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NDIS Forensic Disability Clients and Substance Use: A Wicked Problem

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20 mins

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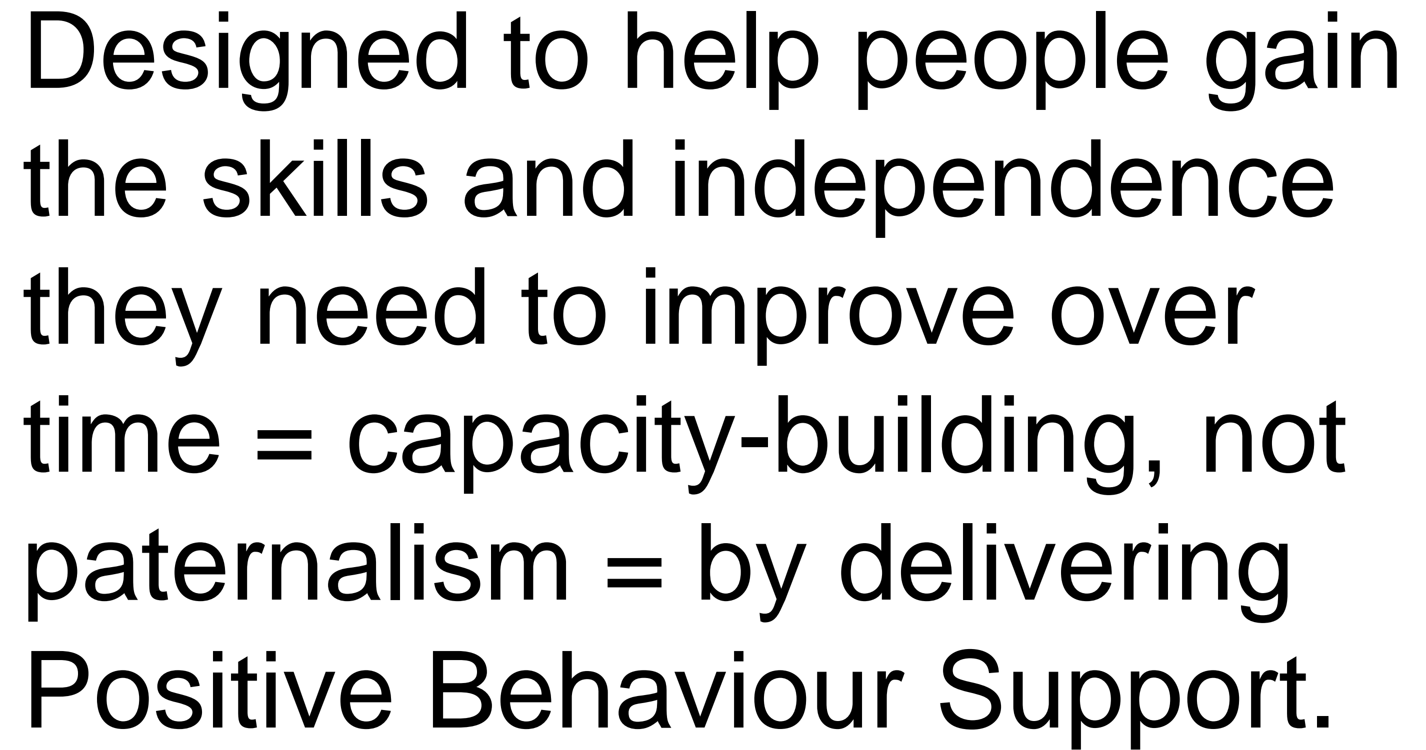
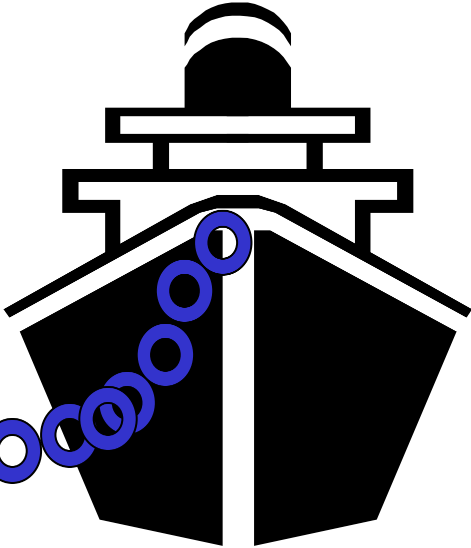
JUST FORENSIC

What does the NDIS do?

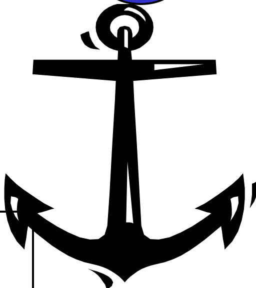


Positive Behaviour Support

Principles



Practice



Theory

PBS Theory cont

An applied science that uses evidence-based practice to address the interaction between the individual and their environment.

Goals

1. Improve quality of life
2. Reduce behaviours of concern

An AOD NDIS user is probably a forensic disability client

Those individuals with a (cognitive) disability who are in contact with the CJS = behaviours of concern and/or AOD-related offending behaviours = problem behaviours.
Because the law is coercive- **reluctant customers-** the approach to behaviour change needs to be:

1. Evidence-based- *will it work?*
2. Ethical- *is the right thing to do?*

AOD user….

Rights-Violator

Rights-Holder

Person with a Disability

Rights-Holder

As duty-bearer <u>client</u> can pursue their own Life Goals = *rights*.

.

Person as an Offender

Rights-Violator

As duty-bearer <u>client</u> has obligations towards others = *responsibilities*.

Person with a Disability

Rights-Holder

As duty-bearer client can pursue their own Life Goals = *rights*.

As duty-bearers, staff support client to improve *quality of life*.

Person as an Offender

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As duty-bearer client has obligations towards others = *responsibilities*.

As duty-bearers, staff support the person to reduce *AOD*.

Person with a Disability

Rights-Holder

As duty-bearer client can pursue their own Life Goals = *rights*.

As duty-bearers, staff support client to improve *quality of life*.

PBS

Replace maladaptive behaviours with adaptive behaviours = case formulation.

Habilitation

Person as an Offender

Rights-Violator

As duty-bearer client has obligations towards others = *responsibilities*.

As duty-bearers, staff support the person to reduce *AOD*.

GLM

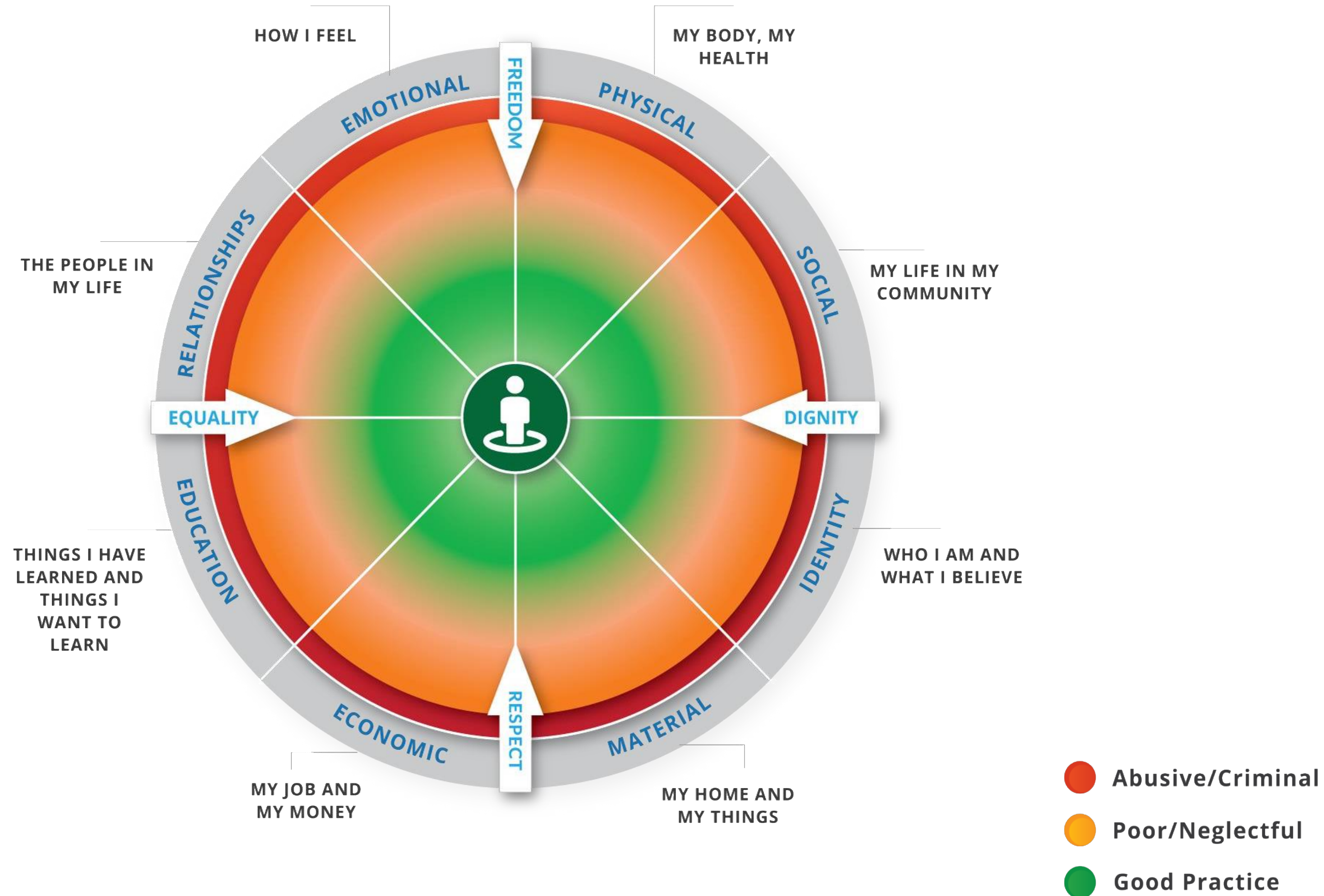
Replace anti-social behaviours with prosocial behaviours = case formulation.

Rehabilitation

Human Rights Model in Disability

Positive Rights	Negative Rights
The right to have access to...positive behaviour support	*The right to be free from*...unlawful restrictive practices
▸ Goal 1 = Maximise quality of life	▸ Goal 2 = Minimise problem behaviours

The Empowerment Circle



- Abusive/Criminal
- Poor/Neglectful
- Good Practice

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Positive Rights

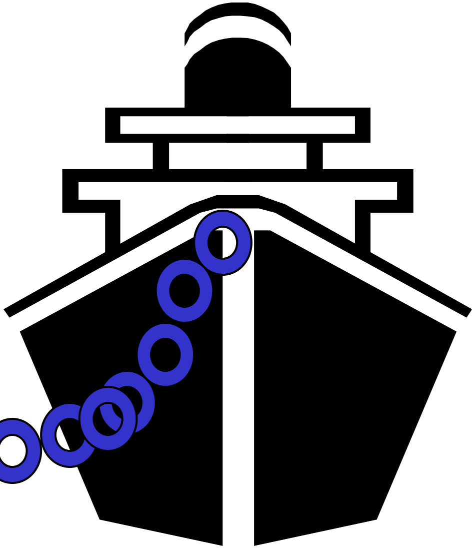
The right to have access to...positive behaviour support to meet these Life Goals:

1. Physical- my body, my health
2. Social- My life in my community
3. Identity- Who I am and what I believe
4. Material- My home and my things
5. Economic- My job and my money
6. Education- Things I have learned and things I want to learn
7. Relationships- The people in my life
8. Emotional- How I feel

Human Rights Model in Disability

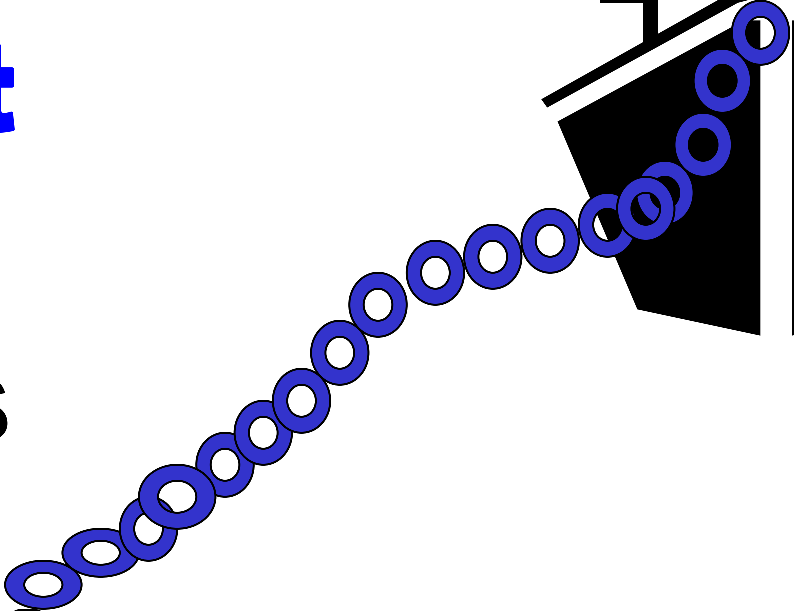
Positive Rights	Negative Rights
The right to have access to...positive behaviour support Physical Social Identity Material Economic Education Relationships Emotional ▸ Goal 1 = Maximise quality of life	*The right to be free from*...unlawful restrictive practices • Chemical restraint • Environmental restraint • Mechanical restraint • Physical restraint • Seclusion ▸ Goal 2 = Minimise problem behaviours

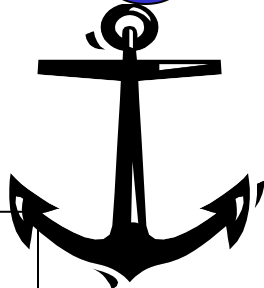
Positive Behaviour Support



Practice

Principles





Theory

Problems

1. Definitions- substance use/misuse/abuse?
2. Definition of “intellectual disability”.
3. Samples do not represent the general client group.
4. Based on self-report, so under-reporting (McGillicuddy, 2006- in Australia).
5. Data on prevalence fragmented (Navonta et al., 2017)- prevalence in Norway is unknown (Juberg, Røsted & Søndenaa, 2017).
6. Treatment modalities, curriculum and prevention strategies are lacking.
7. Still an under-researched area (Newton & McGillivray, 2020).

Problems cont

Higher risk of developing AOD problems than general population, but…

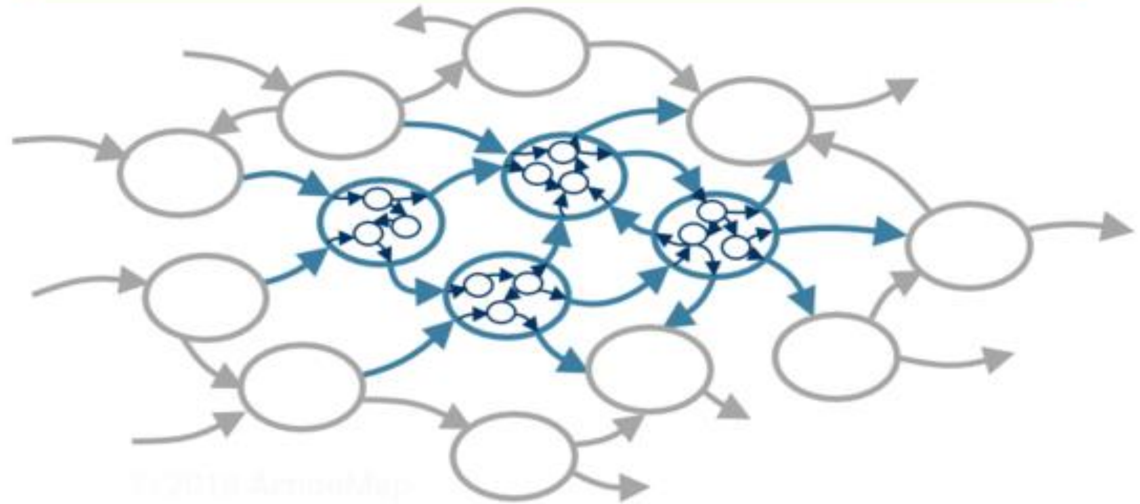
- Little is known about treatment and counsellors lack capacity and hold negative views of the client group;
- There is a need for:
  - Population-specific screening and assessment tools- alcohol, drugs, and prescription medication;
  - Individualised treatment plans and methods that meet diverse literacy and cognitive needs;
  - Treatment in accessible facilities;
  - Population-specific service provider training.

Navotna et al (2017)

My “typical” NDIS AOD Client

- Male or female with a cognitive impairment (ID, ABI)
- Living in the community (next door to you)
- Ambulant or in a wheelchair (from AOD-related injury)
- Using alcohol and/or amphetamines (and violence triggered by lack of cigarettes)
- Harm to self: exacerbating cognitive impairment or mental health conditions, being hit by cars, threats or acts of self-harm, ED and hospitalisation
- Harm to others: assaulting NDIS support workers (including when being transported), assaulting hospital staff, threatening the neighbours, damaging property (inside the home and outside in the community, inc. damaging support worker and neighbours’ cars on the street)

Based upon Rittel and Webber (1973)



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Why is this a wicked problem? (from a social policy perspective)

Partly because the NDIS argues that mainstream services should address these AOD-related (and offending) problems and most AOD services are not equipped to work with cognitive impairment

Why should NDIS care?

1. Substance abuse is a behavioural problem
2. Substance abuse is the outcome of a disability
3. Substance abuse occurs due to a brain disease with disruptions in motivational and reward inhibitory control processes and
4. Substance abuse is a chronic medical problem (like diabetes, hypertension, asthma).

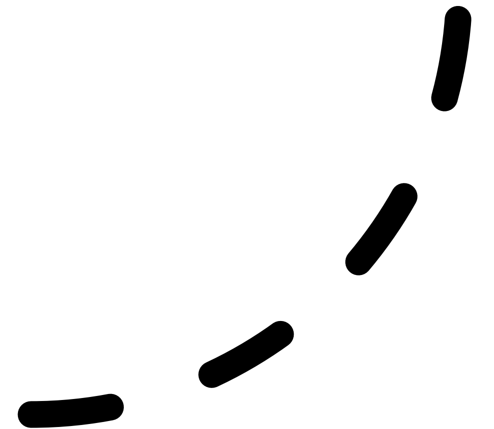
(Sharma & Lakhan, 2017)

These 4 assumptions need to be integrated for NDIS AOD clients into intervention.

Solutions?

Don’t panic and address one behaviour at a time in the Behaviour Support Plan, starting with the behaviour that poses the greatest risk to self and/or others.

Keep it simple.



Solutions?

Conduct a case formulation to determine the link between disability, problem behaviours and AOD use:

i. Direct causal link- AOD use directly causes problem behaviours or vica-versa (eg, not violent when sober)
ii. Indirect causal link- there are internal/environmental causes to problem behaviours and AOD use (eg, poor impulse control as a result of disability, or in the park with family to socialise and get free cigarettes)
iii. General deviant lifestyle (eg, hanging around with anti-social peers, whether there is a disability or not)

Solutions?

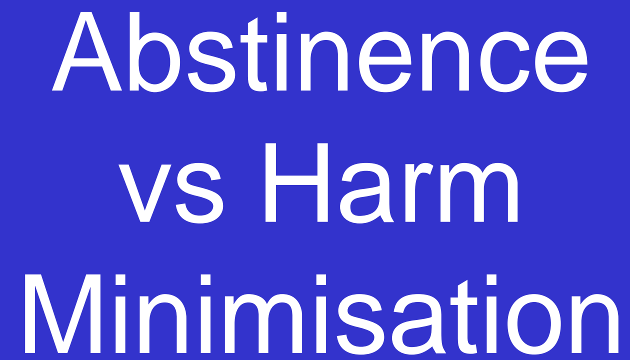
If there is a link between disability and AOD use, carry on and develop the Behaviour Support Plan:

Proactive management- try and stay here!	The client is engaged- try activities that are replacements for AOD use
Early warning signs	Becoming agitated Wanting to leave Talking about AOD use
Low level behaviours	Minor verbal threats (usually regarding real/perceived restrictions)
High level behaviours	Problem behaviours-threats/attempts/acts - Property damage - Harm to others - Harm to self - Absconding
Back to baseline	Client has calmed down or returned to being sober. May be apologetic.

Regulated Restrictive Practices?

Examples:

- Chemical restraint- anti-anxiety medication to reduce cravings
- Environmental restraint- locking doors at night, no alcohol in the house, providing medication via staff



Abstinence more effective because it entails a clear goal- “no AOD use” rather than remembering rules about when, how much etc (Degenhardt, 2000)
The message is more straightforward- don’t drink (Novotna et al, 2017) = paternalism

versus

Controlled use because of self-determination and normalisation theory (Slayter & Steenrod, 2009)
Avoids a barrier to access (Novotna et al, 2017) = self-determination

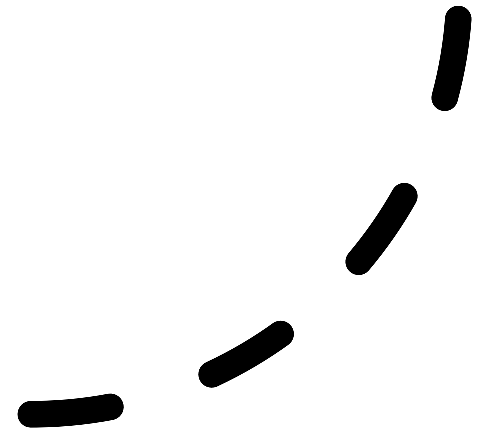
Successful Programs?

Known evaluated programs:

Take it Personal!

Adolescents with a risky personality profile- undergoing a randomised controlled trial, latest update: promising results

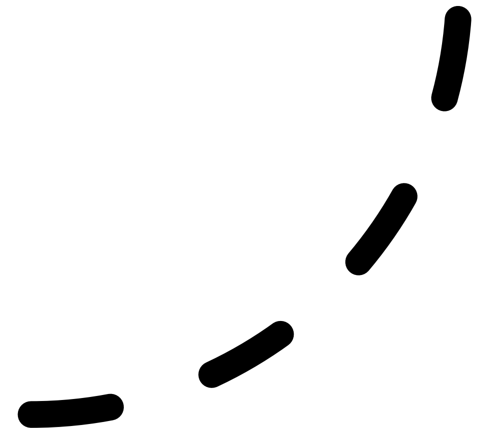
(Duijvenbode & VenDerNagel, 2019)



Successful Programs cont?

EBI-LD Manual for Alcohol Misuse- for mild ID in the community- first manual to be created in the UK, adapting stages of change and motivational interviewing (Kouimtsidas, Scior, Baio, Hunter, Pezzoni, & Hassiotis, 2017).
Applies public health model- harm minimisation and abstinence.
Includes support workers.
30 mins sessions x 6 = 3 hours.

Adequate intensity?

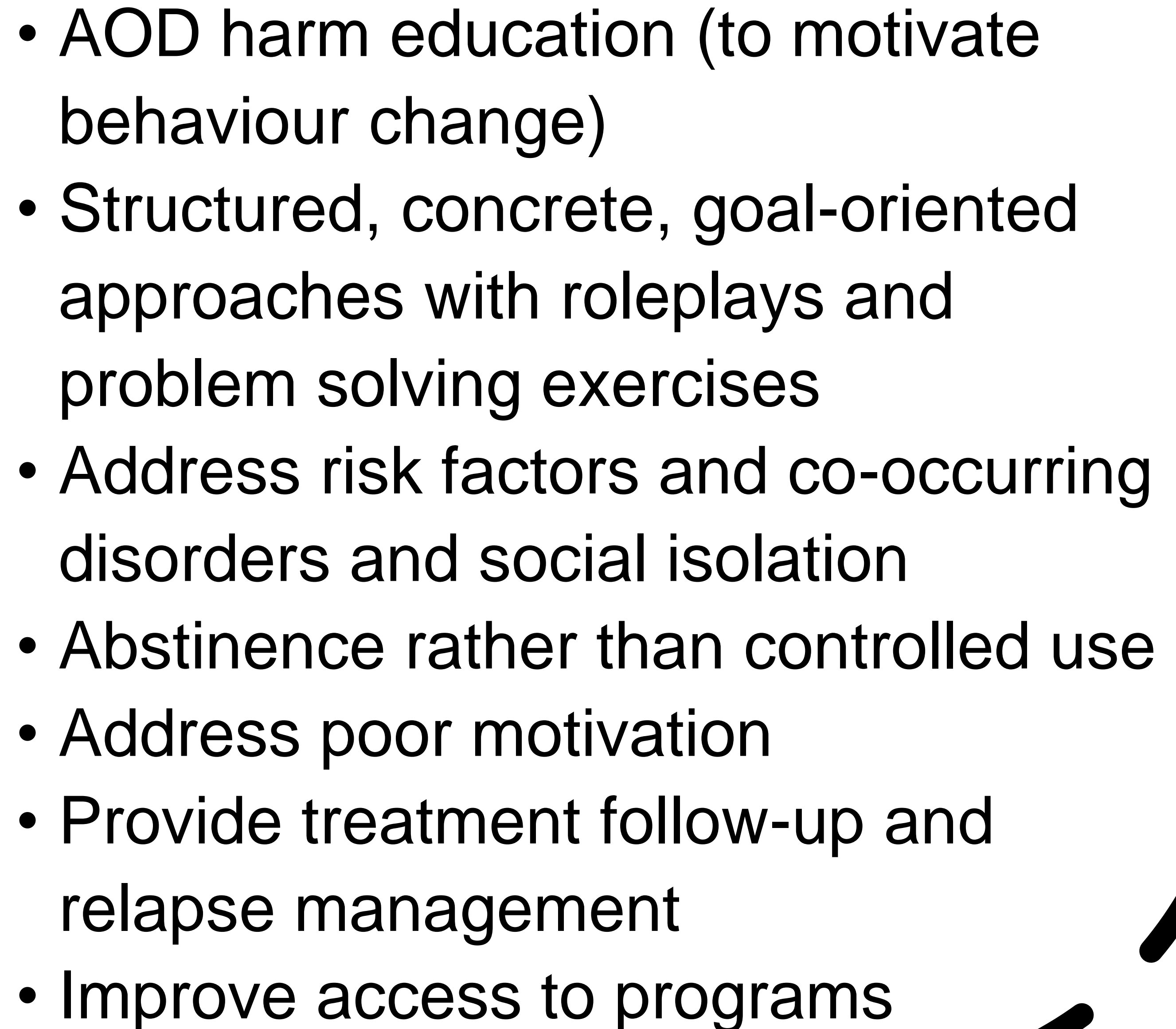


EBI-LD Manual: Outcome?

Clinicians reported:

- The Manual was easy to use
- 30 mins was not long enough (unsurprising)
- Challenge for participants to attend
- Some participants had difficulty keeping drinking diaries
- Good fidelity (delivered as designed)
- But nothing about reduced drinking!!

Requirements for AOD Programs



- AOD harm education (to motivate behaviour change)
- Structured, concrete, goal-oriented approaches with roleplays and problem solving exercises
- Address risk factors and co-occurring disorders and social isolation
- Abstinence rather than controlled use
- Address poor motivation
- Provide treatment follow-up and relapse management
- Improve access to programs

My Group Program (not evaluated)

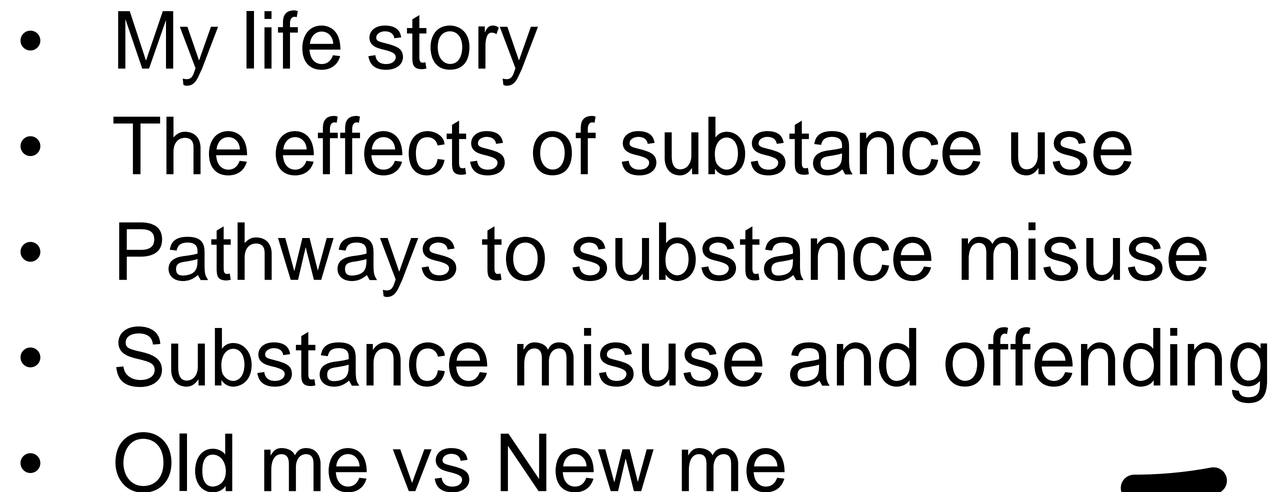
4 modules:

1. Get ready: Introduction

- Introduction to concepts
- Think-Feel-Do Triangle (CBT)

2. Me Today: Get Steady

- My life story
- The effects of substance use
- Pathways to substance misuse
- Substance misuse and offending
- Old me vs New me

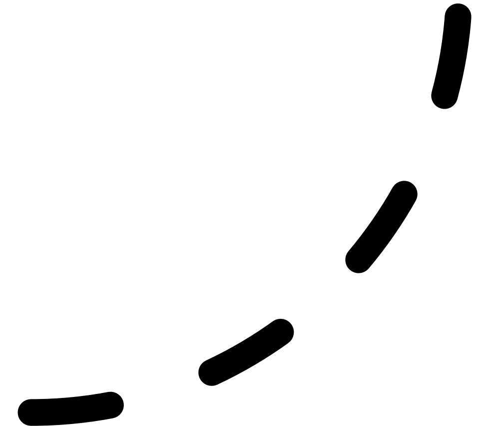


My Group Program cont

3. Old me: Get set
- Offending behaviour
- Building a picture (case formulation)
- Danger set ups
- Life goals and offending

4. New me: Go!
- What I am good at
- My personal plan- life goals, bad and smart talk, set-ups, what-to-dos
- How I know I'm getting there

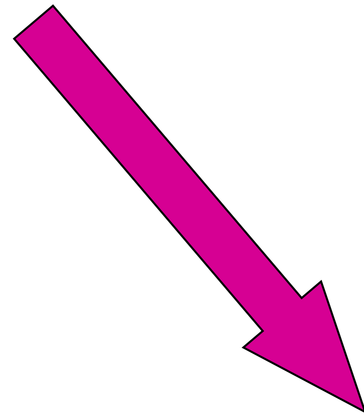
➢ Fred's storybook

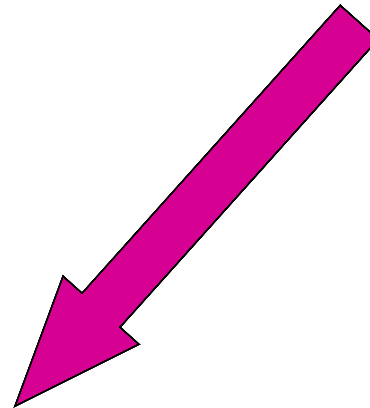


Duty of Care (Best Interest/ Paternalism) = Restricts choice

versus

Dignity of Risk (Self-Determination/ Autonomy) = Promotes choice





Individualised Approach
(Even the law!)

Of course…

"We are talking about prudent risks. People should not be expected to blindly face challenges that without a doubt, will explode in their faces. Knowing which risks are prudent and which are not- this is a new skill that needs to be acquired…a risk is really only when it is not known beforehand whether a person will succeed".

(Slayter, 2009)

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Thanks for listening!

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