy in order to influence the outcome of a court appearance or sentence length. In this case the offender may think of the therapist as part of the punitive legal system and thus want to display their 'good conduct'.
  - Alternately, the client may openly resent therapy and view its role as a continuation of punitive restrictions. The therapist must consider how legitimate this concern is. The client's evaluation may be warranted if therapy is legally mandated with sanctions for non-compliance. The therapist in this situation has a reporting and therefore an inescapably punitive role. Again, these issues may be reframed so that the therapy is collaborative and problem orientated rather than part of a "punishment".
- The prison setting and its artificiality may constrain therapy so that the likelihood of effective and lasting change is minimized. This is exacerbated by the transient nature of the population. Limited time is an issue, especially in remand, where crisis situations such as suicide are most likely to occur.
- Time is also a factor when undertaking therapy in the community as part of a parole requirement, bail or drug court; limited goals must therefore be set.

Problems not only arise with aspects of the client or the system within which the therapist is working. There are issues of transference and counter-transference with which the therapist must be wary. These terms are generally used to label any inappropriate emotional reactions or distortions in perceptions or expectations that may occur between client and therapist and can include:

- Exaggeration or minimization of the client's potential dangerousness. Both of these place the client, the therapist, as well as the community at large in danger.
- The client may perceive the therapist as a judge, making moral evaluations, and thus look to the therapist for forgiveness or fear their opinion.

The above are all inescapable problems and questions the therapist must consider carefully both prior to and whilst engaging the mandated client in therapy.

As I have framed this contribution largely on mandated clients who are offenders, I feel I should also highlight the importance of assessment. In particular, assessment with the purpose of determining a client's risk and needs. These in turn will assist the therapist in identifying how often, the intensity and how to structure interventions based on the unique client before them. Essentially - the Risk Need Responsivity (RNR) literature (Bonta & Andrews, 2007).

The Risk principle outlines to whom to target intervention. That is, matching the level of service / supervision to the client's likelihood to re-offend: essentially this means high risk offenders should get the lion's share of resources – more intervention, more structure, more supervision.
The Need principle indicates what to target: we assess criminogenic needs and target those needs with treatment and intervention. Criminogenic needs are those needs that directly contribute to the likelihood someone will offend. These needs are further classified into static (unchangeable such as age and gender) and dynamic (changeable and treatable). There are 8 central criminogenic needs that research has shown to directly contribute to offending behaviour these are:

- antisocial attitudes and cognitions
- antisocial friends / peers
- self-control deficits / impulsivity
- non-criminal alternative behaviour in high risk situations
- family process (family / marital stressors)
- school / work (lack of stability / achievement)
- Substance abuse
- Leisure / recreation (poor use / lack of prosocial activities)

Non criminogenic needs (e.g.: anxiety, self-esteem, lack of parenting skills, victimisation issues) if attended to do not directly influence criminal behaviour , but they are important in assessment as they can represent barriers and effect how the person responds to treatment.

The Responsivity principle indicates how to target these factors. General responsivity principle states that the use of behavioural, social learning and cognitive behavioural strategies are most effective. The Specific responsivity principle informs us that intervention modes and strategies must be matched to the learning styles, motivation, and demographics of each individual case.

In essence: what factors are protective in this individual (strengths) and what factors might influence effectiveness of treatment. Examples include: language/learning style; race / gender / ethnicity; motivational level.

In conclusion, as suggested above, the distinction between mandated and non-mandated clients is often an illusion and therefore it is an erroneous assumption that non-mandated clients will achieve significantly better results or change – or indeed that mandated clients are impossible to treat successfully. For the truly mandated client in a forensic setting however, a comprehensive assessment of risk, need and responsivity is essential in order ascertain how best to approach the client regarding change as well as inform on more obvious needs and risk.

Significant literature drawn upon:

Bonta, J. & Andrews, D.A. (2007) Risk-Need-Responsivity Model for Offender Assessment and Rehabilitation, Public Safety Canada: Her Majesty the Queen in Right of Canada.

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