

**The Development & Implementation of a Forensic Addictions
Programme in a Secure Setting**

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Abstract

The links between mental health, substance misuse and offending have long been known at a clinical level, and more recently, research has highlighted the need for services to address this tripartite. In response to this need, a Forensic Addictions Service was set up which required the development and implementation of a cohesive and progressive psychologically-based multi-phased and multi-modal Forensic Addictions Programme within a secure setting. This article looks at some of the evidence behind such a development, and the theoretical underpinnings upon which it was based. It also outlines the programme, its ethos and its implementation.

Introduction

The links between mental health, substance misuse and offending have long been known at a clinical level, and more recently this tripartite has received the necessary research evidence that has brought it into line with other areas (Beck, Burns, & Hunt, 2003; Department of Health [DH], 2002; Montoya, 2006; Moran, & Hodgins, 2004; National Treatment Agency, 2002; Scott, Whyte, Burnett, & Maden, 2004; Swofford, Kasckow, Scheller-Gilkey, & Inderbitzin, 1996; Wright, Gournay, Glorney, & Thornicroft, 2002). The need for an integrated and designated service that addressed all three components of the tripartite was identified within a medium secure hospital setting, which led to the development of an appropriate and focussed programme.

Mental health, substance misuse and offending

Beck, Burns, and Hunt (2003) reported that forensic populations show a disproportionate over-representation of mental health problems, such as schizophrenia and affective disorder, which are associated with a higher risk of co-morbid substance abuse.

The Department of Health (2002) reported on the association between substance misuse and increased rates of violence and suicidal behaviour, as did Soyka (2000) who found that a significant risk factor for violence was substance misuse. Thomson (1999) and Beck et al. (2003) also refer to the interaction between mental health and substance use, and its effect on increased violence. In the Safety First Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2001) it was concluded that substance misuse was identified as a factor in over half of the cases of homicide, and substance misuse was over-represented amongst those who commit suicide.

Wright et al. (2002) found that substance misuse indicated a lifetime history of offending behaviour in those individuals with psychosis, in comparison to individuals with psychosis who did not misuse substances. Noordsy, McQuade, and Mueser (2003) stated that clinically there is a high correlation between substance abuse and the following: depression, suicidality, violent and / or disruptive behaviour and antisocial personality disorder. Furthermore, findings from Steadman et al.'s (1998) study of community violence by people discharged from acute psychiatric facilities, which included a comparison group of other residents in the same area, indicated that the highest risk of violence was found in individuals with a combination of substance misuse and personality or adjustment disorder. Welch (2002) in a supporting document to the Department of Health's policy guidance regarding the development of services for individuals with personality disorder (DH, 2003) documents that personality disorders, in particular antisocial and borderline diagnoses, are highly prevalent amongst substance misusers in both treatment and custodial settings.

Coid, Kahtan, Gault, and Jarman's (1999) study of patients in secure hospital settings determined from patient histories and formal diagnoses of substance dependence, that 53% of personality disordered patients were judged as having lifetime alcohol misuse diagnoses, and 47% were considered to have

a lifetime drug misuse diagnosis. Importantly, they reported that these figures were based only on formal diagnoses of substance dependence, but that the rates of co-morbidity are probably much higher as it is frequently the case that many individuals who have chaotic polysubstance misuse are not given a formal diagnosis of substance dependence. Clinical experience has also shown that in the past, and still now, a formal diagnosis of substance dependency is frequently excluded if a mental illness or personality disorder diagnosis is present.

Meeting Service Needs

In 2002 the Department of Health began to address the issue of dual diagnosis at a service level. In their document 'Dual diagnosis good practice guide' (DH, 2002) they highlighted the neglected area of treatment for those with mental health and substance misuse problems. The document emphasised the importance and necessity of addressing substance misuse problems at all levels of care, and no longer only in designated drug dependency units that, in the past, mostly treated those with heroin addictions. The policy advocates a thorough assessment to establish the severity of substance abuse, health, social and psychological problems. It places the responsibility of providing such assessment and treatment on health care providers when co-morbid diagnoses are evident, and it states that all users should have access to services, and not only those who have a full-blown dependency problem, which includes mentally disordered offenders and those with personality disorders.

In response to the evidence the following forensic addictions programme was developed in order to address this dynamic in a formalised manner. The service itself is comprised of a 12-bedded designated ward within an MSU setting, a multidisciplinary team and a specialised psychologically-based programme designed specifically to deal with all three aspects of the tripartite.

Theoretical Underpinnings

“As more research literature is developed on the mental health treatment of offenders, it is apparent that approaches need to be explored that synthesize strategies and interventions from the fields of biology, psychology, and sociology” (Cellini, 2002, pg 78).

Physical tolerance and withdrawal, and the implications of these, are only one aspect of substance misuse. They do not take into account the dynamics, thinking patterns or substance-seeking behaviours that promote and maintain substance misuse problems. The model of treatment that approaches the problem from a multi-dimensional perspective appears to be the one that allows for the widest range of interventions. Engel's (1977) biopsychosocial model, Liberman's psychosocial model (Abou-Saleh, 2004; Adams, 2000; Liberman, Massell, Mosk, & Wong, 1985; Liberman et al., 1993), and the Minnesota Model (Ghodse, 2002) are some of the influential treatment models that have been utilised over the years to inform a broader and deeper model of care that addresses substance misuse from three primary angles, namely, the biological/physiological area of tolerance, dependence and withdrawal, the psychological arena of underlying psychodynamics, coping strategies and behaviours, and the social dimensions of relationships, peer groups, subcultures and social interactions. More recently, other models have drawn upon aspects of these models and developed more specific interventions, such as cognitive behavioural (Graham et al., 2003a; Graham et al., 2003b; Marlatt & Gordon, 1985) or Dialectical Behavioural Therapy (DBT) which has been adapted (with limited success, Verheul, 2001) for use with individuals with borderline personality disorder and drug dependence (e.g. Linehan et al., 1999).

The theoretical underpinnings of this programme were eclectic but predominantly biopsychosocial in nature. Consequently, no one model of intervention was utilised. Concepts and materials were drawn from the models mentioned above, such as psychodynamic, systemic, cognitive-behavioural, motivational interviewing, social skills and medical forums.

Development of the Programme

The programme was developed by a consultant clinical psychologist, in discussion with other multidisciplinary members, who oversaw its progress and continuity. A key concept was to gain a dynamic understanding of the interactions and consequences of the three tripartite components, as well as an intrapersonal understanding of implicating factors, such as trauma or abuse which would be dealt with on a one-to-one basis. These were closely focused upon via a variety of therapeutic interventions, delivered by means of both group and individual work. The aim of the programme was to examine and address patients' core issues, thinking patterns, interpersonal and intrapersonal dynamics, with the intention of preventing relapse, whilst facilitating and promoting recovery and rehabilitation to the greatest possible extent. It has been designed as a cohesive, multi-layered and multi-modal intervention that takes into account the salient characteristics of each individual within the broader context of the group programme. Individualised treatment plans may include all or some of the following: an in-depth assessment of substance misuse, medical and psychiatric interventions, psychological assessments, clinical psychology interventions, psychotherapy and occupational and creative therapy input.

The development of the programme was in two stages. The first programme, which ran for two years, was with one cohort although many of the participants joined and left at different times, which made it difficult to evaluate outcome. It was decided that a streamlined and adapted programme was required that would best fit and accommodate new and older cohorts. Consequently, a revised three-phased programme was developed and implemented in order to facilitate the interspersed nature of intakes/admissions as well as those who were progressing along either a time line, a line of progress, or both.

The adapted programme was designed to run over a two-year period, divided into three phases, each of which was developed to work in a progressive and consecutive format. Phase One and Phase Two were of approximately ten months duration, respectively, and the final phase, Phase Three ran over a three-month period. Each phase aimed to facilitate awareness, insight and skills, and to act as a basis for progression to the next, more advanced stage of work. The programme then culminated in the final phase that focused upon drawing together the work of the previous two phases, and integrating them into plans for patients' futures, whether they be via transfer to another ward or unit, to a place of lower security or into the community. Examples of the modules in Phase One were Understanding Group Dynamics, Substance and Mental Health Awareness, Self-Esteem and the first stage of Relapse Prevention work. Examples of modules in Phase Two were Managing Your Mind, Offending and Empathy, and the second stage of Relapse Prevention. Phase Three included modules such as Pulling it Together and Planning for the Future. As part of the programme, sessions were run on mindfulness by the psychologist. In addition, a weekly group took place for all patients regardless of his (it is a male-only ward) phase status during which the therapeutic components of the different groups attended on the programme as well as off the ward were brought together. The specific intention of this group was to help patients integrate the material from diverse groups and internalise it at a personal level. A further provision was a music therapy group designed to work in conjunction with a more structured Self-Esteem group for Phase One patients. It is important to note that the patients could access all occupational therapy activities and creative therapies off the ward, which included art therapy, music therapy, music lessons, cooking, art groups and so forth, as well as any agreed treatment group, such as the Sex Offender Treatment Programme (SOTP) should it be deemed necessary. However, with regard to the SOTP, attendance at this was only facilitated once the patient had fully engaged, and identified, with the substance misuse programme. This was important in order to minimise patients' use of splitting (or any other defence mechanisms), or using attendance at one group as a means of disengagement from another.

Prior to entry into the modified programme, each patient was assessed using the Substance Abuse Subtle Screening Inventory ([SASSI], Miller, Franklin, & Lazowski, 1999), scales to assess mood (Beck Depression Inventory–II [BDI], 1996, Beck Hopelessness Scale [BHS], 1996; Beck Suicide Inventory [BSI], 1993; Beck Anxiety Scale [BAI], 1993) and a personality inventory (Millon Clinical Multiaxial Inventory–III [MCMI-III], Millon, 1997). A thorough history of his substance misuse, offending and psychiatric status was conducted. Further psychometric tests and clinical interviews (such as a specialist interview by the consultant clinical psychologist on psychosexual development or trauma-related matters) were carried out based on clinical need, and engagement in individual therapy was commenced once the patient had settled into the group programme, and if it was clinically appropriate.

Programme Implementation

The majority of the groups were facilitated by dyads of a consultant clinical psychologist, an assistant clinical psychologist, a specialist nurse and an occupational therapist. All facilitators were trained in substance misuse issues and were supervised by the consultant clinical psychologist on both group material and processes, as well as the dynamics that occurred within the groups.

On arrival, the patient was introduced to the other patients, the nursing staff and the remainder of the multidisciplinary members. He would have been assessed for admission to the ward by two or more members of the multidisciplinary team at which time the programme and the practicalities of the ward, such as random urine screens and the prohibition of aerosol sprays, would have been discussed. Once on the ward, he was re-introduced to the programme and the house rules, and his primary nurse made contact with him. Together, they began the process of developing a working relationship in order to carry out, amongst other tasks, the start of motivational work. The role of the primary nurse was further utilised in carrying out supportive work with the patient on issues that may have arisen on the ward but needed further, or added, exploration and support. Specific psychological issues were dealt with in individual therapy with the consultant clinical psychologist. For the sake of cohesion, the forensic psychologist who facilitated the sex offender programme (SOTP) was supervised by the same consultant clinical psychologist in order to minimise the use of defences such as splitting, and as a means of keeping treatment aims across all interventions integrated and aligned. In addition to this, the multidisciplinary team met at regular intervals to discuss and evaluate the programme, at both a conceptual and practical level.

Programme Evaluation

The programme was difficult to evaluate as individual patients were at different levels of intervention. In addition, there were few readily available evaluation tools that could be used directly as a means of evaluation (British Psychological Society, 2003), and the initial assessment tools were not suitable to be utilised as measures of outcome. As a result of this, the development of a programme-specific evaluation tool was considered.

Informal and verbal evaluations resulted in very positive feedback regarding both the content, and the process and format of the programme. There was considerable emphasis on peer group interaction and specific detail given to integrating the treatment modules both within the programme and those attended off the ward. This appears to have paid dividend as the patients consistently remarked that they have felt contained and boundaried, and that both staff and patients were working towards a common goal. It is unfortunate that a more formal and standardised outcome measure of the programme cannot be provided, as it would have given substance to the patients' responses and sense of progress.

Conclusion

The need for a specialist programme to address the tripartite of mental health, substance misuse and offending was identified and resulted in the development and implementation of a progressive three-phased psychologically-based programme in a forensic medium secure setting. Treatment was multi-phased and multi-modal, and it aimed for cohesion and integration across all interventions in order to enhance the prevention of relapse. The evaluation of the programme as a whole, as opposed to individual modules, required a specifically designed tool, which was not available but the development of which was being considered. However, informal evaluations rendered very positive feedback and robust results with the patients reporting that the programme was informative, beneficial and that it facilitated self-exploration, which led to their reflecting upon their lives as a whole, the motivating factors behind their substance misuse and offending behaviours, how these interacted with their mental health issues, and the consequences and responsibilities of their lifestyles and behaviours. They reported that they felt emotionally contained within the demands of the programme, and that they could now understand and conduct their lives in a more cohesive manner.

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