

A MANUAL FOR EXTENDED BRIEF INTERVENTION:

**ADDRESSING ALCOHOL MISUSE
BY PEOPLE WITH
DEVELOPMENTAL DISABILITIES**

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The Purpose and Intention of This Manual

With the permission of the writers, this manual has been adapted and updated from its original version. This guide has been developed to help community support facilitators, in partnership with professional clinicians, to assist people, with communication and cognitive challenges, to identify address and, if necessary, change their relationship with alcohol. The update for Developmental Services in Canada was completed in 2022.

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In Part I the section on Motivational Interviewing and in Part II sessions 1 and 2 are adaptations of the manual for Motivational Enhancement Therapy developed by Gillian Tober et al, 2002, based on the UKATT MET Manual.

In Part I chapters 3 and 4 are based on the manual of Cognitive Behaviour Therapy for People with Learning Disabilities developed by Azam et al, 2009.

In Part I the sections on alcohol definition and cognitive theories of addiction are based on Christos Kouimtsidis PhD thesis.

Part II sessions 4 & 5 are adaptations of the UKCBTMM manual developed by Christos Kouimtsidis et al, 2004.

Disclaimer

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Overall Introduction

The World Health Organization defines learning disability as “a significant impairment of intellectual ability” (i.e. Full Scale IQ less than 70) and “significant difficulties in social and adaptive functioning,” that are present from childhood (WHO, 1993). The recently published Diagnostic and Statistical Manual of Mental Disorders 5th Edition is in line with this definition, while focusing primarily on the impact of impairments in mental abilities on adaptive functioning in the conceptual, social and practical domains. Recent studies have shown that this population is vulnerable to alcohol use disorders (Burgard et al. 2000) as well as other mental health conditions such as depression and anxiety (Azam et al, 2009). Historically developmental disability was considered an exclusion criterion for psychotherapy, leaving those affected by such conditions few (if any) options for effective treatment.

There has of late been a growing interest, both within the psychotherapeutic community and in the broader social sphere, in developing psychological therapies specifically designed for people with learning disabilities and providing them with the same services the general population has access to. For example, Valuing People (2001) a UK government white paper designed to improve the lives of people with learning disabilities—stated that those with learning disabilities should have the same access to healthcare as people without disabilities do. The use of Behavior and Cognitive Behaviour therapy (BT & CBT) with people with learning disabilities with alcohol problems to date has been limited to single case studies and small group settings. However, with a few modifications in therapeutic approach and communication style these early attempts have indicated that BT & CBT may be successful interventions for those with learning disabilities (Lindsay et al, 1993; Lindsay et al, 1997; McCabe et al, 2006; McGillivray et al, 2008). Azam et al, (2009), have developed a manual for trained therapist of how to offer CBT for anxiety and depression. Specific materials were developed for use in the therapy sessions and for homework.

The original manual builds on the above mentioned developments. It describes the process of treating harmful use of alcohol in people with mild to moderate learning disabilities using extended brief interventions. It is designed for therapists who have experience in alcohol interventions, but have little or no experience with clients who have developmental disabilities. For BT & CBT interventions to be successful with this client population, they need to be made more accessible and modified appropriately to cater to their cognitive abilities and complex communication needs. This manual provides instructions on how to do that, and outlines a therapeutic protocol that can be applied in treatment.

More Canadians, with developmental disabilities, are now living in various innovative models of independent living. There is a great need to balance the right of 'full citizenship' with education and awareness, that both allows for informed choice about alcohol, as well as informed facilitation practices for those in support roles.

Part I: An Overview of Alcohol Disorders and Treatment for People with Developmental Disabilities

Chapter 1: Alcohol Use Disorders and Brief Interventions

Alcohol and definition of alcohol related problems

Just over 40% of the world's adult population consumes alcohol and the average consumption per drinker is 17.1 litres per year. There is wide variation across countries on provenance of abstinence, level of consumption and patterns of drinking (Shield et al, 2013). It has been estimated that around the world at the start of the 21st century 76 million people were suffering from alcohol use disorders (WHO, 2005). In the UK, the Alcohol Needs Assessment Research Project (ANARP) (Drummond et al., 2005) was the first alcohol needs assessment in England conducted on a national scale. ANARP found that 38% of men and 16% of women (age 16–64) have an alcohol use disorder, which is equivalent to approximately 8.2 million people in England. A smaller percentage, 21% of men and 9% of women, are binge (harmful) drinkers and 6% of men and 2% of women are dependent drinkers.

Substance-related and addictive disorders among adults with intellectual and developmental disabilities (IDD): An Ontario population cohort study . *BMJ Open*. 2016;6(9):e011638,2016-011638.alcohol

The prevalence of SRAD among adults with IDD was 6.4%, considerably higher than many previous reports and also higher than found for adults without IDD in Ontario (3.5%).

There are few addiction-related services adapted to the needs of people with DD. *Slayter EM. Understanding and overcoming barriers to substance abuse treatment access for people with developmental disability. J Soc Work Disabil Rehabil*. 2008;7(2):63-80. They are very likely to have comorbid psychiatric diagnoses and a range of physical health issues that require a multifaceted approach to management. *Lin E, Balogh R, McGarry C, Selick A, Dobranowski K, Wilton AS, et al. Substance-related and addictive disorders among adults with intellectual and developmental disabilities (IDD): An Ontario population cohort study. BMJ Open*. 2016;6(9):e011638,2016-011638. *van Duijvenbode N, VanDerNagel JE, Didden R, Engels RC, Buitelaar JK, Kiewik M, et al. Substance use disorders in individuals with mild to borderline intellectual disability: Current status and future directions. Res Dev Disabil*. 2015;38:319-28.

Addiction is a socially defined concept and refers to a syndrome the centre of which is impaired control over a reward-seeking behaviour; impaired control that is leading to significant harm (West, 2006). One of such reward seeking behaviours is alcohol use. Alcohol use per se does not equal addiction unless there is loss of control and associated harm. It is difficult to define when use of alcohol crosses the boundaries of addiction (becomes out of control and/or causes harm). To that effect problem drinkers are divided in three groups: hazardous, harmful and dependent drinkers. An individual's use can escalate from use to dependence through hazardous and harmful use. "Hazardous" use is a term introduced by the WHO. The term refers to a pattern of substance use that increases the risk of future harmful consequences for the user. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user (WHO, 2006).

Harmful use" is a term used in ICD-10 and refers to "a pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis following injection of drugs) or mental (e.g. depressive episodes secondary to heavy alcohol intake). Harmful use commonly, but not invariably, has adverse social consequences; social consequences in themselves, however, are not sufficient to justify a diagnosis of harmful use" (WHO, 1993). The term "abuse" was widely used in the 1980-90s but had various meanings. The term was used in DSM IV but was replaced in ICD-10 by the more precise term of harmful use (WHO, 2006). The term misuse has been also excluded from ICD-10.

The term “dependence” was first introduced in 1976 by a WHO group of investigators to replace the term alcoholism (Edwards & Gross, 1976). The term in ICD-10 is defined as “a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state” (WHO, 1993).

Therefore dependence refers to both physical and psychological elements. Psychological dependence refers to the experience of impaired control over drinking, while physical dependence refers to tolerance and withdrawal symptoms. In ICD-10, the diagnosis of dependence syndrome is made if three or more of six specified criteria are experienced within a year.

Psychological interventions based on psychological theories of addictive behaviour are the main treatment approach in alcohol treatment (Curran & Drummond, 2006). A recent review of the effectiveness of treatment for alcohol problems reported that opportunistic brief alcohol interventions which primarily involved motivational enhancement techniques, are effective in reducing alcohol consumption among hazardous and harmful drinkers to low risk levels.

This is now widely seen as an important public health measure to reduce hazardous and harmful alcohol use, and is primarily employed in people identified in routine medical care settings (e.g. primary care, accident and emergency) (Raistrick et al., 2006).

The same review suggested that CBT approaches to specialist alcohol treatment offer the best chances of success of treatment effectiveness, and that psychosocial interventions can be delivered at a reasonable cost and produce wider social cost savings (Raistrick et al., 2006).

Cognitive Theories of Addiction

Theories that incorporate cognitive processes in the study of addiction can be considered compatible and therefore can be examined under a common framework (Kuhn, 1962; Alford & Beck, 1997). Such theories include expectancy theory (Marlatt, 1979), social learning theory (Bandura 1977 & 2001), theory of reasoned action and planned behaviour (Ajzen, 1985) and PRIME theory (West, 2006). As with other mental health disorders, several cognitive/cognitive-behavioural models of addiction have been developed and evaluated over the years. Whilst they do not all focus on exactly the same elements of the process of therapy, nevertheless there is an overlap. They are situation specific, meaning that the starting point is a high risk situation either internal or external to the individual. They consider behaviour as the result of decision making processes that include concepts which are either conscious or could become conscious and could be modified.

The best known model is the Relapse Prevention model (Marlatt & Gordon, 1985; Marlatt & Witkiewitz, 2005). According to this model, when an individual is exposed to a “high risk situation” (internal or external), the individual is more likely to relapse in the presence of high positive expectancies and low self-efficacy.

The Dynamic Regulatory model is a modification of the Relapse Prevention model, which incorporates the role of conditioned craving in the relapse process (Niaura, 2000). The model proposed that following exposure to external stimuli or activation of internal positive or negative emotional states, if urges, positive expectancies and physiological changes are strong they would undermine existing coping skills through reduced self-efficacy.

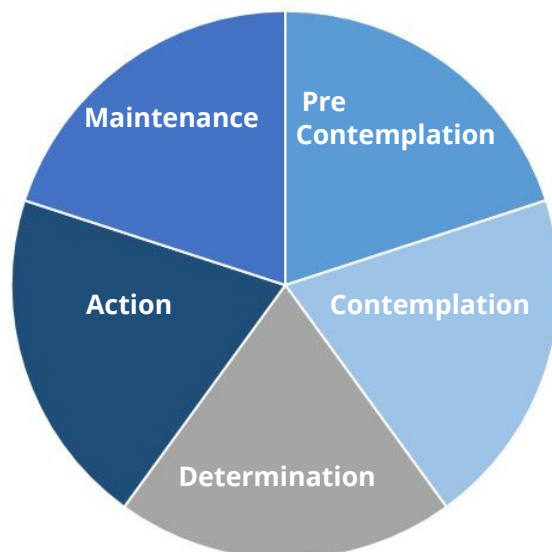
The Cognitive Coping Skills Training (CCST) model (Monti et al., 1989) proposes that acquisition of new skills (interpersonal and intrapersonal) is the main factor that reduces the risk of relapse by increasing self-efficacy. Beck developed a model similar to the Relapse Prevention model in many ways. In addition to positive expectancies, Beck emphasised the important role of core beliefs (schemas), automatic thoughts and “facilitating beliefs”.

Following exposure to activating stimuli (internal or external), core beliefs, positive expectancies and automatic thoughts are activated, which lead to the experience of craving and cognitive dissonance, which is resolved by facilitating beliefs which give permission to proceed with action of obtaining the substance (Beck et al., 1993).

Motivational Interviewing

An influential model that relies mostly on the choice principle, but addresses how people modify addictive behaviour is the Transtheoretical model of behaviour change or Stages of Change model (Prochaska, DiClemente & Norcross 1992). Although it is described as a model it proposes new theory concepts, therefore it could be seen as a theory. The model focuses on this particular aspect of addiction rather addiction itself and proposes that the process of recovery from an addictive behaviour involves transition through stages: (i) pre-contemplation stage in which no change drinking is contemplated; (ii) contemplation in which change is contemplated for the near future; (iii) preparation, in which plans are made on how to change behaviour in a definite way; (iv) action stage in which the plans are put into action and change takes place; and (v) maintenance in which the new pattern of behaviour emerges, establishes and is maintained.

Figure 1: A Stage Model of Change



Adapted from Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Application to Addictive Behaviours, *American Psychology*, 47 (9), 1102 – 1114

Motivational interventions developed in 1990's are partly based on the Stages of Change model and were described as 'Motivational Interviewing. Essentially this approach aims to work with the individual's perception of their alcohol use, rather than imposing the therapist's external view of reality. Most clients, are likely to enter the treatment process somewhere in the contemplation stage, ambivalent about their drink use and the prospect of change. They may already be thinking about changing their drinking but still need consolidation of motivation for change. This phase may be thought of as tipping the motivational balance (Janis & Mann 1977; Miller 1985). One side of the scales favours the status quo (i.e. continued drinking), whereas the other side favours change. The former side of the decisional balance is weighed down by perceived positive benefits from the behaviour and feared consequences of change. Weights on the other side consist of perceived benefits of changing one's behaviour and feared consequences of continuing unchanged. People are likely to experience considerable ambivalence when these weights seem evenly balance. The greater the ambivalence, the greater will be their motivation to resolve the ambivalence. The facilitators's task is to elicit from them a shift in the balance in favour of behavioural change and to recognise the discrepancy between their view of self and their behaviour. Miller and Rollnick (1991) have described five basic motivational interviewing practices underlying such an approach:

- Express empathy
- Develop discrepancy
- Avoid argument
- Roll with resistance
- Support self-efficacy

Express Empathy

Empathy refers to the ability of the facilitator to make sense of the person's experience. Contrasted with approval or identification, empathy is the process of communicating to them that the behaviour in question has its own rationale. This is different from sympathy, which implies a sense of inevitability and feeling sorry for them. Empathy is communicated by the facilitator through reflective listening and selective reinforcement; through affirmation and the way that they summarise the person's position.

Develop Discrepancy

Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be. The approach seeks to enhance and focus the person's attention on such discrepancies with regard to drinking. In certain cases (e.g., the pre-contemplators in Prochaska and DiClemente's model), it may be necessary first to develop such discrepancy by raising the awareness of the personal consequences of the behaviour. Such information, properly presented, can precipitate a crisis of motivation for change. As a result, they may be more willing to enter into a frank discussion of change options in order to reduce the perceived discrepancy and retain emotional equilibrium.

Avoid Argument

If handled poorly, ambivalence about the current behaviour and discrepancy between the consequences of the behaviour and the person's goals or aspirations result in defensive coping strategies that reduce the discomfort but do not alter the behaviour and related risks. An attack on their drinking behaviour tends to evoke defensiveness and opposition and suggests to the person that the facilitator 'does not really understand'. The MET (Motivation Enhancement Therapy) style explicitly avoids direct argument. No attempt is made to have them accept or admit a diagnostic label. The facilitator does not seek to prove or convince by force of argument. Instead, the facilitator employs other strategies to assist the person to see accurately the negative consequences of the behaviour and to begin devaluing the perceived positive aspects of it. In essence when MET is conducted properly, the individual and not the facilitator voices arguments for change (Miller & Rollnick 1991).

Roll with Resistance

How the facilitator handles the resistance is a crucial and defining characteristic of MI. MET strategies do not meet resistance head on but rather roll with the momentum, with a goal of shifting their perceptions in the process. New ways of thinking about problems are invited but not imposed. Ambivalence is viewed as normal, not pathological, and is explored openly. Solutions are usually evoked from them unless specifically requested of the facilitator. This approach for dealing with resistance is described in more detail later (see later section on Handling Resistance).

Support Self-efficacy

People who are persuaded that they have a serious problem will still not move towards change unless there is hope for success. Self-efficacy is a critical determinant of behaviour change. Self-efficacy is, in essence, the belief that one can perform a particular behaviour or accomplish a particular task. In this case, people supported must be convinced that it is possible for them to change their own drinking and thereby reduce related problems. Unless this element is present, a discrepancy crisis is likely to resolve into defensive coping (e.g. denial, rationalisation) to reduce discomfort without changing behaviour. This is a natural and understandable protective process. If one has little hope that things could change, there is little reason to face the problem.

Brief Interventions for Alcohol

Miller and Sanchez (1993) described six elements which they believed to be active ingredients of the relatively brief interventions that have been shown by research to induce change in problem drinkers, summarized by the acronym

F.R.A.M.E.S

FEEDBACK of personal risk or impairment

Emphasis on personal **RESPONSIBILITY** for change

Clear **ADVICE** to change

A **MENU** of alternative change options

Therapist **EMPATHY**

Facilitation of client **SELF-EFFICACY** or optimism

These therapeutic elements are consistent with a larger review of research on what motivates problem drinkers for change (Miller 1985; Miller & Rollnick 1991). Interventions containing some or all of these motivational elements have been demonstrated to be effective in initiating treatment and reducing long-term excessive drinking, alcohol-related problems and health consequences of drinking (Bien, Miller & Tonigan 1993). It is noteworthy that, in a number of these studies, the motivational interventions yielded comparable outcomes to longer, more intensive approaches.



Chapter 2: Alcohol misuse by people with Developmental Disabilities

Despite the sparse literature regarding substance misuse in people with developmental disabilities (characterised by IQ less than 70, developmental delay and adaptive deficits), there is increasing interest in studying such problems in people with developmental disabilities because most now live in the community and are likely to be exposed to substances as well as consuming them (Miller & Whicher, 2010). UK and USA population based studies indicate that the prevalence of substance misuse ranges from 0.5% and 2.5% and may be as high as 25% for any substance in clinic samples (Pezzoni, 2010; , McGillicuddy & Blane, 1999; Sturmey et al, 2003; Hassiotis et al, 2008). Approximately 5% of youths in drug and alcohol services have a degree of developmental disability (Barrett & Paschos, 2006).

The commonest substances that people with mild to moderate developmental disabilities tend to use are alcohol and cannabis, though they may also use heroin or cocaine. Aetiological factors which have been postulated to contribute to use of substances in people with mild to moderate developmental disabilities include hyperactivity, lack of assertiveness, low self-esteem, susceptibility to peer pressure, desire for social acceptance, social isolation, early onset of drinking and lack of example setting in childhood. Substances may also be taken as a maladaptive way of relieving stress or developing relationships within local communities (McLaughlin et al, 2007; Taggart et al, 2007). Those most at risk are young males with mild developmental disability or borderline intelligence who live independently and are less likely to engage in activities and/or to experience mental health problems (Barrett & Paschos, 2006).

Various interventions have been evaluated in the general population to tackle hazardous or harmful drinking and alcohol dependence but the literature in evaluating any interventions is very limited in developmental disabilities. This may be due to the general lack of empirical research in this field, but also to the belief that interventions that are suitable for typically functioning adolescents and adults are also suitable for those with mild-moderate developmental disabilities without need for adaptation. This seems counterintuitive as people with learning disabilities have cognitive deficits that impair their ability to learn or generalise new learning and therefore may require interventions to last longer, to include maintenance sessions and to be supported to seek help and attend appointments.

Most of the treatments that have been applied to people with mild to moderate developmental disabilities are in non-substance misuse services and may well be delivered by people ill-equipped to provide such treatment. A variety of approaches to helping people with mild to moderate developmental disabilities and substance misuse have been tried, such as education about the risks associated with substance misuse, behavioural modification, adaptation of materials by AA or similar organisations with interventions mostly delivered in group settings (Christian & Poling, 1997; Degenhardt, 2000; Didden et al., 2009; Forbat, 1999; Lindsay et al., 1991; McCusker et al., 1993; McGillicuddy & Blane, 1999; McMurran & Lismore, 1993). As a whole, these studies suggest that the capacity of people with developmental disabilities to learn new information is enhanced by providing additional cues and using techniques such as modelling, videotaped vignettes and role-playing (McCusker et al., 1993). Often, sessions are augmented with coping skills lessons and assertiveness training (McCusker et al., 1993; McGillicuddy & Blane, 1999). However the studies conducted to date are fairly small and usually uncontrolled.

Two studies though merit further attention; one is a study of three sessions of group motivational interviewing over two weeks conducted with seven offenders with developmental disabilities in a medium secure unit (Mendel & Hipkins, 2002). The authors found that the participants showed increased determination to reduce drinking at the end of the treatment. The second study (McCusker et al., 1993), is a 10 week evaluation of assertiveness training and modelling compared to waiting list to educate about substance misuse and to help the participants (N=84 randomised to treatment and waiting list controls) to respond appropriately when offered substances in their social network. The authors found that knowledge of the risks associated with use of illicit substances increased at the end of the intervention and this was maintained at six months follow up. The methodological limitations of the studies include the uncontrolled design and possibility of type 2 error in the former study; and insufficient methodological details in the latter to allow appraisal of the findings, as well as the inclusion of several substances which may have compromised the specificity of the intervention.

The National Institute for Health and Clinical Excellence (PH24;18) recommends that brief and extended brief interventions are used to help young persons and adults who have screened positive for hazardous and harmful drinking. The interventions recommended are based on motivational interviewing/enhancement techniques, and are delivered by trained professionals. Their aim is to reduce alcohol intake, reduce risk taking behaviour and even to consider abstinence. The sessions are short at 30 minutes and follow-up is offered. At all times, those who are referred for treatment have their capacity to consent to it assessed and, where further treatment is indicated, referrals to secondary specialist services are provided.

We have chosen to adapt the Extended Brief Intervention (EBI) because it is the most often used and evaluated treatment in the literature for hazardous and harmful drinking in the general population including youth who misuse alcohol. It is a low intensity intervention and can be delivered by trained professionals in the public and voluntary sector. Also, it is our experience that people with mild to moderate developmental disabilities require longer 'treatment' duration overall and thus we will provide five sessions over five weeks with a follow up one-hour session at two months.

Chapter 3: Characteristics of the Facilitator and the Therapeutic Approach

Warmth

The facilitator should convey warmth by being encouraging and offering lots of positive reinforcement where appropriate. The facilitator will need to show an empathic approach coupled with an informal and friendly attitude towards the participant. These qualities are, in some ways, even more important in supporting people with developmental disabilities as they will improve response and motivation to engage in therapy.

Genuineness

The facilitator needs to be honest with the person without being too harsh or judgmental. When supporting people with developmental disabilities it is particularly important to be careful that they don't misinterpret directness as criticism, hostility, or rejection. This can be especially tricky as people with depression are more likely to focus on the negative.

The Importance of Rapport

As in all 'therapeutic' relationships, the participant has to feel secure and trust the facilitator. In some cases it can be difficult for people with developmental disabilities to establish trust because they are more likely to have had a variety of negative experiences with therapists, social workers, and/or other authority figures. You may find people who have developed distorted ideas and representations of therapists or authority figures in general from previous experiences. Overcoming this hurdle is essential to effective support. With time and patience it can be done, but it may take perseverance on your part to establish trust.

The Therapeutic Alliance

In carrying out CBT, with those who have developmental disabilities, the facilitator may be required to adopt a more didactic role (as noted above). However, this needs to be done without being coercive or dismissive. To this end, challenging the person's beliefs too early in the process, is not recommended. Rather the facilitator should slow the pace of support, offer several possible answers to questions that may otherwise feel difficult, yet do this without 'leading' the response. The key here is to be vigilant of their expressions and other nonverbal cues. Communicating with people who have developmental disabilities (both verbally and nonverbally) can be challenging for facilitators who have little or no previous experience working with this type of situation. However, learning the necessary skills to effectively communicate with those who have developmental disabilities is essential for effective support. That is why we have focused on helping the facilitator to add a specific set of communication skills in Chapter 2.

Accurate Empathy

The facilitator needs to try to understand how the person regards them self and their world. By doing this, the facilitator gains a sense of what they may be experiencing. As the facilitator develops empathy that is reasonably accurate, they will be able to understand how the person feels, understands, and responds to events (Beck et al, 1979). This is essential both for developing rapport and for effectively supporting them.

Cultural Sensitivity

Being sensitive to cultural differences and taking them into account during sessions is extremely important. There is considerable variation in the way mental health disorders such as depression and anxiety are perceived and understood in different cultures. The treatment model in this protocol is flexible and can accommodate racial, cultural, and gender differences and issues. However, you must be sensitive to these issues to use the protocol to that end.



Chapter 4: Communicating, in The Therapeutic Setting with People who have Developmental Disabilities

People with developmental disabilities have complex communication needs. They may have difficulty forming sentences, have a reduced understanding of key and abstract concepts, Their speech may be unclear, or they may need increased time to process and retrieve information. Furthermore, a person with developmental disabilities is likely to have reduced vocabulary (Burnip, 2002), and they will probably be more susceptible to suggestibility and may tend to change their answers to questions when provided with negative feedback (Clare & Gujonsoon, 1993; Everington & Fuller, 1999). This is all further complicated by the fact that linguistic and cognitive ability varies considerably from person to person within this population.

What's more, people with developmental disabilities have a lifetime of experiences that have allowed them to mask their difficulty understanding and following verbal communication by drawing on social skills and set phrases that they know are contextually appropriate responses, even if they do not fully understand what is being communicated. This can lead to the illusion that they have understood something that was said in the 'therapeutic' setting when, in fact, this may not be the case.

If the purpose of B & CBT is to help them “learn from their psychotherapeutic experience” and “begin to incorporate many of the techniques of the facilitator”—that is, to “become their own therapist” as it were - these difficulties in communication represent a challenge that must be addressed and overcome to successfully apply B & CBT model in this population. You will need to properly modify the way you communicate to meet the needs of people with developmental disabilities so that you can pitch the material presented at an appropriate level and allow the concepts of B & CBT to be more accessible.

Understanding People with Developmental Disabilities: On the Challenges with Vocabulary, Verbal Ability, and Speech

Even people with mild developmental disabilities will generally have a more limited vocabulary and will acquire fewer and less complex words than the general population. In addition, the ability to form complete, grammatically correct sentences varies within this population—some may be able to do this while others may not. These issues will impact your communication with those who have learning disabilities from the ground up. You may find they have difficulty finding the words to express certain thoughts and feelings. Similarly, if the language you use is too complex, the client may not follow what you are saying. Difficulties in processing and retrieving information (like word finding difficulties) may mean that it takes more time for them to respond verbally. And, if they cannot form complete sentences, you may sometimes find it difficult to understand the meaning of what has been said.

Speech itself may represent another communication barrier that needs to be overcome since physical disability or anatomical differences can result in a variety of speech-related difficulties.

For instance, the anatomical differences found in people with Down's Syndrome - low muscle tone of the tongue, small mouth, and high palate - results in the characteristic alterations in pronunciation in this population (Kelly, 2000). A person with cerebral palsy may have dysarthric speech - weakness in the speech musculature and difficulties with breath support. Other causes of speech difficulties may include dyspraxia - difficulties executing voluntarily and on command the neurological sequence of muscle contractions required to produce individual sounds and words (Murdoch, 1990); and dysfluency—impairment in the ability to produce smooth, fluent speech - a problem that most often arises when someone feels under pressure to perform or respond and where there may be a need to synthesize many different cognitive tasks to arrive at a conclusion.

The following tips will help you overcome some of these basic difficulties with communication. Note that these tips are based on Winn and Baron, 2009. As you become more familiar with a particular person's communication style, pronunciation, and verbal patterns, you will likely be able to "tune in" to their speech and find it easier to understand.

Tips to help you understand people with developmental disabilities

- If you do not understand what someone says, it is important that you do not pretend to have understood. Try to make them feel at ease while acquiring the information you need. You might say, "Sometimes it is difficult for me to understand, could you say that again please."
- Give the person plenty of time to respond, you might have to wait longer than you'd expect. Remember, it does not necessarily take longer to respond because they are unwilling or unable to answer questions, but because it takes them longer to process information.
- Make sure you listen carefully. Pay special attention to speech patterns and pronunciations that are difficult for you to make out.
- Make sure you look at the person when he or she is talking. Body language (more on this below) and watching the words being formed may help you comprehend what is being said.
- If you still cannot understand, ask the person if it is okay to ask the support worker for help with communication. While this is not a technique you want to rely on consistently, it can help in cases where repeated efforts at communication fail.
- Be aware of other things that may affect communication. This could include hearing impairment, visual impairment, physical and mental health issues, epilepsy, medication, time of day (are they a "morning person") general mood, interest in the topic, and more.

Being Understood: Presentation of Key Concepts, Abstract Thought, and Contextualizing Communication

The majority of people with developmental disabilities will have some difficulty understanding what you say to them at least some of the time. How often this is a problem and the degree of misunderstanding will vary from individual to individual depending on the nature of the disability. While assessment can help tease out how much of a challenge this will be in therapy, there are a few simple guidelines that will help facilitate good communication.

First, try to stick with simple, straight-forward, everyday language and limit the number of key concepts or ideas you communicate to no more than three per sentence. While some may be able to understand more complex verbiage and sentence structure, most people with developmental disabilities will better comprehend simple sentences and language.

Second, keep to concrete examples as much as you can and either avoid, reword, or break down complex abstract ideas when possible. While people with developmental disabilities may be able to understand simple abstract ideas such as “What are you doing today?” or “How are you feeling right now?”; complex abstract concepts and questions that revolve around inference or emotions in the context of time are likely to be more difficult for them. You will typically want to avoid questions like, “What would happen if you ...?” “What would it feel like if you ...?” or “What did it feel like when ...?” These lines of questioning are unlikely to be easily accessible by someone with a developmental disability.

Let’s look at an example. Imagine you are discussing the events of the day with someone and they say, “I couldn’t find my shoes,” in a tone that indicates some sadness and/or frustration around this event. Rather than asking, “How did you feel when you misplaced your shoes?” which would likely be too complex the interaction may be broken down as follows:

A: I couldn’t find my shoes.

Facilitator: Tell me what happened.

A: I put them in the wrong place.

Facilitator: How did that make you feel?

You will note in this example, we have deconstructed the “big” question “How did it feel when you misplaced your shoes?” into two component parts so that the action and the feeling are addressed separately. If you think through what you want to say carefully before saying it, in most cases you will be able to find ways like these to communicate your thoughts or questions in a simpler manner.

Finally, make sure you contextualise the information you are attempting to share with them as often as possible. Contextualising communication will often enable a person with a developmental disability to understand what has been said and respond appropriately even if the words aren’t fully comprehended. Good facilitators use context as communication constantly. For example, imagine it’s the end of the day and time for the bus to come to pick up Peter from his day program. Peter has had his afternoon coffee which he has as part of his routine each day before the bus comes.

The other participants are all getting their coats and when Peter's worker asks him to "please go and get your coat and put it on as its cold outside today", Peter is able to follow this verbal request, gets his coat, and puts it on. Peter is relying on his routine and the behaviour of the people around him to understand the verbal request. You can use similar methods in your delivery of directives.

There is one important caveat to note regarding the reliance on context. As mentioned earlier in this chapter, people with developmental disabilities may give appropriate verbal and/or non-verbal responses to questions or comments while not completely understanding what has been said. This is not an attempt at deception, it is simply the product of learned behavioural responses that come from a lifetime of managing social situations.

It is important that you are mindful of this potential pitfall and ensure they understand what you have said by regularly asking them to summarize or repeat what has been discussed during sessions. If clients cannot sufficiently summarize the topic at hand, it's an indication that they may not have understood, despite what they say or what their body language tells you. Don't hesitate to reiterate what you have said or look for new ways to communicate the information you are trying to share if you face this situation. While some people will find it difficult to summarize or repeat back what has been said to them generally, most will eventually be able to do this with a genuine understanding of what has been communicated.

In addition to the above, here are a few more strategies you can employ when communicating with people who have developmental disabilities to help them better understand you. Again, the following is based on Winn and Baron, 2009.

Tips to help people with developmental disabilities understand YOU:

- Speak slowly using everyday words. This means simple grammar, short sentences, and plain English - no jargon
- Think about how to ask questions. Open-ended questions can be more difficult. Yes or no questions are also unhelpful as some people may respond the way they think you want them to. The best method is usually to stick with short, simple either/or questions: Do you like tea or orange juice? Do you feel happy or sad? However, make sure they are not simply repeating the last thing you said by confirming what has been communicated.
- Link your explanation with everyday things. This is especially important if you need to talk about more abstract concepts like time. "Take your medication at breakfast, lunch, and dinner" is more easily understood than "Take your medication three times a day."
- Write the key information down. Then share the written information with other support staff, that way they can go through it together after the session.
- Eliminate distractions. People with developmental disabilities have a hard time ignoring distractions. Make sure you are talking in a quiet place.

In addition to these tips, there are two more strategies you may consider employing with people you are supporting: the use of pictures or symbols and a strong focus on non-verbal communication.

Using Picture and Symbols to Communicate

If verbal communication presents a barrier we encourage you to incorporate pictures or symbols to help people express themselves and/or understand what you are saying. This is an excellent and simple method that can vastly improve communication in difficult situations. As you will see in Parts 2 and 3, we have included pictures throughout the worksheets in this manual. These are from the Photosymbols collection, the primary symbol resource for many of the organizations that produce easy-to-read information for people with learning disabilities. People often find the information communicated in these images easier to recognize and understand because they are photorealistic and in colour. They work well in the 'therapeutic' setting because they are simple and extraneous details often found in photographs have been removed. You can learn more about the Photosymbols collection at www.photosymbols.com.

Focus on Non-verbal Communication

You are likely aware that non-verbal communication such as body language, facial expressions, gestures, signing, tone, pitch and intonation, and behaviour all play an important role in conveying messages. This is quite fortuitous when working with people who have developmental disabilities, because they tend to be keyed into non-verbal communication both as a method of expression and comprehension.

When working with those who use other forms of communication, try to tune in to what their body and other messaging of non-verbal communication are telling you. Learn to interpret this alternate language and you are likely to find it conveys much more than words do. Conversely, you can use your body, facial expressions, etc. to communicate information to them. In some cases, you will find communicating this way enhances their ability to understand your verbal exchanges. So become aware of your non-verbal communication and make sure it accurately reflects what you are saying. Make sure to be active with your body and use lots of non-verbal feedback like nodding your head and changing your facial expression to indicate you are listening and that you understand (or don't understand) what has been said.

Using these concepts and techniques to enhance your ability to communicate with people who have developmental disabilities is essential. If they find it difficult to understand what has been said, it is likely they will become distracted or unmotivated to participate in sessions. This may make the process more problematic and less successful. By learning about, and integrating the strategies above at the very outset of the intervention process, you can minimize communication difficulties and provide people with a better experience.

Idiosyncratic Communication Issues Specific to Certain Populations with Developmental Disabilities

In some cases you may encounter people with very specific, idiosyncratic verbal difficulties that are associated with their particular disability. For example, *echolalia* or *echoed* speech where a person repeats words or sentences spoken by others is often found in people with autism (though you may find it in people with other developmental disabilities as well). If someone is affected by this they may immediately repeat a word or phrase that has just been said. For example, if you say, "Mary's coming today," the person may start saying "today" or even repeat the entire phrase over and over again.

A similar, but slightly different challenge that some people with developmental disabilities have is called perseveration. This is where the individual continues to talk about a distressing event or subject that is of interest to them when it is no longer appropriate. The person may repeat the same words over and over again or may continue discussing the same topic with slight alterations. In situations like these, it can be extremely difficult to break them out of these patterns and engage them in anything other than what they wish to discuss. Interestingly

their ability to communicate about the topic at hand may be extremely misleading about their ability to communicate in general. They may discuss these topics with much greater or much less eloquence than they are capable of in everyday life. This can be a challenge, especially when you are trying to assess the individual's overall communication abilities, so it is important to be aware of these issues before moving forward.

Whether you are facing echoed speech or perseveration, the key is patience. It may be useful to suggest a break or if attempts at distracting them fail, it may be worth considering a shorter session. Occasionally it helps to draw a "contract" with them. Agree to a short two-to-three-minute talk on the subject that they may wish to discuss, then go back to the topic at hand.

Continue to encourage them to come back to their session next time.

Another problem you are likely to face when supporting people with developmental disabilities is a hesitation to openly express thoughts, feelings, ideas and beliefs. Many people who have disabilities have come to believe that what they are saying is either incorrect, unimportant, or both. Luckily, a recent study points toward a way to overcome this problem. The use of "socratic questioning is a helpful way of overcoming this obstacle where, by a series of questions, [the person] is helped to explore, reassess and challenge his or her beliefs" (Stallard, 2002, pg. 21). We encourage you to employ socratic questioning in cases like this, and draw out their thoughts and feelings. When doing this, always remember that questions need to be simple and direct. For example, instead of asking "What did you do yesterday?" you should ask, "What did you do yesterday after you got home from work?"



Finally, it is worth noting that cultural “rules” can come into play with this population just as they do in people who do not have developmental disabilities. Be sensitive to any cultural issues the person may have particularly with regard to eye contact, personal space, and gestures that may have different meanings than what you are accustomed to. Make sure you check what language the person is most familiar with and employ an interpreter as necessary.

Addressing Suggestibility:

As we noted at the beginning of this chapter, studies have concluded that even people with mild developmental disabilities are much more susceptible to leading questions than others. It appears this link between higher suggestibility and developmental disabilities may have to do with memory. Beail (2002) linked poorer memory to higher suggestibility. The studies cited earlier in this chapter offer further support to this tether between memory and suggestibility as each found that memory recall was poorer in people with learning disabilities.

While suggestibility is always an issue, a good facilitator is paying attention to, it represents a particular challenge in supporting people with developmental disabilities. Throughout this chapter we have shown how to simplify communication, reduce abstraction in language, contextualise your thoughts, and use pictures, symbols, and non-verbal communication as methods for more effectively relating to the specific person. All of this must be done while avoiding leading questions and keeping suggestibility at a minimum throughout each meeting. Focus on making sure that they understand what has been said and give clear instructions without leading them. Doing this and using the other strategies and tips in this chapter should set the stage for quality communication starting with the very first meeting. In the next chapter we will outline what these early sessions might look like and provide you the tools needed to assess the communication and cognitive abilities of the person you are supporting.



Chapter 5: Involving a Family Member or 'Paid' Support:

It is extremely important for a family member or staff person to be invited to support treatment. Depending on the person's preference family/support could be present during the whole duration of the session or part of it. In this case at the beginning of each session the facilitator should outline the role of each person. (The person does have the right to say WHO is present)

The Role of the Family/Paid Support:

Another important modification in the use of B & CBT in this population is the role of paid support workers in the process. The involvement of a key family member or a close support worker, is important in assisting the participant to move successfully through the process. The inclusion of an additional person in sessions represents an interesting challenge to facilitators in that you need to be cautious of and regulate the involvement of the family or support worker to ensure that the person doesn't become dependent on or rely too heavily on these people during the sessions. You need to emphasize that ultimate responsibility for change remains with the person but that the involvement of others can be very helpful. It provides an opportunity for family and support staff to provide information, yet encourages the participant to generate their own solutions.

Having family or a support worker, in sessions, will also bring up confidentiality issues that need to be addressed before the sessions begin. Confidentiality ensures that information disclosed to the facilitator is not shared with a third party unless appropriate and agreed upon beforehand. It is an essential element of the process that allows the person to build trust in the facilitator. The facilitator, therefore, needs to establish how much and what information the person is willing to disclose to the family or support worker before bringing the extension of support into the room.

When a significant other/partner accompanies the participant, it is very important that the person is made to feel the main focus of the facilitator's empathy and support. Although the significant other's input may be helpful, their role is secondary. This should be made clear throughout by, for example, making more eye contact with the participant than with the significant other/partner, by deferring to the person more often, and by sitting closer to them. In this way the significant other/partner should be involved but should clearly be 'taking a back seat'.

An important goal is to establish rapport - to create an environment in which the significant other/partner can feel comfortable about sharing concerns openly and disclosing information that may help promote change. To begin with, the facilitator should ask the significant other about their own (past and present) knowledge of the problem behaviour.

- What have you noticed about _____ drinking?
- What do you see that is harmful about _____ drinking?
- What do you see that is good about _____ drinking?

Emphasis should be placed on positive attempts to deal with the problem. At the same time, negative experiences - stress, family disorganization, job and employment difficulties - should be discussed and reframed as normative, that is, things that are common in families with an alcohol problem.

Feedback provided by the significant other/partner can often be more meaningful to someone than information presented by the facilitator. It can help them mobilize commitment to change (Pearlman et al. 1989). In sharing information about the potential consequences of the drinking problem for family members, a significant other/partner may cause them to experience emotional conflict (discrepancy) about the behaviour. Thus, they may be confronted with a dilemma in which it is not possible both to continue the behaviour and to have a happy family. In this way, the decisional balance can be further tipped in favour of making a behavioural change.

At the same time, there is a danger of overwhelming them if the feedback given by the significant other/partner is new, extremely negative or presented in a hostile manner. Negative information presented by both the significant other and the facilitator may result in the participant feeling 'ganged-up on' in the session and could result in treatment dropout.

Handling Significant Other's / Family Disruptiveness:

In some cases, significant other/partner involvement can become an obstacle in enhancing the motivation of the participant to change and can even lead to a worsening of the problem. It is important to identify these potentially problematic situations and to deal with them. The following scenarios are provided to illustrate circumstances where significant other/family involvement might have a negative impact on the process.

- The significant other/family makes comments that appear to exacerbate an already strained relationship and to evoke further resistance from the participant. Your efforts at eliciting useful information from the significant other/family are met with resistance. Your own efforts to elicit self-motivational statements from the person being supported are hindered by significant other/family remarks that foster the participant to become defensiveness.
- Comments made by the significant other/family suggest an indifferent or hostile attitude toward the participant. The significant other/family demonstrates a lack of concern about whether a commitment or attempt is being made to resolve the (drinking) problem. The involvement of the significant other/family appears to have little or not beneficial impact on eliciting self-motivational statements from the participant. When they do not make self-motivational statements, the significant other/family offers no support.
- The significant other/family seems unwilling or unable to make changes requested by the participant that might facilitate an improvement in the drinking pattern or their relationship. For example, despite strong requests from the participant (and perhaps from you) to place a moratorium on antagonistic responses, the significant other/family continues to bring up past drinking habits.
- Of course, it could be the case that the significant other/family has an alcohol problem as well, or may refuse to alter their own drinking pattern in a way that the person has requested, such as not drinking in front of the them, not buying alcohol to have in the house.

In these or other ways, involvement of the significant other/family may prove more disruptive than helpful to the process. The first approach in this case is to use motivational procedures (reflection, reframing) to acknowledge and highlight the problematic interactions. If usual strategies do not result in a decrease in significant other/family disruptiveness, intervene directly to stop the pattern.

Part II: Protocol for Extended Brief Intervention for harmful alcohol use for People with Developmental Disabilities

Session 1 (40 minutes):

Building therapeutic rapport and the role of the support facilitator:

The aim of session 1 is to:

- Build a therapeutic rapport
- Briefly introduce the intervention
- Discuss practicalities
- Introduce the role of the support facilitator

Building Therapeutic Rapport:

The initial session should start with only the person and the support facilitator in the room. Use this first session to start developing rapport and building trust with each other. Take this opportunity to get to know each other and ease into the session. Present yourself as open, honest and transparent in order to build trust. It is important to present yourself as non judgemental, patient, understanding, and empathic. Work to develop a collaborative partnership, encouraging them to take an active part in the conversation. Rapport should be maintained and monitored throughout each session. Particular attention should be paid to the communication needs and information should be presented in a manner that fits with these. Some techniques to this effect that should be used throughout the intervention include:

Rapport building methods:

- **Summarizing** – Use simple language and short sentences, when summarizing discussions. This should be done after each topic to help the transition between each conversation, clarify any misunderstandings and confirm any agreements made.
- **Open-ended questions** – Try to ask questions which open up the conversation and encourage them to freely speak. When asking questions use concrete and simple language, keeping questions short. Avoid asking multiple questions at one time as they may struggle to remember them. Refrain from using 'why' too often as the person may feel they are not answering question correctly.
- **Probing questions** – If you wish to explore a topic in more detail, continue to ask exploratory questions around the topic. This will help them to delve deeper into the issue.
- **Affirming** – Change talk and self-motivational statements should be recognised and reinforced.



Brief Introduction to the Process:

It is important to explore the person's understanding of the intervention, and to confirm their consent to continue with the sessions.

Briefly introduce the intervention in a non-threatening way. The screening and consent would have provided the client with a general understanding of the intervention.

Use clear and simple language, avoiding the use of jargon. Be transparent when explaining the purpose and outline of the intervention. Use this opportunity to communicate the structure of the intervention sessions, and themes covered, but beware of providing too much information, which may overwhelm them. You can also briefly touch upon what their hopes to gain from the intervention are, and discuss their thoughts and feelings about engaging in the intervention. The person will (and must be) aware that the process is aimed at their drinking behaviour. However, they may be very sensitive to any judgement. Hold back from providing personal feedback at this point, as it may elicit resistance.

Discussing Practicalities:

Take this opportunity to discuss practical issues . Such issues can include:

- Preferable time and place to meet
- Exchanging contact details
- Support needed to attend sessions and reasonable adjustments required
- What to do if they cannot make the session or they are running late
- Confidentiality and information sharing
- Settling into the session environment

Role of the Facilitator:

At this time, the facilitator should discuss the possibility of including the family member/designate.

This should include:

- Why including the family member / designate is useful
- How much information they are comfortable sharing with the family member / designate
- The extent to which the family member / designate will need to participate in sessions and potential homework
- Offer them the choice to have the family member / designate present for the whole session or only at the end, then the family member/designate can be invited

End of Session One:

Draw the session to a close by summarizing key points discussed in the session. Confirm that the interventions and what is involved has been made clear. Encourage the person to summarize the key themes discussed to show understanding. If they struggle to do this, repeat capsule summaries until they can summarize too. Check if they have any questions or concerns and ask for feedback on session. It may be useful to provide a session hand out, detailing contact details, meeting time and location. Be aware of literacy skills, i.e. is print too small, too many words etc. - Does someone help them read, if so who?

Session 2 (40 minutes):

Lifestyle and personalised feedback:

The aim of session 2 is:

- To explore the person's lifestyle
- Give personalised feedback on their drinking

Opening the session:

When opening this next session, begin by checking-in . This can involve checking their mood, how their week has been, and any issues or concerns to discuss. Confirm that they are comfortable and willing to continue with the session before starting.

Exploring the Person's Lifestyle:

In order to maintain the therapeutic alliance, avoid prematurely providing personal feedback regarding alcohol consumption. This could be interpreted as threatening and negative criticism. Open the session with an informal conversation to explore hobbies and overall lifestyle activities such as work, friendships, social relationships and activities, leisure, smoking. Use this opportunity to begin to identify lifestyle activities which facilitate alcohol consumption. Recording such activities as they arise throughout each session, will contribute towards latter sessions, particularly when identifying high risk situations and making lifestyle changes.

Personalised Feedback on Their Drinking:

The next stage is to begin to sensitively explore the thoughts about their alcohol consumption. Use open ended and probing questions to encourage them to explore their thoughts and feelings about their drinking. Such questions could include:

- What do you think about drinking alcohol?
- How do you feel about drinking alcohol?

Encourage them to take lead of the conversation, exploring their beliefs and feelings relating to alcohol use. As they verbalises their drinking behaviour they may begin to make links with their lifestyle activities, triggers and reasons for drinking. The ambivalence around their drinking may start to increase and reasons to change may begin to appear.

Now that a collaborative relationship has been formed, personal feedback regarding drinking behaviour can begin to be delivered. This should be done in a non-judgemental and non-threatening way.

The individual **AUDIT** scores can be used to identify their alcohol consumption, drawing links to normative data. It would be useful to present the feedback using graphs, pictures, symbols and plain language to make it easy for them to understand. The facilitator should move at pace suitable for the person's level of understanding. Give them time to process the information and ask questions. A very important part of this process is for the facilitator to monitor and respond to the person during the feedback. Regularly reflect upon your own communication techniques, making sure not to elicit resistance. This will demonstrate to them that the facilitator is listening and understands. It is also useful to paraphrase and summarise the discussion at the end of each point.

This will help them to conceptualise and integrate the points they have made, making reasons to change easily identifiable. If the client is refraining from verbalising their thoughts, use probing and open questions to open up the discussion.

Useful Discussion Points:

- Memory – have they had any period of not remembering what happened while drinking or other memory problems related to alcohol?
- Health – are they aware of any health problems related to their drinking?
- Relationships – has their drinking affected relationships with partner, family or friends?
- Legal – have there been any arrests or other contact with the law because of behaviour while intoxicated?
- Financial – has drinking contributed to money problems?

End of Session Two:

The final part of this session should be used to summarise the key points discussed and any agreements made. Capsule summaries are useful when ending sessions. Aim to summarise discussion points at least 3 times. Encourage the person you are supporting to give feedback about their understanding of the session in order to clarify any misunderstandings. They should also be encouraged to ask any questions or raise any concerns they may have.



Homework:

Homework tasks between sessions can productively bridge sessions and provide insight into someone's lifestyle. Introduce the concept of an alcohol diary exercise. Provide them with a blank, seven day, diary card where they record their daily alcohol intake each day at morning, afternoon, evening ([See Appendix 2](#)).

This can start of very basic, with the total number of alcoholic drinks consumed that day being recorded before bed each night. Check several times that they understand the homework by asking them to give feedback around what they have been asked to do.

There should be a practice run with them before the session ends, using examples of their alcohol intake over the last 2 days. Again gently explore the literacy skills with them. Ask them to make a few sample entries with your help so you can check whether they can read and write and are able to complete the homework task.

Facilitator Skills for Responding to Resistance:

- Simple reflection: One strategy is simply to reflect what the they are saying. This sometimes has the effect of eliciting the opposite and balancing the picture.

A: I'm fed up of talking about my drinking!

FACILITATOR: You're fed up of talking about your drinking.

Reflection with amplification: A modification is to reflect but exaggerate or amplify what the person is saying to the point where they are likely to disavow it. There is a subtle balance here because overdoing an exaggeration can elicit hostility.

Examples are:

A: But I'm not an alcoholic or anything like that.

FACILITATOR: You don't want to be labelled.

A: No. I don't think I have a drinking problem.

FACILITATOR: So you think there haven't really been any problems or harm caused by your drinking.

A: Well. I wouldn't say that.

FACILITATOR: I see; you don't like the idea of being called an alcoholic, (pause); but you think your drinking has caused you problems.

- **Double-sided reflections:** The last Facilitator statement in this example is a double-sided reflection, which is another way to deal with resistance. If someone offers a resistant statement, reflect it back with the other side (based on previous statements in the session).

A: But I can't stop drinking. All my friends do it!

FACILITATOR: It's difficult for you to imagine not drinking with your friends, (pause); but you also worry what it's doing to you.

- **Shifting focus:** Another strategy is to defuse resistance by shifting attention away from the problematic issue.

A: But I can't stop drinking. All my friends drink!

FACILITATOR: You are worried about having to decide right now. Let's just carry on going through your feedback (pause). Later on we can worry about what, if anything, you want to do about it.

- **Rolling with resistance:**

Resistance can also be met by rolling with it instead of opposing it. There is a paradoxical element in this that will often bring the person back to a balance or opposite perspective. This strategy can be particularly useful with those who present in a highly oppositional manner and who seem to reject every idea or suggestion.

A: But I can't stop drinking. All my friends drink!

FACILITATOR: Okay, that's where you're at now, (pause). When we stop meeting, maybe you'll decide that you want to keep on drinking. That it's too difficult to make a change. That's up to you.

Session 3 (40 minutes):

Enhance Motivation and Increase Willingness to Change:

The aim of session 3 is:

To enhance motivation and increase willingness to change.

This can be done by:

- Developing discrepancy and resolving ambivalence
- Elicit change talk
- Providing information and advice
- Discussing options and freedom of choice
- Negotiating the treatment goal

Opening the Session

Like all subsequent sessions, you will start by checking-in . Begin by making a link with the previous sessions. This can be done by reviewing the homework task. If they have not completed the homework, explore reasons why (See Appendix 3). Firstly, ask them how they found the exercise and if there were any problems. Next, collaboratively review their weekly drinking pattern. Do this in a non-threatening and non-judgemental way. Encourage them to talk about their thoughts regarding their alcohol consumption –Are they drinking more than they expected, are they unconcerned about their drinking pattern, do feel they are drinking more than they should? Encourage them to explore these statements further, until they start to recognise a need to change.

Developing Discrepancy and Resolving Ambivalence:

Now that they have recognised a need to change, work with them to identify reasons for changing. This can be done by exploring ambivalence in more detail. One possibility here is to construct a formal 'decisional balance' sheet by having them consider the pros and cons of change (See Appendix 4). When working with those who have an developmental disability, try to make the task as engaging and interactive as possible. It is also important to make the task simple and easy to follow. Methods should be creative and can include using blocks to identify pros and cons, charts, pictures, diagrams, board writing, coloured pens and flash cards. Some may worry about giving the wrong answers, in which case emphasis that there is no wrong answer and their responses will not be judged.

Possible Questions to probe Ambivalence Include:

- What are the positive and negative aspects of continuing the behaviour as before?
- What are the possible costs and benefits of changing problem drinking?
- Developing discrepancy can further enhance positive reasons for change. Prompt them to consider how they perceive their self now and how they would like to be in the future. As discrepancy widens between the actual-self and the ideal-self, intrinsic motivation for change strengthens. A clear motive and desire for change should now begin to emerge.

Eliciting Change Talk:

At this stage they may begin to express change talk. Change talk may either be preparatory or implanting.

- Preparatory change talk: "I should change.", "I need to change.", "I would like to change."
- Implementing change talk: "I can change.", "I am ready to change."

Change talk should be recognised and reinforced in order to further motivate. At this point they may be willing to change, but not ready to put this change into action. One way to identify readiness for change is using the readiness-to-change ruler (See Appendix 5). Ask them to show how ready they feel by marking a score from 0-5 on the readiness ruler. Next, ask them why they have given that score and not lower. This will help to identify their strengths, and reinforce motivation. Next, explore the barriers as why they need not score higher for readiness to change. Enquire about how they can be helped to progress up the scale. A key issue to bear in mind is their ability to understand the scale. It is advisable to clearly explain the scale, and to offer a few practice trails.

Continue to use motivational techniques to reinforce and elicit further self-motivating statement. These include reflecting, summarising, affirming, paraphrasing, probing (see session 1).

Providing Information and Advice:

Often people will ask for key information as important input for their decisional process. In general, however, you should provide accurate, specific information that is requested by them. It is often helpful afterwards to ask for a response to this information: "What sense does this make to you?" "What are your thoughts about it?" The facilitator should also be careful not to lose a motivational opportunity here. This type of questioning is usually associated with the person becoming ready to make a decision about change.

Such Questions Might Include:

- Do alcohol problems run in families?
- Does the fact that I can hold my drink mean I'm addicted?
- How does drinking damage the brain?
- What's a safe level of drinking?
- How quickly will things start to improve?

If a request for advice, make a judgement about whether this is a genuine lack of ideas about what we do, or whether it is a form of resistance. If the former is the case then the above example can be used. Remember the principle of avoiding giving unsolicited advice. The person who asks for advice has a genuine desire to know what the experienced facilitator recommends in the circumstance. It is quite different from the feeling of being told to do something that comes with being given advice one did not ask for. It may, however, be useful to keep the advice as objective as possible.

For example:

- Regarding change that should be made in their drinking: "Many people in your shoes find that to stop drinking altogether, at least for a while is the best choice".
- General kinds of changes that they might need to make in order to support abstinence: "People generally need to find new ways to spend time that don't involve drinking".

They may well ask for information that you do not have. Do not feel obligated to know all the answers. It is fine to say that you do not know but will find out. You can offer to research a question and get back to them at the next session by e mail, text or phone. As there is an absence of informational resources suitable for people with developmental disabilities, you may wish consider creative, engaging and simple ways of delivering your responses.

Discussing Options and Freedom of Choice:

An important and consistent message is every person's responsibility and freedom of choice to change. Intrinsic change has to come from within and can only be decided by the person themselves. Reminders of this theme should be included during the commitment-strengthening process, for example:

- It's up to you what you do about this.
- No one can decide this for you.
- You can decide to go on just as you were or you can decide to change.

The facilitator should now navigate a shift from focusing on reasons for change (building motivation) to making a decision to change. The person may initiate this by stating a need or desire to change, or by asking what they could do. Alternatively, the facilitator may signal this shift (test the water) by asking a transitional question. Such as:

- What do you make of all of this? What will you do about it?
- Where does this leave you in terms of your drinking?
- What are your thoughts about your alcohol use at this point?
- What do you want to do about your worries about your drinking now?

Your goal here is to elicit a clear decision about what they want to do about their problematic behaviour. The overall message to is that "Only you can change your behaviour, and it's up to you".

Negotiating the Goal:

Goals and desired outcomes may have been touched upon briefly in session 1. At this point, work together to establish and agree on a long term goal ([See Appendix 6](#)). There are two important factors to remember when eliciting the goal. Firstly, the goal should be realistic and secondly it should be attainable. This means that the facilitator should take a professional view regarding the appropriateness of potential outcomes. There will be occasions when the facilitator is sure that the most appropriate goal will be abstinence but the person's immediate response is to opt for an attenuated or controlled goal (harm reduction). Ultimately, they must decide upon the desired goal but the facilitator has an important role in steering them towards the most appropriate goal by using selective exploratory techniques. Whatever the goal might be (abstinence or controlled drinking) the therapeutic steps are similar and they are based on the following principles:

- Modifying drinking involves a decision. The person should be in control.
- The decision making process is specific for specific situations.
- For the change to be sustainable change of drinking should be accompanied by relevant changes of lifestyle.

Changes are usually easier when done in small steps, even if the choice is abstinence. These steps are explored in detail in the following session: identifying high-risk situations; developing situation specific coping plans; implementing appropriate lifestyle changes. These steps should be discussed in general in this session. They are complimentary and should start at the same time. Special attention and detailed discussion of what and how it should be done, will be explored in the individual sessions. The order of the following sessions is not obligatory but the facilitator might find it helpful to follow it.

It is important to note that if controlled drinking is negotiated as the outcome goal, the following principles should be kept in mind:

- The final aim should be drinking within the appropriate gender and age limits.
- Drinking should be in the open. Family/support staff should be aware of the person's drinking pattern (with their permission). In this way, trust would be promoted.
- Drinking should be de-mystified. Alcohol should be used in appropriate circumstances for appropriate reasons and with the appropriate expectations.
- Strategies are in place to monitor appropriate use of alcohol.

End of session Three:

The session should be brought to a close by summarising the key themes and agreements discussed. Include an opportunity to provide feedback and raise any concerns. At this stage they may be feeling they have reached a clear decision to change but anxious regarding how to go about doing so. This is a good point to reinforce their reasons for change and desired outcomes, whilst informing them that preparation of how to implement such changes will be explored in the next session.



Homework:

At this stage, work together to develop the alcohol diary exercise further. This time provide them with a blank weekly grid, with each column broken down morning, afternoon, evening. Ask them to record (using X) every alcoholic drink consumed throughout the day (time, location, situation), as well as other non-drinking activities at the end of each period of the end of the day (See Appendix 7). This method will reveal triggers and cue to their patterns as well as insight into other activities they engage in.

Session 4 (40 minutes):

High Risk Situations and coping skills:

The aim of session 4 is:

- Define and identify the client's hierarchy of drinking high risk situations
- Review what past and current coping strategies there are
- Anticipate future high risk situations
- Identify potential unpredictable events
- Develop a personal generic coping plan

Opening the session:

When opening the session, offer an opportunity to talk about recent, concerns or any issues that may have risen since the previous session. Start by reviewing the homework task, linking the current session to the previous. Again, do this in a non-threatening and non-judgmental way. Encourage them to explore reasons behind their drinking and what factors led them to drink each time. Risk situations, triggers and cues to alcohol consumption will start to be revealed. Discuss their engagement in non-drinking activities, paying close attention to pro-social hobbies and activities.

They may have decided to change, but not sure how to go about auctioning the change. This session therefore attempts to prepare the client for change.

What are the High Risk Situations?:

High-risk situations can be broadly defined as situations in which people might encounter alcohol related antecedents, triggers or cues. Their nature may vary considerably, but they can broadly be described as internal (beliefs and/or emotional states) and external (situations, cues).

This part of the session includes a discussion of the typical high-risk situations from their personal perspective and experiences (again, from memory or information from previous sessions or diary of the last few weeks). Explain that 'a high risk situation is where you're at risk of losing control and of drinking more'.

Typical High Risk Situations might be:

- Physically being in a situation associated with drinking
- An emotional state such as feeling anxious, depressed, angry, frustrated, bored
- Or perhaps the opposite, feeling good, wanting to celebrate a positive event
- Interpersonal conflict (arguing with a friend, conflicts at home)
- Social pressure to join in (i.e. others encouraging them to meet at the pub.)

People with developmental disabilities may struggle to comprehend high-risk situations. Useful tools to enhance understanding include short videos clips, pictures, cartoons and diagrams to help them piece together decisions, actions and consequences.

Identifying High Risk Situations:

Work together, to develop a list of the more problematic situations. This can be done either from memory of examples over the past few weeks, discussion of previous lapses, or using hypothetical case scenarios the person produces of what could lead up to a lapse for them. Memory and abstract thinking are challenging tasks for those with developmental disabilities. A recommendable method would be to use the alcohol/activity diary to identify which situations led them to drink alcohol. This will help them to recognise the high-risk situations their lifestyle exposes them to.

Two important tasks at this stage are to enhance responsibility and explore the impact of decision-making. Individuals who misuse substance, often attribute causality of their drinking behaviour on external factors. This serves to justify and rationalise their behaviour, giving themselves permission to drink. Using the alcohol/activity diary, guide them to acknowledge the control they have over situations which lead to drinking alcohol. Reinforce that they have options and do not need to engage in high-risk situations. By taking control and responsibility they can avoid such situations.

Secondly, the facilitator and person should briefly discuss the decision-making process. Guide them to understand how decisions can lead to exposure of high risk-situations, resulting in consequences. People, with developmental disabilities, can have difficulty planning ahead and comprehending the outcome of quick decisions. A situation may be difficult for them to identify because of the interactive nature of emotional state and external events or it may be so pervasive that they are not able to process clearly. Aim to break down complex situations into simple ones and explore each one of them.



What to do about high-risk situations:

Developing situation specific coping plans:

The next step is to enable the client to explore how to cope with the high risk situations. It is essential to review the client's existing coping strategies and the meaning they have for the client.

Developing adaptive strategies may involve:

- i. Learning how to avoid the situation altogether, e.g. taking a different route home to avoid passing in front of the off licence; or avoid certain friends who are drinking.*
- ii. Learning how to cope by confronting the situation and resist drinking by:*
 - Explore their expectancies of drinking. Enable them to challenge the expectations by discussing thoughts and beliefs with a non-using friend or using self-dialogue. Flashcards may be useful reminders for home and community situations.
 - Educate them about the process of craving: 'They are common and normal and not a sign of failure. They are like ocean waves that become stronger, but only to a point, then they start to fade away. Without drinking, cravings will weaken and eventually go away'.
 - Develop a specific behavioural plan for when a situation arises, e.g. going to a party cannot be avoided; make specific arrangements about how to resist drinking.

It is important to emphasise that the ultimate aim is to enable the person to cope with high risk situations as avoidance is not always possible. In the earlier stages, avoidance may be the best option until they have built up a repertoire of coping skills.

Specific Examples of High-Risk Situations:

Here we present in more detail some possible/common stimulus conditions and suggestions of how to address them during the session. Remember that these are only suggestions, which follow the points outlined above and the aim is to enable the client to develop his/her own coping plan.

Arguments

Interpersonal conflicts are situations involving an on-going or relatively recent conflict associated with any interpersonal (one-to-one) relationship such as a parent, friend, family member, or people at school/college

How to cope

Get out of the situation.

In future plan ahead, think about the different possible things that could go well/not well and plan how to react.

Learn to be assertive instead of aggressive.

Joining the "Club"

These are situations where a person is responding to the influence of another person or group of people who exert pressure to engage in drinking.

How to cope

Avoid

Plan ahead

Find excuses

Get help from other friends

Practice what to say/ways of being assertive

Coping with Anger

How to do it

Express it in words rather than actions. Talk to family or a friend.

Get rid of the feelings through exercise.

Hit something safe, like a punch-bag.

Distract yourself. Go for a walk. Buy something. Watch a video.

Coping with Craving

How to do it

Recognise the craving.

Use a brief relaxation technique.

Make positive self-statements.

Distract yourself from the thoughts and feelings.

Go with the craving.

Recall negative consequences.

Use a craving diary.



Anticipating Unpredictable Future High Risk Situations:

Life is unpredictable and not all specific high risk situations can be anticipated. Generalisations of the kinds of events that could become problematic are, however, possible. Crises, negative life events and even positive events (birthdays, pay or benefits day, starting a new relationship) can become a high risk situation. Even without knowing the specifics, it is still possible to develop the equivalent of a 'fire drill'.

Developing a Personal Coping Plan:

When people are stressed, they are more likely to use old coping strategies rather than healthier new ones. It is therefore important for them to try to develop a generic coping strategy that can be adapted to any major crises. This could include:

- A set of important phone numbers of supportive others who can be relied upon
- Recall of negative consequences of drinking
- A set of positive thoughts which can be substituted for drink related thoughts
- A set of reliable distracters
- A list of safe places where they can ride out the crisis with few cues or temptations to drink e.g. parents or non- drinking friend's house

Flashcards may be useful for some of these strategies.

Remember either to do role-play of what they are going to practice, or in some way go through in detail with them an example of their out of session practice.

End of Session Four:

As in previous sessions, this one should be brought to a close in the form of a capsule summary. The person supported should be encouraged to take lead when summarising the topics discussed in the session, demonstrating their understanding. Points should be repeated several times and feedback exchanged between the facilitator and participant Any concerns they have should be welcomed for discussion and eased. To reinforce techniques explored in the session, they could take away flashcards naming techniques.

Homework:

Here you can start to develop the alcohol diary exercise further. This time have them record (using X) every time they want a drink but resist, as well as what they did instead? This will elicit self-efficacy and identify activities which can replace alcohol use (See Appendix 8). They can also record how satisfying they found each activity throughout the day. This will help to establish alternate activities that they can engage as an alternate to drinking alcohol.

Barriers When Using Cognitive Behavioural Methods with People who have Developmental Disabilities:

- Difficulty linking emotions and events or beliefs and event.
- Little confidence in cognitive ability
- Cognitive deficits, typically stemming from a lack of knowledge
- Poor memory
- Difficulty verbalising emotion
- Limited retention and comprehension
- Limited attention span
- Masking disability

Cognitive Techniques:

- Imagery: The facilitator should encourage the participant to imagine saying no to alcohol and considering the outcomes.
- Role-play: People with developmental disabilities may struggle with communication skills and use alcohol to build confidence. Role-play can help them develop effective interpersonal skills without alcohol.
- Distraction Techniques: They should practice diverting attention when craving alcohol.
- Flashcards: Copy motivational statements or behavioural techniques generated during session onto flashcard. For those with poor literacy skills use images (e.g. see Widgit symbols: www.widgit.com). This will act as reinforcement between sessions.
- Relaxation Technique: Self-soothing methods can help to de-escalate and think ahead before turning to alcohol.
- Activity Monitoring: Using a blank grid, they can record activities every hour over 7 days. They then rate the level of satisfaction of the activity on a scale on 1-5. These help to identify alternate activities to drinking alcohol.
- Identifying 'good' and 'bad' situations: What was it, what did they think, How did they feel about it, was the event related to alcohol? (See Appendix 9 and 10).



Session 5 (last session of 1st wave - 40 minutes)

Lifestyle Change:

The aim of session 5 is to:

- Assess current Lifestyle and potential changes
- Develop an Alcohol-Free Lifestyle
- Promote Healthy Living Techniques
- Develop coping plans for the following 3-4 weeks until the final booster session

Opening the Session:

As in preceding sessions, the facilitator should open by discussing any issues or concerns since the last session. Collaboratively review the homework, affirming where they have desired a drink but resisted. Use this opportunity to demonstrate the progress they have made. The main aim of this session is to help them to maintain change. The facilitator and participant should work together to explore ways of adapting a lifestyle to facilitate their new life.

Identify and Implement Lifestyle Changes:

The most important factor that will help to achieve and maintain changes the participant made or wants to make about their drinking, is to change their life style. This includes in addition to those changes related to high risk situations explored in the previous session, generic changes such as structuring their day, plan the next day, rewarding themselves and develop pleasurable activities that do not involve drinking.

One of the problems that many drinkers have is that their whole lifestyle has become orientated around drinking in one way or another. A lot of time and effort is put into it, such that when they stop drinking they find that they have a lot of time on their hands with nothing to do. Feelings of boredom and emptiness can inevitably lead to feeling alone and depression which can ultimately result in lapses and relapse. It is therefore important for the facilitator to work with them on these issues.

Assess Current Lifestyle and Potential Changes:

- How do they spend their time currently? Explore a recent typical week day and a recent weekend.
- Do they have a lot of spare time with nothing to do? If they experience this as boredom, leave further work on this for the next topic, but include here as part of the development of the formulation.
- What did they enjoy or do before drinking? 'What was life like before you started drinking, how did you spend your time?'
- Do they have a good network of non-drinking family and friends? Who is available to develop social activities that do not involve alcohol?
- If the majority of family and friends are drinkers - How can new contacts be made? Is it feasible to maintain contact with close friends who are drinkers without getting back into the network?
- Identify the possible risks (e.g. depression, isolation, relapse) of not filling the vacuum of being a drinker.

Develop an Alcohol-Free Lifestyle:

- Explore how they could structure their day. This should be done by identifying key activities that they still have and use them as the main building blocks, around which other activities could be added. These key activities could be as basic as eating times or morning, lunchtime, afternoon, evening, night.
- Identify the new activities that could be added and decide when and how they will be introduced. Make sure you prompt them to identify their own activities and interests. Offer advice and support when requested but do not impose your views. Invite the family member or support person to contribute.
- To start with you might have to break down some of these activities into smaller ones and perform them in smaller time blocks during the day or at different days of the week.
- Make a generic overall structure for the week and a specific plan for each day of the week.
- Encourage them to re-establish contact or improve contact with non-drinking friends- this may involve exploring potential problems, e.g. 'they think I'm scum, they won't want to see me', and rehearsing and practicing getting in touch with them.
- What positive habits might replace drinking? Is exercise/sport a possibility? Any other absorbing activities that could be seen as a positive addiction (craft work; attending self-help meetings e.g. A.A)?
- Explore potential adaptations that need to take place at different times to accommodate special events or duties, such as visits to family, holidays. It is important that the structure is solid, yet flexible and progressive.
- In considering new activities or extending existing ones, discuss supports they may need, and how this can be arranged.

The person should be encouraged to review this structure and modify it as their life is changing during abstinence or healthy drinking lifestyle and to add new changes and experiences. This should be an on-going learning process, based on small sustainable steps.

If the facilitator and person supported agree to keep a activity monitoring diary, the facilitator should regularly reinforce and support pro-social activities, use the diary to compare their life now to before and reinforcing discrepancy. This will enable them to recognize their progress made towards the ultimate goal. Another option is to list weekly goals on a flashcard, acting as achievable and measurable milestones to reinforce progress.

Promote Healthy Living Techniques:

You should also discuss other healthy living techniques that will help reduce stress and increase overall feelings of joy. These may include:

- Reducing caffeine: Caffeine is a stimulant and can stay in the system for a long time. Too much caffeine can make individuals feel restless, anxious and irritable. It can also prevent inhibit quality sleep and cause headaches, abnormal heart rhythms, or other problems. You may suggest that they moderate caffeine intake and avoid drinks containing caffeine starting in the mid-afternoon. Tea, coffee, energy drinks, many soft drinks, and chocolate contain caffeine.

- Improving sleep habits: Good sleep habits are essential for physical and mental health. To improve sleep habits we recommend you encourage the participant to create a sleep schedule, avoid napping during the day, and establish a pre-bedtime routine to help them realize it is getting close to bedtime. Work with them and the support worker to decide what may be included in such a routine. Examples include having a warm bath, listening to relaxing music, having a glass of warm milk, or other activities that help them to relax.
- Promoting exercise: Regular exercise can improve mood and is good for sleep. Exercise in the morning can help them feel good throughout the day and relax in the evening. Make sure to keep exercise gentle and encourage them to avoid exercising close to bedtime as this stimulates the body and is bad for sleep. Exercise should be added to their daily schedule.

End of session 5

As usual, the session should be brought to a close using a capsule summary. Any concerns should be discussed here and feedback exchanged. This is the last session before a 3 week gap. Check to see that they have all the resources they need and feel confident about maintaining their changed lifestyle over the coming weeks.

Homework:

Using the activity-monitoring diary, identify pro-social activities which they have rated as satisfying or used to replace drinking. From this, collaboratively develop an activity schedule for them to implement their new life (See Appendix 11). Discuss support that they may need in planning and completing activities, and how this can be arranged. Over the next three weeks they can practice living with the changes.



Barriers to maintaining change:

People may lapse or relapse with their drinking, particularly in the event of a trigger or anniversary. This may significantly reduce their self-efficacy and motivation. Educating them about the possibility of a lapse, what happens if one occurs and coping skills to get back on track would all help to feel more in control and prepared. It is important to keep supporting their self-belief, developing discrepancy, highlighting progression and reinforcing the end goal.

Session 6 Final session (60 minutes)

Booster session - Review:

This final session aims to:

- Assess and consolidate the motivation to change drinking
- Review changes achieved and promote further changes
- Review the agreed upon goals

Opening the Session

Open this session by confirming consent to proceed. As there has been a 3 week gap between sessions, start by asking how they have found the past 3 weeks, how did they find following the schedule, how do they feel about alcohol now?

Re-assess Motivation and Self-efficacy to Change Drinking:

The facilitator should be sensitive to any verbal or non-verbal communication of ambivalence or lack of self-efficacy to implement changes and achieve goal of therapy.

Self-efficacy is defined as the level of an individual's confidence in their abilities to organize and complete actions that lead to particular goals (Bandura 1977). Within the context of drinking it refers to the person's belief of their ability to achieve and maintain changes in their drinking, these could abstinence or controlled drinking.

Review Changes in Drinking:

Review the identified high risk situations in detail and assess if coping plans discussed in previous sessions have been implemented. Review if these plans are effective and explore with them any required modifications and further developments. It is also common as the most risky situations have been resolved other less obvious or less regular risky situations to appear. Explore them and develop coping plans using the techniques discussed and practices in previous sessions.

Take the time to provide an overview of the skills you have covered in previous sessions and you practice them together as necessary to reinforce learning. This helps them to have a clear understanding of what has been covered and the successes they have made during the intervention process.

Review Life-style Changes:

Re-assess their overall changes in lifestyle as structure of their day, short-term and long term planning, new positive behaviours and healthier lifestyle. It is important to note here that it is possible that new behaviours or activities that were initially considered positive to carry some risks too. For example new friends or social activities might be directly (new friends might drink or put pressure) or indirectly (by increasing stress) associated with risks of drinking. The facilitator should be open to explore and address any concerns that the participant or the family/support has.

This review will set the stage for the final sessions where you will close the loop, reinforce the techniques and skills learned, and end the sessions with the understanding that they have acquired the needed knowledge to "become their own therapist." In Chapter 10 we will review how these final sessions should look. But before we get to that, let's look at the additional skills and topics you need to address during these middle sessions.

Review Goal of Sessions:

You should also discuss how close the person is to meeting the goals that were established early in the process, how they feel about meeting these goals, what parts of the goals may need further work, and what, if anything, needs to be added to the original list of goals. As the session progresses the initially agreed goal of the sessions might be considered by them as non-realistic.

This could be explained by the development of trust and the associated therapy alliance that will give them the confidence to express any worries or conflicting thoughts. It could also be due to changes already taken place that could promote self-efficacy and their wish to review and achieve more challenging goals. This is usually the case when controlled drinking is the initially agreed goal. They might feel confident enough to proceed to abstinence or realize that abstinence and the associated lifestyle changes are easier to implement. Sometimes though the goal of abstinence might be proven too challenging and controlled drinking with the associated lifestyle changes might become a more realistic short-term goal.

Develop Coping Plans and Promote lifestyle changes for the Following weeks:

Allocate time to explore their thoughts and feelings regarding the forthcoming 3 - 4 weeks and the gap in the process. Promote self-efficacy and develop detailed plans for each week. Help them to be specific and pay attention to the detail. Request help and feedback from family/support. Overall there are three types of plans:

- Specific to high risk situations
- Generic coping plan that could be used in emergency, not predicted new risky situation
- Lifestyle changes and structure

End of session 6:

This is the final session. At this point the facilitator should aim to summarize the intervention development. It is important to build on motivation to maintain change and strengthen their belief and ability to carry out such changes. Any concerns they have, or outstanding issues should be discussed here and feedback provided. The facilitator should confirm that the person has enough resources and feels confident in maintaining their changed behaviour independently.

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PART III: Appendices

Appendix 1: Session 1 Information Overview

Appendix 2: Session 2 Homework Instructions

Appendix 3: Checklist of reasons for not completing the homework tasks

Appendix 4: Ambivalence Record

Appendix 5: Readiness Scale

Appendix 6: YOUR Goals

Appendix 7: Session 3 Homework Instructions

Appendix 8: Session 4 Homework Instructions

Appendix 9: Good Card

Appendix 10: Bad Card

Appendix 11: Weekly Activity Schedule Instructions

2022 updates included:

- Canadian statistics - Part One Overview
- Non gender specific language
- The term 'client' was replaced with 'people supported'
- The role of 'therapist' was replaced with 'facilitator'
- More visuals reflective of the people being supported (photo symbols)
- The term 'therapy' was replaced with 'process', 'meeting' or 'gathering'.

INFORMATION OVERVIEW

Photo of Participant 	Name: Phone: Email: I prefer: Email ☐ Phone ☐ Text ☐
Photo of Facilitator 	Name of Facilitator: Phone: Email: I prefer: Email ☐ Phone ☐ Text ☐
Extended Brief Intervention? 	What EXACTLY is an Extended Brief Intervention for alcohol misuse? • You will meet with _____ for 30 minutes each week for 5 weeks • After 5 weeks you will have a final session for 1 hour • You and _____ will talk about your alcohol use and ways to get to a healthier lifestyle • Sometimes _____ will give you homework. This is to help you practice what you talked about and to get ready for next time How can this 'intervention' help me? It can help you to: • Drink less alcohol or stop completely • Find other activities you enjoy • Live a healthy lifestyle - make healthy choices
	When and where will we meet? Decide on a time and date. How will we contact each other if there is a change?

Session 2 Homework Instructions

- You can either do this homework on your own or ask your support for help.
- Each day you can write in the diary how many alcoholic drinks you drank
- The diary card is divided into Breakfast-morning, Lunch-afternoon and Dinner-evening.
Try to fill in the diary at these times.

MONDAY		
Breakfast	Lunch	Dinner
How many alcoholic drinks did you have?	How many alcoholic drinks did you have?	How many alcoholic drinks did you have?
TUESDAY		
Breakfast	Lunch	Dinner
How many alcoholic drinks did you have?	How many alcoholic drinks did you have?	How many alcoholic drinks did you have?
WEDNESDAY		
Breakfast	Lunch	Dinner
How many alcoholic drinks did you have?	How many alcoholic drinks did you have?	How many alcoholic drinks did you have?
THURSDAY		
Breakfast	Lunch	Dinner
How many alcoholic drinks did you have?	How many alcoholic drinks did you have?	How many alcoholic drinks did you have?
FRIDAY		
Breakfast	Lunch	Dinner
How many alcoholic drinks did you have?	How many alcoholic drinks did you have?	How many alcoholic drinks did you have?
SATURDAY		
Breakfast	Lunch	Dinner
How many alcoholic drinks did you have?	How many alcoholic drinks did you have?	How many alcoholic drinks did you have?
SUNDAY		
Breakfast	Lunch	Dinner
How many alcoholic drinks did you have?	How many alcoholic drinks did you have?	How many alcoholic drinks did you have?

Checklist of Reasons for not Completing the Homework Tasks

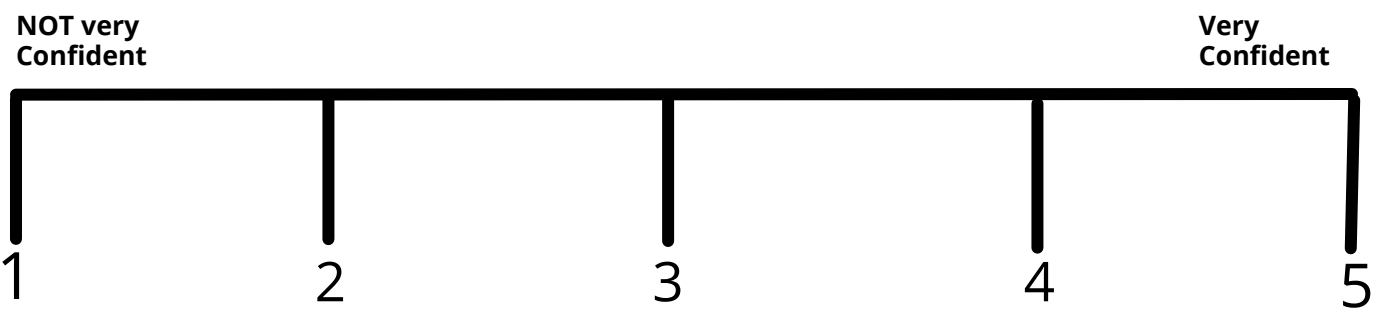
(Adapted from Beck et al, 1979)

 TRUE	 FALSE	REASONS FOR NOT COMPLETING HOMEWORK
		I don't understand how this task will help me feel better.
		I don't know why you asked me to do this.
		I forgot to do the homework.
		I don't think the homework is helpful.
		I don't have time to do the homework. I am too busy.
		I was afraid that I would do it wrong.
		I didn't feel like doing the homework task.
		I don't like doing what you tell me.
		I didn't understand the homework.
		What's the point? Nothing I do will help me get better.
		I didn't do the homework because it made me feel: • Bad • Sad • Mad • Anxious • Other

AMBIVELANCE RECORD

[illegible]

READINESS SCALE



Notes:

Your Goals:

What is your goal?

What do you need to do to change?

How important is this goal?

A Little Important



Important



Very Important



How confident are you in achieving your goal?

A Little Confident



Confident



Very Confident



What help do YOU need to achieve this goal?

Session 3 Homework Instructions

- You can either do this homework on your own or ask for help.
- Each day you can write in the diary: How many alcoholic drinks you had AND what other activities have you been doing

MONDAY		
Breakfast - morning	Lunch - afternoon	Dinner - evening
When and where did you drink?	When and where did you drink?	When and where did you drink?
What else did you do?	What else did you do?	What else did you do?
Were you alone? YES NO	Were you alone? YES NO	Were you alone? YES NO
TUESDAY		
Breakfast - morning	Lunch - afternoon	Dinner - evening
When and where did you drink?	When and where did you drink?	When and where did you drink?
What else did you do?	What else did you do?	What else did you do?
Were you alone? YES NO	Were you alone? YES NO	Were you alone? YES NO
WEDNESDAY		
Breakfast - morning	Lunch - afternoon	Dinner - evening
When and where did you drink?	When and where did you drink?	When and where did you drink?
What else did you do?	What else did you do?	What else did you do?
Were you alone? YES NO	Were you alone? YES NO	Were you alone? YES NO
THURSDAY		
Breakfast - morning	Lunch - afternoon	Dinner - evening
When and where did you drink?	When and where did you drink?	When and where did you drink?
What else did you do?	What else did you do?	What else did you do?
Were you alone? YES NO	Were you alone? YES NO	Were you alone? YES NO
FRIDAY		
Breakfast - morning	Lunch - afternoon	Dinner - evening
When and where did you drink?	When and where did you drink?	When and where did you drink?
What else did you do?	What else did you do?	What else did you do?
Were you alone? YES NO	Were you alone? YES NO	Were you alone? YES NO
SATURDAY		
Breakfast - morning	Lunch - afternoon	Dinner - evening
When and where did you drink?	When and where did you drink?	When and where did you drink?
What else did you do?	What else did you do?	What else did you do?
Were you alone? YES NO	Were you alone? YES NO	Were you alone? YES NO
SUNDAY		
Breakfast - morning	Lunch - afternoon	Dinner - evening
When and where did you drink?	When and where did you drink?	When and where did you drink?
What else did you do?	What else did you do?	What else did you do?
Were you alone? YES NO	Were you alone? YES NO	Were you alone? YES NO

Session 4 Homework Instructions

- You can either do this homework on your own or ask for help.
- Each day you can write in the diary: How many times you wanted to drink alcohol but did not AND what you did instead of drinking alcohol

MONDAY		
Breakfast	Lunch	Dinner
How many times did you want an alcoholic drink but did not have one? What did you do instead?	How many times did you want an alcoholic drink but did not have one? What did you do instead?	How many times did you want an alcoholic drink but did not have one? What did you do instead?
TUESDAY		
Breakfast	Lunch	Dinner
How many times did you want an alcoholic drink but did not have one? What did you do instead?	How many times did you want an alcoholic drink but did not have one? What did you do instead?	How many times did you want an alcoholic drink but did not have one? What did you do instead?
WEDNESDAY		
Breakfast	Lunch	Dinner
How many times did you want an alcoholic drink but did not have one? What did you do instead?	How many times did you want an alcoholic drink but did not have one? What did you do instead?	How many times did you want an alcoholic drink but did not have one? What did you do instead?
THURSDAY		
Breakfast	Lunch	Dinner
How many times did you want an alcoholic drink but did not have one? What did you do instead?	How many times did you want an alcoholic drink but did not have one? What did you do instead?	How many times did you want an alcoholic drink but did not have one? What did you do instead?
FRIDAY		
Breakfast	Lunch	Dinner
How many times did you want an alcoholic drink but did not have one? What did you do instead?	How many times did you want an alcoholic drink but did not have one? What did you do instead?	How many times did you want an alcoholic drink but did not have one? What did you do instead?
SATURDAY		
Breakfast	Lunch	Dinner
How many times did you want an alcoholic drink but did not have one? What did you do instead?	How many times did you want an alcoholic drink but did not have one? What did you do instead?	How many times did you want an alcoholic drink but did not have one? What did you do instead?
SUNDAY		
Breakfast	Lunch	Dinner
How many times did you want an alcoholic drink but did not have one? What did you do instead?	How many times did you want an alcoholic drink but did not have one? What did you do instead?	How many times did you want an alcoholic drink but did not have one? What did you do instead?

Good Card

Think of an activity that you did this week that you enjoyed
What was it?
How much did you enjoy it?
What did you enjoy about it?
How did it make you feel?
How often could you do this activity?



Bad Card

Think of a bad thing that happened this week
What was it?
How bad was it?
What did you not like about it?
How bad did it make you feel??
Did it involve, tempt you or lead you to drinking alcohol?



Weekly Activity Schedule Instructions

- You can either do this homework on your own or ask for help.
- Each day you can write in the diary: What you did for work OR to have fun
- The diary card is divided into Breakfast-morning, Lunch-afternoon and Dinner-evening.
Try to fill in the diary at these times.

DAY	BREAKFAST - Morning	LUNCH - Afternoon	DINNER - Evening
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			
SUNDAY			

