Addressing AOD use in adults and adolescents with an intellectual disability: A proposed intervention for the NSW Community Justice Program

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**PHASE 1**
- Conduct a literature review
- Develop an assessment/evaluation framework
- Create group and individual cognitive-behavioural therapy manuals
  - For adults & adolescents with intellectual disability

**PHASE 2**
- Develop a service delivery framework
- Train staff in the framework
- Conduct trial program delivery
AOD use leads to....

PROBLEM BEHAVIOURS
• Risk taking
• Moodiness, aggression and violence
• Interpersonal problems
• Vulnerability to exploitation

PHYSIOLOGICAL CONSEQUENCES
• Cognitive & motor deficit
• Seizure activity
• Cardio/respiratory/gastro problems

MEDICATION INTERACTIVE EFFECTS
• Mental confusion
• Sedation
• Dementia
• Coma & death

(Chapman & Wu, 2012; Slayter, 2006)
Step 1: Conduct a literature search...
At 2012 only 2 publications provide guidelines regarding assessment and treatment - the US Treatment Improvement Protocol (TIP) and the National Association of the Dually Diagnosed (2003) - and neither of them are based on empirical data (Chapman & Wu, 2012; Slayter, 2006).
Even though the need for research and practice in this area was recommended 3 decades ago, their treatment needs “...remain largely overlooked and underserved” (Chapman & Wu, 2012, p. 1154) and there are numerous barriers to access.

Because of researcher prejudice against the client group as being too difficult.

I would add that this prejudice occurs amongst AOD practitioners as well (i.e. my colleagues/staff).
2 Key Review Articles (but no prevalence estimates yet)

McGillicuddy (2006)
- Use of cigarettes/alcohol/drugs amongst adolescents and adults
- Slightly lower substance use rates but a problem for many individuals
- They are not receiving appropriate services

Chapman & Wu (2012)
- Updated findings since 2006
- Abuse starts in adolescence
- There is a low likelihood of receiving treatment or staying in treatment
- There is a lack of theoretical coherence
We don’t know much....

1. Generally have lower rates of drug and alcohol abuse but ↑

2. Australia = higher alcohol rates + drug use + CJS (including Indigenous offenders regarding alcohol use)

3. Those that use drugs and alcohol may have bigger problems

4. Smaller amounts of drugs and alcohol could have bigger effects (Lindsay, Tinsley & Emara, in press)
Theoretical Positions

- Cognitive-behavioural therapy?
- Harm reduction vs abstinence?
- Stages of change and motivational interviewing.
- Self-efficacy.
- Relapse prevention.
What is known practice to date?
TIP 29- best practice guidelines for cognitive disabilities (US)
TIP 29- Screen Assessment

All clients with an AOD problem are entitled to an assessment (regardless of disability).

Not gobbledegook- be as specific as possible:-
not “do you use alcohol” but “do you like to drink beer/wine/coolers”.
Use props like photos of glass/bottle sizes.
Assessment

- Substance use- available substances, pattern of drug use, co-existing problems.

- Risk factors- unknown but may be young, adult, mild-borderline IQ, dual diagnosis, interpersonal problems.

- Dual diagnosis- links between drug use, psychiatric diagnosis and the CJS.

- Stage of change or treatment readiness.
Assessment cont

The functions of drug use:-

1. Coping skills deficits.

2. Poor regulation of +ve and –ve effects.

3. A learned behaviour acquired by +ve reinforcement (increase pleasant thoughts/feelings) or –ve reinforcement (decrease anxiety/tension).

4. Distraction from problems.

(Didden, Embregts, van der Toorn, & Laarhoven, 2009)
Tip 29- Treatment Planning

Service providers to understand:

◆ The role of denial
◆ Risk-avoidance (embarrassment, rejection, failure = isolation)
◆ Risk-taking (don’t see or act to avoid risky situations)
◆ A strength-based approach (but be aware of limits and capacities).
Tip 29- Treatment Planning cont

Strength-based approach:-

◆ Make changes to address disability (therapeutic understanding)
◆ Use motivational techniques that reward rather than punish behaviour
◆ Create explicit behaviour contract with logical consequences
◆ Encourage alternative leisure activities
◆ Adjust treatment goals to fit the person (small steps)
◆ Revise and adjust the Treatment Plan
Tip 29- Counselling

A practical, concrete approach (cognitive remediation strategies):-

◆ Individualised treatment goals.
◆ Roleplays and dramatherapy
◆ Apply to ‘real world’
◆ Multi-modal strategies
◆ Journals/booklets

_remove barriers to participation, but don’t make compromises or fails to challenge the behaviour."
Treatment

- Cognitive-behavioural treatment?
  - Use applied behaviour analysis, skills training and punishment/reinforcement
  - versus
  - Use CBT- increase motivation, skills training and relaxation, thinking errors
  - but
  - Empirical evidence for both positions lacking.

- Disability issues- social stigma, poor self esteem, interpersonal sensitivity.

- Social skills, including refusal skills.

- Trauma- the role of victimisation in triggering and sustaining drug use and teach self-protective skills.
How to do it (hopefully)

Piano Stairs

http://www.youtube.com/watch?v=2lXh2n0aPyw
Assess

Treat

Manage
Tip 29- Community Linkages

Interagency coordination a priority:-

◆ Treatment plan: employment, recreation, social isolation, physical abuse.
◆ Be aware of approaches used by other agencies & collaborate.
◆ Avoid duplication = one lead case manager.
◆ D&A agencies should commit to servicing/revising services to people with an ID.
Example 1: Alcohol Program

- To understand the effects of alcohol and its link to anger & violence
- Practical exercises
- Role plays regarding alcohol and individual high risk situations
- For males and females
- 8 weekly sessions of 1 hour per week with 6-8 clients
- IQ = mild-borderline

(Lindsay, Tinsley & Emara, in press)
Alcohol Program Sessions

1-2: Introduction, rules, alcohol games and quizzes, and roleplaying being drunk.

3-5: Alcoholic vs non-alcoholic drinks, effects on body and brain, comparing drinks, and male/female limits.

6-7: Alcohol = violence, fights, money problems, and stress, sensible drinking and strategies to refuse drinks.

* In the community, use alcohol diaries and practice in bars.
Alcohol Program cont

Evaluation:-

• Compared 12 people with 10 on a waiting list
• At the start, no difference between the two groups on alcohol knowledge
• Treatment group improved alcohol knowledge which still stayed better 2 months later.

* But, did this reduce alcohol-related violence?
Case Example: Ms A

- Long history of being drunk and abusive and fights with police.
- Wouldn’t work with services as she thought they were trying to control her.
- Only after she went to group did she see the alcohol-violence link.
- Then she did a violence program.
- Learned controlled drinking & left the hospital.

(Lindsay, Tinsley & Emara, in press)
Example 2: Alcohol Program

Goal: To teach concrete skills for relapse Prevention (RP).

Program:
1. Basic training (slips, not failure)
2. Skills training (role plays)
3. 12 step program
4. Self-efficacy “I can change”
   ▶ Stages of change model + motivational interviewing strategies.

Outcome:

↑ knowledge of RP strategies.

But, does that translate into the community?

(Glassmire, Welsh & Clevenger, 2007 in Horn et al, 2011)
LACK OF THEORETICAL COHERENCE
AOD Intervention

The Will + The Way

(motivation) (capacity)

Behaviour Change
Intellectual Disability + Offending Behaviour

(social model)  (clinical approach)

The Good Lives Model

Humanistic Approaches
(The right to full equality, integration and the highest standard of health, CRPD, 2008)
Social Disability Definition

• UK- disability is a social construct created by the environment- society disables individuals which results in social exclusion.

• US- disability is the experience of discrimination and segregation through various barriers- economic, social, attitudinal etc.

Regardless, society needs to include all individuals and their individual differences
The Good Lives Model

• The work of Ward & Stewart (NZ/Aust).

• Psychological theory = emphasises offender human need and well-being.

• Ways of living that are beneficial and fulfilling to the individual - to meet physical, social and psychological needs.

Meet individual needs, not just manage risk.
Human Needs

Human Needs = all human beings

1. Life (healthy living and functioning)
2. Knowledge
3. Excellence in work (mastery experiences)
4. Excellence in leisure (mastery experiences)
5. Excellence in agency (control over own life)
6. Inner peace (freedom from emotional turmoil & stress)
7. Friendship (intimate/romantic/family r’ships)
8. Community
9. Spirituality (broad sense of meaning and purpose in life)
10. Happiness
11. Creativity
Good Lives Model cont

• A strengths-based theory that explains why a person may engage in AOD use.
• Focuses on treatment readiness- don’t just manage risk but engage the person.
• Considers practitioners attitudes/values about offenders and the therapeutic alliance.
• Individualised case formulation determines the human needs linked to AOD use.
• No. 1 goal is to enhance well-being (No. 2 goal is to manage risk).
• A “good life” is defined by the person (and we may not agree with that definition).
• Persons with a disability are fellow human travellers- they are no different from other human beings, they are not “the other”.

Healthy functioning
Being safe

Family & social supports
Meaningful work & education
Leisure activities

Choices
Intimate relationships
Competence & mastery

Community Safety
Physical Needs
Social Needs
Psychological Needs
13 Practice Principles: (Adapted from New Orleans Project)

1. Recognise all individuals as rights-holders (not just rights-violaters).

2. Integrate a biopsychosocial model of behavior = person + environment.

3. Understand that disability + D&A use affects behavior.
13 Practice Principles: Assessment

4. Screen all individuals in disability services.

4. Provide comprehensive assessments for those identified.
13 Practice Principles: Treatment


6. Deliver evidence-based treatment at the correct dose and intensity that matches need (unknown).

6. Deliver treatment that is individualised.
13 Practice Principles: Management

9. Deliver services based on persuasion, not coercion.

9. Ensure staff competence and an engaging style.


9. Ensure an integrated delivery system.
Program Delivery (hopefully!)

- Interagency Support to Maintain Change
- Staff Support to Maintain Change
- Group and/or Individual Treatment
- Screen + Case Formulation
- Service Delivery Framework

Readiness to Change:
- Maintain
- Ready
- Getting Ready
- Not ready
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