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ETHICAL PRACTICE WITH SPECIAL POPULATIONS

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Ethical Practice With Special Populations

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This distance learning coursework was developed for CEUMatrix by Charlotte Chapman, , M.S., MAC, CCS, LPC.

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Ethical Practice with Special Populations

Introduction

Clinical work has become more complex over the years as clients present with numerous issues and more treatment approaches have been developed. In addition to gaining competency with more complex clinical populations, counselors also need the knowledge and ability in ethical decision making with these populations. Codes of ethics, laws and credential regulations are developed as general, minimal guidelines for practice. Therefore they do not typically offer ethical guidelines for resolving the dilemmas encountered in treating some of these special populations.

For the purposes of this course, we will focus on four special populations: clients from the non-dominant culture; clients from criminal justice systems; adolescent clients, and clients with co-occurring issues. Why is a course needed on ethical practice with these populations?

Culturally diverse clients are becoming more a part of helping professionals' caseloads as former "minorities" become more a part of the general population. According to the 2007 U.S. Census, minorities, now roughly one-third of the U.S. population, are expected to become the majority in 2042, with the nation projected to be 54 percent minority in 2050. By 2023, minorities will comprise more than half of all children. This trend increases the possibility that the culture of the helping professional may not be the same as those of the clients he/she is treating. This has implications for ethical treatment and is why it is important to consider cultural diversity as one of the topics in this course.

Clients are increasingly being referred via the criminal justice system either as an alternative to incarceration, as part of probation, or for aftercare from many of the treatment programs being offered in prisons. These clients will present many ethical issues due to the need to integrate the viewpoint of the criminal justice system in the treatment process. The criminal justice/legal system is designed to protect society; therefore clients are often treated in adversarial and arbitrary ways. The mental health system is designed to help the individual client so it is designed to provide helping relationships that meet client needs. Training programs for mental health counselors do not usually include course work on the knowledge and skills needed in working with this client population. In addition the criminal justice system can be seen as a different "culture" thus adding all of the dilemmas when working with culturally diverse populations.

Another special population is adolescent clients. The ethical challenges of this client population have a lot to do with the developmental issues of adolescents. They are not children and they are not adults so there is a constant tension between wanting to help them develop independence and at the same time

concerns about some of the decisions that are made by this age group. They typically have parents, guardians, school personnel, social services, and possibly criminal justice staff who want to be involved in their treatment. This can create conflicts for the counselor in trying to balance autonomy, confidentiality, and client welfare issues. Adolescent clients can also be seen as a culture different from that of the adult counselor, therefore requiring some of the same ethical practice that will be discussed in the cultural diversity section and concerns with regard to the principle of competence.

The increase of clients being diagnosed with co-occurring issues has impacted the caseloads of mental health counselors, substance abuse counselors and criminal justice staff. These clients still suffer stigma and discrimination in our society which relates to ethical issues of access to treatment. There are also the ethical issues of autonomy and the safety of the client vs. the safety of society. The issue of professional competence is a dilemma to discuss in treatment of this special population along with the values conflicts counselors may have when dealing with lifestyle choices, for example, the decision of a client with bipolar disorder to not take medication and use alcohol instead. These are just some of the reasons why it is important to include this client population in this course.

We will discuss how to apply ethical principles and what needs to be considered in an ethical decision making process in treating each of these special populations. Each area will have case examples and suggestions for additional reading and resources. We will also look at various codes throughout this course for some assistance with ethical decision-making in these four areas. The codes that will be referenced are the following:

- American Counseling Association
  http://www.counseling.org/resources/codeofethics.htm
- American Psychological Association
  http://www.apa.org/ethics/code.html
- National Association of Alcoholism and Drug Abuse Counselors
  http://naadac.org/ethics.htm
- National Association of Social Workers
  http://www.naswdc.org/pubs/code/default.htm

In each module we will discuss the fact that there is a wide range of clients within the category of each population which makes the issue of competency even more challenging. For example, the range for adolescents can be twelve years to twenty-one when just considering the research in brain chemistry and development. To treat a twelve year old client and twenty year old client the same would be unethical. This is true also for discussing a population of

culturally diverse clients, criminal justice clients and co-occurring disordered clients; there are multiple clinical presentations within each of these groups. The purpose of this course is to try to highlight ethical issues common to these populations with the goal that the individual student will take the information and apply it to whatever client population is appropriate within the larger generalization.

Part of the ethical decision making process is self-reflection. Counselors bring their own beliefs and values to the counseling relationship. One of the reasons for this course is that these client populations can challenge counselors' values, worldview, and normal practices. Self-awareness is a critical part of good ethical practice. For these reasons, please be honest in completing the following self-inventory. This inventory will also introduce some of the ethical issues to be discussed further in the course.

Self-Inventory

There is no right or wrong answer and in fact, you may want to answer 'all of the above' or a combination of the answers or create your own answer. You might benefit by discussing some of your responses in supervision or with a trusted colleague. Please feel free to email the instructor as well by contacting ccjp@ccjp.com. You may also identify other areas of concern in working with these special issues that you need to discuss with others. Please use this self-inventory in a way that will best meet your learning needs.

1. Cultural competence means that:
    a. counselor has had training and supervision about a specific culture
    b. counselor seeks consultation from members of the culture to improve knowledge about a client's culture
    c. a counselor refers clients to counselors of his own cultural background
    d. Other:
    ____

2. The culture I would have the most difficulty working with is:
    a. Hispanic
    b. Caucasian
    c. Asian
    d. African American
    e. Bi-racial

    And the reasons why are:
    ____

3. I believe that a client who is court-ordered to treatment:
    a. will be dishonest so that the report to the court looks good
    b. will be unmotivated
    c. will be easy to help change because of external motivators
    d. Other:
    ____

4. If a client I was treating committed a crime and was sent to jail I would:
    a. ask to be able to visit her in jail and continue our counseling relationship
    b. close the case
    c. contact the client's lawyer, assuming I had a valid release, and discuss what the client wanted of me at this time
    d. Other:
    ____

5. I would have difficulty treating a client who had committed:
    a. Breaking and entering
    b. Domestic violence
    c. Drug dealing
    d. Other:
    ____

6. If my sixteen -year old client revealed that she was pregnant and did not want her parents to know, I would:
    a. Discuss the situation with her and try to determine her reasons for privacy
    b. Refer her to another counselor
    c. Advise her that I need to contact her parents anyway and why
    d. Other:
    ____

7. If my sixteen-year old client revealed that he has been breaking and entering homes in his neighborhood to get money, I would:
    a. Discuss making restitution to the home owners with him
    b. Advise him that I need to contact his parents for a family discussion
    c. Would contact law enforcement authorities
    d. Other:
    ____

8. If my client who has a diagnosis of bi-polar disorder and long years of unsuccessful treatment stated that he wanted to discuss physician -assisted suicide, I would:
    a. Refuse to discuss this and refer him to a spiritual direction counselor
    b. Listen to his views and then try to persuade him not to pursue this
    c. Begin commitment proceedings to a psychiatric facility
    d. Other:

9. If my client who has a diagnosis of alcoholism and depression stated that she was refusing to take medication prescribed by a psychiatrist, I would:
   a. Discuss her reasons for refusal and then attempt to educate her about the benefits of anti-depressants
   b. Tell her that I could not work with her and refer her
   c. Respect her decision and not bring it up unless she wanted to discuss it again
   d. Other:

      ____

10. If I was treating a client who presented with a history of anxiety and then several sessions later revealed he also has a cocaine addiction I would:
    a. Refer the client as I do not feel competent to treat this
    b. Seek consultation/supervision
    c. Require that the client go to inpatient treatment and then see me for aftercare
    d. Other:

       ____

11. When a client discusses suicidal ideation my response is to:
    a. begin to ask screening questions to decide if hospitalization is needed
    b. respond so that the client can feel my care and concern
    c. get the client to sign a contract agreeing they will not commit suicide
    d. refer for psychiatric consult
    e. Other

       ____

12. The main reason I entered the helping profession is to work with these types of clients ____

Module One: Cultural Diversity

"*Although there are certainly some counselors practicing today who remain culturally encapsulated, counseling professionals now generally recognize that they must learn to practice in a diversity-sensitive manner. Our understanding of multiculturalism is based on the premise that all counseling can be viewed as multicultural when culture is broadly defined to include not only race, ethnicity, and nationality but other cultural variables as well. Culture also includes gender, age, social class, sexual orientation*, *disability, language, and religion*" (Remley and Herlihy, 2001, p.49)

Questions to Consider:

- What is your reaction to this quote? Do you agree that all counseling should be viewed as multi-cultural? Why or why not?

Case Scenario

Tanya is a counselor at a mental health counseling center. She is considered the "multi-cultural expert" because she has lived in several other countries, is fluent in Spanish and has had a lot of training and experience in working with diverse clients. She has a new client, Aisha, who is from a middle-eastern country, first generation raised in the United States. Aisha is twenty four years old and is having symptoms of depression. She tells Tanya that her parents are arranging a marriage for her and Aisha believes that her depression will lift once she follows through with her parents' wishes. She thinks her symptoms are related to the fact that she is living as a single woman at an age where most women in her culture are already married. She was educated in the U.S. and has several friends also her age who are single and thought she would enjoy this lifestyle but in the past year she has become more and more depressed. Aisha states that she will be moving back to the state where her parents live in a few months so that she can meet her fiancé and the wedding plans can begin.

Questions to Consider:

- As Tanya, what are your reactions?
- What type of treatment plan would you hope to create?
- What ethical concerns do you identify?

The topic of multicultural counseling is vast and complicated. The concept includes many diverse groups of clients and different theories of counseling. For those who have not had specific training in multi-cultural issues, other resources are listed at the end of this chapter. Culture can refer to many things as discussed in the opening quote of this module. We will focus on the application of

these ethical principles in clinical practice: justice (nondiscrimination), beneficence and non-maleficence (client welfare), and competency in treating diverse clients.

Justice

"*Understand what it means to be White, what it means to be Asian, what it means to be a Latina/o, because if you are unaware of your worldview, you have the tendency to impose them, and assume that they are universal; you impose them upon people who are different than yourself, whether they are clients or neighbors, or colleagues, and you may become guilty of cultural oppression. And the role of counselors and mental health professions, and indeed our society is to make the invisible visible, because as long as our worldview is invisible, we potentially oppress and hurt others."*
(Sue, 2009)

Question to Consider:

- Take a few minutes to reflect on this quote by Dr. Derald Wing Sue.
- Are there ways in which you or your agency potentially oppress or discriminate against client populations unknowingly because of invisibility issues?

Each professional code of ethics includes a section on nondiscrimination.

The American Counseling Association states:
A.2c. Developmental and Cultural Sensitivity
Counselors communicate information in ways that are both developmentally and culturally appropriate. Counselors use clear and understandable language when discussing issues related to informed consent. When clients have difficulty understanding the language used by counselors, they provide necessary services (e.g., arranging for a qualified interpreter or translator) to ensure comprehension by clients. In collaboration with clients, counselors consider cultural implications of informed consent procedures and, where possible, counselors adjust their practices accordingly.

The NAADAC Code of Ethics states;
Principle 1: Non-discrimination
I shall affirm diversity among colleagues or clients regardless of age, gender, sexual orientation, ethnic/racial background, religious/spiritual beliefs, marital status, political beliefs, or mental/physical disability.

These principles reflect the fact that clients are diverse, and that it is an ethical obligation to acknowledge this in practice. However, there are no specific guidelines as to how to do that. Some professionals may acknowledge diversity,

but still practice mono-culturally. This is understandable based on the fact that many professionals are trained in educational programs that are mono-cultural and practice in mental health, substance abuse or criminal justice systems that are based on Euro-American values and beliefs. For example, just the value of verbally talking to another person outside of your own family or tribe is Euro-American. So what does it mean to practice mono-culturally?

This refers to the belief that one’s own group is superior and that the values held by this group are “normal” and shared by everyone. The corresponding belief can also be that other groups are inferior and their values and behaviors are therefore abnormal or their values and beliefs are not even acknowledged. These beliefs can impact ethical practice in many ways. One exampled could be refusing to let the partner of a gay or lesbian client participate in a family program. Another example would be an agency that forbids clients to bring items of spiritual significance to their treatment group because of "state policy". A counselor who makes judgmental statements about a client’s pursuit of healing practices to help with depression is practicing mono-culturally. Counseling practices that do not show consideration for important relationships or different spiritual beliefs would be considered discriminatory.

Other forms of mono-cultural practice and discrimination may operate on more subtle levels, partly because they stem from culturally-bound practices and communication styles that seem "normal" to members of the predominant culture and are therefore not examined. These subtler forms of discrimination may arise in the dynamics of counselor/client communication during assessment and/or in counseling sessions derived from the predominant culture's theories and techniques.

Question to Consider:

Think about your own professional training. What are some of the values inherent in the theories and approaches you were taught?

Some of these approaches may be:

- Assessment techniques that involve intrusive questioning about a client's family and personal life
- The expectation that clients will discuss feelings.
- Belief that clients have "faulty" cognitive belief systems and behaviors that need to be changed by you, “the expert”.
- Group counseling or referral to support groups that involve discussion of personal issues in front of other people.

- The value system that talking to someone outside of the family or community is the way to seek help.
- That the main goal of helping is to relieve symptoms and often medication is necessary to do this; in other words, outcome driven rather than process, relationship driven.

- That helping is formal, structured, time-limited and costs money.

We can examine each of the above beliefs and identify ways in which some cultures would find these approaches offensive. How this impacts ethical practice relates to the counselor's response to a client's reaction. For example, a professional referring a client to group is met with disagreement. This client is then labeled "resistant" to treatment. In fact, their reactions may be indicating several things;

- a lack of understanding due to language barriers

- a reluctance to discuss personal issues with someone outside of their family/community

- not seeing the value or reason for attending the group

Good ethical practice in these situations calls for the professional to be able to understand the cultural meaning of the client's response in order to know how best to proceed.

Other subtle forms of discrimination may be:

- Where an agency is located: in the neighborhood of the client population vs. a non-accessible location.

- Structure of waiting area: are there culturally relevant pictures and items?

- When are appointments or activities scheduled; do they conflict with religious practices?

- Diversity of staff

Research by Sue and Sue (1990) indicated that minority clients were given less preferred forms of treatment and more negative psychological evaluations than their majority counterparts. One of the ethical dilemmas for counselors is how to prevent this and provide for different treatment needs without giving preferential treatment resulting in "reverse" discrimination.

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Finn (1994) suggests that four general counseling techniques, already in use by professionals, can be integrated into a multicultural practice:

- Individualization of the counseling approach
- Avoidance of assumptions
- Building of trust
- Identification of issues that affect client treatment outcomes.

This means that counselors do not need to discount their professional training and knowledge. They can use this knowledge and initially approach every client from every culture, even the one that is similar to their own, with an open mind, understanding that each client sees the world differently, communicates differently, and has a unique, personal belief-system that may or may not be based on their culture.

Beneficence and Non-Maleficence

Beneficence (doing good) and non-maleficence (do no harm) are closely related to the principle of justice. Discriminatory techniques can certainly compromise client welfare. Some examples are:

- labeling a client or an incorrect diagnosis due to lack of cultural understanding
- using techniques or language that the client cannot understand
- using the same approach for all clients

Practices that have been proven effective with one client population do not necessarily transfer to all clients. Research needs to be carefully examined as to its appropriateness for these other client populations. No one argues that a counselor should use the same approach with a child as they do with an adult client. The same argument holds true for clients of different cultures, religious beliefs, lifestyles, etc. Although many approaches may be transferable and helpful, it should not be assumed this is true until tested. Involving feedback from the clients about treatment approaches as well as utilizing multicultural competent consultants are some ways to practice beneficence.

Another practice related to ethical concerns that needs to be examined is the issue of informed consent. This practice needs to be expanded with culturally diverse clients who are not familiar with an American approach to mental health,

criminal justice or substance abuse treatment. Part of the informed consent process needs to include an explanation about the values, beliefs, methods of treatment and a discussion of how this may correspond or conflict with the client's culture. For example, in criminal justice systems and substance abuse treatment programs in America, the focus is typically abstinence based with referral to twelve-step programs. This is not the same approach (value) in substance abuse treatment in many European, Asian and other countries.

Also to ensure that informed consent has been properly administered, the counselor needs to address any language barriers and utilize an interpreter when necessary.

Competence

Ethical concerns are focused on determining what knowledge, skills, abilities and attitudes constitute competency in multicultural practice. Sue and Sue (1996) suggest that the following competencies are required:

- Awareness of one's own cultural biases and assumptions
- Awareness of cultural biases and assumptions of other races
- Development of culturally appropriate individual and systematic interventions

Several multicultural competency surveys have been developed. They are offered here as another resource for improving professionals' competency in this area.

- The Multicultural Awareness Knowledge and Skills Survey (MAKSS) by D'Andrea et al. (1991)
- The Multicultural Counseling Awareness Scale: Form B (MCAS) by Ponterotto, Sanchez, and Magids (1994)
- The Cross-Cultural Counseling Inventory (MCI) by Sodowsky, Taffe, Gutkin, and Wise (1994)
- The Survey of Graduate Students" Experiences with Diversity (GSEDS) by Talbot (1992)

In addition, the Association for Multicultural Counseling and Development (AMCD) approved competency guidelines in 1991. To review these competencies go to www.amcdaca.org/amcd/competencies.pdf.

Additional recommendations for competency areas for those professionals providing substance abuse treatment are offered in the Center for Substance Abuse Treatment's publication *Cultural Issues in Substance Abuse Treatment* (CSAT, 1999). A brief outline of some of these:

1. Awareness of the role migration has played in the settlement experiences of each culture.

2. Awareness of generational and gender issues specific to each culture and the relationship of substances of use and abuse.

3. Knowledge of the communities in which a treatment program is located.

A culturally competent model of treatment also includes representation of the client population in the policy and program planning process.

As previously stated, self-awareness is an essential element of competence. It is also an important part of the ethical decision-making process. Ethical competence requires that professionals address their own personal and professional attitudes and behaviors in relation to the clients they are treating. Competent counselors are aware of their own prejudices and limitations and make referrals when they know their biases, lack of knowledge, or program/policy barriers will impact the delivery of services. In fact, referrals are required when a client's needs cannot be met. This may be difficult to do when there is an economic consequence to not accepting clients, but it is an ethical mandate. Following up on the example of denying same sex partners to participate in treatment, if the agency is going to enforce that policy then they should know of other resources where this client can have his/her partner included in treatment and make the referral. Some professionals may practice in a geographic area where referral is not possible due to lack of programs. Ethically competent counselors make every effort to get the training and supervision needed to provide for each client's welfare.

Education and training are an important part of the process of increasing cultural competency, but may not always provide opportunities for personal exploration and increasing self-awareness. Supervisory consultation may assist with self-discovery, depending on the multicultural experience and competency of the particular supervisor. Ongoing peer consultation groups, which include diverse members, are another means of increasing cultural awareness, addressing cultural biases and improving competency.

"Stop spending all your time with persons who think, act, dress, and behave like yourself. Start spending time with people who are different from yourself so that you can become better prepared to work in a future culture that will be different

beyond anything we can now imagine. Behaviors have no meaning outside the cultural context where those behaviors are learned and displayed." (Paul Pedersen, ACA)

Question to Consider*:*

- What areas have you identified that you need to improve regarding your ethical practice with clients you work with?
- Develop a plan for what you need to do.

Case Scenario Discussion

This client may challenge our belief system about families, parental authority and how marriages should begin. Even though Tanya has a lot of expertise, this may not be an issue she is familiar with or a culture she has been trained to treat. Being an "expert" in any specialty does not mean you don't have to still look at competency issues with each client. Personal reactions of the counselor as well as education and training are part of the ethical concern of competence in treating Aisha. In addition, client welfare is a concern. This is a client with symptoms of depression that she believes are related to living against the value system of her culture. Tanya may believe that the depressive symptoms are caused by something else. How much do you respect the client's autonomy about the cause of their symptoms? Where would be the best place to start a collaborative helping relationship? First would be to make sure your depression screening instruments or assessment approach is culturally appropriate for this client. Another option might be consulting with a psychiatrist trained to treat or from this cultural background. Arguing with Aisha about the arranged marriage or judging her decision to obey her parents' wishes would be considered unethical practice.

In conclusion, here is information from the American Psychological Associations' website on multi-cultural practice relevant to this case discussion:

With people from Middle-Eastern, Arabic, or Muslim decent, therapists have to be more careful to avoid mistakes, generalizations, and stereotypes. These will make sessions unproductive and further will hinder the therapeutic rapport and trust, if not hurt the relationship with Arab Americans.

Typical clients are second or third generation immigrants, American-born to a Middle-Eastern or Arabic-speaking family. They are young, educated, and fluent in English, and perhaps in other languages as well. They are open to seeking help and more accepting to the idea of counseling and psychotherapy than previous generations. Usually, they are trying to reconcile their own identities and resolve their psychosocial tensions within

their immediate family, with their immediate community, and with their hosting society or culture at large.

These challenges include their identity formation of "cultural self," functioning well within the systems of the hosting society, handling or avoiding intergenerational conflicts, and reconciling their back-home traditions, customs, and norms with their newly acquired values or adopted lifestyles of the new world. All of these dynamics could lead either to cognitive dissonance, emotional splitting, social alienation, familial disturbances, relational troubles, and general life dissatisfaction—or they may lead to greater inner harmony, expanded personal identity, enhanced family integration, increased psychosocial functioning, rich individual–collective experience, and healthier cultural navigation.

Resources for Module One:

Internet

- American Psychological Association videos on Multicultural Counseling
  www.apa.org/videos/series5.html
- National Hispanic Cultural Center
  www.nationalhispaniccenter.org
- Micro-training and Multicultural Development
  Derald Wing Sue's series on Racism
  www.emicrotraining.com
- Office of Minority Health
  http://www.omhrc.gov/
- Indian Health Services
  http://www.ihs.gov/
- The National Center for Cultural Healing
  http://www.culturalhealing.com/
- Association for Multicultural Counseling and Diversity
  http://www.amcdaca,org/amcd/default.cfm

Suggestions for further reading:

- Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and

Human Services. (1999). Cultural Issues in Substance Abuse Treatment. (DHHS Publication No. SMA 99-3278). Rockville, MD: Author. http://www.samhsa.gov

- Ewalt, P.L., Freeman, E.M., Fortune, A.E., Poole, D.L. and Witkin, S.L. (Eds). (1999). Multicultural issues in social work: Practice and research. Washington, D.C.: NASW.
- Remley, T.P. and Herlihy, B. (2001) Ethical, Legal and Professional Issues in Counseling. Upper Saddler River, New Jersey: Merrill Prentice Hall.
- Sue, D. W., & Sue, D. (2003). Counseling the culturally different: Theory and practice, 4th edition. New York: John Wiley & Sons.
- Tseng, W. and Streltzer, J., eds. (2001) Culture and Psychotherapy: A Guide to Clinical Practice. Washington, D.C.: American Psychiatric Press.

Module Two: Criminal Justice

"*Several studies indicate that clients who enter treatment because they are forced to do so by the criminal justice system make as much progress as those who enter treatment voluntarily. However, some researchers are opposed to coerced treatment on philosophical or constitutional grounds, and there are clinicians who believe there is little benefit to forced treatment*."
(CSAT, TIP 17, p. 10)

Questions to Consider*:*

- How do you respond to clients who are mandated to treatment?
- If you don't work with mandated clients, what do you think some of the issues are in trying to apply ethical principles with these clients?

Case Scenario

Joe is in private practice as a licensed psychologist. Tricia is court-ordered to him to participate in an eight-week parenting program that he offers for anyone found guilty of child abuse/endangerment. When Tricia meets with Joe for her intake assessment, she discloses information regarding extensive childhood sexual abuse in her family of origin. She describes symptoms of anxiety and depression. Joe determines that she is not appropriate for the group program at this time and recommends to her that she participate in individual counseling with him along with a psychiatric evaluation for medication. Tricia states she will do anything to get her children returned to her, but she does not want the court to know about her history of child abuse because her step-father (the perpetrator) is still alive and she is afraid he will try to hurt her or her children. In Joe's report to the court he leaves out this information per Tricia's request. The judge then orders her to attend the group program.

Questions to Consider:

- As Joe what are your reactions?
- What are your ethical concerns?
- Would you have responded in a different way? How?

Counselors may interact with the criminal justice system in various ways. Some may be employed as a counselor in a therapeutic community; some may accept court ordered clients for evaluations only; others run programs in their practice or within an agency specifically designed for court-ordered clients. These are just some of the examples of how counselors interact with the criminal justice system.

This module will examine the values and beliefs that are similar and that are in conflict between the mental health system and the judicial system that can create ethical concerns for practitioners.

Some writers have suggested that part of what fuels ethical and clinical conflicts is a “cultural misunderstanding”. In other words, the mental health system can be viewed as one culture and the criminal justice system as another culture, each with their own values, language and world views.

“*Counselors must demonstrate ethical standards of the profession and abide by the law. This task is made challenging by the fact that the mental health and legal systems represent two different, sometimes conflicting, cultures.*”
(Rowley and McDonald, 2001, p. 422)

Questions to Consider*:*

List two of the different values between the criminal justice system and the mental health/substance abuse treatment system that would lead to ethical dilemmas in your practice/agency.

Ethical Dilemmas:

Since the roles of professionals vary with regard to criminal justice issues as does the wide range of client profiles, we will focus on aspects of the ethical decision making process that can be applied to any helping relationship in this context. As stated above, this can be viewed as a cross-cultural experience and therefore we will build on some of the ethical issues discussed in the first chapter on cultural diversity as a way to help understand some of the ethical dilemmas. We will also examine which codes of ethics provide guidance for professionals working in this area.

For the purposes of this chapter we will use this model for ethical decision-making:

- Self-awareness
- Identify ethical principles and appropriate code for guidance
- Identify legal concerns: consult with an attorney if needed
- Review with colleagues and/or supervisors
- Develop and document a plan of action

The first step in the ethical decision making process is to identify the difference between the two systems to help clarify the “cultural” conflicts. This will also address the need for counselor self-awareness that is an essential part of ethical practice when working with different belief systems, worldviews and cultures.

Rowley and Mc Donald (2001) offer the following comparisons:

Counseling	Criminal Justice
Systemic and linear reasoning	Linear reasoning
Subjective-objective understandings	Objective, fairness understandings
Growth, therapeutic priorities	Order, protection priorities
Individual or small group focus	Society focus
Priority on change	Priority on stability
Cooperative, relational emphasis	Adversarial, fact-finding
Recommendations, consultation emphasis	Legal sanctions and guidance emphasis
Ethical, experiential basis	Legal reasoning basis

Question to Consider continued*:*

• Do you agree/disagree with these examples?

One way to summarize the contrast between the two is to focus on the relationship with the client. A counseling relationship is therapeutic and typically involves establishing trust and empathy with the goal of helping. In contrast, the criminal justice system does not typically consider itself part of the helping professions. Relationships are primarily custodial and focused on safety issues. These represent two contrasting worldviews of how the individual is to be treated or, in other words, a cultural conflict. The goals of the justice system are retribution/punishment and deterrence of future behaviors that harm society. Many systems will not allow the term ‘client’ applied to the inmates and therefore deny the existence of any type of helping relationship. This can result in a language conflict. Other systems might have counselors on staff but the priority still remains safety and punishment vs. individual help. For example, counseling sessions will be interrupted or canceled if there is any concern about disruption to the normal routine of the institution.

It might be helpful to think about these relationships on a continuum. At one end would be the extreme example of the mental health system; private practice. At the other end would be the extreme example of the criminal justice system; prison. Professionals can then place themselves along this continuum based on how much of their relationship with clients is therapeutic and how much is custodial.

Continuum

Private Practice Agency Setting Community Corrections Institutional Corrections

Primarily Therapeutic **---*Primarily Custodial***

Questions to Consider*:*

- Where are you on this continuum?
- How does this impact your ethical decision-making?

It was suggested that one of the first steps in ethical decision making with regard to criminal justice and cultural diversity is to increase self-awareness.

Identification and clarification of your role and the client/counselor relationship is an important part of this process. Knowing where you are on this continuum can provide help in clarifying your role and describing the nature of the client/counselor relationship. The following discussion will provide more information for you to consider regarding these issues. In a private practice setting, counselors act independently within the regulations that govern their credentials. They can decide which clients will be treated and when and how. Typically, they determine how much of their practice will involve work with the criminal justice system. They do not have to accept mandated clients. How much information has to be reported to legal authorities is determined per a contract. The focus is on the individual needs of the client. This is a “culture” in which the ethical principles of autonomy, beneficence and discretion can be upheld.

In an agency setting in the mental health/substance abuse system, the needs of the individual client are still the focus but agency policies and community issues become part of the ethical dilemmas. Maintaining good working relationships with judges, sheriffs, probation officers and the community can impact decisions regarding treatment programming. Especially those professionals working in public sector programs can sometimes be seen as “part of” the judicial system by clients as well as by judges. Confidentiality issues can be difficult in these situations. The guidelines established by HIPPA can be helpful with some of these concerns. There are also federal guidelines dictating confidentiality requirements for substance abuse clients and for school settings that can add to the dilemma. In addition, agency policies do not always benefit clients. An agency director may feel it is more important to keep a judge satisfied because of long term consequences rather than support a client’s right not to divulge information.

Moving down the continuum, community corrections professionals are seen as part of the justice system. They must define who their client is: society, the court,

or the person sitting in their office? Their role is a combination of social control (custodial) and helping (therapeutic). They may often be more directive, taking an expert role with clients, and typically utilize external controls to try to motivate clients. Ethical conflicts can involve conflict between the needs of the individual client vs. the needs of the legal system and society. Confidentiality rights of the individual are often not a priority.

At the end of the continuum are those professionals working in institutions. This is where security becomes the priority with more of a custodial role. They may define their "client" as society. This is a "culture" with different norms and upholding principles of autonomy, beneficence and discretion is very difficult. For example, it is expected that information disclosed to them by an inmate in a counseling session that may indicate a security problem is to be reported to superiors. A counselor not following this guideline could lose their employment and/or endanger other inmates.

In addition to ethical conflicts regarding autonomy, beneficence and confidentiality, counselors working with the criminal justice system also must adhere to the principle of competence. Traditional counseling programs do not often include courses on understanding criminal behavior or the legal system. As counselors move down this continuum they will need additional training that provides the knowledge and skills for working with this client population and within this different culture.

Some professional associations offer specialty divisions for members interested in criminal justice. In the addictions counseling field, there is a Certified Criminal Justice Addiction Counselor credential available in some states. These are the domains that an applicant for this credential must have completed education and training for competency:

1. Dynamics of Addiction & Criminal Behavior
2. Legal, Ethical & Professional Responsibility
3. Criminal Justice System & Processes
4. Clinical Evaluation: Screening & Assessment
5. Treatment Planning
6. Case Management, Monitoring & Participant Supervision
7. Counseling
8. Documentation

(www.icrcaoda.org/CCJPstandard.asp)

Codes of Ethics

Another important aspect of the ethical decision-making process is consulting a code of ethics or standards of practice appropriate to the provider's credentials.

There are codes of ethics within the criminal justice system as well. (See resources at the end of this chapter)

The **American Psychology Association** offers some guidelines for help in ethical decision making in this area.

7.01 Professionalism.

> *Psychologists who perform forensic functions, such as assessments, interviews, consultations, reports, or expert testimony, must comply with all other provisions of this Ethics Code to the extent that they apply to such activities. In addition, psychologists base their forensic work on appropriate knowledge of and competence in the areas underlying such work, including specialized knowledge concerning special populations.*

7.02 Forensic Assessments.

> *(a) Psychologists' forensic assessments, recommendations, and reports are based on information and techniques (including personal interviews of the individual, when appropriate) sufficient to provide appropriate substantiation for their findings.*
>
> *(b) Except as noted in (c), below, psychologists provide written or oral forensic reports or testimony of the psychological characteristics of an individual only after they have conducted an examination of the individual adequate to support their statements or conclusions.*
>
> *(c) When, despite reasonable efforts, such an examination is not feasible, psychologists clarify the impact of their limited information on the reliability and validity of their reports and testimony, and they appropriately limit the nature and extent of their conclusions or recommendations.*

7.03 Clarification of Role

.

> *In most circumstances, psychologists avoid performing multiple and potentially conflicting roles in forensic matters. When psychologists may be called on to serve in more than one role in a legal proceeding; for example, as consultant or expert for one party or for the court and as a fact witness - they clarify role expectations and the extent of confidentiality in advance to the extent feasible, and thereafter as changes occur, in order to avoid compromising their professional judgment and objectivity and in order to avoid misleading others regarding their role.*

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7.04 Truthfulness and Candor.

> *(a) In forensic testimony and reports, psychologists testify truthfully, honestly, and candidly and, consistent with applicable legal procedures, describe fairly the bases for their testimony and conclusions.*
>
> *(b) Whenever necessary to avoid misleading, psychologists acknowledge the limits of their data or conclusions.*

7.05 Prior Relationships.

> *A prior professional relationship with a party does not preclude psychologists from testifying as fact witnesses or from testifying to their services to the extent permitted by applicable law. Psychologists appropriately take into account ways in which the prior relationship might affect their professional objectivity or opinions and disclose the potential conflict to the relevant parties.*

7.06 Compliance With Law and Rules.

> *In performing forensic roles, psychologists are reasonably familiar with the rules governing their roles. Psychologists are aware of the occasionally competing demands placed upon them by these principles and the requirements of the court system, and attempt to resolve these conflicts by making known their commitment to this Ethics Code and taking steps to resolve the conflict in a responsible manner.*

This code addresses the issues of competence, an adequate assessment process, clarifying limits, dual relationships, and acknowledgment of the conflicts between the legal system and a code of ethics. The other codes we have discussed do not specifically address criminal justice clients. They all do address the issue of non-discrimination. The ethical expectation is that a court-ordered client would receive the same standard of care as a non-mandated client; respect, compassion, competent and appropriate services. The referral source for a client does not change the ethical guidelines regarding his/her welfare.

Legal Concerns

Professionals working with this client population will need to seek legal advice in the ethical decision-making process probably more than with any other client population. Conflicts between ethical principles and the law will occur. For example, a practitioner may believe their behavior is ethical but it is illegal, i.e. refusing to testify when properly subpoenaed because it would harm the therapeutic relationship. These clients also present with legal issues that counselors are not trained to respond to (unless they have a law degree). Clients

have questions about laws and the legal process that should be referred to a legal expert. How involved the counseling professional becomes with a client's attorney will depend on the counselor's clinical theory and treatment approach. These clients may also discuss criminal behavior, current as well as past, for which they have not been charged. This can present many concerns for a professional, such as your own value system about illegal behavior, and is another reason for legal consultation.

Consultation and Developing Plans

As discussed in Module One, consultation with someone who is an expert is recommended as one way to insure ethical practice. A clinical supervisor may not have the knowledge needed regarding the criminal justice system and counselors may need to seek help outside this relationship.

When developing a plan to respond to an ethical dilemma, counselors should attend to the cultural diversity issues: this is a system with different values, language, etc. A plan that seems viable in a clinical setting could be detrimental in a legal setting. For example, encouraging clients to be assertive, a common theme in some counseling approaches, could prove detrimental in a criminal justice setting where silence or letting the lawyer do the talking will be safer.

Whatever plan is developed for ethical situations, it is essential that it be documented. In the legal system, a counselor's word that something happened will not be valued. If it is not written, "it didn't happen" in the worldview of the legal system.

Therapeutic Jurisprudence

This is a new theory emerging from the increasing need for mental health and substance abuse systems to collaborate with courts. The fundamental principle underlying this theory is that "consistent with principles of justice, the knowledge, theories, and insights of mental health and related disciplines can help shape the law." (Rottman and Casey, 1999).

Drug courts, mental health courts and family courts are some of the first initiatives where this theory has been applied. In these courts there is an organized collaboration between criminal justice staff and mental health staff. Instead of being incarcerated, defendants are sent to therapeutic alternatives and receive intensive case management services. Therapeutic jurisprudence requires that the court system (judges, commonwealth attorneys and sheriff departments) be involved in a process that promotes therapeutic outcomes rather than only punitive outcomes. The mental health system collaborates by

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suggesting therapeutic options that do not compromise the normative values of the legal system.

“Five independent meta-analyses have now all concluded that Drug Courts significantly reduce crime by as much as 35% in comparison to traditional case dispositions. Researchers also concluded Drug Courts reduce drug abuse and improve employment and family functioning.”(National Association of Drug Court Professionals)

This is a cross-cultural theory that is just starting to be implemented. It is discussed here as another aspect of the ethical decision making process that may be helpful to practitioners having difficulty in working within the criminal justice system. (For more detailed information, see resource list at end of this module).

Question to Consider:

What have you identified as changes you need to make to your practice or in your agency with regard to ethical treatment of the type of clients you serve from the criminal justice system?

Case Scenario

The assumption in this case is that Joe has a contract with court systems to provide a parenting program for mandated clients. Part of this contract includes assessing clients prior to admitting them to the program. The ethical concerns in this scenario are autonomy, beneficence and discretion/confidentiality.

Joe is supporting Tricia’s autonomy by accepting her right to say she does not want certain information disclosed to the court. It may also be a safety issue regarding how confidential the court will keep the information and the likelihood that Tricia’s perpetrator would find out about this. Once Joe releases this information to a criminal justice agency, he no longer can guarantee Tricia’s privacy. However, in upholding this ethical principle when working within a criminal justice system, client welfare can be compromised in that now the judge does not have all of the information that supported Joe’s recommendation. One possibility is that, hopefully, Joe has a good relationship with the judge and could perhaps ask to discuss this in private in the judge’s chambers, citing client welfare and safety as a concern. From the start, Joe must be sure that Tricia understands the consequences of withholding information from the court.
Ethical obligations to society are also a concern when working with criminal justice systems. Now that Joe knows about Tricia’s step-father, does he have an ethical obligation to report this? Hopefully this would have been covered in Joe’s

contract with the court, in re, how soon and what type of information must be reported.

Another concern regarding beneficence is that Tricia was referred for the parenting program and then told that Joe was recommending something different. Some of her resistance about the court report could have been a reaction to this and further clinical exploration by Joe may resolve this. The section of the psychologist code of ethics referenced in this module speaks to the need to resolve these conflicts in a responsible manner. (7.05)

It could be argued that Joe did so by respecting Tricia's decision. It would have been unethical to place her in the group just to appease the court. If Tricia had an attorney, one option is to ask if she would be willing to sign a release so that Joe could speak with him/her and discuss what is in the client's best interest. The attorney may also be able to get Tricia's permission to discuss the situation with the judge. At the very least, the attorney would be aware that this client needs more services than a parenting program. Another clinical option would be to ask Tricia to take a few days to think about this and schedule another appointment as a continuation of the assessment. Ask also if there is someone she could talk it over with like a minister, family member or trusted friend. This continues to support Tricia's autonomy but allows for some time to reflect on possible outcomes with the court.

Resources for Module Two:

Internet

• National Institute of Justice Journal
www.ojp.usdoj.gov/nij
Rottman, D. and Casey, P. (1999) Therapeutic Jurisprudence and the Emergence of Problem-Solving Courts, p. 12-19.

• American Probation and Parole Association Code of Ethics
http://www.appa-net.org/eweb-dynamicpage.aspx?webcode=IA_CodeEthics

• National Association of Drug Court Professionals
http://www.ndci.org/

• The American Psychology-Law Society (a division of APA)
http://www.ap-ls.org

• International Association of Addiction and Offender Counselors (a division of ACA)
http://www.iaaoc.org

• International Certification Reciprocity Consortium for Alcohol and Other Drug Abuse. (credentials)
www.icrcaoda.org/.

Suggestions for further reading

Goldsmith, R.J. and Latessa, E. *Coerced Treatment of Addictions in the Criminal Justice System:Psychiatric Annals Vol. 31 (11)*. 2001.

Huddleston III, C. W., Marlowe, D., and Casebolt, R. *Painting The Current Picture: A National Report Card On Drug Courts and Other Problem-Solving Court Programs in the United States, Vol.II, No. 1*. National Drug Court Institute, 2008.

Newburn, Tim. *Criminology.* Willan Publishing, 2007.

Module Three: Adolescents

"*For clients under the age of 18, the law in all states stipulates that they are not adults and, therefore, are not competent to make fully informed voluntary decisions. Consequently, whether or not non-emancipated minor clients are developmentally capable of making informed decisions, their privacy rights legally belong to the parents or guardians. Herein lies the most pressing issue in counseling minors …*" (Huey, 1990, p. 241)

Questions to Consider:

- What is your response to the above quote?
- What ethical concerns do you have in working with the type of adolescent clients you do? If you do not work with adolescents, what do you think might be the issues in trying to apply ethical principles?

Case Scenario

Sonya, a licensed professional counselor, is providing group and individual counseling for adolescent females identified as "at risk" for substance abuse in an in-school program at the high school. Jan, a 15 year old, is one of her clients who has been in group and individual counseling for several months. She was referred by the school guidance counselor and her parents have refused to meet with Sonya but sent written permission for Jan to participate in the group at school. After one of the group sessions, Jan asks to talk with Sonya privately. She states that she thinks she is pregnant. The father of the baby is an 18 year-old senior at the high school that she had been dating but they broke up a few weeks ago. Jan is crying and says she has been really depressed since the break up and now doesn't know what to do about the pregnancy. When Sonya says she needs to contact her parents, Jan becomes even more upset and says she will run away from home rather than face her parents about this. Sonya then agrees that she won't talk to her parents without her permission on the condition that Jan makes an appointment immediately with her family doctor and gives Sonya permission to talk with the doctor. Jan agrees.

Questions to Consider:

- What are your reactions to this scenario?
- What are the ethical concerns?
- Do you agree with this approach? What would you have done instead?

The nature of adolescent development poses unique ethical issues for counselors when providing services to this client population. Some of the complexities of treating adolescents are related to these factors: rapid growth of

the brain and body during adolescent years, emotional and social influences on adolescent behavior, impact on normal development due to substance abuse and experimenting, identity and self-esteem development, and family dynamics. In addition, today's adolescents are living in a culture where they are exposed to more information about all types of issues, such as via the internet, which may cause more rapid development intellectually but not emotionally or socially.

When treating a special client population, such as adolescents, it is the professional's responsibility to create an ethical decision making process that takes into account the special issues of this population and the application of ethical principles.

In this module we will discuss the following ethical principles and how they might be integrated with clinical practice in treating adolescent clients: competence, autonomy, beneficence and discretion (confidentiality).

Competence

It may be obvious but still needs to be stated that adolescent clients are different than adult clients. In addition, a 12 year old client is very different from a 16 or 18 year old client; so we cannot categorize all "adolescents" together. Because of these differences, treatment approaches and interventions that have been effective for adults are often not appropriate or effective for adolescents. Some adolescent clients will not have yet developed a high degree of insight so insight oriented therapy that is helpful for adult clients will not be helpful for them. There is also debate in the literature about how effective group treatment is for adolescent populations. (See reference section at the end of this module).

For those professionals who believe adolescents are most effectively treated in the context of their family, this would require a different knowledge and skill base separate from that of individual or group counseling and involve a different type of ethical decision making process. Family counseling with adolescent clients is also different from a family counseling approach a professional would use with adult clients. Counselors working with adolescent clients would need additional training in the following areas to uphold the ethical principle of competence:

- Adolescent development; different tasks for early adolescence, middle and late
- Effective treatment approaches for these stages of development
- Training in family therapy, if using this approach; training in group, if using this approach
- Ethical and legal issues specific to this population

In addition, adolescents are often viewed as a different culture from that of their adult counselors. They have their own ways of communicating, different values, their own rituals, and a different worldview. As discussed in Module 1, when working with a client population of a different culture, professionals have an ethical responsibility to be aware of this difference and to monitor their own personal reactions about this difference.

Dr. Joseph Nowinski states that the clinical mistakes he has observed that often occur in treating adolescents is over-identification or under-identification by the counselor. (Nowinski, 1990). Over-identification refers to the pattern of when an adult tries to act like the adolescent's peer. This is an ethical concern because of the possibility for boundary violations as well as confusion on the part of the client as to the professional's role. The pattern at the other extreme is those adults who have no empathy or are judgmental of the adolescent. This would be under-identification. The ethical concerns with this pattern would be that the lack of empathy would damage a therapeutic relationship and make it difficult to provide effective treatment, which would compromise the ethical principle of competence.

There are also other counter-transference reactions that can impact counselor competency. All of us have our own experiences as adolescents. There can be unresolved issues from this such as attitudes towards authority. Or we can project onto clients that they "should" be reacting to adolescence the same way we did. A counselor who is parenting their own adolescent may need to closely monitor reactions to clients to keep the boundaries clear between parenting and counseling. Some of the transference reactions of a counselor who is also a parent may be towards clients' parents and the pull to step in and correct faulty parenting needs to be monitored.

The National Association of Alcoholism and Drug Abuse Counselors offers an Adolescent Specialist Endorsement credential for professionals working in the substance abuse field with this client population (www.naadac.org) Here are the requirements for this credential:

- Five years or 10,000 hours of validated, supervised experience working in mental health or the addictions profession.

- Two and a half years or 5,000 hours of validated, supervised experience working with the adolescent population.

- Evidence (documentation) of at least 70 contact hours of training related to adolescent treatment within the last five years. Up to 20% of the 70 hours can be from a nationally or regionally recognized online or distance learning program. At least 80% must be face-to-face contact.

Autonomy

Autonomy is the principle of promoting client self-determination. Counselors working with adolescents may often find themselves in a conflict with this principle and the principle of beneficence (client welfare). As stated above, this conflict can also transfer to the parents of the adolescent when the counselor's values about parenting conflict with what the family is doing. It is difficult to support the self-determination of an adolescent client who has under-developed problem-solving skills; as well as it is difficult to support the autonomy of parents when it appears their actions are harmful to adolescents. In addition to parents, adolescents have other social systems which influence their decisions and may need to be considered in an ethical decision making process: schools, peers, faith communities, and sometimes criminal justice or social services. The welfare of the client vs. the welfare of these other entities forms part of the ethical concern in supporting autonomy. A critical part of the ethical decision making process in these situations is to identify for everyone who the client is as that is what guides the process: if your client is the family that is different than if your client is the school, a group, or the individual adolescent. For example, an adolescent tells his counselor that he has gotten a job and he is very excited. However, the job is in an area of the community that is known for criminal activity and violence. The counselor, wanting to support the adolescent's job choice, would feel in conflict with regard to his welfare and safety. Should the counselor contact the employer? Notify the adolescent's parents? Offer other suggestions for employment?

Another aspect of this dilemma is the obligation of the counselor to keep these other systems informed regarding the client's welfare and course of treatment. This can lead to conflicts about protecting the privacy of the adolescent, which includes the principle of discretion, and supporting the autonomy of the adolescent to decide who receives personal information about him/her. As noted in the opening quote, further complicating autonomy and discretion are the various state and federal laws and regulations. (See links at the end of this module for further information on federal resources.) Most professionals dealing with autonomy and discretion issues which conflict with laws will need to consult with an attorney.

In addition to all of the factors previously discussed, the culture of the adolescent and his/her family can influence how the principle of autonomy is applied. Many cultures value the welfare of the family more than the autonomy of an individual. The family or community's interest is seen as just as important if not more so than the adolescent's interest. Cultural values and viewpoint would of course need to be included in all aspects of the adolescent's treatment but especially with regard to autonomy.

Beneficence

What is in the best interest of the client? This is a complicated question to answer with adolescent clients. As previously stated, the developmental needs of adolescents are very different. One 16 year old client can be more mature than another 16 year old client; a 13 year old client has very different needs than an 18 year old client. Some clients in their early twenties can still present with adolescent issues. Using age as a factor in making decisions is supported legally, but is not the best factor in ethical and clinical decisions. Age is also used as part of the decision-making as to when to include parents: most adult clients do not have counselors discussing with them the need to call their parents about their treatment. However, adolescents making decisions that appear to be harmful often have parents contacted by the concerned counselor. When working with adolescent clients, it is difficult to separate the ethical principles of beneficence and autonomy as they are often part of the treatment issues presented.

All codes of ethics speak to the issue of the professional clarifying loyalties, confidentiality guidelines, and practice issues at the beginning of the clinical relationship.

Here are examples of two of the codes:

National Association of Social Workers

1. *Social Workers' Ethical Responsibilities to Clients*

1.02 *Self-Determination*

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

1.03 Informed Consent

> *(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.*

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> *(b) Freedom of Choice. Counselors offer clients the freedom to choose whether to enter into a counseling relationship and to determine which professional(s) will provide counseling. Restrictions that limit choices of clients are fully explained.*
>
> *(c) Inability to Give Consent. When counseling minors or persons unable to give voluntary informed consent, counselors act in these capacities*

National Association of Alcohol and Drug Abuse Counselors

Principle 2: Client Welfare

I understand that the ability to do good is based on an underlying concern for the well being of others. I shall act for the good of others and exercise respect, sensitivity, and insight. I understand that my primary professional responsibility and loyalty is to the welfare of my clients, and I shall work for the client irrespective of who actually pays his/her fees.

This last part of the above code, about who pays the fees, is especially relevant with adolescent clients as it relates to the issue of other systems being involved in the adolescent's care. Typically adolescent clients do not have the funds to pay for treatment so either parents or another party, such as social services, is funding the treatment. This can cause a dilemma when those who are paying for services demand information or request that the counselor act in a certain way; for example, demand that the counselor do urine screens to test for drug and alcohol use.

It is good ethical practice with any client population, but especially critical with adolescent clients, that their family/support system be included in the informed consent process, if possible, to clarify all of the above areas discussed. Written clarification is recommended that states under what circumstances parties will be notified of clinical information without the adolescent's consent, how emergency situations will be handled to include a definition of emergency, and the counselor's treatment approach/philosophy with adolescents and families.

Also including how requests for information from parents will be handled can prevent ethical dilemmas. One of the most obvious examples of when parents may request clinical information to promote their interest rather than the adolescent's is in custody battles. Having all of this clarified in writing ahead of time allows clients as well as others to make an informed choice about whether to continue in treatment with you should they disagree with any of these practices. For example, if you do not provide urine screens and social services wants this as part of the treatment, they know this ahead of time and will either arrange for this to be done elsewhere or go to another treatment provider. If parents want you to testify in court during custody hearings, letting them know in

the informed consent that this is not part of your practice will avoid future conflicts.

Professionals are advised to think through in their own practice or agency what situations would involve responding to parents' requests and what situations would not. For counselors working in school settings, the federal regulations allow for a non-custodial parent to obtain education records but not counseling records (FERPA, 1974).

For professionals who decide that parents need to be contacted or will respond to parents' requests for information, the ethical response is to do this in a way that continues to support the adolescent's autonomy and welfare. Some options are:

- discuss with the adolescent the reasons for involving the parents;
- have the adolescent present when the parents are given the information;
- have the adolescent share the information rather than the professional.

Discretion

The ethical principle of discretion states that counselors protect the privacy of their clients. The reason for this is to promote a therapeutic relationship in order for treatment to be effective. This is even more critical with an adolescent client being seen by an adult professional where issues of trust, power and authority are prevalent in the relationship. If an adolescent client thought that everything said to a professional was going to be repeated to others, he/she would not be willing to disclose any personal information. If confidentiality is broken, will the adolescent client continue in this relationship? Or if they do continue, will they be honest? Again some of this has to do with the individual characteristics of the adolescent client, the agency setting, and the nature of the confidential information. One of the guidelines providers can use when discussing this issue is to say to adolescents "I may decide to contact a third party in certain situations but it doesn't mean I will always do so." Also to preserve autonomy and avoid power struggles, providers can stress that they will make every effort to discuss this with the client before disclosing confidential information to others.

Those professionals providing group services for adolescents need to clarify confidentiality guidelines there as well. The ethical and legal obligation for discretion belongs to the professional and not to the other clients in the group. Although a group rule may be established to not discuss confidential information, there is no way a professional or agency can enforce this. It is suggested that this be discussed in the group as part of ongoing informed consent. The same issue needs to be discussed in family counseling. Family members can discuss with anyone what has occurred in a counseling session. One possibility is to use this as an opportunity to discuss how families respect privacy and boundaries.

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Anytime third parties are a part of the adolescent's treatment, concerns regarding discretion need to be addressed.

An example of guidelines for these issues regarding discretion is as follows from the **American Counseling Association Code of Ethics**.

> *B.2. Groups and Families*
>
> > *(a) Group Work. In group work, counselors clearly define confidentiality and the parameters for the specific group being entered, explain its importance, and discuss the difficulties related to confidentiality involved in group work. The fact that confidentiality cannot be guaranteed is clearly communicated to group members.*
> >
> > *(b) Family Counseling. In family counseling, information about one family member cannot be disclosed to another member without permission. Counselors protect the privacy rights of each family member.*
>
> *B.3. Minor or Incompetent Clients*
>
> *When counseling clients who are minors or individuals who are unable to give voluntary, informed consent, parents or guardians may be included in the counseling process as appropriate. Counselors act in the best interests of clients and take measures to safeguard confidentiality.*

This is all complicated by state laws and federal regulations, which is more than can be addressed in this module. The ethical obligation of professionals working with adolescents is to stay current regarding the laws that pertain to this client population. Some areas of concern:

• Right to consent to treatment without parental notification may be different for mental health services than for substance abuse services and different for each state

• Mandated requirements for reporting may be different in each state (some states now require parental notification anytime there is threat of suicide or violence, including college age clients)

• Reporting of pregnancy or abortion counseling for a minor may be mandated

• Privileged communication extends to adolescents in individual counseling; not in group or family counseling

• Federal regulations may conflict with state laws, school policies, and cultural norms

• Child abuse is mandatory to report in all states.

Question to Consider:
What changes do you need to make in your practice or your agency to improve your practice with the adolescent clients you see?

Case Scenario Discussion

Sonya's decision involves several ethical principles: beneficence, autonomy, discretion and competence. The dilemma she faces involves deciding if the welfare of the client is best served by contacting the parents; or by keeping the client engaged in the therapeutic relationship and avoiding a possible running away scenario, which would not be in the client's best interest. She has made the decision that she thinks is in the best welfare of her client: to preserve the therapeutic relationship. To do this she has contracted with her regarding medical care to attend to Jan's medical needs as well as the baby's health. This approach supplants the parental authority, but it prevents the client from leaving treatment prematurely. In addition, Jan may not be pregnant so it prevents a potential family crisis situation.
On the other hand, this is a medical issue, and Sonya is presumably not competent to address medical concerns, and Jan is a minor. If Jan **is** pregnant and has a miscarriage or other complications, ethical and legal consequences could occur. One way to address this is to make sure Jan makes the call from Sonya's office to obtain an appointment immediately. Gaining Jan's permission to speak with the doctor, Sonya can then consult with him/her about the issue of involving the parents. The doctor is not under the same confidentiality requirements and could make his/her own decision regarding the family. This removes Sonya from the role of contacting them and hopefully diffuses Jan's threat to terminate treatment. Sonya does need to let the doctor know about Jan's threat to run away from home and about her increased depression in the past few weeks.

If the doctor responds that Jan is pregnant and reports that the parents have not responded to his/her phone calls; then Sonya is back in the dilemma, along with her own reactions to the parents' lack of involvement in Jan's treatment as well as her medical care. Sonya will need to be careful about her own reactions and not step into a parenting role with Jan.

One option is to remember that adolescents often do not always think about the consequences of their decisions. Discussing this with Jan could be helpful. Has she realized that her parents are going to see that she is pregnant in a few months? How will they react then? This type of clinical intervention may help resolve the ethical/legal conflicts. If Jan still refuses to talk with her parents then

Sonya would need to consult with someone at the school and perhaps an attorney.

Another point of view is that adolescents often threaten to do things in the heat of the moment and do not follow through. Rather than making the initial contract she did, Sonya could discuss with Jan the reasons, legally and ethically, for contacting at least one of her parents. Jan may be receptive to involving one parent rather than both. Or Sonya can help Jan discuss all of her options, including the decision to run away from home, and request that she present this in the next group counseling session. This supports Jan's autonomy and utilizes clinical interventions first. The risk, of course, is that Jan may run away in the mean time. If she does attend group, Sonya could facilitate a group role-play to help Jan practice discussing this situation with her parents and preparing for all of their possible reactions. This would also provide additional support for Jan by utilizing group members.

Whatever course of action is taken, Sonya needs to carefully document her ethical decision making process. Client welfare issues (in re preventing the running away behavior) are typically a good defense but this would need to be well-documented.

Resources for Module Three:

Internet

- Family Educational Right to Privacy Act
http://www.cpsr.org/cpsr/privacy/ssn/ferpa.buckley.html

- Code of Federal Regulations 42CFR: Confidentiality for Alcohol and Drug Abuse Programs
http://www.access.gpo.gov/nara/cfr/cfr-table-search.html

- Center for Effective Collaboration and Practice
http://cecp.air.org/

- Strength Based Services International
http://www.empowerkids.org/

- Center for Adolescent Research
www.ceasar-boston.org

- American Academy of Child and Adolescent Psychiatry
http://www.aacap.org/publications

Suggestions for further reading:

Davis, J.L. & Mickelson, D.J. (1994). School counselors: Are you aware of ethical and legal aspects of counseling? The School Counselor, 42, p. 5-13.

Kymissis, P. and Halperin, D.A., eds. (1996) Group Therapy with Children and Adolescents. Washington, D.C.: American Psychiatric Press.

Liddle, HA. and Rowe, CL. (2006). Adolescent Substance Abuse: Research and Clinical Advances. Boston: Cambridge University Press.

Stevens, SJ. and Morral, AR. (2002). Adolescent Substance Abuse Treatment in the United States: Exemplary models from a national evaluation study. Binghamton, NY: Haworth Press.

Nowinski, J. (1990). Substance Abuse in Adolescents and Young Adults. New York: W.W. Norton & Company.

Monti, P., Colby, S., O'Leary, T. (2001) Adolescents, Alcohol, and Substance Abuse: Reaching Teens Through Brief Interventions. New York: Guilford Press.

Salo, M.M. & Schumate, S.G. (1993). Counseling Minor Clients. Alexandria, VA: American Counseling Association

Module Four: Clients with Co-Occurring Disorders

"*In response to a Congressional mandate, in December 2002, the Department of Health and Human Services provided Congress with a comprehensive report on treatment and prevention of co-occurring substance abuse and mental disorders. The report emphasizes that people with co-occurring disorders can and do recover with appropriate treatment and support services. It also finds there are many long-standing systemic barriers to appropriate treatment and support services for people with co-occurring disorders, including separate administrative structures, eligibility criteria, funding streams, as well as limited resources*."
(CSAT, TIP 42, page 15)

Question to Consider

• What unique ethical issues have you encountered in working with the types of clients you see who have co-occurring disorders?

Case Scenario

Minakshi is a licensed clinical social worker in private practice and has been providing individual counseling for Robert, a 26 year old client. His presenting problem was that he was feeling depressed and having trouble sleeping. He has been married five years, and they have a one-year old child. After meeting for a few sessions, he reveals to Minakshi that he has been shooting heroin and having affairs. He states his wife does not know about the heroin or the affairs. When Minakshi expresses concern for his welfare as well as his wife's, Robert states they have been practicing safe sex; but, lately, his wife has been talking about having another child. Minakshi suggests that Robert needs to discuss his behavior and drug use with his wife. Robert becomes upset and refuses, stating that he is afraid that his wife would leave him and take his son away, and then he would become even more depressed. Robert does not appear for the next scheduled appointment. Minakshi gets a call from the emergency services counselor at the local mental health clinic stating that Robert was hospitalized due to a suicide attempt. Minakshi asks if the counselor has a release of information and he says no, but Robert mentioned her name when he was being screened. Minakshi decides to go ahead and tell the counselor everything she knows about Robert.

Questions to Consider:

- What are your reactions to this scenario?
- What are the ethical concerns?

There are many issues that arise in working with clients with co-occurring diagnoses. The complexities of all of the diagnoses, medication issues and

lifestyle choices are all part of working with these clients. Frequently they also have medical and legal concerns and some have lost the support of their family due to the symptoms and behaviors that are part of their disorder. In addition, there are multiple treatment approaches which can include numerous professionals involved with the care of one client.

The focus of this module is the general application of ethical principles to providing services for clients with co-occurring disorders. We will address what some of the ethical dilemmas are in trying to apply the principles of autonomy, beneficence, discretion and competence.

As previously stated, it is impossible to generalize with such a wide range of client profiles, perhaps even more so with this special population due to the numerous combinations of substance use and mental health disorders. One concept that may be helpful as a conceptual framework is the quadrants of care model originally developed by Ries (1993). Briefly, this model suggests the following four quadrants based on severity of symptoms in both mental health and substance abuse that can help with planning for treatment needs of this large clinical population:

- Quadrant 1: mental disorders less severe; substance abuse disorders less severe: primary treatment would be in health care settings

- Quadrant 2: mental disorders more severe; substance abuse disorders less severe; primary treatment would be in mental health system

- Quadrant 3: mental disorders less severe; substance abuse disorders more severe; primary treatment would be in substance abuse system

- Quadrant 4: mental disorders more severe; substance abuse disorders more severe; primary treatment would be state hospitals, jails/prisons.

For more detailed discussion of this model, see TIP 42, referenced at the end of this module.

In terms of ethical practice this model can help with the principles of autonomy and beneficence: with autonomy, the less severe the illness, the better the client can participate in decision making and self-efficacy. In terms of beneficence, this gives a beginning guideline that can help with treatment planning to best ensure client welfare.

Autonomy and Beneficence

> *"Is it ethically justifiable to confine people against their will, to subject them to procedures against their will, or to overrule their life choices on the basis of medical diagnosis?"*
> *(Judy Chamberlin, National Empowerment Center)*

This quote speaks to the heart of the principle of autonomy. Does the fact that a client has a mental health diagnosis give anyone the right to take over their life and make decisions for them? Most professionals would say "it depends". When applying the principle of autonomy several concerns with clients with co-occurring issues are:

- Clients may be limited in their ability to act autonomously due to impairment

- The risk of supporting client's autonomy is real and significant due to life-threatening behaviors such as suicide attempts

- Clients choices may impact the autonomy of others in a harmful manner

In addition, the counselor may truly not believe that a client with this diagnosis can make choices about their own life. This may pull the counselor to act in a paternalistic way, such as we discussed in Module 3 with our work with adolescent clients.

The **National Social Worker's Association Code of Ethics** addresses this issue of self-determination vs. paternalism:

> *1.02 Self-Determination*
> *Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.*

This speaks to the dilemma of balancing autonomy and client/society welfare. There is a fine line between helping a client and being paternalistic. Good assessment skills as well as the development of a good collaborative, therapeutic relationship are critical to being able to find the balance with these two principles with this client population.

There is also some disagreement among professionals as to what is the best treatment for clients with co-occurring issues. The practice for many years has

been to deny substance abuse treatment to anyone taking additional medications because of the theoretical belief that abstinence only was best in treating substance abuse issues. This may still be a value system of a practitioner or an agency, however, research is showing that this is not the most effective way to help these clients. The trend is to provide integrated care that provides medication assistance as needed while also addressing substance abuse issues. To follow this approach some professionals may have to question their own value system or own treatment experiences. For further information about current best practices, please see resources at the end of this module.

One of the more critical areas where autonomy and beneficence conflict is when clients have suicidal ideation. Clients with co-occurring disorders are more likely to present with this issue because of the correlation between self-harm and substance use disorders as well as the correlation between self-harm and depression, post-traumatic stress disorder and some of the other psychiatric disorders. In addition, many of the risk factors for suicide that have been found in research are common factors in the lives of clients with co-occurring issues. Examples are; the feeling of not belonging or being cared about (Joiner, 2005); rigid, all or nothing thinking (Maris, 2002); illness, somatic complaints and sleep disturbance (Pope and Morrin, 1990); between one fourth and one third of suicides are associated with alcohol (Moscicki, 2001).

Professionals working with this client population need to be trained in assessing and responding to suicidal ideation and behaviors. All codes of ethics and laws require helping professionals to intervene to prevent suicide, obviously supporting the principle of beneficence over autonomy.

Discretion/Confidentiality

There is a lot of confusion between the legal and ethical requirements with regard to confidentiality for clients in the therapeutic relationship.

One area is the issue of duty to warn a third party. In the absence of a state law, counseling professionals usually rely on the case law of Tarasoff. In this case, a judge ruled that a psychologist should have warned a young woman that his client had threatened to kill her. In the case scenario in this module, there may be concern that if the counselor does not warn the wife and she becomes infected with a disease that she may have a liability suit against the counselor. This adds to the legal dilemmas of this situation. It is always best to consult with an attorney before proceeding when there are liability concerns as well as violation of the principle of discretion. In addition, many states have duty to warn laws that should clarify what situations are covered under that law. Professionals are advised to stay current regarding these laws.

Ethically, professionals need to determine which principles they will uphold in these situations, and then they need to apply their ethical decision-making process the same for each situation. A professional's personal ethics and value system may be in conflict with laws and codes. Therefore, the professional needs to have clear policies. In other words, don't notify a third party in one situation because of negative transference issues with the client or personal beliefs and not notify a third party in a similar situation.

Counselors need to be careful regarding discrimination and the influence of their own values, for example in the above scenario, illegal drug use and extra-marital affairs. If a professional decides that they will uphold the principle of acting in the best interest of society and warning a third party, then this principle should hold true in most cases. If he/she is not going to warn a third party in a case, this should be carefully documented. Whatever the policy, it should be clearly stated in the informed consent along with how these situations will be handled.

Another dilemma with discretion with this client population is the move to integrated systems of care. Whereas having everyone communicate about clients' treatment is seen as beneficial to clients, it poses a lot of confidentiality and privacy concerns. In the above scenario, the counselor responded to another system who was trying to provide care for her client and violated her client's individual rights. Some would argue that this was the correct thing to do. The "need to know" guideline for discretion is helpful in ethically practicing with this client population. What a case manager needs to know to coordinate services is different from what the probation officer needs to know. Should Sonya have told the emergency services professional "everything" she knows about Robert? It is understandable that in a situation where a client has attempted suicide there is a pull to do more because of the level of concern. Some would argue that confidentiality and protecting the therapeutic relationship are of no value if the client dies and that Sonya should act to do whatever it takes to help her client. Professionals should carefully think about the content and amount of information they are sharing with others about clients, as well as the reasons they are sharing, in all situations.

Complicating this further is that fact that professionals working in programs that receive federal funds for substance abuse treatment have specific guidelines for confidentiality. A resource for consultation in this area is the Legal Action Center http://www.lac.org/contact.html. For programs designed to address co-occurring issues, if they receive federal funds and if a client has a substance use disorder diagnosis, these federal guidelines should be utilized. For assistance with how HIPPA and these federal regulations overlap or conflict, see CSAT TIP 42, appendix K.

Competence

As discussed in all of the previous modules, special populations require additional education and supervision beyond the minimal qualifications required for most credentials. Adding to the ethical dilemmas with this principle is the fact that all clients with co-occurring disorders cannot be grouped together. A client with schizophrenia and alcoholism is very different from the client who has PTSD and opioid dependence. To expect one counselor to be competent to treat all of the clients who can be classified as co-occurring is unrealistic. However, the lack of knowledge and skills when treating specific disorders (competence principle) can compromise client welfare. We will discuss a few examples.

In working with someone with a diagnosis of schizophrenia, it is crucial to understand the different types of presentation you might encounter. "*Negative psychotic symptoms involve the restriction or absence of thoughts, feeling, and behaviors that most people experience….These impairments may make it difficult for patients to engage in an interview or to respond with much spontaneity and fluency. Instead of recognizing how these patients may have difficulty ascertaining and describing their experiences, clinicians may mistakenly presume these patients are unmotivated for change*." (Arkowitz, Westra, Miller and Rollnick, eds. Page 279) This could lead to questionable ethical practice if a counselor judged the client as unmotivated rather than recognizing that this reaction is part of their disorder.

Another example is clients with post-traumatic stress disorder who can present clinical challenges for professionals not trained in this area. The experience of trauma causes a range of reactions. A client could look very guarded and shut down, again causing a professional to believe they are "resistant" or "unmotivated". This same client could then appear for the next session as very emotional or "flooded" with reactions to the trauma. This could cause an untrained professional to label the client as bipolar or something else that would cause inappropriate treatment.

Most professionals are familiar with the diagnosis of borderline personality disorder and the reactions to this disorder that people trying to help these clients may have. To judge or over- react to a client because they exhibit the problems of their diagnosis is unethical practice. Training, as well as consistent supervision or peer group consultation, are necessary for professionals to ethically manage their reactions to the intensity of some of the behaviors that manifest in this client population. Some promising approaches for effective treatment with clients with borderline personality disorder have emerged. See resources at end of module.

The issue of suicidal ideation and behaviors was discussed under autonomy and beneficence but it is also obviously a concern with regard to competence. Even

with appropriate knowledge and skills, suicidal clients can be very challenging for professionals in terms of personal reactions, value conflicts and burn-out.

Questions to Consider:

- How do you respond when someone mentions suicidal thoughts?
- Do you have confidence that your training has prepared you to deal with this?

There are many issues that can impact ethical decision making in dealing with suicidal clients.

- Not taking a client seriously because of his/her profile, for example, a successful college student who is upset about a relationship ending. In fact, suicide is the second leading cause of death among college students. Good ethical and clinical practice is to always take a suicidal statement seriously. That does not mean it has to be taken literally, but that it is recognized as a serious communication that needs to be addressed.

- Some professionals label suicide threats as a “manipulation” or “attention-seeking” especially if this is a pattern in the course of treatment. The reason for the threat is not at issue until the client is safe and stabilized. To try to examine motive, personality characteristics, etc. while someone is talking about ending their life is ill advised and could lead to unethical practices.

- Avoiding the discussion of suicide because of the professionals own discomfort about discussing death. This is dangerous because of the message it can send to clients that the topic is “taboo”. Good supervision or personal therapy is needed in this situation.

- Discounting the client’s statement because he/she is drunk or high. As mentioned previously, one fourth to one third of suicides involve alcohol, so these statements are to be taken seriously, sober or not.

To summarize, here is a quote from Dr. Marsha Linehan, the founder of Dialectical Behavior Therapy:

“Fears of legal liability often cloud the therapists' abilities to focus on the welfare of the client: fear interferes with good clinical judgment. Many outpatient therapists simply "dump" their suicidal clients onto emergency and inpatient facilities believing that this will absolve them of risk. There is no empirical data that emergency department and/or inpatient treatment reduces suicide risk in the slightest and the available literature could support a hypothesis that it may instead increase suicide risk” (www.kspope.com/suicide)

SAMHSA's Treatment Improvement Protocol (TIP) 42 lists beginning, intermediate and advanced levels of competencies recommend for counselors. (www.ncbi.nlm.nih/gov/books/bv.fcgi?rid=hstat5.section.74246) (An exam and evaluation are available from www.ccjp.com so that you can receive credit for studying TIP 42.). As part of these competencies, the following values and attitudes are necessary:

- Desire and willingness to work with people who have COD
- Appreciation of the complexity of COD
- Openness to new information
- Awareness of personal reactions and feelings
- Recognition of the limitations of one's own personal knowledge and expertise
- Recognition of the value of client input into treatment goals and receptivity to client feedback
- Patience, perseverance, and therapeutic optimism
- Ability to employ diverse theories, concepts, models, and methods
- Flexibility of approach
- Cultural competence
- Belief that all individuals have strengths and are capable of growth and development
- Recognition of the rights of clients with COD, including the right and need to understand assessment results and the treatment plan

Awareness of personal reactions and feelings are a critical part of the ethical decision making process, as has been repeatedly discussed. Some of the counter-transference reactions professionals can have to a client with co-occurring issues are complex. One example is the reason a professional chose to enter his/her profession. For some counselors who started working in the substance abuse treatment field, they were not interested or prepared to deal with trauma, depression, suicidal issues, and thought disorders. Part of their passion for becoming a counselor may have been related to their own recovery from substance use or that of a family member. In contrast, a mental health counselor may have chosen their field with the expectation that there would not be any clients with illegal drug use or addiction issues. Someone entering the criminal justice field thought he/she would be working just with issues of legal and illegal behavior rather than the complexities of psychiatric issues. It is understandable that these professionals might say "this is not the client population I want to work with". In working with clients with co-occurring issues, these feelings and reactions need to be discussed with supervisors and or colleagues and resolved so that their competency and ability to help these clients is not impacted.

Credentials are now being developed that recognize competency as a counselor for clients with co-occurring disorders. See resources at the end of this Module.

Case Scenario

Throughout this module questions have been raised about the decisions this counselor made with her client. Menakshi is clearly taking the position that Robert's welfare would be best served if she reveals information without his permission. The Social Work Code of ethics supports her decision to do so. She would need to clearly document why she acted in this way because legally, Robert would have the right to sue her for violation of confidentiality. Menakshi may have also caused harm to the therapeutic relationship by acting in this way. By disclosing information to her about his drug use and affairs, Robert obviously had trusted her as his counselor. Menakshi will need to talk with Robert about her reasons for doing so in hopes that the trust is not lost.

Menakshi may have felt strongly about upholding the ethical principles that she did because of concern for Robert's welfare and his wife, and that this is more important than keeping a client engaged in treatment. She may also have had reactions about his illegal drug use and feeling unprepared to provide services for him. When Menakshi initially started her work with Robert, she believed she was working with someone with depression and sleep issues. Once this client presented with more complicated issues, Menakshi may have needed to advise Robert that she would be getting consultation or supervision prior to being so direct with him about the need to inform his wife of his illegal drug use. If her reactions are about personal values or issues, her ethical next step is to make an appropriate referral.

Question to Consider:
What changes do you need to make to your practice or in your agency to improve ethical practice with the types of clients you see with co-occurring disorders?

Resources for Module Four:
Internet

Co-Occurring Center for Excellence
www.coce.samhsa.gov

SAMHSA's National Registry of Evidence Based Programs and Practices
www.nrepp.samhsa.gov

ICRC certification in co-occurring disorders
www.icrcaoda.org/CCDPstandard.asp

National Empowerment Center
www.power2u.org

An Overview of Dialectical Behavior Therapy in the treatment of Borderline Personality Disorders
www.priory.com/dbt.htm

Suggestions for further reading:

Arkowitz, H., Westra, H., Miller, W., Rollnick, S., eds. Motivational Interviewing in the Treatment of Psychological Problems. New York: Guilford Press, 2008.

Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons with Co-Occurring Disorders. Treatment Improvement Protocol (TIP) 42. DHHS Publication 05-3991. Rockville, MD: SAMHSA, 2005.

Hills, Holly. Treating Adolescents with Co-Occurring Disorders. Florida Certification Board/Southern Coast Addiction Technology Transfer Center. Monograph Series #2, 2007.

Landsverg, G., Rock, M., Berg, L., and Smiley, A., eds. Serving Mentally Ill Offenders and Their Victims: Challenges and Opportunities for Social Workers and Other Mental Health Professionals. New York: Springer Publishing, 2002.

Minkoff, K. and Drake, R., eds. Dual Diagnosis of Major Mental Illness and Substance Disorder. San Francisco: Jossey-Bass, 1991.

Mueser, K.T., Noordsy, D.L., Drake, R.E., and Fox, L. Integrated Treatment for Dual Disorders: A Guide to Effective Practice. Guilford Press, 2003

Najavits, L.M. Seeking Safety: A Treatment Manual for PTSD and Substance Abuse. New York: Guilford Press, 2002.

Najavits, L.M. Psychotherapies for Trauma and Substance Abuse in Women: Review and Policy Implications. Trauma, Violence and Abuse, 10, 290. 2009

Appendix A: Post Test and Evaluation for *Ethical Practice with Special Populations*

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in any **one** of the following manners:

1. *Submit your test via the Internet.* All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Take Exam' and you will be presented with the electronic exam.

   To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. , which is the final step in the process. Once you submit the evaluation, you will receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

   If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

   OR

2. *Submit your test by mail using the answer sheet found at the end of this package.* First, complete the cover page that will identify the course and provide us with the information that will be included in your Certificate of Completion. Then, answer each of the questions by selecting the best response available and marking your answers on the sheet. The final step is to complete the course evaluation (most certifying bodies require a course evaluation before certificates of completion can be issued). Once completed, mail the information, answer and evaluation sheets to this address:

   CEU Matrix - The Institute for Addiction and Criminal Justice Studies
   P.O. Box 2000
   Georgetown, TX 78627

   Once we receive your exam and evaluation sheets, we will grade your test and notify you of the results.

   If successful, you will be able to access your Certificate of Completion and print it. Access your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Certificate' and you will be presented with a download of your Certificate of Completion that you may save / and or print. If you would rather have your Certificate of Completion mailed to you, please let us know when you mail your exam and evaluation sheets; or contact us at ceumatrix@ceumatrix.com or 800.421.4609.

   If you do not obtain the required 80% score, we will provide you with feedback and instructions for retesting.

   OR

3. *Submit your test by fax.* Simply follow the instructions above, but rather than mailing your sheets, fax them to us at **((512) 863-2231**.

If you have any difficulty with this process, or need assistance, please e-mail us at **ceumatrix@ceumatrix.com** and ask for help.

Answer the following questions by selecting the most appropriate response.

1. The ACA Code of Ethics gives specific guidelines on competency in culturally diversity counseling.
    a. True
    b. False

2. Mono-Cultural practice is:
    a. believing that your values are the preferred set of values
    b. practicing only within your own culture
    c. referring clients of other cultures to counselors who match with that culture
    d. using assessment techniques that are culture-specific

3. The criminal justice system is designed to:
    a. provide alternatives to incarceration.
    b. protect society
    c. provide treatment for clients with co-occurring issues
    d. all of the above

4. Adolescent clients pose unique ethical concerns for all of the following reasons EXCEPT:
    a. they typically have parents, guardians, school personnel, social services, and others concerned about their welfare.
    b. peer acceptance.
    c. impulsive actions.
    d. the greater likelihood of dealing drugs to maintain their use habits.

5. Treating a court-mandated client differently than other clients is a violation of the ethical principle of:
    a. discretion
    b. justice
    c. jurisprudence
    d. competence

6. Part of the ethical decision making process is self-reflection.
    a. True
    b. False

7. Culture can also refer to a community or lifestyle.
    a. True
    b. False

8. Under-identification with an adolescent client can result in unethical practice because:
    a. counselor is trying to parent the adolescent
    b. counselor is trying to be a peer to the adolescent and cross boundaries
    c. counselor is not expressing empathy or understanding of the adolescent
    d. counselor is treating the adolescent as an adult

9. Which of the following would define the term mono-cultural?
    a. The belief that one's own group is superior and that the values held by this group are "normal" and shared by everyone.
    b. The belief that other groups are inferior and their values and behaviors are therefore abnormal or their values and beliefs are not even acknowledged.
    c. Both a and b are correct definitions of mono-cultural.
    d. Neither a nor b are correct definitions of mono-cultural.

10. A counselor is working with a client of Chinese descent who would like to include an herbalist in his program of recovery. The counselor refuses to consider this request because of the uncertain benefit that herbs may have. Would this be an example of a counselor practicing mono-culturally?
    a. Yes
    b. No

11. Which of the following might be considered subtle forms of discrimination in a treatment program?
    a. Choices in the location of an agency
    b. Scheduling of treatment activities at inappropriate times (such as times that interfere with religious practices)
    c. Staff composition does not include representation of the clients' culture
    d. All of the above might be considered subtle forms of discrimination.

12. Research by Sue and Sue (1990) indicated that minority clients were given less preferred forms of treatment and more negative psychological evaluations than their majority counterparts.
    a. True
    b. False

13. Using techniques or language that the client cannot understand violates the principle of ________.
    a. trust
    b. beneficence
    c. jurisprudence
    d. competency

14. According to authors Sue and Sue, which of the following competencies are required for ethically competent practice?
    a. Awareness of one's own cultural biases and assumptions.

b. Awareness of cultural biases and assumptions of other races.
c. Development of culturally appropriate individual and systematic interventions.
d. A, b and c are all correct responses.

15. The following is true of working with clients of Middle-Eastern decent:
    a. they are trying to reconcile their traditions with newly acquired values
    b. they are guarded and suspicious of counselors
    c. they do not want their parents included in counseling
    d. they typically embrace their adopted culture, causing family conflicts

16. Several studies indicate that clients who enter treatment because they are forced to do so by the criminal justice system make more progress than those who enter treatment voluntarily.
    a. True
    b. False

17. The mental health system and legal system represent two different and often conflicting systems:
    a. True
    b. False

18. One of the differences between the mental health "culture" and the criminal justice "culture" is:
    a. individual vs society focus
    b. counselors vs. police
    c. therapeutic jurisprudence vs. rehabilitation
    d. ethical decision making vs no ethical decision making

19. Professionals working with the criminal justice population will need to seek legal advice in the ethical decision-making process probably more than with any other client population.
    a. True
    b. False

20. A term being used to describe the involvement of judges, attorneys and law enforcement officials in a collaborative process that promotes therapeutic outcomes is:
    a. therapeutic communities.
    b. rehabilitation counseling
    c. therapeutic jurisprudence.
    d. therapeutic justice communities.

21. Which of the following is considered to be the most pressing issue when counseling minors?
    a. That their privacy rights legally belong to the parents or guardians.

b. That adolescent drug use is at an all-time high.
c. That placing adolescents back in the same school and peer environment virtually guarantees relapse.
d. That adolescent development is so complex, thus making counseling approaches virtually ineffective.

22. Because it is difficult to support the self-determination of a client who has questionable problem-solving skills and who is still in the process of developing values, judgment and other characteristics of maturity, counselors working with adolescents will often find themselves in a dilemma with which of the following principles.
    a. Justice
    b. Beneficence
    c. Competence
    d. Autonomy

23. One of the long standing barriers to treatment for clients with co-occurring disorders is:
    a. these clients do not seek help
    b. administrative structures
    c. commitment laws
    d. lack of education and training of staff

24. SAMHSA's list of values and attitudes for working with clients with co-occurring disorders includes:
    a. awareness of personal reactions and feelings
    b. having your own recovery plan
    c. letting the client's family guide the course of treatment
    d. all of the above

25. One of the issues that counselors have which impacts client welfare when dealing with suicidal ideation is:
    a. not knowing commitment procedures
    b. fears of legal liability
    c. not wanting to violate client's confidentiality
    d. refusing to get consultation

26. A possible personal reaction a professional might have to working with clients with co-occurring issues that can impact competence is:
    a. this is not the client population I want to work with
    b. I don’t believe this client population should be incarcerated
    c. this client population should be forced to take medication
    d. this client population is not capable of making decisions

Fax/Mail Answer Sheet
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You will receive notification of your score within 48 business hours of our receipt of the answer sheet. If you do not pass the exam, you will receive instructions at that time.

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Course: Ethical Practice for Special Populations

1. [A] [B] [C] [D] [E]	11. [A] [B] [C] [D] [E]	21. [A] [B] [C] [D] [E]
2. [A] [B] [C] [D] [E]	12. [A] [B] [C] [D] [E]	22. [A] [B] [C] [D] [E]
3. [A] [B] [C] [D] [E]	13. [A] [B] [C] [D] [E]	23. [A] [B] [C] [D] [E]
4. [A] [B] [C] [D] [E]	14. [A] [B] [C] [D] [E]	24. [A] [B] [C] [D] [E]
5. [A] [B] [C] [D] [E]	15. [A] [B] [C] [D] [E]	25. [A] [B] [C] [D] [E]
6. [A] [B] [C] [D] [E]	16. [A] [B] [C] [D] [E]	26. [A] [B] [C] [D] [E]
7. [A] [B] [C] [D] [E]	17. [A] [B] [C] [D] [E]	
8. [A] [B] [C] [D] [E]	18. [A] [B] [C] [D] [E]	
9. [A] [B] [C] [D] [E]	19. [A] [B] [C] [D] [E]	
10. [A] [B] [C] [D] [E]	20. [A] [B] [C] [D] [E]	

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COURSE TITLE: **Ethical Practice with Special Populations**

DATE:____________________________

COURSE CONTENT		
Information presented met the goals and objectives stated for this course	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was relevant	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was interesting	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information will be useful in my work	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Format of course was clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
POST TEST		
Questions covered course materials	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Questions were clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Answer sheet was easy to use	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good

COURSE MECHANICS		
Course materials were well organized	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Materials were received in a timely manner	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Cost of course was reasonable	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
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