EFFECTIVE CHEMICAL DEPENDENCY TREATMENT FOR
INDIVIDUALS WITH MENTAL RETARDATION

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Social Work

by
Cecilia Louise Flores Badger

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To my husband Bob whose love and support has enabled me to achieve a lifelong dream of which this research is a part. Without your willingness to sacrifice for my achievements it would not have been possible.
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First and foremost to my God, who upholds me in this life. Your grace enabled me to complete this undertaking. As I progressed in this research your promises sustained me through times of tiredness and confusion. “He giveth power to the faint; and to them that have no might he increaseth strength” Isaiah 40:29. “For the Lord God will help me; therefore shall I not be confounded…”Isaiah 50:7 (King James Version).

To individuals with mental retardation and those who are dependent on chemicals. Your daily struggle to achieve a life of joy and peace in our society has not gone unnoticed.

And finally to Sue Steiner, Ph.D, my committee chair and Seema Sehrawat, Ph.D faculty committee member. You introduced me to worlds that had previously been intimidating and taught me to be comfortable within them. Sue, you ignited an interest for the development of government policy and revealed to me its relevance to the field of Social Work. Equally as daunting was the process of systematic research. Seema, through your teaching I became confident enough to attempt this study. I give my gratitude to both of you for your patience, guidance, and encouragement throughout this process.
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ABSTRACT

EFFECTIVE CHEMICAL DEPENDENCY TREATMENT FOR INDIVIDUALS WITH MENTAL RETARDATION

by

Cecilia Louise Flores Badger

Master of Social Work

California State University, Chico

Spring 2012

Legislation such as the Community Mental Health Act of 1963 and the Lanterman-Petris-Short Act of 1967 paved the way for individuals with mental retardation to begin living their lives outside of the institutions many of them had been confined to. When these individuals moved into general society they became exposed to, and some began the use of, illicit and addictive drugs. As this usage continued some became dependent upon the use of the chemicals. This dependence turned into addiction for some. When providing services within conventional treatment centers for this dual diagnosed population, it became apparent that mainstream treatment methods were not effective. The special needs of their unique condition required different ways of providing treatment. Although some studies have been done in an attempt to determine what these alternative treatment methods might be, all have been conducted from the viewpoint of treatment providers. This study was conducted from the distinct perspective
of the addict and their support system in an attempt to determine what they see as
effective chemical dependency treatment for themselves and those they care about.
CHAPTER I

INTRODUCTION TO THE STUDY

Background

Taber (2005) defines mental retardation (MR) as “below average intelligence…associated with impaired learning or communication; poor social, community, or interpersonal adjustment; and an inability to function independently (e.g., to support oneself, to live safely and healthfully)” (p. 1342). The definition does not say “cannot learn” but rather “impaired learning.” This is an important distinction to make as it is relevant to the types of treatment programs that are available to this special needs population.

According to the National Health Survey on Disability “over thirty thousand people with MR received services for alcohol/illicit drug abuse. This group constituted 2.2% of the non-institutionalized population with MR in 1994” (Slayter, 2008). Through a review of the available literature it is noted there are few, if any, treatment programs in existence that specifically address the recovery needs of this population (McLaughlin, Taggart, Quinn & Milligan, 2007; Slayter & Steenrod, 2007; Lottman, 2001). Standard treatment agencies willing to provide services are hindered by lack of knowledge and training of staff, additional time and money necessary to provide for the slower learning rate of these individuals, and reimbursement resources (McLaughlin, Taggart, Quinn & Milligan, 2007; Slayter & Steenrod, 2007; Lottman, 2001).
Statement of the Problem

As effective treatment is lacking, individuals with mental retardation who are addicted to substances continue on the downward spiral that is often the result of untreated addiction. Consequences of this spiral can include psychological stressors such as loneliness and isolation; material losses due to lost wages and homelessness, involvement with the criminal justice system due to reduced ability to make healthy behavioral choices, and increased medical conditions as a result of damage to the body (Cocco & Harper, 2002; McLaughlin, Taggart, Quinn & Milligan, 2007; Slayter, 2008; Slayter & Steenrod, 2007). Any or all of these issues can bring the individual into contact with social work service providers. However, with the current lack of population-specific tools to assess and treat these individuals, social workers will continue to be hindered as to what services will work best and how to implement them.

Purpose of the Study

The purpose of this study is to determine what components, if any, used in traditional chemical dependency treatment programs work with the mentally retarded population and which do not. In addition, the study will be looking at what methods might work that are not currently being utilized with this population.

If adequate chemical dependency treatment is to be provided for individuals with mental retardation, it is imperative to develop an effective treatment. Through this qualitative research project, the researcher intended to explore the particular recovery needs of this population.
Theoretical Bases and Organization

Chemical Dependence

There are many theories surrounding the causes of use and addiction to chemicals. These theories include moral, psychological, cultural, and biological theories (Inaba & Cohen, 2004; Larson, 1997; Kinney, 2009; McNeece & DiNitto, 2005; White, 1996). The moral theory of addiction is keyed to mankind’s sinful nature and his inability to regulate himself (Kinney, 2009; Inaba & Cohen, 2004). Sometime between 27 and 25 years BC, Titus Livius wrote in the Ad Urbe Condita

The delights of wine and feasts were added to the religious elements of the bacchanals. When wine inflamed their minds, and night and promiscuity …erased any feelings of modesty, all manner of corruptions began to be practiced. (Inaba & Cohen, 2004, p. 6)

In more modern times, significant public policy has been based on the concept of man’s sinful nature (Kinney, 2009). As early as 1874 the Woman’s Christian Temperance Union was working to eliminate alcohol consumption (Women’s Christian Temperance Union, 2011) “…to promote total abstinence from alcoholic beverages and put liquor dealers out of business, for the purpose of reducing crime, poverty, and immorality” (State of Texas Historical Society, n.d.). The success of their campaign was evidenced by the eighteenth amendment to the United States Constitution in 1920. The amendment was a failure and repealed in 1933 by the twenty first amendment to the Constitution. Public policies based on the moral theory continue to be written. These include federal and state laws. In 2009 eighteen percent of state prisoners were incarcerated for drug use and in 2010 fifty one percent of federal inmates were
incarcerated for the same reason. This did not include the breaking of any other laws such as property violations or harm to others (Guerino, Harrison & Sabol, 2011).

Psychological theories include cognitive-behavioral, learning, psychodynamic, personality and a search for altered consciousness (Kinney, 2009; McNeece & DiNitto, 2005). One aspect of cognitive-behavioral theory is that individuals use alcohol and other drugs (AOD) to experience pleasure and that the level of dependency is related to the intensity of gratification each individual experiences when using (McNeece & DiNitto, 2005).

The learning theory of addiction purports that individuals utilize AOD to reduce unpleasant feelings such as anxiety, stress and tension. As they become reinforced by the reduction of these feelings a psychological addiction begins to form and they use until the purpose is no longer about reducing feelings but rather avoiding withdrawal symptoms (Kinney, 2009; McNeece & DiNitto, 2005).

Within the psychodynamic theories, Chordokoff suggests that drugs are used to generate a sense of security that was not obtained in the developmental years of the user (McNeece & DiNitto, 2005). According to Catanzaro addiction to masturbation, expressions of hostility, homosexuality, narcissism, oral fixation, and tendencies towards self-destruction have all been suggested as causes for chemical addiction (McNeece & DiNitto, 2005).

McNeece & DiNitto (2005) reference Schuckit’s description of traits of individuals with an addictive personality as dependent, immature, impulsive, highly emotional with a low tolerance for frustration, an inability to express anger in an adequate manner and confusion over sex-role orientation. Kinney (2009) talks about
Weil’s proposal that altered consciousness is an innate desire for humans. He gives the example of young children whirling or hyperventilating to achieve this condition. His theory contends that the use of alcohol and other drugs is a way to obtain this status on a more adult level.

McNeece and DiNitto (2005) encourage us to distinguish between the effects of a drug and the experience an individual has when taking the drug. For example, the physiological effects of depressants such as opiates, sedatives, and alcohol include a slowing of the heart rate and respiration, relaxation of the muscles, a decrease in coordination, a dulling of the senses, a diminishing of pain and an increase in sleepiness. Socially, however, small amounts of these drugs will reduce inhibitions thereby allowing for freer, more open behaviors. Higher amounts will relax the mind, reduce anxiety and often control neuroses. Some can even bring on exhilaration (Inaba & Cohen, 2004). This distinction is important, according to McNeece and DiNitto (2005) because even though the physiological effects of drugs are the same for each person, the experience will be different depending on the culture of the environment in which it is used. White (1996, p. 5) defines group norms as “prescribed patterns of perceiving, thinking, feeling, and behaving.” These group norms and the promotion or discouragement of AOD use within the culture determine what is an acceptable level of usage.

The biological theory of addiction supposes that individuals are genetically predisposed to alcohol addiction if at least one of their parents is an alcoholic (Inaba & Cohen, 2004; McNeece & DiNitto, 2005). The genetic theory was given credence when researchers Ernest Nobel and Ken Blum identified the DRD2 A1 Allele gene. This gene was found in over seventy percent of alcoholics receiving treatment in their study.
However, less than thirty percent of social drinkers were discovered to have it. This particular gene is also implicated in cocaine addiction (Inaba & Cohen, 2004). Another aspect of the biological theory is that of neurobiology which specifically addresses the functioning of the brain (Inaba & Cohen, 2004; Mcneece & Dinitto, 2005). Electroencephalography, a test to measure brainwaves (Gray, Ambady, Lowenthal, & Deldin, 2003) has shown that the range of P300 event-related potentials (ERP) is reduced in alcoholics and their sons. P300 ERP, measures “a person’s cognition, decision making, and processing of short-term memory” (Inaba & Cohen, 2004, p. 69). This reduction in ERP is not present in non-alcoholics.

Mental Retardation

Biological theories have also been useful in identifying causes of mental retardation. These include genetic theories on such conditions as Down Syndrome and Fragile X, which are caused by chromosomal imbalance at conception (Haydar, 2005; Hockenberry & Wilson, 2007; Rio, et al. 2010; Pastva, Corwin & Morin, K. 2004), neurological theories on conditions such as Fetal Alcohol Syndrome and lead poisoning (Karr-Morse & Wiley, 1997; Mcneece & Dinitto, 2005, Hockenberry & Wilson, 2007) and other chromosomal damage that occurs either prenatal or postnatal.

Hockenberry and Wilson (2007) cite numerous other theories on the causes of mental retardation. These include infections such as rubella and syphilis in the mother during gestation or trauma such as physical injury to the brain, a lack of oxygen or exposure to radiation. Other theoretical causes include environmental deprivation “associated with a history of mental retardation among parents and siblings” (p. 991) and
nutritional abnormalities such as inadequate nutrition, imbalances in fat, carbohydrate, or amino acids (Hockenberry & Wilson, 2007).

Recovery

The concept of addiction as a disease and, consequently, the medical model of recovery are largely based on the biological theories of addiction (McNeece & DiNitto, 2005). With the advancement of scientific knowledge, treatment physicians are using more precise treatment methods to work with those addicted to chemicals. These methods include medications to assist with the adverse effects of detoxification, withdrawal, and cravings as well as the use of imaging systems to monitor the brain of addicts (Inaba & Cohen, 2004; McNeece & DiNitto, 2005; White, 1996).

Daniel Amen, MD states, in regards to the use of imaging,

There’s so much these scans and looking at the brain can offer the field of addiction…it’s much more powerful than showing them a picture of fried eggs and bacon. It’s very helpful in denial to actually sit in front of a computer screen with somebody that has been using drugs and they say, ‘Oh, there are really no problems’ and you say, ‘let’s look at yours’. (Inaba & Cohen, 2004, p. 380)

Other theoretical perspectives of treatment include nutritional balance, harm reduction, cognitive, aversion, psychotherapy, behavioral, and insight-oriented therapies to name just a few (Inaba & Cohen 2004; Larson, 1992; McNeece & DiNitto, 2005).

Theories concerning causes of mental retardation have been substantiated based on results of evidence based studies (Haydar 2005; Rio, et al. 2010; Pastva, Corwin & Morin, 2004). Unfortunately, to date, there has been no conclusive evidence to determine the cause or treatment for chemical dependence, which effects so many of the world’s population, either directly or indirectly (Inaba & Cohen, 2004; McNeece &
DiNitto, 2005; White, 1996). As a result, just like in the population at large, there is no conclusive evidence of what works or does not work in regards to treatment with the mentally retarded population (Cocco & Harper, 2002; McLaughlin, Taggart, Quinn & Milligan, 2007; Slayter, 2008; Slayter & Steenrod, 2008). This study is not so much concerned with the causes of chemical dependency in individuals who are also mentally retarded. Instead, it looks at a variety of treatment components from various theories in an attempt to identify effective treatment for this population.

Limitations of the Study

The design of this exploratory study was to be an availability sampling. It was the intent of the researcher to locate subjects referred from regional centers in northern California. Due to the confidentiality protections afforded to the study population by state and federal mandates (California Department of Developmental Services, 2009; McNeece & DiNitto, 2005), along with the small size of the study population within the general public (Cocco & Harper, 2002; Lottman, 2001; Slayter & Steenrod, 2008), finding research participants, even within the regional centers, was especially challenging.

It was the original intent of the researcher to identify and interview a minimum of nine interviewees for this qualitative study. The primary subjects would have been three individuals with a dual diagnosis of mental retardation and chemical dependency. These individuals would have experienced a treatment episode for chemical dependency, after which they would have returned to consuming unprescribed and/or
illicit chemicals. The remaining six interviewees would have been a family member or friend and the assigned regional center case manager for each primary subject.

The researcher initially approached the regional center whose geographic area she resides within. A case manager supervisor was contacted and informed of the type of study being conducted. A referral was made to a case manager who had a client fitting the study criteria. Several attempts to contact the case manager went unanswered and it was necessary to expand the search to five other regional centers.

Of these contacts, two were willing to assist but unable to identify individuals meeting the study criteria. One regional center was able to identify a person for the study. However, the individual had stopped responding to contact attempts by the regional center and the case manager was unable to locate her. Of the remaining two, both located in central California, one had several individuals identified who met the study criteria. However, the administration refused to allow contact, citing agency policy regarding client protections.

A supervisor at the remaining regional center was able to identify two individuals meeting the study criteria. Of these two, one case manager refused to contact the individual as she believed her client was not stable enough to withstand the questions of the interview guide (see Appendix A). One case manager contacted her client and he agreed to participate in the study.

Because the data collection process relied on self-reporting it is possible that social desirability bias came into play with the subject answering questions according to what he thought was expected rather than what he actually thought about the question at hand.
Due to the small sample size of the study, it is important that no attempts be made to generalize findings from this study to all individuals with the dual diagnosis of mental retardation and chemical dependency.

Nonetheless, as this is an exploratory study, information obtained from this subject can be utilized to direct other studies on the subject. However, before this can take place, the quandary regarding access to viable subjects must be resolved.

Definition of Terms

The term developmental disabilities includes various conditions such as cerebral palsy, autism, epilepsy, mental retardation, and other conditions similar to mental retardation that require the same type of interventions as mental retardation (California Department of Developmental Services, 2011a). For the purpose of this paper, developmental disabilities will be defined as: “below average intelligence…associated with impaired learning or communication; poor social, community, or interpersonal adjustment; and an inability to function independently (e.g., to support oneself, to live safely and healthfully)” (Tabor, 2005, p. 1342). The term will be used interchangeably with mental retardation.

Other definitions used in the writing of this paper include:

- Addiction: a physical and/or psychological dependence on chemicals that causes an individual to continue using the substance in spite of repeated adverse effects to various domains in their life (Tabor, 2005).

- Case Manager: an individual that assess the needs of a client and either directly provides services or refers out according to the identified needs. This individual also
monitors the services provided and makes changes according to changes in the client’s status (Hepworth, Rooney, Rooney, Strom-Gottfried & Larson, 2010).

- **Chemical/Substance Dependence:**

  A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug taking behavior. (American Psychiatric Association, 2000, p. 192)

- **Mental Retardation:** a diagnosis given to an individual who has been identified as having an IQ below 70 and who shows deficits in their adaptive functioning (California Department of Developmental Services, 2008).

- **Regional Center:** a non-profit entity established by the State of California created to coordinate services for individuals who are mentally retarded (California Department of Developmental Services, 2011a).

- **Regional Resource Development Projects:** a branch of the California Department of Developmental Services that assists the department in the smooth transitioning of individuals moving in and out of developmental centers and into the community (California Department of Developmental Services, 2011a).

- **Treatment:** formalized activities provided to an individual who has an addiction to chemicals in an effort to assist them in reducing the negatives effects brought on by the addiction (U.S. Office of the Federal Register, 2011).

- **Treatment Episode:** the time between the beginning and end of the formalized activities for chemical dependency (U. S. Department of Health and Human Services, 2010).
CHAPTER II

REVIEW OF THE LITERATURE

In the 1970s California implemented a substantial depopulization of state institutions for the mentally retarded (MR) (Slater, 2008). This was a result of the Lanterman-Petris-Short Act (LPS) of 1967 (California Welfare & Institution Code, n.d.; Lenell, 1977). At the end of that fiscal year there were 34,087 individuals residing in state hospitals for the mentally ill and developmentally disabled (California Legislative Analyst’s Office Major Milestones, 2000). By the end of the 2011 fiscal year there were 1,886 individuals residing in institutions for the developmentally disabled (California Department of Developmental Services, 2011b). Data collected in 1967 combines the mentally retarded population with the mentally ill population to determine the number of individuals institutionalized. By 2011 the two populations had been statistically separated from each other. Therefore, although it is difficult to determine the exact measurement of the decrease, it is certainly significant.

The LPS established a process by which individuals with developmental disabilities could be removed from the restrictive, isolative environments of locked state hospitals and be placed into communities to live. The intent was “…to end the inappropriate, indefinite, and involuntary commitment of mentally disordered persons, developmentally disabled persons, and persons impaired by chronic alcoholism, and to eliminate legal disabilities…” (California Legislative Counsel, n.d.). Presumably, the
rationale was that these individuals be given the same opportunity as the rest of society to live their lives according to what worked for them.

As these new freedoms took shape, individuals within the community of mental retardation became exposed to the same societal conditions as the general public. Included in these conditions were access to alcohol and other drugs (Slayter, 2008). As a result, just like in the general population, many began abusing these substances and some became addicted to them (Cocco & Harper, 2002; McLaughlin, Taggart, Quinn, & Milligan, 2007; Slayter, 2008; Slayter & Steenrod, 2008). According to Lakin, Anderson, & Kwak, in excess of thirty thousand individuals with developmental disabilities obtained services for abuse of chemicals in 1994. This constituted 2.2% of the non-institutionalized population with MR during that year (Slayter, 2008).

There is agreement among the research that the problem exists within this particular population at a very low rate (Cocco & Harper, 2002; Lottman, 2001; Slayter & Steenrod, 2008).

Because this social problem relates to such a small percentage of the general population, there remains a deficit of information regarding effective treatment for individuals with both mental retardation and a history of substance abuse (Cocco & Harper, 2002; Lottman, 2001; McLaughlin, Taggart, Quinn & Milligan, 2007).

Historically, services for mentally retarded individuals and individuals with mental illness, which encompasses chemical dependency, were provided by the same service providers. Services for the developmentally disabled and those with mental health issues were separated by The Mental Health and Mental Retardation Act of 1963 in recognition that treatment issues are different for each of these populations (Slayter,
2008). As treatment issues are different for each group, philosophies also tend to be different on how best to help individuals that fall within these populations (Slayter, 2008; Slayter, 2010).

Traditionally, services for individuals with mental retardation have focused on empowerment and self-direction with an emphasis on teaching living skills and self-advocacy (Slayter, 2008; Slayter, 2010; Slayter & Steenrod, 2008). Conversely, services for individuals with chemically dependency have focused on giving up control of one’s actions as an acknowledgment that the chemicals have impaired healthy judgment (Slayter, 2008; Slayter & Steenrod, 2008).

Because of this separation, persons working with individuals who are mentally retarded have been reluctant to provide services to individuals with chemical dependency and chemical dependency workers have been reluctant to provide services to those with mental retardation (Slayter, 2008; Slayter & Steenrod, 2008). As a result, service providers have been unable to agree on which discipline should be providing services to individuals diagnosed with these dual conditions (Lottman, 2001; McGillicuddy, McLaughlin, Taggart, Quinn & Milligan, 2007; Slayter, 2008; Slayter & Steernd, 2008).

Research concerning this segment of the population has been limited for varied reasons. One reason is that confidentiality for both groups has been legislated, thereby making collection of data especially difficult (California Department of Developmental Services, 2009; McNece & DiNitto, 2005). In addition, recovery programs do not typically record the functioning level of their clients and programs directed at serving those with mental retardation do not typically screen for chemical
dependency (McLaughlin, Taggart, Quinn & Milligan, 2007). Another factor limiting available research is that funding has been restricted as there are so few citizens that the problem affects, thereby making this a low priority for those who control the budget (Cocco & Harper, 2002; Lottman, 2001).

Although only a small section of society is affected, they are at increased risk for negative effects as a result of the dual condition of substance abuse and mental retardation (McNeece & DiNitto, 2005; Slayter, 2008). This factor indicates it is a subject worthy of study as we attempt to find solutions to resolve the problem so great for many of our most vulnerable citizens (McLaughlin, Taggart, Quinn & Milligan, 2007; Slayter, 2008; Slayter & Steenrod, 2008).

By nature of their cognitive disability those with mental retardation have an inherently vulnerable status within society’s mainstream (McNeece & DiNitto, 2005; Slayter, 2008; Slayter & Steenrod, 2008). These vulnerabilities include a lack of social and safety skills along with an increased risk of fiscal and sexual exploitation (Cocco & Harper, 2002; Slayter, 2008; Slayter & Steenrod, 2008). As a group, they also tend to be isolated as a result of their poor social skills (McNeece & DiNitto, 2005; Slayter & Steenrod, 2008). Finally, logic and the author’s experience as a community program specialist suggest that those who must subsist on their own income, without contributions of family or friends tend to reside in low income areas. This increases the opportunity others have for exploitation of these individuals (Cocco & Harper, 2002; McGillicuddy, 2006; McLaughlin, Taggart, Quinn & Milligan, 2007; Slayter, 2008; Slayter & Steenrod, 2008).
When under the influence of chemicals, these vulnerabilities are increased as cognitive abilities decrease accordingly (Cocco & Harper, 2002; Slayter, 2008). The chance of contact with law enforcement, and ultimately incarceration, are increased as anti-social behaviors become more likely while under the influence (McLaughlin, Taggart, Quinn & Milligan, 2007; Slayter, 2008; Slayter & Steenrod, 2008). Many individuals with mental retardation must take psychotropic medications and/or seizure medications in order to maintain their health and well-being (Lottman, 2001; McNeece & DiNitto, 2005. Slayter, 2008; Slayter & Steenrod, 2008). As alcohol and other drugs are likely to have an adverse effect with both of these, the likelihood of increased medical complications is also present (Cocco & Harper, 2002; Lottman, 2001; McNeece & DiNitto, 2005; Slayter, 2008; Slayter & Steenrod, 2008).

It is evident by Taber’s (2005) defining characteristics of mental retardation that individuals with this condition are at greater risk for increased negative consequences of substance abuse than are the general public (Slayter, 2008; Slayter & Steenrod, 2008). These consequences include an even greater risk of problems related to lack of impulse control, decrease in self-care skills, and loss of hard won community acceptance (Slayter, 2008; Slayter & Steenrod, 2008).

Although studies are limited, the existing research agrees there is a lack of relevant recovery services to this identified populace. This lack can be attributed to many factors. First and foremost, staff within chemical dependency treatment programs has little to no training or experience with this population (Lottman, 2001; McLaughlin, Taggart, Quinn & Milligan, 2007; Slayter & Steenrod, 2008). In addition, there are no standardized treatment tools or models that have been proven to be effective for this
population (Cocco & Harper, 2002; Lottman, 2001; McLaughlin, Taggart, Quinn & Milligan, 2007; Slayter & Steenrod, 2008).

As individuals with mental retardation learn and retain at a slower pace than does the general public (Slayter, 2008), it becomes necessary to reduce the pace of providing relevant information about the recovery process (Lottman, 2001). This can become a problem for two reasons. First, it slows the process down for others thereby impeding their recovery. Second it increases the cost of recovery as presenting all relevant information at a slower pace necessitates longer treatment episodes (Lottman, 2001; Slayter & Steenrod, 2008).
CHAPTER III

METHODS

Design of the Investigation

As noted previously, there have been studies conducted to determine what components of recovery programs do not work, or are especially challenging, for mentally retarded individuals during the treatment process for chemical dependency. These studies have been conducted from the viewpoint of treatment program staff. Many barriers have been identified, such as lack of assessment tools, shortage of funds for specialized treatment, and insufficient training for program staff. What this researcher was unable to locate, however, were studies conducted in regards to what does work in the treatment process for this specific population. In addition, no studies were found that were conducted from the viewpoint of individuals with a dual-diagnosis of both mental retardation and chemical dependency.

Due to the difficulty of finding suitable subjects, the study was conducted as a one-person case study with supplemental research conducted with the individual’s regional center case manager. The researcher used qualitative methodology to build upon the lack of research conducted in this area. The interview guide for the primary subject was created as a means to explore the thoughts and feelings of individuals who have been through treatment and found it ineffective in meeting their particular needs. It is the hope
of this researcher that information gathered will aid in developing an effective treatment program to assist individuals with mental retardation.

Upon making telephone contact with the primary subject, a date and time was agreed upon to meet at the regional center office for the interview. On the morning of the interview the researcher was informed by the subject that he did not have a way to get to the regional center office. He requested the interview be done at his home. The researcher had previously been informed by the case manager that this might happen due to the subject’s lack of transportation. Therefore, it was agreed to conduct the interview at the home of the subject.

This researcher was greeted by the subject at his front door. Following an introduction between the two of us, he introduced his wife and sister. A kitchen chair had been arranged in the living room for the subject to sit on and I was offered the overstuffed chair. As his wife and sister began to settle onto the couch, the subject was asked if he preferred to be interviewed in a more private setting. He stated he preferred his wife and sister remain, which they did.

Because individuals with mental retardation have been identified as having low levels of reading skills (Cohen, et al., 2006), a verbal process of interviewing seemed preferable for the comfort of the subject over any other investigative method considered. The verbal interaction was also intended to put the subject at ease as individuals with mental retardation have also been identified as having low social skills (McNeece & DiNitto, 2005; Slayter & Steenrod, 2008).

The purpose and format of the study had already been explained to the subject and a signature on the consent form obtained by his case manager. The process was
repeated by the researcher, not only for the benefit of the interviewee, but also for the benefit of his wife and sister. The subject was asked permission to record the session, which he gave, and the interview began. Following the interview, a request was made to both his wife and sister to be interviewed for the study. Both declined. One stated she was too nervous and the other stated she was scared.

Upon completion of the interview with the primary subject the researcher interviewed the case manager in an office at the regional center. Following the interview, the case manager provided contact information for the Individual Living Skills (ILS) instructor who, she said, had agreed to an interview and would have more information on the primary subject’s response to his previous treatment episode. Attempts to contact the ILS instructor went unanswered. As a result of these numerous challenges, the sample size of this study consisted of two individuals, the primary subject and his regional center case manager.

The measurement tool utilized in this qualitative study was the interview guide for the primary subject, referenced above (Appendix A). A second interview guide (See Appendix B) was utilized for the case manager. The questions and answers were recorded via a small tape recorder. The interviewer kept written notations to a minimum in an effort to keep feelings of intimidation and discomfort from the respondent. In this manner, the interviewer was able to focus on the respondent, increasing the likelihood he would know the importance of his participation.

Although there was only one primary subject, transcribed interviews were coded so as to protect the identity of this subject. The recordings were transcribed, verbatim, by the researcher as soon as possible following the interview. The recordings
themselves were kept until the end of the research, at which time they were destroyed by the researcher. Transcriptions of the interviews were kept indefinitely by the researcher in a file on a computer requiring a password known only to the researcher.

Due to the small scale of this research project the researcher and interviewer were one and the same. Participants were informed, via the informed consent form, of their right to privacy and the voluntary nature of their involvement (See Appendix C). Finally, this research project was reviewed (See Appendix D) and approved (See Appendix E) by the Institutional Review Board of California State University Chico known as the Human Subjects Research Committee.

As noted, an interview guide was utilized to gather information pertaining to the research. When the interviews were completed, data was coded to determine any themes regarding what is working and what is missing in treatment, as well as any other emerging themes. A volunteer with a Master degree in Social Work was utilized as a second coder to minimize bias from the researcher.

Specific questions in the interview guide were chosen for diverse reasons. Questions, such as age, gender, ethnic background, etc., were asked to track the demographics of the participants. Other questions were chosen to gain a clearer understanding of what the individual believed worked or did not work in their treatment episode. Questions were also designed to get a perspective on what the individuals thought might work for them but was not offered during treatment. Additional questions were designed to explore what types of activities the individual thought might be effective in sustaining sobriety after the treatment episode ended.
Recovery is an on-going, life process and does not end with the termination of official treatment services. White (1996) explains the time after formal treatment as “one of the most essential elements in the treatment of the culturally enmeshed addict…the replacement of core activities from the culture of addiction with these core activities from the culture of recovery” (p. 383). Therefore, the last group of questions was constructed to explore what components might be useful in developing an after-care treatment plan for the study population. The questions were developed in their simplest form, some with the use of “contingency questions” (Rubin & Babbie, 2007, p. 98), in order to accommodate the communication challenges presented by mentally retarded individuals (Tabor, 2005).

Population and/or Sample

The primary subject for this study was an individual with a dual diagnosis of mental retardation and chemical dependency. He had previously experienced two separate treatment episodes for chemical dependency in programs designed for the addict whose intelligence is within the accepted “normal” range. Following both treatment episodes, he returned to consuming illicit drugs. The secondary interviewee was the case manager for the primary subject.

Data Analysis Procedures

As noted earlier in this report, there is minimal research available for review in regards to treatment options for individuals who are mentally retarded. As a result of the small pool of research, there have been no tools, such as tests or formulas, developed and/or interpreted to assist with this research topic. Because this qualitative report relies
on a lone primary subject and one individual within his system of support, it is likely the use of tools would have proven both invalid and unreliable had any been available for use. Due to this it was necessary for the researcher to develop a unique set of questions for the interview guide.

Data analysis procedures focused on the respondent’s answers to the interview questions. The researcher sorted each question with the corresponding answer. When this task was complete a review of each answer was conducted by both coders as they independently searched for themes. Themes were classified by the individual coders as they emerged. When this process was complete topics identified by both coders were merged into one document for further review.
CHAPTER IV

RESULTS AND DISCUSSION

Presentation of the Findings

When asked what he liked about his time in the day treatment the client stated a movie he watched had helped him. When asked to elaborate he stated “what the drug was really all about and what was in it. I just couldn’t believe how much junk that was in it.” He seemed genuinely surprised at what the drug was doing to his body. Unfortunately, this was the only activity he was able to identify as having provided positive results.

He felt much of the program was geared at a level higher than his ability to understand. This was also the conclusion of the case manager. According to the subject, there was no attempt made to alter the curriculum to accommodate his disability. This continued even after he informed his recovery counselor that he could not follow the program or participate in activities as they were being presented.

He stated he told his counselor that he could not understand “those big old fancy words that they used and that they talked so fast.” He said “I asked her if she could break it down so I could understand cause I was in special ED all my life and I just don’t understand those big old words.” When asked how he felt when he heard those words with the staff talking so fast he replied “it made me feel stupid like what am I here for?
You know, I’m just here for nothing.” He stated he needed them to slow down some “so I could understand.”

Much of chemical dependency treatment is based on written assignments in an effort to assist the client in recognizing patterns of harmful behavior. Because of this the subject was asked if he had been given any written assignments during his treatment episode. He explained that he was asked but he was unable to complete them because “I don’t know how to spell all that good.” He said his counselor asked him why he hadn’t completed his work when he turned it in and he informed her “well, I told you in the beginning I didn’t know how to spell all that good.” He stated she did not attempt to help him with the assignment but instead “she just looked at me like I was crazy.” When asked if he got into trouble for not completing the assignments he said “no, she just got her blue-black book and started writing.” Based on the researchers experience as a chemical dependency counselor, it is presumed his counselor was documenting the results of his written assignment. He went on to explain that he stopped going to the treatment program because he could not follow the curriculum. He stated “it just wasted my time and the state is paying for it.” He said the overall experience was “ok, but I, like I said, I felt kind of stupid when I was in there.”

The subject stated he had been drug free for about six years. When asked how he did it since he had received so little benefit from his treatment episode he stated “I just stay to myself. I just don’t want to meet a lot (of people) because you never know whose using or not…my neighbors could be on it for all I know.” He was also able to identify that he sometimes experiences cravings.
Conversation with his case manager revealed many areas of concern regarding effective treatment for the primary subject specifically and mentally retarded individuals in general. She stated numerous times that information presented was not geared for the specific needs of people with mental retardation. Programs are offered by those who have no knowledge of the special needs of this population. She also identified this same problem in regards to other programs such as parenting classes and anger management classes for this population. Additionally support staff, who might have been able to assist the client in understanding material presented, was not allowed into the treatment sessions. This is due to confidentiality issues surrounding clients in treatment for chemical dependency.

Conversely, the problem of the case manager not having knowledge of chemical dependency issues was evident by her comments of “I thought he was acting a bit strangely but I couldn’t put my finger on it because I haven’t been around people who are on substances.” Another statement made indicating a lack of knowledge regarding chemical dependency treatment was “well, at first the person has to accept that they have a problem and then agree that they want help with it.”

Discussion of the Findings

Results of this study lead the researcher to conclude, as shown in other studies; there is a lack of understanding from chemical dependency professionals when working with the developmentally disabled. This deficit of understanding is manifested in a lack of skills necessary to adequately communicate recovery concepts to their clients dual-diagnosed with chemical dependency and mental retardation. In addition, at least
with the counselor of the primary subject in this study, there appears to be a lack of desire to learn these skills. The subject of this study stated he repeatedly informed his recovery counselor that he was unable to understand the words she was using. He also informed her he was unable to complete the written assignments as presented to him. However, the recovery counselor made no attempt to adjust her verbiage when interacting with the subject. Neither did she attempt to adjust the written assignment to an approach he could participate with.

As the subject was incapable of comprehending the recovery material in the style it was presented to him, he internalized feelings of inadequacy. Consequently, he stated he left treatment earlier than recommended. Furthermore, the primary subject was unable to benefit from his treatment episode in a manner that would encourage social interaction with non-users. Therefore, it became necessary for him to isolate from others in an effort to maintain his sobriety. As a result his quality of life has been diminished.

Just as recovery professionals do not have a base knowledge of skills necessary to work with people with mental retardation, professionals working with people with developmental disabilities lack a working knowledge of chemically dependency and treatment. This was displayed when the primary subject’s case manager stated “the client does not want any help, he is passive aggressive.” In regards to receiving recovery services she stated “…that motivation, the responsibility, wasn’t there.” White (1996) states addiction is more than something that happens within an individual. It is based on the human need to interact with their environment on certain levels. He goes on to state that this interaction must be as strong in recovery as it is in
addiction if the addict is to recover. The motivation and responsibility the case manager referred to will continue to be lacking until this is accomplished.

Another area of concern surrounds the lack of collaboration between service providers. The primary subject’s case manager indicated she lacked knowledge of the specific treatment episode for the client. She stated she had not recognized the symptoms of chemical dependency and was unsure how the referral for recovery services was obtained. She indicated her belief that the independent skills worker was responsible not only for the referral itself but for the selection of the recovery program utilized. When questioned about her level of confidence in the recovery program to provide adequate services to her client she stated “I didn’t have that kind of interaction with that program.”

It is evident the case manager and the recovery counselor did not interact in an effort to coordinate services. Although both types of service providers are mandated to safeguard client confidentiality, there are legal provisions for the sharing of information, should the client agree. A signature by the client on a release of information form from each agency would have allowed the sharing of knowledge between the two organizations, thus allowing coordination of services. Had this been done, a more comprehensive delivery of services from both agencies could have been implemented to better serve the client.

A noteworthy topic arose when the case manager stated she was aware that available services in the community were not sufficient to meet the needs of the developmentally disabled population. She stated “…if they’re (providers) not familiar with working with our clients, it makes it kind of like a set up.” It is interesting that the primary subject was able to identify this when he made comments regarding his time
being wasted on a service that was not directed to his specific needs. The case manager went on to say “unless it’s something that we (the regional center) put on, they’re not going to understand the need for the different levels of giving the information.” This speaks to the heart of the matter in regards to ineffective services. In spite of all good intentions, traditional recovery programs are wasting precious public monies while delivering services that simply do not work for many individuals with mental retardation.

Finally, from the perspective of the client, changes to the current system should include a reduction in the pace at which information is disseminated. It would also be beneficial if the information was offered in alternate ways other than reading and writing. Art therapy, role playing, and one-on-one interaction are but a few ways this could be accomplished. Should it become necessary to present information in written form, adapting the written word to better suit the comprehension level of the mentally retarded individual would be advantageous. In addition, if it is necessary for the client to complete written assignments, providing a proxy writer to record the client’s words may ensure completion of the task.

Summary, Conclusions, and Recommendations

This qualitative study was initiated to explore answers to three questions in regards to addiction treatment for individuals who are dual diagnosed with both chemical dependency and mental retardation. These questions are: (1) what components of traditional treatment work for this population?, (2) what components of traditional treatment do not work for this population?; and (3) what methods might work that are not currently being utilized for this population?
The original research design called for three primary and six secondary subjects identified through the regional center whose service area the researcher resides within. However, due to the interpretation of confidentiality laws by the regional center’s administration, it was necessary to seek subjects from other regional centers. This too proved to be a challenge. After contact with six regional centers one primary subject and one secondary subject were identified.

Study findings suggest that due to the lack of client-centered service delivery, the primary subject benefited little from his recovery treatment episode. As a result, he continues to lack recovery skills necessary to ensure a meaningful existence. In an attempt to remain clean and sober he has isolated himself from social interaction with individuals outside of his immediate family.

Results of this study did not answer the research question of what components used in traditional chemical dependency treatment programs work with the mentally retarded population. However it did provide some answers to the question of what components do not work for treatment with this population. Components identified as not being beneficial include writing assignments, the utilization of vocabulary too advanced for their understanding, and a high speed of delivering information. By interpreting these factors, the third research question, what methods might work that are not currently being utilized with this population, can be answered. These methods include a reduction in the pace at which information is presented, a reduction in the level of vocabulary used to present information, and utilization of varied delivery systems.

As previously indicated, this study cannot be generalized to encompass treatment needs for all chemically dependent individuals with mental retardation. It does
however, support previous studies that have identified some barriers to treatment for this population. Further research with a larger sample population is necessary if relevant information is to be obtained that can be extrapolated to the broader population of individuals with both mental retardation and chemical dependency.
REFERENCES


White, W. L. (1996). *Pathways from the Culture of addiction to the culture of recovery: A travel guide for addiction professionals*. Center City, MN: Hazelden

Interview Guide

Name:                                            Phone Number                           Interview 

Address:                                                                                            Date of Interview

1. What did you like about the treatment program you were in before?

2. What didn’t you like about the treatment program you were in before?

3. Did the counselors do anything special for you so you would understand the material better?

4. If so, what did they do?

5. If not, what would you have liked for them to do to help you understand the material they gave you?

6. What do you think would have been helpful for you to stay clean and sober after you left treatment?

7. Did your family and/or friends help you try to stay clean and sober after you left treatment?

8. If so, what did they do that helped?

9. If not, what would you have liked them to do to help you stay clean and sober?

10. Did you go to AA/NA meetings after you left treatment?

11. If so, did you feel comfortable when you went to meetings?

12. If you did, what helped you to feel comfortable?

13. If you didn’t, what was it about the meetings that made you feel uncomfortable?
14. What do you think could have been done to help you feel more comfortable in the meetings?

15. Was there anything else you did to stay clean and sober after you left treatment?

16. If so, what did you do?

17. Do you have friends who don’t use drugs or alcohol?

18. If so, what types of activities do you do with them?

19. Is it hard for you to meet up with your friends who don’t use?

20. What other types of activities do you like to do when you’re not using drugs or alcohol?

21. How many times have you been to a treatment program?

22. When was the last time you were in treatment?

23. Did you complete each one?

24. Did you leave early?

25. If so, why?

26. If you could choose, what drug would you use?

27. When was the last time you used?

28. Is there anything else you want to tell me about your treatment experience or your drug using experience?

29. Male ☐ Female ☐

30. Age:

31. Ethnic Identification
32. Marital Status

33. Current Income

34. Source of Income

35. What was the name(s) of the treatment program you were in before?

36. Primary receiver of services ☐ Support ☐
APPENDIX B
Interview Guide – Part II

Name:                                            Phone Number                           Interview #
Address:                                                                                            Date of Interview

1. What did you like and dislike about the treatment program the primary subject was previously in?

2. Are you aware of anything the counselors did special for the primary subject so they would understand the material better?

3. What part of treatment do you think helped the primary subject the most?

4. What part of treatment do you think did not help the primary subject at all?

5. What did the primary subject do to help themselves stay clean after they left treatment?

6. What are your thoughts on what might have helped the primary subject stay clean following treatment?

7. Is there anything else you want to tell me about the treatment experience or drug using experience of the primary subject?

8. Male ☐                                  Female ☐

9. Relationship to primary subject:

10. What was (were) the name(s) of the treatment program(s) the primary subject was previously in?
CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY

INVESTIGATOR’S NAME:  CECILIA BADGER
PROJECT #
DATE OF PROJECT APPROVAL: MAY 26, 2011

Study Title: The search for effective treatment for individuals with co-morbidity of chemical dependency and intellectual disabilities

INTRODUCTION

This is an agreement called a consent. It says it’s okay for us to use what you say to help us put together a better program for people who have trouble not using drugs or alcohol. This consent might contain words you don’t understand. Please ask a friend, family member or the researcher to explain any words or information you don’t clearly understand.

This is a research study. Research studies include only people who want to help find answers to a problem. As part of this group you have the right to know what is going to happen before it happens and how what you tell us will be used. This is so you can make the decision whether or not to join in the study. We tell you this so you know you don’t have to help us if you don’t want to or if it makes you feel uncomfortable.

Please take as much time as you want to make your decision.

You are being asked to take part in this study because you have been in treatment for chemical dependency or know somebody who has.

You will need to sign your name at the bottom of this paper if you want to join in the study.

WHY IS THIS STUDY BEING DONE?

We are doing this study to try and find out what type of treatment for drug and alcohol use works best for people who have a developmental disability.

HOW MANY PEOPLE WILL TAKE PART IN THE STUDY?

People who have been in treatment before, and those who care about them, will take part in this study. We are hoping that 12-24 people will join us.
WHAT IS INVOLVED IN THE STUDY?

If you take part in this study you will be asked to meet with somebody who will ask you questions about when you were in your treatment program. The questions will be about what you liked and did not like about the program and what you think might help if you went to a different program.

HOW LONG WILL I BE IN THE STUDY?

The interview might take up to two hours.

WHAT ARE THE RISKS OF THE STUDY?

There are a few things you might not like if you decide to join in the study. You might become angry or frustrated when you remember some of the things that you did, or that happened to you, when you were in treatment. If this happens, or if you become angry or frustrated because of anything else when you are answering the questions, please let the person asking the questions know right away so they can help you with your feelings.

ARE THERE BENEFITS TO TAKING PART IN THE STUDY?

The good thing that might happen to you if you take part in this study is that you can tell people how you feel about the time you were in treatment. You will be helping those who build treatment programs to know what to do to help other people with developmental disabilities to get clean and sober. You will be helping people who want to become social workers learn more about how to help you stay clean and sober. You will also be helping them to learn how to do research so they can help people in other ways.

WHAT OTHER OPTIONS ARE THERE?

You don’t have to be a part of this research group if you don’t want to be. Just tell the person helping you with this paper if you don’t want to be a part of it.

WHAT ABOUT CONFIDENTIALITY?

Nobody outside of the research will have any information about you. Those who do have information about you will not give it to anybody else without first asking you if it is okay to do so. Anything we find out about you that we want to use in the report will be used under a made-up name so nobody will know it is about you. You can have a copy of the report if you want. You will be told what name we used for you so you can know what was said about you. What we find out about you during this study will only be used for learning about research. If you want a copy of the research paper when it is done you can get it by calling the researcher and asking for it.
WHAT ARE THE COSTS?
It won’t cost you anything to be a part of this research study.

WILL I BE PAID FOR PARTICIPATING IN THE STUDY?
We won’t be able to pay you for being in the group but we will be offering refreshments.

WHAT IF I GET HURT DURING THE STUDY?
California State University, Chico doesn’t pay people if they get hurt during a study. They do have insurance to help you pay for any medical treatment you might need if you get hurt badly. They also have insurance to help you in case the researcher does something they are not supposed to do. If the insurance is needed, it does not mean the researcher is saying they did anything wrong. They are only saying they know you need help.

WHAT ARE MY RIGHTS AS A GROUP MEMBER?
You don’t have to agree to be a part of this study. If you do agree you can change your mind at any time and stop being a part of it. If you want, you can get a copy of the report if you ask for one by phone.

WHOM DO I CALL IF I HAVE QUESTIONS OR PROBLEMS?
If you have any questions about your rights as a member of this group, if you have worries about the study, or if you feel like you’re being forced to stay in the study when you do not want to, you may contact the lead person, Cecilia Badger at (530) 933-5297 or by email at cbadger@mail.csuchico.edu and tell her about it.

If you have questions about the research or if you want a copy of the report after it’s done, you may call or email the lead person at anytime.

If you ask for one, a copy of this consent form will be given to you to keep.

SIGNATURE
I agree that the reason for the group, how the group will be done, what the risks are and what good the group will do for me have been made clear to me. I know I do not have to join in the group if I don’t want to. I know what is in this consent form and my questions have been answered. By signing below I am letting the researcher know I want to join in the group.

_________________________________________  ______________________________
Subject                                          Date

IRB #                        Page 3 of 4    Staff Initials ________
SIGNATURE OF STUDY REPRESENTATIVE

I have explained the purpose of the research, the study procedures, identifying those that are investigational, the possible risks and discomforts as well as potential benefits and have answered questions regarding the study to the best of my ability.

______________  ________________
Study Representative****       Date

****Study Representative is a person authorized to obtain consent.