THE DEVELOPMENT OF A PRACTICE MODEL FOR THE RESIDENTIAL TREATMENT OF SUBSTANCE ABUSE WITH PERSON WITH A DEVELOPMENTAL DISABILITY

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THE DEVELOPMENT OF A PRACTICE MODEL FOR THE RESIDENTIAL TREATMENT OF SUBSTANCE ABUSE WITH PERSON WITH A DEVELOPMENTAL DISABILITY

A Project

by

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Division of Social Work
Abstract

of

THE DEVELOPMENT OF A BEST PRACTICE MODEL FOR THE RESIDENTIAL TREATMENT OF SUBSTANCE ABUSE WITH PERSON WITH A DEVELOPMENTAL DISABILITY

by

Kelly Hood

This exploratory project focused on individuals with developmental disabilities and their use and abuse of substance. The lack of empirical research published for this specified population is the reason why this project was established. This population was overlooked based on society’s ignorant views that individuals with developmental disabilities are not using or abusing substance.

There were two purposes for this research project. The first purpose of the researcher project was to bring awareness and knowledge to the Social Work community about the lack of research in hopes for further studies on persons with developmental disabilities and their use and abuse of substance. The second purpose of this research project was to create a best practice model for treatment facilities/programs that incorporate the special needs of co-occurring disorders. There is lack of empirical data for facilities/programs that serve persons with developmental disabilities and substance abuse. The main goal of this project is to describe current available treatment facilities, as well as focus on developing a best practice for treatment facilities working with this population.
The research design used for this project was the Exploratory Research Design. Data was collected through forensic literature from databases for secondary, empirical data through articles, books, journals and websites. The project also focused on a best practice model for treatment facilities of individuals with co-occurring disorders that include developmental disorder, serious mental illness and substance abuse. No human subjects were used in this research project. Analysis of the treatment facility was created by reviewing the established requirements constructed by the Substance Abuse and Mental Health Administration. This researcher established a best practice treatment facility that incorporates and met all 12 Principles of the Substance Abuse and Mental Health Administration guidelines. This treatment facility was used as standard for the best practice model outlined in this project. This researcher also used an already established treatment facility, Autus in Northern California as example of a treatment facility already established.

There is a need for awareness of the lack of information, research on persons with developmental disabilities and treatment facilities. Finalization of this project helped bridge the gap between of lack of awareness and information. The forensic literature review in this project illuminates what the Substance Abuse and Mental Health Administration deems is a best treatment facility by proposing the structure of such a treatment facility.
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Chapter 1
THE PROBLEM

Introduction

Substance abuse is serious and a common problem in America. Yet, there is a part of the population left out when discussion, research and treatment of this problem occurs. Throughout years there has been a professional psychiatric bias against the acceptance of the possibility that person’s with a developmental disability could have a co-morbid mental illness and substance abuse issues. Within the past ten years, there has been a growing and significant clinical recognition of the high incidence of mental illness and substance use and abuse disorder in persons with a developmental disability. Gillick (2003) reported that individuals who have an intelligence quotient estimated to be below 75, do not have treatment for substance abuse as an option, and of this group, three percent may have some form of mental retardation. There is a need for more empirical, evidence based focus research on persons with a developmental disability and substance abuse along. Lacking for this population is a residential treatment program integrating evidence-based practices and person centered theory.

Background of the Problem

Substance Abuse and Serious Mental Illness (SMI) are intricately connected, but many treatment facilities treat each population separately. The term Serious Mental Illness (SMI) is used by the Substance Abuse and Mental Health Services Administration (SAMHSA) and it is based on a definition found in Public Law 102-321, “The Alcohol,
Drug Abuse and Mental Health Administration Reorganization Act” (Substance Abuse and Mental Health Services Administration, n.d.). This law enabled States to request block grants to fund community mental health services for adults with SMI, and as such developed the operational definition of SMI. Serious Mental Illness or SMI is:

- The person must have one 12-month disorder other than substance use disorder that meets DSM-IV criteria and have a “serious impairment
- Global Assessment of Functioning of less than 60 (Epstein, Barker, Vorburger & Murtha, 2002).

SAMHSA defined co-occurring disorders as an individual having one or more substance related disorders and one or more mental disorders (Substance Abuse and Mental Health Services Administration, 2006). SAMHSA has two working definitions of co-occurring disorder, an individual-level definition and service definition. The individual-level definition states the person has one more substance-related disorders as well as one or more mental disorders.

At any given time, there are roughly, “10 million individuals who are diagnosed with both a SMI and Substance Abuse disorder in the United States” (Mojtabai, 2004, p. 525). In the past, treatment facilities that treated either SMI or substance abuse were broken down into two different programs and prior to 1980 the issue of servicing persons with developmental disabilities and substance abuse was not even being researched (Gillick, 2003). Of the programs that did acknowledge and recognize the co-morbidity issue in persons who have developmental disability they were mostly unrecognized, were small, and very specialized and isolated from the larger field (Gillick, 2003).
As a result of the national movements of normalization and mainstreaming, more person’s with a developmental disability are now living in community based settings with many more opportunities and fewer restrictions. More exposure to the mainstream of life’s experiences increase the risk inherently of being in the mainstream. However, there is lack of information connecting the link between persons with developmental disabilities and their difficulty living in the community (Cocco & Harper, 2002).

According to Gillick (2003) persons with a developmental disability experience the freedom found in deinstitutionalization yet increasingly experience entrapment in a society that is often not sensitive to or empathetic to their service needs (pg. 2). It is not enough to physically integrated into the mainstream of life if person’s with a developmental disability are not accepted and embraced socially and with accessible and effective mental health, health, educational, and vocational services.

**Statement of the Problem**

There is a need for evidenced based research on the treatment of co-morbid disordered in persons with Developmental Disabilities. There is a growing need to develop community based, integrated, and person centered models of effective treatment for this population.

**Purpose of the Project**

There is a lack of knowledge and education of co-occurring diagnosis for persons with developmental disabilities and substance abuse. The researcher’s personal forensic literature review showed that there is very little awareness and knowledge reflected in the research with this population. Through exploratory research, the primary purpose of this
project was to propose a best practice and evidenced based inclusive residential program designed to address both the SMI and Substance Abuse issues for persons with a developmental disability. A secondary purpose is to foster program development and evolution of effective treatment models for this population.

**Theoretical Framework**

This issue is best understood through the Ecological Systems model. The Ecological System model is based on the concepts of habitat and niche (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2010). Habitats are where individuals live that consists of physical and social settings. When these habitats are rich with resources, people tend to thrive (Hepworth et al., 2010). One task for human maturation is for humans to find their own niche in society. This is also true for the niche of this framework, which refers to the statuses occupied by the members of the community (Hepworth et al., 2010). This may not be a valid premise for individuals who lack equal opportunities because of race, ethnicity, gender, poverty, age, disability, sexual identity or other factors (Hepworth et al., 2010).

In addition to habitat, this researcher hopes to study further, the impact that the lack of facilities has on individuals with mental retardation and how they are able to find their niche. With lack of resources to flourish in their habitat, a person can never create an appropriate niche so he/she could be self-sufficient.

The overarching model for this research project was the Social Ecology Model (SEM), also called Social Ecological Perspective. This is because it is a framework, which helps the researcher examine the multiple effects and interrelatedness of social
elements in an environment. Social ecology is the study of people in an environment and the influences on one another. SEM is essentially a Systems Theory approach to understanding development that occurs in various spheres due to actions in different systems.

According to Gregson (2001), Microsystems consist of individual or interpersonal features and those aspects of groups that comprise the social identity which may include roles that a person plays (i.e. sister, brother, son, daughter, client, etc.) or characteristics they have in common. These interpersonal attributes are strong as to how an individual perceives oneself. These qualities and factors can be learned, as in membership group, but many are ingrained (e.g., ethnicity, gender, disability). In the interpersonal sphere, there are also many components of the individual, including psychological and cognitive factors, like personality, knowledge, and beliefs (Gregson, 2001). The individual in his or her own microsystem is constantly shaped, not only by the environment, but also by any encounter that that individual has with the “dominant culture”. Examples of this microsystem outside the self, includes groups of friends, family, vocational opportunities, day program opportunities, recovery groups, to name just a few.

Mesosystems are the organizational or institutional factors that shape or structure the environment with which the individual and interpersonal relations occur (Gregson, 2001), these aspects can be rules, policies, and acceptable behavioral expectations within a residential facility, or in a recovery group, or, in a day activity treatment program. Mesosystems are essentially the norm-forming component of a group or organization, and the individual is an active participant in this group or organization.
Exosystems refer to the community level influence, including established norms, standards, and social networks (Gregson, 2001). Likely, there will be many organizations and interpersonal relationships, which compose the community; this web of organizations and relationships creates the community.

Macrosystems are the culture contexts, not solely geographically or physically, but emotionally and ideologically. The ideologies of mainstreaming, normalization, and even self-advocacy are significant examples of the ideological framework that shape this research, as the proposed residential design exists within this sociological and ideological macro context.

The second model that was used to inform this project was Biopsychosocial Model. According to Hepworth et al. (2010), the biopsychosocial model expands on the ecological theory, viewing interplay between environments, physical behavioral, psychological, and social factors. According to this model, social, cultural and economic conditions have a significant measurable effect on health status and relapse prevention in the field of addiction and recovery. Addictions frequently disrupt personal or family equilibrium and coping abilities. This model acknowledges that psychiatric and/or recovery treatment alone is often incomplete and occasionally impossible to render without accompanying social support(s) and integrated person centered residential counseling services. Multi-professional, interdisciplinary team collaboration on the interrelated biological, psychological, and social issues for any given client can be an effective approach to solving complex mental health and substance problems.
Hypothesis

The major question, or issue, was the need for an evidence based, integrated, and person centered residential treatment program for persons with SMI and Substance Abuse presented as co-morbid disorders.

Definition of Terms

Throughout this project and for the purpose of this project, the term “persons with developmental disabilities and mental retardation” was used to represent a more person centered-affirming approach. Additionally, the term “substance abuse” referred to the use of alcohol and drugs that result in negative consequences for the individual that encompasses all parts of his/her life. SMI is defined as a person must have one 12-month disorder other than substance use disorder that meets DSM-IV criteria and have a serious impairment and a Global Assessment of Functioning less than 60 (Epstein, Barker, Vorburger & Murtha, 2002).

Assumptions

Persons with developmental disabilities, who live in the community, struggle to acculturate, strive to belong and are additionally challenged by having substance abuse problems. This population has additional problems finding facilities that have proper resources that incorporate substance abuse into their educational and treatment model. Treatment facilities/programs lack the knowledge; education and experience of faculty to be able attend to the needs of persons who have dual diagnosis with both substance abuse and mental retardation.
**Justification**

Normalization and mainstreaming are philosophical as well as policy based values that in essence that that every person with a disability deserves the opportunity to live life in mainstream of society, and to live a life that is as normalized as possible. Serious Mental Illness and substance abuse issues are serious health and mental health issues facing everyone in society, disabled or not. Treatment for these disorders should be a right not a privilege in our society, and that should be a right for persons with developmental disability as well. Denial of serious mental illness and substance abuse in this population has devastating consequences at multiple levels. The NASW code of ethics mandates that we as social workers commit to addressing discrimination and oppression and this project clearly advocates for a more inclusive and effective approach to this serious mental health issue.

This project is based on the core beliefs and values of the social work profession. According to the social work code of ethics, social workers value competence (National Association of Social Workers, n.d.). Social Workers who have knowledge about and/or working with persons that have developmental disabilities and substance abuse the social worker would be able to serve this population with expertise. Thus, working at the core value of social work however, if the social worker does not have the knowledge, there should be local treatment facilities where the social worker can refer the individual to so that the social worker is not working out of his/her own scope (National Association of Social Workers, n.d.).
Social workers should have respect and dignity for their clients. This change should occur when social workers strive to ensure access to needed information is available (National Association of Social Workers, n.d.). By providing information to individuals, it allows them to exercise self-determination, allowing them to experience learn dignity and worth. Social workers respect and give dignity and respect to the worth of the person (Gillick, 2003). This dignity and worth is the contributing factors of the body of research for the project, which will contribute to the knowledge and education that supports these values and principles.

**Delimitations**

One limitation to this research is the availability of information found on persons with mental retardation and substance abuse. Just as limited is the lack of treatment facilities in Northern California. These two combined limitations are what this researcher is hoping to increase with this project. It is imperative to create a large body of research that draws the connection for a need to work with dual diagnosis clients. This larger body of research can be used to establish more treatment facilities that serve persons with development disabilities and substance abuse. This researcher hopes to create another step in research so that both of these limitations can eventually be addressed more fully.
Chapter 2

REVIEW OF THE LITERATURE

Introduction

There is a substantial and growing body of research on developmental disability, particularly, mental retardation, and an equally impressive literature base on the treatment of substance use and abuse in the general population. However, there is a paucity of research on the treatment of person’s with a developmental disability, specifically, mental retardation who also have a history of substance use, abuse, and dependence.

Historically, the incidence of mental illness in general, and substance abuse in particular have been either ignored or even denied by the established psychiatric community. Given this professional bias, it is understandable then that the lay population would also deny the existence of mental illness and particularly, substance abuse in this population.

Yet, as this literature review and thesis project document, there exists a problem with use, abuse, and dependence on drugs and alcohol in individuals, specifically those with a Developmental Disability. For the purposes of this literature review, and thesis project, the subcategory of mental retardation will be used. Although there is a proposal to remove the term mental retardation from the proposed The Diagnostic and Statistical Manual of Mental Disorders (DSMV) and replace it with the term intellectual disability, the term will be used in this project for diagnostic accuracy purposes. Also, although the clinical category of Developmental Disability includes conditions like learning disability, autism spectrum disorder, seizure disorder, cerebral palsy, and significant neurological
disorders, due to the fact that most of the literature focuses specifically on mental retardation, that subcategory was used.

Given that there is a societal and even professional psychiatric denial of the possibility of co-morbid presentation of mental illness and mental retardation, it is obvious there is an equally disturbing denial of the presence of what might be called a tri-diagnosis of mental retardation, a specific mental illness, and a history of substance use, abuse and dependence. As the literature review documents, there has only been a recent awareness and acceptance of substance abuse in this population, and as such there is an even larger absence of research regarding “best practice” or “evidenced based” treatment protocols or programs that serve this specialized population. In this chapter, the separate bodies of research on mental retardation and substance abuse are presented to establish the conceptual base, and then the specific challenges of treatment of mental illness and substance abuse in persons with mental retardation is considered. Finally, a case is made for the need to design and disseminate a best practice recovery program model that incorporates the 12-step methodology, for persons with mental retardation and substance use, abuse, and even dependence.

**Definitions and Perceptions of the Population**

As stated previously, persons diagnosed with mental retardation is the phraseology that is incorporated throughout this thesis project. However, there are many different terms that are used in the literature and the general population that have been used to inappropriately describe this population including such terms as, intellectual disability, learning disability, earning difficulty, mentally subnormal, severely mentally
subnormal, mentally impaired, mentally defective, spastic, idiot, imbecile and moron (Gates, 2003). Many different etiological factors contribute to potential expression of what is diagnosed as a developmental disability. Genetic inheritance states that an individual’s genes are blueprints that are passed down from mother and father through reproductive cells. There are at least three types of disability that derive from genetic governance; gene inheritance, chromosomal abnormality, and spontaneous mutations (Hughes & Rycus, 1998). However, genetics only accounts for a small proportion of individuals who are diagnosed with a developmental disability. Most pregnancies that involve genetic abnormalities end in miscarriage (Hughes & Rycus, 1998). Children, who have been hit by a direct blow or assault to the head particularly, especially to the brain or central nervous system, are most at risk of neuro-developmental etiology of developmental disability. Common causes of this trauma are falling on concrete, auto accidents and child abuse such as shaken baby syndrome (Hughes & Rycus, 1998).

Exposure to toxic substance abuse through ingestion by a pregnant woman can seriously affect the growth and development of the fetus in utero. This can occur through ingestion of Teratogens or toxins such as alcohol, tobacco, illicit drugs, and fumes from materials of gas, glue, paint and varnish (Hughes & Rycus, 1998). According to the US National Research Council, three percent of developmental disabilities are directly related from environmental exposure industrial chemicals and another 25 percent of developmental disabilities arise because of interaction between environmental (Grandjean & Landrigan, 2006).
Age is another factor. If the mother becomes pregnant before 15, or is older than 35, the child has a greater risk of having a developmental disability due to the prematurely and/or chromosomal implications (Hughes & Rycus, 1998). Another factor is complications during pregnancy and birth. Rhesus factor (RH) incompatibility occurs when the fetus is Rh+ factor and the mother is Rh-factor, which causes antibodies to build in the mother and attack and destroy the red blood cells of the fetus. When a child is born prematurely, their lungs are not developed. Therefore, the baby cannot breathe properly and the brain lacks oxygen, which can be a factor in the cause of a developmental disability. Prolonged and difficult labor can have a negative impact on the child. An example of this is the umbilical cord being wrapped around the baby’s neck. Viral and bacterial infections such are Rubella and German Measles, if contracted by the mother when the child in womb during the first trimester, affect the brain and vital organs. Immunization helps to reduce these diseases but there are still individuals who have not been immunized. Venereal diseases such as syphilis and herpes are associated with fetuses being born with a developmental disability (Hughes & Rycus, 1998).

Child neglect and abuse are linked to an increased risk of developmental disability (Hughes & Rycus, 1998). Poor nutrition, lack of medical care, exposure to toxins, and high incidences of drug and alcohol abuse in parents all account got abuse and/or neglect (Hughes & Rycus, 1998).

A functional definition developmental disability was established and adopted by the federal government in 1978 and most states, including California, incorporated this definition into their legislation. The definition states that developmental disability is a
condition that yields substantial impact of adaptive functioning and that is a chronic
condition, that specifically:

- Was caused by mental and physical impairments or both
- The Symptoms of which appear in the individual by the age of 22
- Results in difficulty in adaptive behavior in the areas of: self-care, receptive
and expressive language, learning, mobility, self-direction, and the capacity to
live independently and to be self-sufficient.

(Hughes & Rycus, 1998, p. 6)

The most important part of this definition is the age. Most definitions state that in
order for a person to be diagnosed with a developmental disability they must experience
one or more of the symptoms and be diagnosed before the age of 22 (Hughes & Rycus,
1998). “There is a three pronged definition for diagnosis and definition for conditions of
mental retardation: deficits in intellectual functioning, deficits in adaptive behavior, and
onset of these deficits during the developmental period” (Tasse, 2009, p. 1).

The Diagnostic and Statistical Manual of Mental Disorders (2000) forwards a
“clinical definition” of mental retardation in the Diagnostic and Statistical Manual of
Mental Disorders (DSM-IV-TR) stating that the intellectual function of a person with an
IQ of 70 or below before age 18 years and who on currently, is impaired in adaptive
functions. The DSM-IV-TR operationalizes the diagnosis of mental retardation using
specific categories according to the IQ and adaptive functioning levels of the individual.
For the list of four different categories that DSM list based on an individual’s IQ see
Appendix B.
There are many different definitions and reasons why a person has developmental disabilities. It is a good reason to understand how and why a person has developed their disability so that resources can be made available to him/her, as well as the type of resources that are applicable. Through all of these different variances, a person can be able to infiltrate, acculturate into society and gain treatment or resourced based on the severity of their disability. The less restrictive way of living is the best way for a person to live.

**Community Living**

Due to legislation like PL 94-142, (the right to education that is individualized and in the least restrictive setting), Sect. 504 (the right to full employment), and American Disabilities Act Association (American Disabilities Act, 2005), persons with a developmental disability are now educated in the community mainstream. Living in the least restrictive environment is not only the best way of living it is a right and the law. They are able to work and live in that same community mainstream with opportunities for person-centered care and normalized life experiences.

Employment is a primary goal for persons with mental retardation. It is a positive psychosocial and economic benefit to the employee who gains a sense of purpose, accomplishment and the ability to gain friendships as well as increasing ones financial independence (Howarth, Mann, Huafeng, McDermott & Butkus, 2006). Individuals who are employed can maintain a job for the length of time that individuals in the ‘general’ public work (Howarth et al., 2006).
Living in the community exposes individual to different opportunities. There is a myth that persons with mental retardation do not drink or use drugs, however, that is simply a myth. Individuals with developmental disability and intellectual disability who live in communities experience greater individual freedom and participate in more social activities such as association with family and friends (Horner et al., 1988; Stancliffe & Lakin, 1998; Lakin & Stancliffe, 2007), Individuals of this population do use alcohol and drugs (McGillicuddy, 2006). A study by DiNitto and Krisef (1983) illustrated that usage of drugs and alcohol is apparent persons with mental retardation are less likely to use than the general population but individuals with mental retardation have a higher likelihood to abuse drugs and alcohol (as cited in McGillicuddy, 2006).

Multiple Risk Factors

There is a connection between persons with mental retardation, substance abuse and poor community functions. Several factors can be further explored for this link. First, as was outlined in the aforementioned section, more people who have been diagnosed with mental retardation are living in the community. This increases the individual’s social practices, both negative and positive in their environment, which can expose them to higher risk. Second, persons with mental retardation experience greater difficulty with substance abuse relative to those individuals in the general population (Cocco & Harper, 2002). Individuals with mental retardation engage in substance misuse and experience negative consequence based on their misuse (as cited in Cocco & Harper, 2002). Cocco and Harper (2002) stated that there is a connection between substance use and living in the community and that these factors are indicators of further research that
needs to be administered. These factors collectively state that there is a need for further exploration for the link between individuals with mental retardation and substance abuse. A lack in research exists between these groups.

**Substance Abuse**

Substance abuse is a growing problem in society. In 1991-92, 30% of all US citizens used marijuana, yet this number increased in 2001-02 to 35.6 percent. Overall, marijuana use became stable, but abuse and dependence rates increase, as well as abuse to prescription drugs has increased (“Alcoholism & drug weekly”, 2004). Since 1990 there has been a tenfold increase in prescription drugs such as opioids in the United States (“Alcoholism & drug weekly”, 2004). In 2007, there were 21 million prescriptions for opioids pain killers (“Alcoholism & drug weekly”, 2004). Emergency room visits from 2004-08 for opioid misuse doubled (“Alcoholism & drug weekly”, 2004).

**Substance Use, Abuse, and Dependence**

According to the DSM IV-TR, there are three different patterns of what used to be called addiction. They are substance use, substance abuse, and substance dependence (APA, 2000, p. 191). Substance use refers to the behavior of drinking or drug taking, substance misuse is behavior that refers to use of drinking or drug taking with negative consequences and substance abuse meets medical or psychiatric diagnosis (Cocco & Harper, 2002). According to DSMIV-TR, substance is defined as “drug of abuse, a medication, or a toxin” (APA, 2000, p. 191). Substance dependence impacts areas of cognitive, behavioral, and physiological symptoms. The negative symptoms related to these factors occur and the individuals still continues to use the substance (APA, 2000).
Criteria for Substance Dependence:

1. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect
   b. Markedly diminished effect with continued use of the same amount of the substance

2. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for the substance
   b. The same substance is taken to relieve or avoid withdrawal symptoms

3. The substance is often taken in larger amounts or over a longer period than was intended

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.

5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.

6. Important social, occupational, or recreational activities are given up or reduced because of substance use

7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance. (APA, 2000, p. 197)

Substance Abuse is a “maladaptive patterned surrounding substance use that shows through recurrent and significant adverse consequences that relate to repeated use.
of substance” (American Psychiatric Association [APA], 2000, p. 198). According to DSM-IV-TR, substance abuse is repetitive and significant adverse consequences that relate reoccurrence use of substance (APA, 2000). Criteria for Substance Abuse must meet the below listed criteria for within a 12-month period:

1. Recurrent use of substance that hinders the individual’s ability to meet his/her major obligations at work, school or home
2. Recurrent use of substance in situations that are physically hazardous
3. Recurrent use of substance that causes legal problems
4. Continuing to use even regardless of the impact the substance abuse has created on the individual’s social or interpersonal problems.
5. Symptoms have never met the criteria for Substance Dependence.

(APA, 2000, p. 199)

**12-Step Programs/Alcoholics Anonymous**

Alcoholics Anonymous (AA) currently has 2 million members with over 100,000 groups spread over 150 counties. Bob Smith, MD and Bill Wilson founded AA on June 10, 1935. The twelve-step program was modeled after the Oxford Group, which was a religious sect that attempted to recreate the practice of the first century Christianity (Gross, 2010). AA toned down the religious doctrine to accommodate non-religious believers and believers other than those of Christianity faith. Today AA is not affiliated with religion; however, it makes reference to God and/or a higher power (Frost, 2003, p. 1).
According to Alcoholics Anonymous website (2011) AA has many core values (“Information on alcoholics anonymous”, 2008). There is no solicitation or recruitment from its members. To join a person simply needs to have a passion to stop drinking. The core of AA is a community group meeting. AA has two types of meetings: open and closed. An open meeting is available to the public, yet a closed meeting is only available to those individuals who believe they have a drinking problem. In these meetings, there are never case notes of members or meeting minuets. AA does not require its members to attend a specific number of meetings. The only purpose of AA is to help individuals stay sober. This is done through being completely abstinent from alcohol. AA’s focus is one day at a time, which its members’ focus on time increments of 24 hour periods. AA believes that alcoholism cannot be cured, but arrested (Frost, 2003, p. 1). The belief is that alcoholism is an illness that affects both a person’s mind through a mental obsession and physically by an individual being physically sensitive to alcohol (Frost, 2003).

AA incorporates 12 steps into its program:

1. We admitted we were powerless over alcohol-that our lives have become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God; as we understood Him.
4. Made searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being that exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all people we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

   (Gross, 2010, p. 2362).

AA incorporates 12 traditions into its program:

1. Our common welfare should come first; personal recovery depends upon A.A. unity.

2. For our group purpose there is one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.

3. The only requirement for A.A. membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting out groups or A.A. as a whole.
5. Each group has but one primary purpose-to carry its message to the alcoholic who still suffers.
6. An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every A.A. group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. A.A., as such, ought never to be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never to be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.
12. Anonymity is the spiritual foundation of all our traditions, ever rending us to place principles before personalities (Gross, 2010, p. 2362).

The efficacy of AA has been linked to one of the few treatment models that are related to a positive outcome. Twelve Step programs have been proven to be more
effective than cognitive behavior skills training when working with substance abusers (McCrady & Morgenstern, 1993; as cited in Straussner & Bryne, 2009). There has been research through different studies that attending AA meetings increase an individual’s chances of being successful in abstinence (McCrady & Morgenstern, 1993; as cited in Straussner & Bryne, 2009). Bottlender and Soyko (2005) studied a group of 103 alcoholic dependent individuals. The study showed that those who participated in self-help groups fared better than those who did not (as cited in Straussner & Bryne, 2009). Those individuals who sporadically attended the self-help groups had higher rates of relapse (Straussner & Bryne, 2009). Another study by McCrady et al. (2004) included 90 men dealing with alcohol related issues resulted in a correlation between the men’s drinking outcome and their AA attendances (as cited in Straussner & Bryne, 2009). The length of abstinence is also directly related to AA. Bond et al. (2003) stated that an increase in AA participants of 12-36 month post treatment would increase the chances of an individual’s abstinent at three years by 35 percent (as cited in Straussner & Bryne, 2009).

Specific activities in AA work as a predictor of an individual’s success. The two activities that are highly associated with abstinence are having a sponsor and doing service (Straussner & Bryne, 2009). Witbrodt and Kaskutus (2005) determined that these two activities are predictors of abstinent (as cited in Straussner & Bryne, 2009). The other did not state what “doing service” exactly is but one could assume that it would mean being involved in the meeting such as reading the 12 steps out loud or collecting donations, simply doing extra in the AA meeting besides attending.
AA success rate is only five to ten percent, not the 50-75% that AA states (as cited in Straussner & Bryne, 2009). The 50-75% success was proven as antiquated and based on the fact that AA members in the 1940s were preselected (Straussner & Bryne, 2009). However, it is a popular method in treatment.

AA works because it attempts to enable change. These changes occur through different paradigms. “There were various paradigms; such as social support, positive psychology, working through transition, grief, and loss issues, spirituality and religion” (Straussner & Bryne, 2009, p. 354). Social support changed in a positive way for individuals. Through AA, individuals learned to utilize the AA support network where individuals can ask for help from individuals who can relate to each other.

Zemansky examined positive psychology through optimism, gratitude, meaning and purpose in life, subjective well-being, spirituality, and the process of recovery among active members of AA (as cited in Straussner & Bryne, 2009).

**The Concept of Co-Morbidity and “Dual-Diagnosis”**

Individuals with dual diagnosis may be able to utilize AA to its fullest potential. Individuals with dual diagnosis who participate in 12-step programs have improved outcome (Bogenschutz, 2007, as cited in Straussner & Bryne, 2009). A study by Timko and Sempel (2004), of 230 individuals with dual diagnoses found that great attendance in the 12-step program was associated with better psychiatric, outcomes and longer duration in the 12-step programs was associated with better alcohol outcomes (as cited in Straussner & Bryne, 2009). Another study that analyzed 112 individuals with dual diagnosis who had been placed into one of two treatment groups, Cognitive Behavioral
Therapy (Smart Recovery) or a 12-step program documented that the 12-step program was more effective in decreasing alcohol use and increasing social interaction (Straussner & Bryne, 2009).

Terms that are associated with mental disorders come from DSM-IV-TR. They can be seen throughout the disciplines of social service, medical, and behavioral health fields. Mental disorder is defined as intense emotions, thoughts and/or behaviors that occur over an extended period of time that result in impairment in functioning (Substance Abuse and Mental Health Administration, n.d.). Major relevant disorders for COD include schizophrenia, other psychotic disorders, mood disorders, anxiety disorders, and personality disorders.

Mental disorders have characteristics of:

1. The nature and severity of symptoms
2. The duration of symptoms
3. The extent to which symptoms interfere with one’s ability to carry out daily routines, succeed at work or school, and form and keep meaningful interpersonal relationships.

(Substance Abuse and Mental Health Administration, n.d.).

Substance Abuse and Mental Health Service Administration state that serious mental health is defined by a person is over 18, currently or in the last year has a diagnosable mental behavior, emotional disorder of sufficient duration to meet the requirements of DSM-IV-TR that result in impairment, which substantially interferes or limits of one or more daily functions. These daily functions/activities are defined basic
daily living skills such as eating or maintaining personal hygiene, instrumental living skills such as, negotiating transportation or taking medicine as prescribed, and having the ability to function socially, familial, and academically (Substance Abuse and Mental Health Administration, n.d.).

Co-Occurring Disorders (COD) includes both co-occurring substance-related and mental disorders. Individuals with COD typically have one or more substance-related disorder along with one or more mental disorder. There are terms that are used when discussing the course of COD, which are remission, recovery and relapse (Substance Abuse and Mental Health Administration, n.d.). Each specific course has distinct characteristics. Remission there is an absence of impairment due to either the substance use or mental disorder. Recovery states an individual is gaining increased self-awareness and developing skills for sober living along with following a program of change (Lowinson et al., 1992; as cited in Substance Abuse and Mental Health Administration, n.d.). Relapse is when an individual returns to active use of the substance or the return of having disabling psychiatric symptoms that relate to a non-addictive mental disorder (Substance Abuse and Mental Health Administration, n.d.).

In a meeting with the National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders, the National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors created a conceptual framework that classifies clients into four distinct care base quadrants (Substance Abuse and Mental Health Administration, n.d.). The four quadrants are:
1. Low addiction/low mental illness severity
2. Low addiction/high mental illness
3. High addiction/low mental illness
4. High addiction/high mental illness

( Substance Abuse and Mental Health Administration, n.d. )

The model provides and understanding to COD and the levels of coordination that treatment facilities need to use in helping their clients. SAMHSA has illustrated 12 overarching principles in working with individuals who have COD. These principles help to guide and create a foundation for planning, delivering, financing and evaluating services and systems of care ( Substance Abuse and Mental Health Administration, 2006 ) theses principles are:

Principles that guide the systems of care for consumers with COD include:

Principle 1 states that throughout all behavior heath settings COD is to be excepted and system planning much occur to address the needs of the consumer in aspects of policies, regulations, funding mechanisms and programming ( Substance Abuse and Mental Health Service Administration, 2006 ).

Principle 2 states a mingled system of both mental health and addiction services accentuates continued and quality of all interested parties, consumers, providers, programmers, funders and systems ( Substance Abuse and Mental Health Service Administration, 2006 ).

Principle 3 is a system of care that is all-inclusive must be able to be penetrated through multiple points and have the perception as caring and accepting by the consumer.
Principle 4 states there should be options for consume and there is no right model for systems of care and,

Principles 5 and 6 states that there must be collaboration that reflections the importance of partnership between science and serve between professionals in primary care, human services, housing, criminal justice, and education.

Principle 7 it is to be expected that COD may be diagnosed in any person and treatment facilities should see to it that this assumption is infiltrated into all aspects, screening, assessment, and treatment planning.

Principle 8 states that COD is considered primary in treatment.

Principle 9 examines the provider’s attitude and states empathy, respect and the belief in the individual’s ability to recover.

Principle 10 documents that treatment should be individualized for each consumer.

Principle 11 states that special needs of children and adolescents need to be created for all aspects of treatment and delivery.

Principle 12 states that the community contributes to the recovery of the consumer with COD (Substance Abuse and Mental Health Administration, 2006, p.5).

These principles outline the service and delivery of individuals with COD. Individuals with COD can enrich the community but must be given the opportunities of great treatment facilities that are trained to serve in this special population.

There is a need for integrated services. There is overarching literature that suggests a need for integration of services provided to consumers of COD. This need is
Based on high community rates of COD, when each disorder is untreated there is a negative impact associated with each disorder, and a majority of treatment facilities for OCD are unprepared to manage both substance abuse and mental disorders of the consumers (as cited in Rosenthal, 2005). There is an optimal design of integrated services for individuals seeking treatment with OCD that includes meeting stage-specific needs of the consumer, a treatment team that oversees all aspects of care making certain care is accessible and involves various ranges of services (Rosenthal, 2005). This range of services includes but is not limited to medication for addiction as well as mental illness, case management, motivational interviewing, counseling, COD-adapted evidence-based therapies such as cognitive-behavior therapy and relapse prevention, 12-step recovery meeting that include dual recovery, and psychosocial rehabilitation (as cited in Rosenthal, 2005).

**Integrated Residential Recovery Program for Persons with Mental Retardation**

For this project, the population that is being focused on is individuals with mental retardation who are suffering from substance abuse. This is a less commonly recognized population, which lacks trained professionals to serve in this population.

**Mental Retardation and Substance Abuse**

In the general population, 52 percent of adults have used alcohol regularly and six percent have used illicit drugs (as cited in Burgard, Donahue, Azrin & Teichner, 2000). Individuals with mental retardation make up two percent of The United States (Burgard et al., 2000). Deinstitutionalization has been a positive experience for individuals with mental retardation. This population has increased participation in community life since
the deinstitutionalization era (as cited in Slayter, 2010). Individuals are able to live in a less restrictive experience, but not without consequences. Individuals who live in the community, experience increased exposure to substances, and with compounded characteristics of this population, may also increase their susceptibility to substance abuse.

Factors that relate to stigmatization are intrapersonal and interpersonal variables. Such variables include but are not limited to low self-esteem, impaired regulatory behavior, and a desire of social acceptance to peer pressure. Environmental factors are linked to substance abuse in persons with mental retardation. These environmental factors include negative role models, inappropriate living conditions and large amounts of free time. Lastly, cognitive limitations such as memory deficiency and illiteracy may increase substance misuse (as cited in McGillivray & Moore, 2001).

It is this freedom that has allowed individuals with mental retardation to become exposed to substances that create potential for developing substance disorders, (as cited in Slayter, 2010). However, there is no empirical evidence that makes this link that deinstitutionalization is a consequence to individuals with mental retardation and substance abuse (Lottman, 2001).

Very little research is in the literature on the identification, assessment, and treatment of persons with mental retardation and substance abuse. Yet, there is a speculation on the link between this population and substance abuse. Just as in the general population, many persons with mental retardation develop substance misuse while in elementary school (as cited in Cocco & Harper, 2002). Individuals with mental
retardation have a higher chance of developing substance abuse issues simply because of there being g stigmatized in their community-based activity such as school and work. Individuals that feel stigmatized may use substances as a coping method (as cited in Slayter, 2010).

Overall, the data alludes to the fact that individuals with mental retardation possibly drink less than those in the general population (McGillicuddy, 2006). In an early study, Krisef and DiNitto (1981) reported that 52 percent of the respondents divulged a lifetime of alcohol use (as cited in McGillicuddy, 2006). In another survey, alcohol and marijuana use in four different samples was examined. They were, those residing independently, those receiving living assistance, those residing in the inner city and those recently discharged from an institution. Within the sample of the study, twenty-five percent stated they used substances, and of that twenty five percent one third were grouped as abusers (McGillicuddy, 2006). However, there is research that stated, individuals in this population have a tendency to binge drink more often than those in general population (Cocco & Harper, 2002).

Individuals in this population have negative consequences due to substance abuse. The specific consequence that relate to substance abuse focus around physical and psychiatric problems, legal problems, and interpersonal problems and sexual promiscuity, being late for work (Cocco & Harper, 2002).

In a survey of thirty young adults with mild mental retardation with offending behavior who self-reported alcohol or other drug use, which resulted in their involvement in the criminal justice system, 60 percent of the sample reported that they had been under
the influence of alcohol or drugs at the time of the offense (McGillivray & Moore, 2001). Data showed that offending behavior is likely to occur from the dual diagnosis of mental retardation and substance abuse (McGillivray & Moore, 2001).

In another study by Krisef and DiNitto (1981), they reported a high rate of negative consequences in individuals of mental retardation. The data shows that 63 percent of substance abusers in the mental retardation population state they have job related problems. These numbers are for negative consequences are at levels higher that found in the general population (McGillicuddy, 2006).

**Substance Abuse Treatment Facilities for Individuals with Mental Retardation**

There is a lack of resources for a person who is mentally retarded and seeking treatment for substance abuse. There is even less empirical research on the utilization and efficacy of chemical treatment programs. Krisef and DiNitto (1981) surveyed 100 Associations for Retarded Citizens (ARC) and 100 Alcohol Treatment Program (ATP) in cities relating to alcohol problems and treatment for clients with mental retardation. Research showed that ARC had 23 percent of their client alcohol-related arrest and ATP had 55 percent of their clients were under the influence when they were arrested suggesting this data shows that persons with mental retardation do not come into treatment programs until the problem is severe similar to the general population (Lottman, 2001).

Agencies that serve this specialized population may need to be different from those that serve the general population. The lack of study and treatment facilities is surprising based on the knowledge that there is a need for this type of program. A study
has shown that the mentally retarded cannot have their needs meet by programs
developed for the general population (McGillicuddy, 2006). McGillicuddy and Blane
(1999) developed and evaluated two separate ten-week interventions that followed two
specific goals:

1. Education of the mentally retarded client about the dangers of cigarettes,
alcohol, and illicit drugs.
2. Provide participants a behavioral repertoire that he/she could use when being
confronted with the above-mentioned substances (McGillicuddy & Blane,
1999, p. 874).

The intervention was focused around increasing the individual’s assertiveness
skills such as ways to refuse request as unhealthy or risky involving substance abuse.
The second intervention group, modeling intervention, focused on the client’s ability to
distinguish between good and bad role models, and chose from desirable behavior within
substance use. Both interventions resulted in increased knowledge about substance use
and resulted in skill enhancement. However, neither group were over achieving in
delayed treatment on substance use further research could be need and/or this could be
due to low levels of abuse found in the sample population (McGillicuddy, 2006).

Speculations for treatment facilities are made in this population because there is a
lack of empirical data. There is a consensus that treatment programs should be different
based on this population’s decreased literacy, slower learning and short-term memory
deficits (McGillicuddy, 2006).
In their study, McGillicuddy and Blane (1999) stated the reason why there is not a vast amount of empirical research on this population is for two reasons. First, individuals with MR are a protected class; therefore, getting a consent form is labor intensive. He/she may be illiterate and may need to have addition effort in helping comprehend forms/paperwork. Also, consent forms that are from a non-disabled person representing the MR individual are necessary (McGillicuddy & Blane, 1999). Another reason they stated why studies have not been conducted in individuals with MR perception was that his/her cognitive ability is distorted or limited. Therefore, he/she cannot supply accurate information.

McGillicuddy and Blane (1999) discussed two studies that recruited participations from local community service agencies. Study 1 included 122 individuals with MR, which were questioned regarding their personality characteristic, substance use, skills to avoid drugs and alcohol. Study 2 included 84 participants that were randomly assigned to different prevention programs. The three different prevention programs were, assertiveness building, modeling and social inference or delayed treatment, control condition (McGillicuddy & Blane, 1999). Both studies showed that participants improved their knowledge about substance and increased their skill set in the short-run.

Another study conducted through the greater Cincinnati area via a structured telephone survey of generic substance abuse services were questioned if they are or are willing to serve the mentally retarded population. Of the agencies served, 79 percent of those agencies surveyed stated they are willing to serve this population. Yet, of that
population, each agency stated none of them had extensive training and lack experience dealing with this specific population (Lottman, 2001).

The agencies that did accept individuals with mental retardation differed from agencies that did not accept this population in their perceived difficulty of integrating the client into their treatment program and the ability to received payment through Medicaid (Lottman, 2001). Of agencies that accepted clients that are mentally retarded they were asked to complete a 24-item Likert scale ranking barriers to service delivery specifically for their mentally retarded patients.

The barrier that ranked the highest was lack of staff training in this specified population. Barriers that rank the lowest were client’s behavior and difficulty communicating. Results of this survey suggest service accessibility in theory is not equal to service utilization in practice (Lottman, 2001).

Another barrier that is needs to be considered is when treatment programs use practices that involve individuals adapting to the community. Delany and Poling (2001) examined a program in Maine that uses Alcoholics Anonymous in their program, and stated that individuals with mental retardation may feel threaten to this basic community adaptation (as cited in Lottman, 2001).
Chapter 3

METHODOLOGY

Research Design

The research design that was used for this study was the Exploratory Research Design (Babbie, 1989). Exploratory Research is a type of research conducted for a problem that has not been clearly defined, like the best practice design of a residential facility for the treatment of person with a developmental disability, which have co-morbid disorders. Exploratory research often relies on secondary research such as reviewing available literature and/or data, or qualitative approaches such as informal discussions with consumers, residential providers, and formal approaches through in-depth interviews and focus groups. The results of exploratory research are often qualitative and that was the intent of this project. This methodology is also at times, referred to as a grounded theory approach to qualitative research interpretive research, and is an attempt to unearth a theory from the data itself rather than from a predisposed hypothesis.

Babbie (1989) identified three purposes of social science research. The purposes are exploratory, descriptive and explanatory. Exploratory research is used when problems are in a preliminary stage. Exploratory research is used when the topic or issue is new and when data is difficult to collect. Exploratory research is flexible and an address research questions of all types (what, why, how).
Variables

The independent variable for this research was proposed design model for a best practice, research based integrated residential recovery program for persons with a developed disability and co-morbid mental health and substance abuse issues. The program design was informed by the existing data as well as interviews with providers or authors identified in the literature, or in a snowball type methodology in which one contact led to another contact in the field or recovery or developmental disability or both.

The dependent variable was the evolution, or critique of the proposed residential program. Although it was beyond the scope of this thesis project to fully evaluate the proposed residential program that is intended as a follow-up research project by Dr. David Demetral and this researcher. The elements of the proposed program have been evaluated, but the total programs design evaluation was beyond the scope of this present project.

The design method for this research project is exploratory-based (Rubin & Babbie, 2008). There is lacking, empirical data for facilities/programs that serves that population of persons with developmental disabilities and substance abuse. The main goal of this project is to describe current available treatment facilities, as well as focus on developing a best practice for treatment facilities working with this population.

The hypotheses for this project are; What makes an elite treatment facility to serve persons with developmental disabilities and substance abuse?
Data Gathering Procedure

The information for this exploratory project was gathered through a forensic literature review of empirical data of persons with mental retardation and substance abuse and any treatment facilities that serve this population. The researcher examined literature and program designs on this topic in order to develop a Best Practice design model of a residential program already written information on this topic. Using the data bases of EBSCO, Wilson, Info Track and Sacramento State Scholar Works Repository, the key subjects searched will be mental retardation, substance abuse, substance use, substance disorder, alcohol, drugs, drug, adults, adult, dual diagnosis, co-occurring mental health disorder, treatment, treatment facilities, intelligence disabilities, intellectual disability, mental illness, mental health disorder, learning disabilities, cognitive functioning from articles published. The researcher has developed a tool, Literature Review Template to help record, sort and evaluate the research that has been collected (Appendix A).

Protection of Human Subjects

Due to the fact that there is no human subject and this project is solely a forensic literature review, there was no direct contact with human subjects. The researcher will do a divergent literature review on existing treatment facilities. However, literature that was used in this project did not come directly from one specific facility/program. The literature used in this project has already been published within the last ten years from facilities/programs, articles from scholarly journals and books that discuss current and relevant material for individuals with development disabilities with substance abuse and addiction within the United States of America.
This researcher is not affiliated with any such treatment facilities so there is not a conflict of interest. There will be no contact with the patients/clients of the treatment facility therefore their privacy and safety is in no way compromised. There will not be any contact made to human subject such as, treatment facilities and/or programs due to the main focus of this project is to use data already found through a forensic literature review. This writer will only focus on data that has been previously collected through published work. Therefore, there is no risk or harm.

The Research Committee of the Social Work Division at University of California, Sacramento, deemed this project as exempt and the human subject’s approval number is 10-11-070.
RESULTS

The purpose of this project was to propose a best practices residential program for persons with a developmental disability and co-morbid (mental health and substance abuse) disorders. In order to insure that the proposed program did meet a best practices standard of care the guidelines established by the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment were used to evaluate every component of the proposed program.

Treatment Improvement Protocols (TIPS) were developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services (DHHS). What is represented in TIPS are best practice guidelines for the treatment of substance use disorders. CAST draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. It was TIP 42 “A Treatment Improvement Protocol: Substance Abuse Treatment for Person’s with Co-Occurring Disorders” that was used by this researcher as the best practices “benchmark” to measure all of the elements of the proposed residential treatment program against.

The consensus panel of CSAT developed a list of guiding principles to serve as fundamental building blocks for any program that offers services to clients with COD (Co-Occurring disorders). The following six guiding principles were used to frame the
proposed residential program for DDCODC clients (Developmentally Disabled Co-Occurring Disordered Clients).

Guiding Principles:

1. Employ a recovery perspective
2. Adopt a multi-problem viewpoint
3. Develop a phased approach to treatment
4. Address specific real-life problems early in treatment
5. Plan for the client’s cognitive and functional impairments
6. Use support systems to maintain and extend treatment effectiveness

(HHS Publication, 2004).

Employ a Recovery Perspective

There are two main features of a recovery perspective: It acknowledges that recovery is a long-term process of internal change, and it recognizes that these internal changes proceed through various stages.

1. Adopt a Multi-Problem Perspective

The DDCOD client generally has an array of mental health, medical, substance abuse, legal, family, and social problems. Treatment must address housing, work, recreational and holistic life style options.

2. Develop a Phased Approach to Treatment

Many clinicians view clients as progressing through phases including engagement, stabilization, treatment, and after care.

3. Address Real life Problems
The growing recognition that COD arise in a context of personal and social problems, with a disruption of personal and social life gives rise to the need for case management; psycho-social rehabilitation, problem solving, decision making, and life skills.

4. Plan for the Client’s cognitive and Functional Impairments

The manner in which interventions are presented must be compatible with the client needs and functioning. Impairments like mental retardation call for relatively short, highly structured, repetitive treatment sessions that focus on practical life problems. Gradual pacing, visual aids, icon based materials, repetition, and behavioral techniques like reinforcements and role-plays, along with cognitive behavioral strategies recommended.

5. Use Support systems

Mutual Self-Help based on the alcoholic anonymous model.

**Specialized Residential Facility**

This researcher identified a specialized residential facility located in a small rural community in Northern California that represents a “best practice” approach to advanced treatment of co-occurring disorders in persons with a developmental disability. For purposes of confidentiality, and to protect the copyright privilege of the facility and its materials, the name of the facility has changed, and the elements of the program have been altered wherever possible to prevent copying of the program design or elements without approval.
This writer has established that Autus Treatment Facility (ATF), a treatment facility that serves developmental disabled adults who are in recovery, meets, and even exceeds the parameters established by the CSAT as a “best practice model” program for this specific population. The ATF meets specific guidelines that are best suited to meet the needs of developmentally disabled individuals in recovery through their own specialized residential recovery program. Clearly, the six guiding principles established by US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, and Center for Substance Abuse Treatment are present in every aspect of ATF’s curriculum and programs. These principles, or best practices, are referenced throughout this chapter as ATF’s program elements are described.

ATF is located in a small rural community in Northern California and has been operating for three years. The facility focuses on recovery through a 12-Step Program. The facility is a co-ed house that has space for six residents; each bedroom has room for two residents. ATF has three licenses: Business, Community Care, and Vendor. The program applied for was granted a license with Community Care Licensing (CCL) and is vendorized to provide specialized services by the Valley Mountain Regional Center. Vendorization is required to be able to accept referrals as well as provide services for the referred residents. Vendorization also establishes the rate of reimbursement and the expectations for the provision of clinical services in a service contract.

**Entering into Autus Treatment Facility**

All of the residents are referred to ATF by the Valley Mountain Regional Center. Valley Mountain Regional Center is the non-profit state agency that has case
management responsibilities for each of the referred residents. Each of the residents are involved in the court system either as a Civil Commitment under the Welfare and Institutions Code Section 6500 as a Danger to Self or Others, or as a condition of probation of parole. They have spent time in other treatment facilities that are not geared toward individuals with developmental disabilities, including state hospitals, jails, or other residential treatment programs. The program at ATF is based then on inter-agency collaboration between Valley Mountain Regional Center and the Court System, as well as other social Service agencies involved in the referred resident’s life (i.e. CPS).

ATF acknowledges that the potential client has already attempted help through “traditional” treatment programs that were not individualized and developed with the specific cognitive and functional challenges of persons with a development disability and substance abuse disorders. Several Guiding Principles are evident here: Principle 1 - Employ a recovery perspective; Principle 2 - Adopt a multi-problem viewpoint; and Principle 4 - Address specific real-life problems early in treatment.

Once the court has decided that an individual is appropriate for consideration for placement into a drug and alcohol treatment program, the Service Coordinator from Valley Mountain Regional Center initiates a placement referral and assessment by the team at ATF. Because the ATF program exists within the context of Community Care Licensing and each resident has certain rights established under Title 17 of the Welfare and Institutions Code, each resident must have an individualized and very specific court order that addresses potential areas that could be perceived as rights violations if not reviewed and approved by the referring court. ATF has developed an addendum that the
court must agree to before the client is treated at ATF. Following are the conditions of that addendum:

1. While a participant in residential portion of the Autus Treatment Facility treatment program, it is ordered that (client) is subject to random search of his/her room, all areas of the house, as well as his/her pockets and personal possessions specifically for drugs/alcohol/drug paraphernalia and/or weapons.

2. While a participant in the residential portion of the Autus Treatment Facility treatment program (client) must follow all rules of the program.

3. While a participant in the residential portion of the Autus Treatment Facility treatment program, the staff of Autus Treatment Facility has the right to check all liquids for alcohol content. If found with liquids containing alcohol, (client) will be required to dispose of the liquid. This will not apply to liquids prescribed or recommended by a physician.

4. While a participant in the residential portion of the Autus Treatment Facility treatment program, (client) will be required to comply with all physician orders including pain management if found appropriate.

5. While a participant in the residential portion of the Autus Treatment Facility treatment program, (client) will be required to participate in random drug and alcohol testing.

6. While a participant in the residential portion of the Autus Treatment Facility treatment program, (client) understands that un-authorized leaving the
program, leaving an activity, leaving a community based recovery activity will require notification of the police/sheriff.

7. While a participant in the residential portion of the Autus Treatment Facility treatment program, (client) understands that upon being located by the police/sheriff he/she is intoxicated, that the Autus Treatment Facility staff will recommend that he/she be processed like any other citizen requiring detoxification.

8. While a participant in the residential portion of the ATF program, (client) understands that upon being located by the police/sheriff, he/she is not intoxicated, and the AFT staff will recommend that he/she be returned ATF home. Guiding Principle 6, use of Support systems to maintain and extend treatment effectiveness, by requesting support from police/sheriff. When police/sheriff bring the resident back to ATF, treatment is not stopped for the resident’s recovery (Autus, 2011).

The process of recovery begins as soon as the client enters the house. These conditions for admission outline the legal terms of engagement and provide protections for the resident’s rights as well as outline the parameters of the treatment program.

After the court has made referral to the ATF, and the Service Coordinator from the Valley Mountain Regional Center has made a formal referral to the ATF, the Administrator from ATF will meet with the individual for an assessment. Once the assessment is completed, the management staff makes the decision to accept the client into the program.
Structure of Autus Treatment Facility

The Autus Treatment Facility’s, house structure consists of many different elements to help the client succeed in recovery. The house uses a multi-model approach. The model is multi-phased and each phase is goal and task oriented. Guiding Principle 1Employ a recovery perspective, is evident in every element of the program design. A client can advance within four treatment phases or levels on meeting behaviorally specific recovery based and functional living based objectives and input from the Interdisciplinary Decision Team (IDT). The team consists of each essential component that is important in the client’s life, such as Sponsors, Service Coordinators from Valley Mountain Regional Center, Probation/Parole Officer(s), and staff from the ATF. The stepwise progression through the ATF reflect Guiding Principle 3 in that it is a phased progression that is based not on time but on meeting sobriety and treatment conditions as well as a behaviorally specific set of expectations focused on eventual transition out of the program and back into a post treatment life of recovery.

Level I

Level I is known as the Orientation Phase. During this level, clients begin by becoming physically healthy. The staff of ATF understands that the first 30-45 days in the house can be stressful and the major focus is on allowing the person to begin to experience physical recovery and slowly adapt to an environment based on holistic health and assessment and treatment of both the substance abuse issues and the mental health issues. There is an understanding that the client needs time to detoxify. This process includes basic functional and yet essential tasks such as, eating three meals a day,
shower/bathing on a regular basis, and adjusting their sleeping pattern. It is during this level that the client learns the rules of the house. This includes, what is expected of them such as their chores, how to interact with other residents, and what groups to attend. As the ATF program is addressing specific real-life problems early in treatment, Guiding Principle Four is evident here. Any personal problems, life-skill challenges or disruptions in a resident’s daily life would be addressed in this phase.

The client is introduced to the 12-Step Program, with them admitting, “I have a problem”, with prompts from other residents and staff. An introduction to recovery is fostered and supported during Level I. This is step one in the Alcoholics Anonymous 12-Step program. Twelve-step programs are followed in the house, in the community, the day program, and at Valley Mount Regional Center. The 12-Step Program is often referred to as “The Circle”. There is a 12-Step meeting at the ATF house on Tuesday evening, and community AA/NA meetings are held on Monday, Wednesday and Thursday. Integration into the community recovery programs is essential, and each resident is supported developing the social skills and recovery knowledge to be successful in their quest for eventual sponsorship in a community based recovery groups that meet their personal and spiritual needs. There is also a mandatory Saturday meeting and a study group every Wednesday. Clearly, Guiding Principle 6 highlights the need to use support systems to maintain and extend treatment effectiveness, is reflected here, specifically Alcoholics Anonymous based programs.

Other groups held in ATF are Daily Reflections and House Groups. Daily reflection allows the client to look at their actions and be able to analyze them in a safe
and supportive environment with their peers in the house and ATF staff. House Group occurs every day, and it allows residents and staff to communicate about the structure and functioning of the house. For many residents this is the first time they have been exposed to a functioning family atmosphere and modeled problem solving, communication and social skills, and personal empowerment.

The staff helps to create a 24-hour plan with the client. This plan outlines each hour in the day and asks the client to provide a list of tasks they have planned to support sobriety. Many clients are not used to having structure, and the 24-Hour Plan creates that needed structure for the client. Within this plan, the client and staff member will fill up the 24-hour day with all the tasks the client needs to complete throughout the day to maintain sobriety and deal with urges and challenges associated with relapse. The 24-hour plan includes when the client wakes up, showers, eats, completes chores, and goes to group act. All six guiding principles are evident in this first significant step towards recovery. A 24-hour plan provides the resident a highly structured and empowering approach to cope with the first stage of recovery.

To be able to move on to Level II, the resident must maintain sobriety. There is random drug testing in the ATF program as outlined in the court order. Guiding Principle 1-Employ a recovery perspective is utilized here. Additionally, the client could not have had any unauthorized leaving from the ATF facility. Once the client has completed 30 days at ATF, admitted that he/she has a problem, learned the rules of the house, attended all required ATF groups and developed a 24-hour plan, the resident is then able to move to Level II with the agreement of ATF staff.
**Level II**

The second level in ATF focuses on sobriety, reliable and effective self-monitoring along with focusing on the “Old-Me”-“New-Me” recovery concept. For most residents, Level II is intended to take two to four months.

While focusing on sobriety, the primary expectation of the client throughout this level is to attend all ATF groups, and have an eighty percent attendance rate at “outside recovery groups”. After each group, the ATF staff facilitator along with the ATF resident completes a Group Participation Summary. This form allows the resident and the staff to focus on a series of questions aimed at quality of participation, support offered to other members, level of insight reflected, and overall participation behaviors. Levels of denial, minimization, and projection of blame are also monitored after each group. The facilitator is able to provide feedback based upon agreement or non-agreement with the group members’ self-monitoring group participation summary sheet. Guiding Principle 6-Use of support systems to maintain and extend treatment effectiveness is employed here with an eye towards mutual self-help and community outreach. Also utilized here is Guiding Principle 4-Address specific real-life problems early in treatment, by allowing for needed multi-modal interventions.

Many residents have had years of negative self-talk conditioning, often displaying such cognitive distortions as that they are not good enough, that their voice does not count and their opinions/comments have no value. It is through the ATF groups and the self-reflection that the residents are empowered and given cognitive behavioral tools to
counter these negative self-statements. This is also when the stage is set to introduce the “Old-Me” concept and begin to construct what a “New-Me” might look like.

In Level I, the client is able to gain familiarity with the 12-Step Program in the comforts of ATF. This allows the individual to understand the flow of meetings, what is expected of him/her, when the leader of the 12-Step talks and when is it appropriate for him/her to talk. Level II requests that the resident attend community recovery groups. The community groups give a chance for the resident to build a connection with other addicts/alcoholics, be immersed in the context of community generic recovery programs, and to begin to forge the interpersonal relationships vital in the pursuit of sponsorship like themselves for support. This connection is the support that Alcoholics Anonymous thrives on, and states what is needed to prevent relapse.

Accountability for self also occurs within Level II. This is accomplished in one way by using a process of self-monitoring. Each day the resident is expected to monitor and record on a number of essential “target” behaviors. Each of these behaviors have been generated and agreed upon by the residents and staff of ATF, so it is a community generated and supported self-monitoring process. The residents of ATF fill out the form on a daily basis, and there are 11 behaviors monitored on this form. This form is a level of personal commitment to the program.

The behaviors of the Self-Monitoring sheet include:

- Unauthorized “leaving/walking away” of ATF facilities/programs.
- Refusal to complete assigned chore(s).
- Refusal to take “prescribed” medication after prompted by staff.
• Refusal to go to outside Community Recovery group after being prompted by staff.

• Refusal to participate in ATF Group or 1:1 after being prompted by staff.

• A drug test result of a “Dirty Test.”

• Bartering without staff’s awareness/permission.

• Refusal to get out of bed after prompted by staff.

• Refusal to attend PCS on assigned day.

• Refusal to bath/shower one time daily.

• Refusal to clean room every day.

The resident completes the form on a daily basis and the ATF staff signs the form in agreement or not. In this way a sense of reliable self-monitoring, that is so essential to recovery can be supported, modeled, reflected upon, and supported. All of the Guiding Principles can be seen at play when the Self-Monitoring sheet is used. This is especially true of Principle 5-Plan for the client’s cognitive and functional impairments is evident in that these categories are clearly stated, focused, essential target behaviors that lend themselves to empowering support and contingency management, as well as provides the data for consideration for advancing in the four levels of the ATF program. If the staff does not agree with the completed Self-Monitoring sheet, the resident and staff member can have an open dialogue about why the discrepancy exists. The Self-monitoring sheet helps the client make the connection with three ideologies, their 24 hour plan (eat, sleep, bath), Recovery Movement and shift from their “Old-Me” to the “New-Me” way of thinking, feeling, and behaving. Use of this form for accountability and self-monitoring
fosters the connection between responsibility and honesty in the recovery journey. It also allows the resident to “see” that daily self-discipline, self-monitoring, and honesty are all essential to the full implementation of a living 24-hour plan. It also builds in a skill set that should be easily generalizable outside the ATF setting after treatment.

Throughout, ATF facilitates the “Old-Me” to the “New-Me” in almost all programs. This cognitive approach to behavior walks the client through their life, persona, character, values, morals and lens when they were using, and makes the transition to what life is and will continue to be like as he/she moves to a life of recovery and sobriety. Since learning, insight, understanding cause and effect, and memory recall are impaired for residents of ATF, the staff need to maintain specific objectives so that learning can occur throughout the process of “Old-Me”-“New-Me”. At any time when working with residents of ATF, but more particular in this channel of Recovery, the staff needs to keep key objectives in the forefront such as (Annand, 2002, p.36):

1. having patience;
2. being persistent;
3. responding immediately to both abstinence-producing and abstinence-destructive in past, current and future behavior; and,
4. Developing a tolerance for the need to be repetitive through processes or information.

Level II also focuses on the client’s responsibility within ATF house. The client is expected to complete all assigned chores, maintain a clean room, do all laundry, and to not steal, and stay on or within all ATF facilities. After the resident has completed the
“Old-Me”-“New-Me”, attended 80% of the community 12-Step Programs, completed three consecutive months of self-monitoring sheets with 90% accuracy, and has the approval for the IDT, the resident can then make a presentation. The resident’s presentation must focus on his/her ability to understand the 12-Step Program, as well as how to use it. If the ATF staff has agreed, the client can then advance to Level III.

**Level III**

Level III focuses on maintenance of sobriety and continued self-monitoring. The resident’s sobriety is measured by a clean drug test for a minimum of 120 days. Throughout the resident’s recovery into sobriety, AA recognition chips are given to the resident in a public acknowledgement ceremony called “birthday night” at the ATF facility. Chips are given to the resident to celebrate and congratulate their levels of sobriety based on 30-day increments. A birthday is another form of celebration and occurs when a person reaches established milestones of sobriety. When a resident reaches a “birthday”, the entire ATF program openly and publicly celebrates it. The circle encompasses attendees from all levels of the staff, the resident’s social worker, all residents of the house, and the resident’s AA/NA sponsor.

In Level III, the resident is asked to begin practicing sharing at a public meeting within the community. Sharing is a narrative. The story that an individual articulates to the other participants of the circle, allows him/her to tell their story to recovery. By this time, the resident would have attended several community meetings, and the meeting place and attendees would be familiar to the resident. He/she would then practice sharing
in the safe environment of the ATF 12-Step program. In Level III, the resident’s attendance to community recovery group is now expected to be at a 95 percent rate.

The accuracy of self-monitoring during this time is elevated from 80 percent to 90 percent. Self-monitoring is increased to 90 percent because after six consecutive months of being in treatment at ATF, the client is expected to have a greater understanding of self and their own recovery. Guiding Principle 3-Develop a phased approach to treatment, is reflected here as evidenced by the increased level of accuracy in self-monitoring. Along with self-monitoring, there are the behavioral expectations of no stealing, no leaving ATF functions without permission, maintaining a clean room, do own laundry, maintain proper hygiene and compliance with all prescribed medications.

Once the resident is able, and has completed all of these tasks, he/she may present to move to the next step. The presentation, once again, addresses their understanding and ability to use the steps of the 12-Step Program. The staff members, residents, and Service Coordinator from the Valley Mountain Regional Center (as well as Probation/Parole) decide if the resident is ready for progression to level IV.

**Level IV**

Level IV focuses on the daily application of the 12-Step Program. The resident will also complete a Life-Map Relapse Prevention planning and Chair an ATF group. These steps help to provide the resident with empowerment and ownership of their own recovery. The Serenity Prayer is recited at every 12-Step Meeting. When a person leads the Serenity Prayer, he/she brings the Circle together and begins leading the Serenity Prayer. The Serenity Prayer is not read, but reflected upon, verbally. Memorization
occurs through the repetition of the prayer being said at every meeting the client has attended, thus far. Having repetition of the Serenity Prayer is a key factor to comprehension and memorization.

Life Mapping is used by ATF to take the resident on a journey from where they once were to where they envision themselves to be in the future. This road map of life encompasses the use of “Old-Me”-“New-Me” through narratives from the residents with help from the staff member.

Relapse Prevention comes from partnership with the staff, and is guided by the resident and focuses on a plan to continue to stay sober. With partnership from the staff, the resident will come up with a plan to recognize triggers he/she typically will encounter and constructs a game plan to have self-control and safety strategies in place when there is the urge to use. Some of these essential self-control and survival strategies include emergency contact people, sponsorship, and remaining away from “old neighborhoods and old playgrounds”.

**Level V**

Level V occurs in a minimum of 12 months. This level focuses on maintaining what the resident has learned in Levels I through IV and Chairing a Community meeting. The resident should be able to articulate how he/she is living life consistently with the 12-Step Program. Being able to articulate this inside and outside of the ATF is monitored and supported.

Chairing a Community meeting enables the individual to use all he or she has learned through “Old-Me”-“New-Me”, the 12-Step Program, and Relapse prevention
process. Not only are these tangible exercises through ATF, but they are what helps the client make the journey to recovery. Specifically, what the client has learned through a positive, structured, and caring environment. Through these exercises and the environment that ATF brings the client, hopefully the client will gain self-respect and self-esteem that will help in their journey of recovery.

**Staff at Autus Treatment Facility**

The staff members at ATF are an extremely important aspect of Recovery. ATF believes that the staff should have past knowledge or personal experience with recovery and or addiction, or in working with individuals who are developmentally disabled and/or have mental health illness. The commitment to Principle 3, development phase approach, and Principle 5, plan for the client’s cognitive and functional impairments is apparent in the experience and knowledge that the staff brings to the implementation of the ATF program. Each staff member brings different levels of service. ATF employs six core staff members, and at the house of ATF, there will always be two staff members on site. The shifts of the house cover 24 hours: Day, Swing, and Graveyard. One of the staff members facilitates the 12-Step Program.

In addition to the core staff members, there is a Nurse, Psychiatrist and Behavioral Health Specialist. The nurse’s main job function is to maintain the physical health of the residents. The psychiatrist, who specializes in both addiction and serious mental health, focuses on prescribing psychiatric drugs, conducting physical exams and evaluating the patient’s mental health. Principle 6, use support systems to maintain and extend treatment effectiveness is evident in the commitment to provide this level of
specialization on site and ever available to each resident, and the staff when they seek consultation and support with a resident. There is a commitment at ATF to have staff with direct knowledge of Recovery either through direct personal experience, or through education. These individuals are the residential and clinical support team for the residents of ATF.

Staff at Autus Treatment Facility is an integral and critical part of the residents’ success in recovery. Most, if not all of the Guiding Principles reflect an inherent need for specialized knowledge, skills and abilities of staff to be able to succeed in a treatment facility such as ATF.

Eco Map

Integration of services and responsive to the legal system and regional center is an essential element of the ATF program. What is represented in the Eco-Map in figure 1 is the pictorial representation of the integration and “connections” that ATF has to the various elements of the system of care for each resident.

Court Services

Court Services has strong connection to ATF because every resident is either court ordered to ATF under the terms and conditions of W&I 6500 or under the terms of their probation or parole. W&I 6500 is a civil commitment for placement up to one year, and then is review able each year, thereafter.

12-Step Program

The 12-Step program is the framework for the recovery program at ATF. Every resident has an individualized recovery plan that includes attendance at, and participation
in a local AA/NA chapter/meeting. Also, the commitment is made to developing interpersonal relationships with the local generic AA/NA to develop a sponsorship relationship. The 12-Step Program has two key components connected to the program. The first component is the in-house 12-Step Program. Staff members, who are in recovery, are responsible for participating and even facilitating the in-house program. The resident also visits different 12-Step meetings throughout the local community. The resident has a voice in what meetings they would like to attend in the community. Sponsors are also a key part of ATF, then seen through the different Levels of ATF and how ATF request that a resident find a sponsor.

The Valley Mountain Regional Center

Every resident is eligible for services with the Valley Mountain Regional Center. This non-profit state agency serves the assessment, eligibility, case management, and funding services for each resident. Each resident has an assigned Service Coordinator who is worked with closely to support the Individualized Program Plan (IPP) while a resident of the ATF.

The Day Activity/Vocational Program

The day activity and vocational program is the day program learning, socialization, vocational, and life-long learning option for each resident. This day activity and vocational program is a community based immersion model of recovery and social rehabilitation that builds on an individualized service plan that includes selected classes to meet the spiritual, emotional, learning, social, and vocational needs of each resident.
**Staff**

The staff at ATF is another large factor. Without the staff, ATF would not be in existence. The staff members have a true dedication to the residents. All staff members have knowledge, experience, and compassion for the residents.

**Family**

The resident’s family can be an important role in their journey to recovery. Individuals in recovery need to have a strong stability and support system to help them through the journey.
Conclusions

It is the experience of the researcher that there is little empirical data and research on the subject of individuals with developmental disabilities and substance abuse. After performing a forensic literature review, this researcher has come to discover that there is lack of information on individuals with dual diagnosis and substance abuse. Not only is there an overall lack of research and published data, it is extremely rare to find a treatment program that meets the guiding principles for Co-Occurring disorders in the general population and there are even fewer residential options for a person with a developmental disability, serious mental illness and a substance abuse history.

The second part of this research project was to propose a best practice model of a treatment facility that could be based on and infuse the guiding principles that are established for a “best practices” program that serves the person with a Developmental Disability. The best practice model is based on the need for a specified treatment center that focuses on recovery, knowledge and experience in working with adults with developmental disabilities. Through the forensic literature review, this researcher located the Autus Treatment Facility (ATF), a treatment facility specifically designed to meet the multiple bio-psycho-social needs of the person with a developmental disability, SMI, and substance abuse, and that was responsive to the call for integrated services to meet the
multiple needs of this client. A best practice framework was used to analyze the fit of ATF in the best practice model.

There is a common misunderstanding in society that individuals with developmental disabilities are not exposed to drugs or alcohol nor would they even want to consume these substances. However, this researcher discovered that this population is exposed to substance abuse when individuals are not living in institutions and are living in the community. Individuals living in the community experience greater individual freedom and therefore participate in a greater amount of social activities, including associations with family and friends (Cocco & Harper, 2002). Through these activities and associations, the individual is more exposed to alcohol and drugs (Horner et al., 1988; Stancliffe & Lakin, 1998; Lakin & Stancliffe, 2007).

Research has shown that usage of drugs and alcohol is apparent in persons with mental retardation but he/she is less likely to use than the general population. According to Cocco and Harper (2002), individuals with mental retardation have a higher likelihood to abuse drugs and alcohol.

There are three specific links between persons with mental retardation, substance abuse and poor functions. First, more people diagnosed with mental retardation live within the community rather than in institutions. Second, individuals with mental retardation experience greater difficulty with substance abuse than do individuals with substance abuse problems who do not have mental retardation disorders and who live within the community. Third, individuals with mental retardation engage in substance
misuse and experience negative consequence based on their misuse (Cocco & Harper, 2002).

The project documented that there is a lack of treatment facilities in Northern California to treat adults with developmental disabilities and substance abuse. Treatment facilities that serve this population need to have specific requirements that are specific to this population. The specific factor that relates directly to this population is adaptive behavior in the areas of: self-care, receptive and expressive language, learning, mobility, self-direction, and the capacity to live independently and to be self-sufficient. Based on this factor, a treatment facility should have a specialized program that can incorporate the needs of the individual(s) along with a focus on a recovery that embraces the 12-Step program.

This researcher was able to locate the Autus Treatment Facility in a small rural town in Northern California, through her research of treatment centers specializing in individuals with developmental disabilities and substance abuse. Autus Treatment Facility (ATF) is a six-bed treatment facility; residents are court ordered and are all eligible for services with the Valley Mountain Regional Center.

ATF incorporates all of the six steps that Substance Abuse and Mental Health Services Administration (SAMSHA) states as requirements that must inform and shape any program that serves persons with co-occurring disorders (or COD). The six guiding principles are:

1. Employ a recovery perspective
2. Adopt a multi-problem viewpoint
3. Develop a phased approach to treatment
4. Address specific real-life problems early in treatment
5. Plan for the client’s cognitive and functional impairments
6. Use support systems to maintain and extend treatment effectiveness

(HHS Publication, 2004).

**Multi Modalism**

ATF uses a multi-model approach with residents in recovery. The multi-model plan incorporates elements from Ecological Model, Choice Theory, and Constructivist Model. The Ecological Model is evident in ATF in the integration of the Life Plan, and IPP/ISP. Choice Theory focuses on residents past and current coping skills, strategies, and behaviors that each resident uses to meet his /her basic human needs. Person-Centered is used by staff when each resident of the house is treated with empathy, unconditional acceptance, non-judgment, and with constant focus on that individuals' feelings and emotions especially related to their mental illness and substance use/abuse. The Constructivist Model states that each resident has a story to tell, and a life vision. Staff and clinical approach the program with focus of empowerment, visioning, deconstruction of the “Old Me” and support construction of the “New Me.”

ATF incorporates a 12-Step Program for recovery. A multi-phased treatment program that uses five-level steps to aid in recovery is used at ATF. The two main features of a recovery perspective are acknowledgment that recovery is a long-term process of internal change, and recognition that these internal changes proceed through various stages of specific requirements.
Level I focuses on the resident becoming familiar with the ATF house rules and the 12-Step Program. Level II brings the resident to community meetings for the 12-Step Program. Level III focuses on sobriety and self-monitoring for residency. Level IV focuses further movement of the individual in individual steps of the 12-Step Program. Level V occurs once the resident has not had any absences or leaving of ATF functions, maintaining sobriety, learning and maintaining ATF house rules, obtaining a sponsor, saying a serenity prayer in a 12-Step Meeting and completing all other steps.

ATF requires their staff to have past experience with individuals with developmental disabilities and/or serious mental health issues, and/or substance abuse. ATF has six core staff members; there are always two staff members working at all times during a 24-work day. In addition to the core staff, ATF employs a Behavior Health Specialist, Nurse and Psychiatrist.

ATF is used in this project as a best practice model because it combines the requirements of Substance Abuse and Mental Health Service Administration, with the understanding that individuals with both a developmental disability and serious mental illness learn in a different manner than the general population. These individuals have different cognitive abilities than those in the general population. Thus, the staff must understand about working with individuals with developmental disabilities. There must be consistence and repetition to help in the learning process for ATF residents.

**Recommendations**

This research project outlines a lack of empirical data for individuals with developmental disabilities and substance abuse. Pointing out the lack of research for this
population will bring out the need to further need for research. The research also states there is a lack of treatment facility that is geared towards individuals with development disabilities and substance abuse issues. This treatment facility was found to be the only treatment facility that focuses on this population.

This project may be used to help develop or replicate a model to follow ATF so that individuals with developmental disabilities and substance abuse issues are treated in the best possible manner. ATF has so many levels that are interwoven and complex that this research was not able to examine every aspect of the program.

It is out of the scope of this researcher to provide a complete in-depth investigation of ATF. The perceived vulnerability of the residents of ATF precluded this researcher to conduct interviews with the residents as determined by the Human Subjects Review Committee at California State University of Sacramento. However, the information that this researcher gathered from ATF was enough to provide a basic best practice model. A complete and thorough evaluation and analysis along with a comprehensive and documented study is recommended to capture all aspects and details of all ATF’s programs.

Restrictions of this project hindered this researcher to conduct interviews with the residents of ATF. This would give additional component to the project that would examine how successful ATF residents have been in their recovery from the perspective of the residents.
## APPENDIX A

### Literature Review Templates

<table>
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<tr>
<th>#</th>
<th>Citation</th>
<th>Source (Database)</th>
<th>Key Findings</th>
<th>Relevance to this research or research questions</th>
<th>Author/s &amp; year</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Most pregnancies that involve genetic abnormalities end in miscarriage</td>
<td>CSUS Library</td>
<td>Factors that contribute to developmental disabilities</td>
<td>1. This book helps establish why individuals develop or are born with a developmental disabilities</td>
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# APPENDIX B

## Mental Retardation Categories

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<th>DSM IV Description</th>
<th>IQ Level</th>
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<tr>
<td>317 Mild Mental Retardation</td>
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<tr>
<td>318.0 Moderate Retardation</td>
<td>35-40 to 50-55</td>
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<tr>
<td>318.1 Sever Mental Retardation</td>
<td>20-25 to 35-40</td>
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<tr>
<td>318.2 Profound Mental Retardation</td>
<td>20-25</td>
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(Diagnostic and Statistical Manual of Mental Disorder, 2000)
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