SUBSTANCE USE DELIVERY EXPANSION PROJECT BLUEPRINT

Fiscal Year 2023/24 through 2025/26

MHSA Acknowledgement and Liability

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Westside Regional Center

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1. Introduction

Although prevalence estimates vary, research consistently indicates that approximately 30-40% of individuals with intellectual and developmental disabilities (I/DD) experience co-occurring mental health conditions, commonly referred to as a dual diagnosis.[1] Among individuals with dual diagnoses, an estimated 20-30% also experience substance use disorders (SUD), with alcohol and cannabis being the most reported substances.[2]

Despite the expectation that healthcare systems be inclusive and accessible, individuals with I/DD and co-occurring mental health and substance use disorders frequently encounter significant barriers to care. These include diagnostic overshadowing, limited provider training in disability-informed substance use treatment, lack of appropriate accommodations, and fragmented service systems spanning developmental disabilities, mental health, and substance use treatment.[3] As a result, substance use disorders among

[1] Cooper, S.-A., Smiley, E., Morrison, J., Williamson, A., & Allan, L. (2007). Mental ill-health in adults with intellectual disabilities: Prevalence and associated factors. *The British Journal of Psychiatry, 190*(1), 27–35. https://doi.org/10.1192/bjp.bp.106.022483

[2] Chapman, S. L. C., Wu, L.-T., & Weidenmaier, J. (2011). Substance use among persons with intellectual disability: Research findings and implications. *Intellectual and Developmental Disabilities, 49*(5), 365–377. https://doi.org/10.1352/1934-9556-49.5.365

[3] Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions*. National Academies Press. https://doi.org/10.17226/11470

people with I/DD are often under-identified and under-treated, leading to delayed intervention and poorer health outcomes.[4]

Workforce capacity challenges further compound these systemic barriers. Direct support professionals and service providers consistently report low confidence and limited formal training in identifying substance use concerns and supporting recovery among adults with I/DD.[5] These gaps underscore the need for structured, accessible, and evidence-informed training models tailored to the unique needs of this population.

Consistent with national findings, a local needs assessment conducted with direct service providers vendored through Westside Regional Center (WRC) and Frank D. Lanterman Regional Center (Lanterman RC) confirmed a strong demand for targeted workforce training and improved access to recovery-oriented supports for adults with I/DD and SUD.

In response, WRC and Lanterman RC developed the **Substance Use Delivery Expansion Project**, funded through the Mental Health Services Act (MHSA) Cycle V (FY 23/24–25/26) in partnership with the California Department of Developmental Services. The initiative sought to: (1) Strengthen direct service provider capacity through a structured **E-Learning Certification Program**, and (2) Improve access to recovery-oriented supports for adults with I/DD and SUD through a **Peer Mentoring Program (PMP)**.

This blueprint documents the processes, tools, and implementation strategies used to design, implement, and evaluate these programs, serving as a replicable guide for Regional Centers and community partners seeking to expand substance use and mental health supports for adults with I/DD. For further information, please contact Andy Ponce at AndyP@WestsideRC.org.

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2. Project Overview

The Substance Use Delivery Expansion Project aimed to improve substance use and mental health support for adults with I/DD by combining workforce development, peer-driven recovery, and cross-system collaboration.

Core Strategies

- **Workforce Training:** Build service provider knowledge and foundational skills through a structured, evidence-informed E-learning Certification Program.

[4] Slayter, E. (2010). Disparities in access to substance abuse treatment among people with intellectual disabilities. *Journal of Social Work Practice in the Addictions, 10*(3), 237–251. https://doi.org/10.1080/1533256X.2010.493871

[5] McLaughlin, D., Taggart, L., Quinn, B., & McFarlane, C. (2014). Learning disability nurses' experiences of supporting people with learning disabilities and mental health needs. *Journal of Clinical Nursing, 23*(17–18), 2563–2574. https://doi.org/10.1111/jocn.12452

- **Peer Mentoring Model:** Foster self-efficacy, recovery skills, and community belonging among adults with I/DD through a structured peer mentoring program.
- **System Coordination:** Strengthen alignment across WRC, Lanterman RC, behavioral health partners, and community recovery networks.

Programs Developed

- **E-Learning Certification Program** – A competency-building, modular training for providers supporting adults with I/DD and SUD.
- **Peer Mentoring Program (PMP)** – A recovery support model emphasizing mentorship, skill-building, and community connection.

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3. Project Goals & Objectives

Goal	Objective	Timeline	Deliverable
1. Recruit Staff	Hire project consultants; identify WRC + Lanterman RC staff to assist with project deliverables	Q1 FY 23/24	Position postings, Request for Proposals, interview scoring sheets (see Appendix A)
2. Conduct Needs Assessment & Evaluations	2.1 Conduct provider survey and needs assessment	Q2 FY 23/24	Survey + analysis report (see Appendix B)
	2.2 Conduct quarterly evaluations of Certification Program + PMP	Quarterly	Evaluation dashboards
3. Develop Certification Program	3.1 Create curriculum	Q3 FY 23/24	Curriculum drafts + transcripts
	3.2 Build e-learning modules	Q4 FY 23/24	508-compliant digital modules
	3.3 Launch Certification Program on LMS	Q2 FY 24/25	Final LMS module files
4. Develop Peer Mentoring Program	4.1 Select provider to develop PMP	Q2 FY 23/24	Provider contract
	4.2 Approve program design + evaluation → launch PMP in Q1 24/25	Q4 FY 23/24	Program design materials (curriculum, handbook,

Goal	Objective	Timeline	Deliverable
			evaluation tools) (see Appendix C)
5. Form Grant Advisory Council	Host quarterly meetings	Quarterly	Meeting agenda + minutes

4. E-Learning Certification Program

4.1 Purpose & Target Population

The Certification Program, *Supporting Adults with Developmental Disabilities and Substance Use Challenges*, was developed to: (1) Address the gap in service provider knowledge of substance use among adults with I/DD; (2) Equip staff with the skills to identify, differentiate, and support SUD and mental health concerns; and (3) Improve early intervention, engagement, and recovery-oriented support.

Target Audience

- Direct support professionals
- Behavioral specialists
- Residential/day program staff
- Service coordinators/case managers
- Other Regional Center vendored providers and community

4.2 Development & Implementation

The steps below summarize the development and implementation process for the E-Learning Certification Program.

Step 1: Conduct Needs Assessment

Purpose: Identify provider training needs, knowledge gaps, and service challenges related to supporting adults with I/DD who experience co-occurring mental health and substance use concerns.

Activities:

- Collaborated with the Evaluation Consultant to design a 36-item provider survey targeting WRC and Lanterman RC vendored service providers.
- Developed survey questions that captured:
    - provider background and experience
    - the scope and behavioral characteristics of the population served

    - provider knowledge and confidence in supporting individuals with I/DD and co-occurring MH/SUD
- Recruited participants through regional center email listservs, provider bulletins, and direct outreach to vendored agencies.
- Held regular project team meetings to refine survey items, finalize data collection procedures, and ensure consistent administration.
- Conducted a comprehensive literature review (10-year scope) across social, health, and behavioral science databases to identify national trends, evidence-based practices, and treatment considerations for individuals with I/DD and SUD.
- Synthesized survey findings and literature insights to identify training priorities and guide curriculum development.

Deliverables:

- Provider Survey Report (Appendix B)
- Literature Review Guide (Appendix B)
- Data Extraction Sheet (Appendix B)
- Literature Review Summary (Appendix B)

Replicability Notes:
Allow 8–10 weeks for survey development, distribution, data collection, analysis, and literature review synthesis.

Step 2: Curriculum Development

Purpose: Build an evidence-informed curriculum that responds directly to provider training needs identified through the needs assessment and literature review.

Activities:

- Convened weekly collaboration meetings with project staff, the Project Manager, Research Assistant, and Subject Matter Experts (SMEs) in developmental disabilities, mental health, substance use, and Motivational Interviewing (MI).
- Identified core learning objectives and competencies, including:
    - differentiating behaviors related to I/DD, mental health conditions, and substance use
    - recognizing signs of SUD among adults with I/DD
    - navigating treatment systems and barriers
    - applying person-centered, culturally responsive, and MI-aligned communication strategies
- Developed the training outline, module sequence, and curriculum structure.

- Drafted base content for each module, including conceptual explanations, examples, case scenarios, and practice opportunities.
- Created downloadable learner resources (e.g., reference guides, scripts, and toolkits) to reinforce key concepts and provide practical tools for service providers.
- Provided e-learning design and development consultant, Yukon Learning, with the curriculum outline, base content, and resource materials for instructional design and scripting.

Collaborative Script Development with Yukon Learning (E-learning Design and Developer):

- Yukon Learning's instructional design team converted the base content into draft transcripts for each module.
- Project staff and SMEs completed multiple rounds of review, providing annotated edits to ensure accuracy, clarity, and alignment with plain-language and universal design principles.
- Yukon Learning incorporated revisions and submitted updated drafts until each transcript met content and quality expectations.
- Finalized transcripts and accompanying resources were approved for e-learning module development.

Deliverables:

- Complete curriculum outline and module script package
- Downloadable learner resources
- Final approved transcripts for all program modules

Replicability Notes:
Build in multiple structured review cycles with SMEs and instructional designers; allow sufficient time for iterative feedback and transcript refinement.

The final version of the program includes an Introduction module, five core modules, and two assessment modules. The Introduction module provides an overview of the program's purpose, structure, and navigation, while the five core modules titled below, address the following areas:

1. **Understanding the People You Support**

Overview: This module offers an in-depth overview of IDD, mental health conditions, and co-occurring disorders. You will learn to recognize signs of mental health concerns and identify when a mental health assessment may be necessary. The module also defines dual diagnosis and trauma, outlines the core principles of trauma-informed care, and examines the types and impact of trauma. This foundational knowledge will empower you

to provide effective, person-centered support for individuals with IDD and co-occurring mental health needs.

2. **Recognizing the Risks, Impact, and Signs of Substance Use Disorder**

Overview: This module provides an overview of substance use disorders, with a focus on cannabis and alcohol. You will explore the risk factors that make individuals with IDD more vulnerable to substance use, learn to recognize behavioral and physical signs of substance use, and examine the unique challenges in identifying substance use within this population.

3. **Navigating Systems of Care for Substance Use and Mental Health Treatment**

Overview: This module explores treatment options for individuals with IDD and substance use disorders. You will learn how to identify and describe mental health symptoms, understand evidence-based practices for treatment, and navigate common barriers to accessing care. This module also introduces harm reduction principles and their applications in prevention, treatment, and recovery, and includes resources to support these strategies.

4. **Cultivating the Mindset for Supporting People with Accessing Treatment**

Overview: This module focuses on understanding and addressing the impacts of stigma and discrimination while exploring layers of oppression, internalized stigma, and implicit bias. You will learn strategies for challenging misconceptions and develop a mindset that enables you to support individuals with IDD and substance use disorder by applying core principles like cultural humility, trauma-informed care, strengths-based approaches, person-centered care, self-determination, and Motivational Interviewing.

5. **Developing and Applying Motivational Interviewing Skills**

Overview: This module introduces Motivational Interviewing and the R.U.L.E.S. approach for conducting Motivational Interviewing effectively. You will gain an understanding of how to use reflective listening, empathy, and open-ended questions to have effective conversations and support behavior change. This module includes a role-play scenario to help you practice and apply Motivational Interviewing skills in real-world situations.

The link to the program is available here.

Step 3: E-Learning Module Design

Purpose: Transform approved curriculum scripts into interactive, accessible e-learning modules for delivery through the Learning Management System (LMS).

Activities:

- E-Learning design and development consultant, Yukon Learning conducted a Developer Kickoff Call to introduce the development team, confirm design standards, and outline production milestones.
- Converted approved scripts into fully developed e-learning modules using Articulate Storyline 360.
- Integrated multimedia components, including:
    - professional voice-over narration synchronized with on-screen animations
    - interactive activities (e.g., branching scenarios, reflections, image hovers, click-to-reveal elements)
    - embedded knowledge checks and assessments
- Incorporated project-developed downloadable resources into relevant modules.
- Ensured accessibility through 508-compliant features (e.g., closed captions, transcripts, color contrast, alt text, screen reader compatibility).
- Produced SCORM-compliant files for LMS upload and testing.

Deliverables:

- Complete set of SCORM-compliant modules
    - The final version of the program includes an Introduction module, five core modules, two assessment modules, and integrated learner resources.

Replicability Notes:
Maintain early and clear communication with instructional designers; ensure accessibility checks occur throughout development, not only at the end.

Step 4: Pilot Testing

Purpose: Validate the functionality, clarity, accessibility, and overall learner experience of the e-learning modules before program launch.

Activities:

- Conducted pilot testing with WRC and Lanterman RC staff and selected service providers.
- Tested module navigation, audio performance, interactive elements, and LMS functionality (enrollment, progress tracking, assessment scoring).
- Gathered feedback on:
    - clarity of content and learning objectives
    - pacing and readability
    - usability and ease of navigation
    - effectiveness of knowledge checks and interactive activities

    - accessibility features (captions, transcripts, font legibility, screen reader compatibility)
- Compiled pilot feedback and worked with Yukon Learning to revise modules accordingly.
- Re-tested revised modules to ensure consistent quality across browsers and devices.

Deliverables:

- Pilot testing notes and feedback
- Final module files with revisions applied, approved for LMS upload

Replicability Notes:
Plan for at least one full review cycle after pilot feedback; test LMS functionality early to avoid launch delays.

Step 5: Program Launch & Outreach

Purpose: Make the Certification Program accessible to service providers and ensure smooth enrollment, tracking, and communication.

Activities:

- Uploaded finalized SCORM-compliant modules (Introduction, five core modules, Initial + Final Assessments) to the LMS.
- Coordinated with LMS administrators to test:
    - course enrollment
    - progress tracking and assessment scoring
    - certificate generation
- Verified successful functionality across devices and browsers.
- Launched the program first to WRC and Lanterman RC vendored providers, then statewide across all Regional Centers.
- Implemented a multi-channel outreach strategy, including:
    - announcements via RC email listservs and provider bulletins
    - direct email invitations to vendored providers
    - informational flyers summarizing program purpose and CEU eligibility
    - updates shared at stakeholder and advisory council meetings

Deliverables:

- LMS enrollment and learner progress reports
- Outreach materials (flyers, announcements, email templates)

Replicability Notes:
Engage LMS administrators early; plan staggered communications to maintain enrollment momentum.

4.3 Evaluation

Purpose: Assess program reach, knowledge gains, participant experience, and early application of learning among service providers.

Evaluation Plan

Measure four core components:

1. **Knowledge Gain** – Changes in learner understanding before vs. after training
2. **Program Completion** – Module and assessment completion rates
3. **Participant Satisfaction** – Learner perceptions of content quality, clarity, and usefulness
4. **Application of Learning** – How learners report using the skills in practice (via follow-up survey)

Evaluation Framework

The program used a mixed-methods approach combining:

- **Quantitative data** (LMS scores, completion metrics)
- **Qualitative feedback** (open-ended responses)
- **Short-term outcomes** (pre/post)
- **Intermediate outcomes** (3-month follow-up survey)

Data were reviewed quarterly by project staff and the Statistical Consultant.

Data Sources & Methods

LMS (Learning Management System):

- Initial + Final Assessment scores
- Module completion tracking
- Participant satisfaction surveys

Three-Month Follow-Up Survey (SurveyMonkey):

- Self-reported application of skills
- Continued relevance and usefulness of content
- Open-ended reflections on impact and remaining support needs

Qualitative Feedback:

- Embedded LMS survey comments
- Narrative responses in follow-up survey

Summary Matrix of Evaluation Components

Component	Metric	Data Source	Frequency	Success Criteria
Knowledge gain	Pre/post assessment scores	LMS	Ongoing	≥20% improvement
Completion	Modules completed	LMS	Quarterly	80% completion rate
Satisfaction	Participant feedback	LMS survey	Quarterly	≥80% satisfied
Application of learning	Use of skills in practice	3-mo survey	Quarterly	≥50% reporting applied learning

4.4 Outcome & Findings (as of June 2026)

Program Reach & Participation

- Launch date: March 7, 2025
- Launch audience: Initially available to WRC and Lanterman RC vendored providers
- Statewide distribution: Promoted across all Regional Centers; course link distributed to ~22,900 active service providers through LMS listserv
- Ongoing outreach: Targeted outreach to 274 organizations and agencies, along with two statewide LMS email campaigns (March and May 2026), supported continued enrollment and statewide participation.
- Enrollment metrics:
  - Total number of learners enrolled: 1066

Program Completion

- Number of learners who completed the program: 40% (436/1066)
- Number of learners in progress: 38% (403/1066)
- Number of learners not started: 26% (277/1066)
- Completion rates per module:

- Initial assessment: 90% (681/756)
- Introduction: 79% (841/1066)
- Module 1: 87% (600/685)
- Module 2: 89% (560/626)
- Module 3: 90% (515/572)
- Module 4: 85% (476/558)
- Module 5: 94% (452/478)
- Final Assessment: 88% (455/518)

Knowledge Gains (Initial and Final Assessment Results)
Among participants who completed both the Initial and Final Assessments (N=436), results indicate meaningful learning gains. Average scores increased from 61.27% on the Initial Assessment to 80.45% on the Final Assessment representing a 31.3% increase in knowledge over the course of the program.

The median change score was 20 points. In addition, the Final Assessment scores consistently approached 78% improvement, suggesting that learners achieved a solid understanding of key concepts related to substance use disorders, co-occurring mental health conditions, and strategies for supporting adults with I/DD by the conclusion of the training (14% learners showed no change, and 9.5% decreased their scores on the Final Assessment compared to the Initial one).

Qualitative Findings from Learner Reflections
As part of Module 4, Cultivating the Mindset for Supporting People with Accessing Treatment, learners completed an open-ended reflection through the Learning Management System (LMS). Learners were asked to respond to two questions:

1. Which mindset do you think will be the easiest for you to put into practice, and why?
2. Which mindset do you think will be the most challenging for you to put into practice, and why?

Responses were analyzed to better understand how learners perceived the ease and challenges of applying key mindsets emphasized in the training.

Across the qualitative responses, participants demonstrated strong alignment with the core mindsets emphasized in the training, including person-centered care, motivational interviewing, cultural humility, strengths-based approaches, and self-determination. Many described these mindsets as natural extensions of how they already work. Person-centered care, motivational interviewing, cultural humility, and strengths-based approaches were most frequently identified as easier to apply, often because they aligned with personal values such as respect, encouragement, and active listening.

At the same time, several of these same mindsets—particularly cultural humility, Motivational Interviewing, and trauma-informed care—were also described as challenging by other participants. These challenges were commonly associated with the need for awareness of existing bias, more advanced technical skills, heightened emotional sensitivity, or limited prior training. Responses reflected a wide range of interpretations and comfort levels, including occasional off-topic or placeholder entries, as well as identity-based reflections that highlighted how lived experience shaped perceptions of ease or difficulty.

Overall, the findings suggest strong alignment of values with these frameworks, alongside a clear need for continued support and skill-building—especially in cultural humility, Motivational Interviewing, and trauma-informed practice.

Application of Learning (3-Month Follow-Up Survey)

Results from the 3-Month Follow-Up Survey provide evidence of how providers applied knowledge and skills learned through the Supporting Adults with Developmental Disabilities and Substance Use Challenges E-Learning Certification Program in their work with adults with I/DD.

As of June 2026, 84 providers completed the 3-month follow-up survey (n = 84). While the findings reflect the experiences of providers who responded to the survey and may not represent all training participants, they provide valuable insight into the sustained application of learning and changes in professional practice following completion of the training.

Increased Confidence and Practice Change

Provider confidence increased following completion of the training. Average confidence ratings increased from 3.49 before the training to 4.40 at the 3-month follow-up on a 5-point scale (1 = Not at all confident; 5 = Extremely confident). At follow-up, 50.6% of respondents reported feeling very confident, while 44.6% reported feeling extremely confident, meaning that 95.2% of respondents reported high levels of confidence three months after completing the training.

Providers also reported meaningful changes in their professional practice following the training. 87.9% agreed or strongly agreed that they had changed the way they approach supporting individuals with I/DD who have, or may be at risk for, co-occurring mental health and/or substance use disorders. Similarly, 86.7% agreed or strongly agreed that they felt more confident communicating with individuals about these concerns. Confidence was also high in applying trauma-informed practices (81.5%) and making referrals to mental health or substance use treatment services (79.3%), suggesting that providers continued to apply key knowledge and skills gained through the training in their work.

Frequent Use of Core Strategies
Providers reported consistently applying a broad range of evidence-based concepts and recovery-oriented strategies introduced through the training. Across most domains, most respondents indicated using these approaches often or always in their work, demonstrating sustained integration of key training concepts into everyday practice.

The strategies most frequently applied included person-centered care (95.2%), self-advocacy support (90.5%), Motivational Interviewing principles (86.9%), coping strategies (86.9%), strengths-based approaches (88.1%), supporting change talk (85.7%), OARS communication strategies (84.5%), and cultural humility (79.8%), with respondents reporting using these approaches often or always following completion of the training. Mindfulness techniques were also commonly incorporated into practice (77.4%). While refusal skills were applied less frequently than the other strategies, a majority of providers (60.7%) still reported using these approaches often or always in their work.

Overall, these findings suggest that providers continued to integrate the person-centered, recovery-oriented, and trauma-informed principles emphasized throughout the training into their routine practice, supporting the sustained application of learning beyond program completion.

System Navigation and Referrals
Providers reported applying knowledge gained through the training to connect individuals with I/DD to a variety of mental health, substance use, and community support services. Since completing the training, the most frequently reported referral was to Regional Center services, with 76.4% of respondents indicating they had referred an individual for services such as case coordination or crisis response.

Providers also reported making referrals to Medi-Cal primary care providers (27.3%), private or residential substance use treatment programs (18.2%), crisis services such as the 988 Lifeline or Los Angeles County Department of Mental Health Help Line (16.4%), the LA County Substance Abuse Service Helpline (SASH) (12.7%), and both the Los Angeles County Department of Mental Health (LACDMH) ACCESS Line and the SAMHSA Treatment Locator or Helpline (10.9% each).

These findings suggest that the training increased providers' awareness of available behavioral health and community resources and supported their ability to navigate referral pathways to connect individuals with appropriate services.

Observed Outcomes
Providers reported observing a range of positive outcomes among the individuals they supported following completion of the training. The most frequently observed change was increased independence or self-advocacy, reported by 44.1% of respondents. Providers also reported observing increased willingness to seek help (33.3%), greater confidence or

self-efficacy in navigating care systems (27.4%), increased self-reported satisfaction or well-being (25.0%), and improved engagement with mental health or substance use treatment (23.8%).

While 20.2% of respondents indicated that the question was not applicable to their role and 13.1% reported no noticeable changes, the findings suggest that many providers observed meaningful improvements in self-advocacy, help-seeking behaviors, and engagement with services among the individuals they supported following implementation of the training.

Satisfaction and Sustainability

Overall satisfaction with the training was high, with an average satisfaction rating of 4.46 out of 5. Nearly all respondents reported positive experiences, with 64.3% indicating they were very satisfied and an additional 27.4% reporting they were satisfied with the training. Only 3.6% of respondents selected a neutral rating, and no respondents reported being dissatisfied.

Support for the training was further reflected in its strong recommendation rate. All respondents (100%; n = 84) indicated they would recommend the training to other direct service providers. These findings suggest the program was well received by participants and demonstrated strong support for its continued use as a workforce development resource. Combined with the sustained application of knowledge and skills reported throughout the 3-month follow-up survey, the results indicate the program strengthened provider capacity to support adults with intellectual and developmental disabilities (I/DD) and co-occurring substance use and mental health challenges.

Conclusions

Overall, the evaluation demonstrates that the E-Learning Certification Program successfully met the project's defined performance benchmarks. Participants demonstrated knowledge gains exceeding the target of at least 20%, reported high satisfaction with the program, and showed sustained improvements in confidence and professional practice three months after completion. The program also achieved broad statewide reach, enrolling more than 1,000 service providers and expanding access to evidence-informed training on supporting adults with I/DD and co-occurring substance use and mental health conditions.

Importantly, providers reported applying person-centered, trauma-informed, culturally responsive, and recovery-oriented approaches in their daily work and observed positive changes among the individuals they supported, including increased self-advocacy, help-seeking, and engagement with services. These findings suggest that the training not only increased knowledge but also translated into meaningful changes in professional practice that have the potential to improve the quality of services and outcomes for adults with I/DD and co-occurring substance use and mental health conditions.

4.5 Lessons Learned & Recommendations

- **Plain language and person-centered language are essential.** Participants responded positively to content that avoided jargon, used concrete examples, and incorporated visuals. Future programs should continue to prioritize plain-language principles, person-centered framing, and universal design to ensure accessibility and relevance for providers supporting individuals with I/DD.
- **Shorter, interactive modules support learner engagement.** Future iterations should continue emphasizing concise modules that incorporate scenarios, knowledge checks, and interactive learning activities.
- **Subject matter experts' (SME) involvement throughout the scripting phase is critical.** Cross-disciplinary review (including I/DD, SUD, MH, and MI specialists) reduced inaccuracies, strengthened examples, and ensured cultural relevance. Early and continuous SME involvement is recommended for similar initiatives.
- **Pilot testing is essential to identify usability and accessibility issues.** Pilot testing identified navigation, pacing, and accessibility issues that were not evident during development. Incorporating a structured pilot phase with dedicated time for revisions should remain a core component of future implementation.
- **Improving course completion requires more than outreach.** While statewide promotion successfully increased enrollment, overall completion rates remained lower than anticipated. Future implementation should include strategies that support learners throughout the course, such as organizational leadership support, protected training time during work hours, supervisor encouragement, milestone recognition, and periodic outreach to promote continued progress.
- **Training effectiveness should be paired with organizational implementation strategies.** Participants who completed the training demonstrated meaningful improvements in knowledge, confidence, application of evidence-based practices, and satisfaction, indicating that the curriculum was effective. Future efforts should focus not only on maintaining high-quality content but also on supporting organizations in integrating the training into workforce development plans and staff onboarding to maximize participation and impact.
- **Additional strategies are needed to increase follow-up evaluation participation.** Although respondents reported sustained improvements in practice and confidence three months after completing the training, participation in the follow-up survey remained lower than anticipated despite offering a $25 gift card incentive. Future evaluations may benefit from shorter surveys, integrating follow-up into routine organizational workflows, supervisor reinforcement, or alternative approaches for collecting long-term outcome data.

5. Peer Mentoring Program (PMP)

5.1 Purpose & Target Population

The Peer Mentoring Program (PMP) was developed to provide recovery-oriented, peer-led support for adults with I/DD who are experiencing or are at risk for SUD and co-occurring mental health challenges. The program emphasizes peer connection, skill-building, self-efficacy, and access to community-based recovery resources through structured group activities and mentorship by individuals with lived experience.

The PMP primarily serves:

- Adults (18+) with I/DD receiving Regional Center services
- Individuals seeking substance-free social connection and recovery support
- Participants interested in progressing into peer mentor leadership roles

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5.2 Development & Implementation

The PMP was developed and implemented by Sober State, LLC, which led the program design, curriculum development, and service delivery. The program integrates evidence-based and recovery-oriented practices, including Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), mindfulness, psychoeducation, and trauma-informed care.

Key design features included:

- Weekly structured peer support groups facilitated by trained mentors and supervised staff
- Clear role progression from mentee to mentor to alumni
- Incentive-based engagement model to reinforce participation and pro-social behavior
- Integration of substance-free community outings and recovery-oriented activities
- Ongoing staff supervision and mentor support

A detailed description of the PMP's structure, curriculum, group format, mentor training process, incentive system, policies, and evaluation tools is provided in the **Peer Mentoring Program Blueprint** (see Appendix C)

5.3 Replication Guidance

Agencies seeking to replicate the Peer Mentoring Program are strongly encouraged to reference the PMP Blueprint Manual, which provides step-by-step guidance on:

- Program setup and staffing
- Group facilitation structure and weekly meeting flow
- Mentor training and advancement criteria
- Participant eligibility, intake, and retention strategies
- Incentive models and supervision protocols
- Evaluation tools and outcome tracking

The Blueprint Manual is designed to function as a comprehensive implementation guide and may be adapted to meet local community needs while maintaining program fidelity.

5.4 Evaluation

The PMP evaluation was designed to assess participant progress across multiple outcome domains, including personal recovery goals, health and behavioral outcomes, social connection, and overall program engagement. Together, these measures provide a comprehensive view of participant experience and program impact over time.

The four components evaluated in the PMP include: program goals, health outcomes, connections to local resources, and program feedback.

Program goals include self-efficacy, social connectedness, self-confidence, and skill development from participants' self-reported baseline data and completion of the program. Skill development refers to at least three goals that participants have set for themselves at the beginning of the program. Some examples of goals include increasing physical activity, social engagement, and improvement in psychological health. Program staff fill out the pre-, post-, and post-service assessments derived from the Measuring Outcomes in Services and Supports (MOSS) questionnaire for participants. There are eight questions in the MOSS and each on a 5-point Likert scale.

Health outcomes are collected in KIPU, an electronic medical record system, and percent changes are calculated with aggregated reports in KIPU. Specifically, anxiety and depression are assessed with General Anxiety Disorder (GAD-7), and Patient Depression Questionnaire (PHQ-9). Drug use and other mental health outcomes are also collected. Project staff track changes in participant behavior observed through engagement in local recovery group meetings or events, attendance at peer group activities, demonstration of learned skills, and meeting personalized goals. Participants will also self-report any changes in their knowledge about substance use, harm reduction strategies, and access to recovery support services across the duration of their engagement in the program.

Project staff engage participants in monthly to quarterly interviews to attain qualitative data related to overall satisfaction with the peer mentoring program, satisfaction with their

mentor/mentee, factors that may impact their ability to continue in the program, and any themes related to belonging, self-efficacy, or self-confidence.

Summary Matrix of Evaluation Components

Component	Tools	Frequency	Success Criteria
Program goals	MOSS	Admission + semi-annual	≥20% improvement
Health outcomes	GAD-7, PHQ-9, KIPU data	Monthly	Improvement in symptoms
Engagement	Sign-in sheets	Weekly	≥50% attendance
Feedback	Focus groups/interviews	Semi-annual	Positive themes

5.5 Outcome & Findings

Out of the 18 total participants, 6 have achieved mentor status as of June 2026. MOSS data results show that participants' self-efficacy increased by 1.23 points, social connectedness increased by 2.17 points, self-confidence increased by 1.57 points, and skill development increased by 1.33 points. The increases in numbers showed that participants are positively impacted by the program. Furthermore, by analyzing statistics on KIPU, depression and anxiety on average decreased by 26% and 28.5% by the 12th PMP session respectively (See Figure 1 and Figure 2 for data on participants with six months or more data points). The participation rate of monthly outing is 72% on average.

During the entire grant period, PMP staff and participants engage in at least 2 community outreach efforts per month, and up to 5 social media posts per week. To further improve the program, PMP staff seek feedback via focus group interviews with participants, in which common themes such as connectedness to peers and increase in confidence are observed. Program retention rate is 90%. Most dropouts are due to lack of interest or relapses.

Qualitative post-program responses indicate meaningful progress across all targeted outcome areas. Participants consistently described increased knowledge of substance use, harm reduction strategies, and coping skills, including greater awareness of personal triggers and the use of practical techniques such as reaching out for support, engaging in healthy activities, and practicing honesty with themselves and others. Many respondents reported a reduction in or active efforts to eliminate substance use by the end of the program, citing boundary-setting behaviors such as avoiding high-risk environments and limiting contact with individuals associated with past use. These behavioral changes were often framed within a clear "before and after" narrative, suggesting applied learning rather than abstract understanding.

In addition, participants demonstrated increased self-efficacy and motivation to change their substance use behaviors, frequently noting an improved sense of control, confidence, and personal commitment to recovery. Responses also reflected increased knowledge of and access to local health and recovery support services, with several participants indicating new or strengthened connections to counselors, program staff, and other supports. Many respondents reported improvements in emotional well-being, including reduced feelings of unhappiness, stress, or emotional instability, while also acknowledging ongoing challenges. Taken together, the qualitative data suggest the program effectively supported behavioral change, strengthened internal motivation, expanded access to supportive services, and contributed to improvements in mental health outcomes, consistent with a harm-reduction and recovery-oriented approach.

Below are the overall participants outcomes:

1. Skill development (MOSS) (e.g. knowledge of harm reduction strategies and coping skills) increased by 49.7% and satisfaction increased by 43.3%.
2. Participants demonstrated the following reductions in substance use:
    1. Alcohol: 44.4% (4/9) of the participants decreased use
    2. Marijuana: 54.5% (6/11) of the participants decreased use
    3. Illicit drugs: 85.7% (6/7) of the participants decreased use
    4. Overall substance use: 28.6% (2/7) of participants decreased use.
3. Self-efficacy (MOSS) and motivation to change their substance use behaviors increased by 49.7% and satisfaction by 79.8%.
4. Participants demonstrated a 100% (18/18) increase in knowledge about and access to local health and recovery support services after participating in PMP.
4. Mental health symptoms like depression and anxiety decrease depending on the session. Due to small sample size, the averages fluctuate a lot depending on newly enrolled participants. By the 12th session, depression decreased by 26%; Figure 1 and Figure 2 show score distributions for participants with 6 months or more data points.

Figure 1. Depression score distribution of participants over sessions.

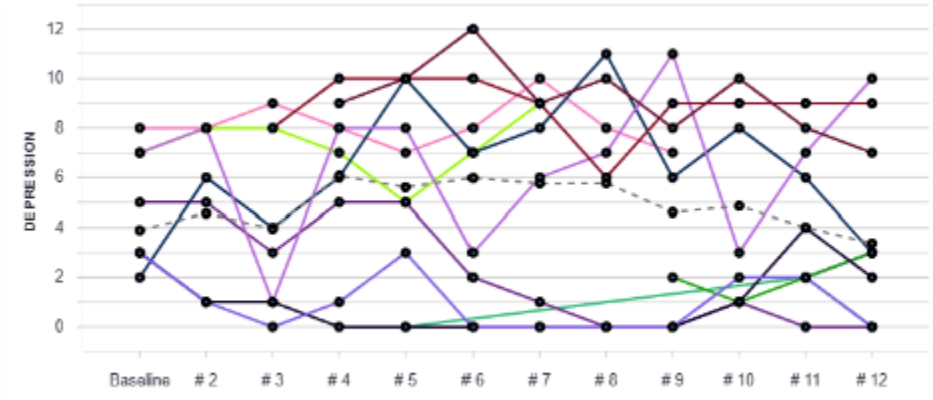
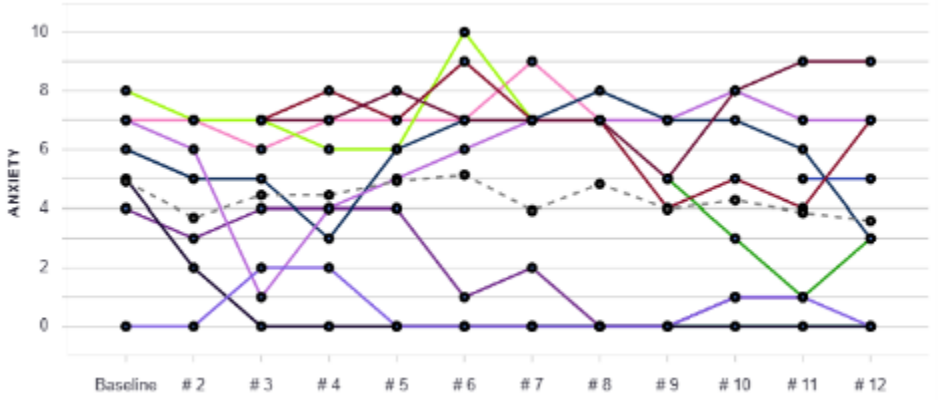


Figure 2. Anxiety score distribution of participants over sessions.



Participant Video Testimonials

To complement the evaluation findings, video testimonials were collected from PMP participants and mentors to capture their lived experiences and perspectives on the program's impact. The testimonials highlight personal recovery journeys, increased confidence, social connection, and the value of peer support.

View the video here.

Conclusions

Overall, the evaluation demonstrates that the Peer Mentoring Program successfully met the project's definition of success. Participants actively engaged in the program, reported high satisfaction, and experienced meaningful personal gains. Findings demonstrated improvements in confidence, recovery skills, social connectedness, and knowledge of community resources, while participant feedback highlighted increased hope, motivation, supportive peer relationships, and positive changes in their recovery journeys.

Quantitative and qualitative findings further indicate that the program contributed to meaningful recovery-related outcomes, including reductions in anxiety, depression, and substance use among many participants. Participants also reported applying harm reduction strategies, strengthening healthy coping skills, and making positive behavioral changes that supported their long-term recovery.

Together, these findings demonstrate that the Peer Mentoring Program provided a valuable recovery-oriented support model that complements formal behavioral health services. By leveraging the shared lived experiences of peer mentors, the program fostered community inclusion, strengthened recovery supports, and empowered adults with I/DD and co-

occurring substance use challenges to build confidence, sustain recovery, and navigate community resources with greater independence.

5.6 Lessons Learned & Recommendations

- **Peer leadership develops through consistent practice and support.** Mentor confidence and leadership skills strengthened over time through repeated opportunities to facilitate meetings, model recovery, and receive ongoing coaching. Leadership development is a gradual process that benefits from structured roles, mentorship, and sustained investment.
- **Relationship-building is the strongest driver of engagement and retention.** While incentives encouraged initial participation, long-term engagement was driven primarily by the supportive peer environment, meaningful relationships, and opportunities for social connection. Participants often returned to the program even after periods of absence because of the sense of belonging fostered within the group. Future programs should prioritize community-building alongside structured activities.
- **A consistent and flexible program structure improves accessibility.** Predictable meeting routines helped participants feel comfortable and prepared while allowing flexibility to accommodate individual needs. Expanding to a hybrid meeting format could further improve accessibility by enabling participants who are ill, have transportation barriers, or live farther away to continue participating and remain connected to the group.
- **Multimodal teaching approaches increase participation and strengthen learning.** Participants benefited from combining visual supports, repetition, modeling, discussion, and hands-on activities. Programs serving adults with I/DD should incorporate multiple communication methods rather than relying primarily on verbal instruction.
- **Incentive structures should balance engagement with long-term sustainability.** The program demonstrated that meaningful peer relationships and engaging activities were stronger motivators than financial incentives alone. Future implementations may consider a more sustainable incentive structure by providing smaller incentives early in the program while reserving larger milestone incentives for sustained participation and achievement.
- **Staff continuity and community partnerships strengthen long-term program success.** Consistent staff support helped maintain trust and stability within mentoring relationships, while partnerships with recovery groups, mental health providers, and disability-serving organizations expanded community connections and support beyond PMP sessions. Continued outreach and collaboration will be important for sustaining the program beyond the MHSA funding period.

6. Project Timeline

Activity	Fiscal Year (FY) 23/24				FY 24/25				FY 25/26			
	Q1 **7/1/23-9/30/23**	**Q2** **10/1/23-12/31/23**	**Q3** **1/1/24-3/31/24**	**Q4** **4/1/24-6/30/24**	**Q1** **7/1/24-9/30/24**	**Q2** **10/1/24-12/31/24**	**Q3** **1/1/25-3/31/25**	**Q4** **4/1/25-6/30/25**	**Q1** **7/1/25-9/30/25**	**Q2** **10/1/25-12/31/25**	**Q3** **1/1/26-3/31/26**	**Q4** **4/1/26-6/30/26**
Establish leading team (objective1)	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Perform literature reviews, needs assessment (objective 2.1)	☐	☒	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Assess the initial impact of the e-learning rollout (objective 2.2)	☐	☐	☐	☐	☒	☒	☐	☐	☐	☐	☐	☐
Assessment of the e-learning; data collection (objective 2.2)	☐	☐	☐	☒	☒	☒	☒	☒	☒	☒	☒	☒
Conduct final program evaluation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
Perform literature reviews (objective 3.1)	☐	☒	☒	☒	☐	☐	☐	☐	☐	☐	☐	☐
Create training curriculum (objective 3.2)	☐	☐	☒	☒	☒	☐	☐	☐	☐	☐	☐	☐
Upload training into LMS, recruit, track participation, evaluate (objective 3.3)	☐	☐	☐	☐	☒	☒	☐	☐	☐	☐	☐	☐
Develop and promote RFP for Peer Mentoring Program; interview and contract with selected provider (objective 4.1)	☒	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Assist in development of program design and evaluation of PMP (objective 4.2)	☐	☐	☒	☒	☐	☐	☐	☐	☐	☐	☐	☐
Monitor implementation of PMP (objective 4.2)	☐	☐	☐	☐	☒	☒	☒	☒	☒	☒	☒	☒
Assist in reviewing sustainability of PMP (objective 4.2)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒	☒
Identify and invite Grant Advisory Council members (objective 5)	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hold Grant Advisory Council meetings (objective 5)	☐	☐	☐	☒	☐	☒	☐	☒	☐	☒	☐	☒

7. Project Impact & Sustainability

7.1 System-Level Impact

The Substance Use Delivery Expansion Project strengthened system-level capacity to support adults with I/DD and co-occurring substance use and mental health conditions across Los Angeles County.

Key impacts include:

- **Increased workforce capacity:**
  Service providers gained foundational knowledge, shared language, and practical tools to identify substance use concerns, understand co-occurring conditions, and support treatment engagement among adults with I/DD.
- **Stronger cross-system collaboration:**
  The project facilitated coordination among Regional Centers, service providers, subject matter experts, and community partners, supporting more aligned approaches to workforce development, peer support, and service delivery.

- **Broader community reach:**
  Through statewide LMS distribution and community-based Peer Mentoring Program activities, the project extended beyond individual agencies to reach a wide network of service providers and adults with I/DD.

7.2 Sustainability Strategies

Several components of the project were designed to remain active beyond the grant period and support ongoing impact:

- **Sustained access to training:**
  The E-Learning Certification Program remains available through the LMS, allowing continued access to training, onboarding of new staff, and refresher learning for existing providers.
- **Continuation of peer support services:**
  The Peer Mentoring Program continues through contracted provider services, maintaining access to recovery-oriented support for adults with I/DD and SUD.
- **Planning for long-term sustainability:** As part of the project's sustainability efforts, internal planning and consultation were initiated to support exploration of vendorization for the Peer Mentoring Program. WRC connected Sober State with internal staff knowledgeable about the vendorization process to help inform next steps and evaluate long-term sustainability opportunities.
- **Ongoing advisory input:**
  The Grant Advisory Council established during the project created a foundation for continued cross-system dialogue and may continue to inform future service improvements.

7.3 Future Directions

Building on the project’s outcomes and lessons learned, future efforts may include:

- **Curriculum refinement and updates** to reflect emerging best practices, updated resources, and learner feedback.
- **Implementation of learner engagement strategies** (e.g., leadership support, protected training time, supervisor encouragement, and periodic reminders) to improve completion of the E-Learning Certification Program while maintaining broad statewide access.

- **Expansion of peer mentoring services** to reach additional participants or regions, informed by evaluation of findings, program capacity, and future sustainability planning.
- **Structured collection of relapse data** to understand and minimize dropout rates and further improve substance use outcomes.
- **Cross-Regional Center training opportunities** leveraging the LMS platform to support broader workforce development across California.

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8. Appendices

Appendix A. Project Staffing Materials

A1. Position Postings

A2. Request for Proposals

A3. Interview Scoring Sheets

Appendix B. E-Learning Certification Program Materials

B1. WRC/FDLRC: Supporting People with Substance Use Concerns: Provider Survey

B2: Provider Survey Report

B3: Literature Review Guide

B4: Literature Review Summary

B5: Data Extraction Best Practices and Scope of IDD SUD

B6: 3-Month Follow-Up Survey

Appendix C. Peer Mentoring Program Materials

C1. Peer Mentoring Program Blueprint

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8. Acknowledgement

Westside Regional Center and Frank D. Lanterman Regional Center extend sincere thanks to the members of the interdisciplinary Grant Advisory Council, whose expertise spanned multiple systems of care. Their cross-sector perspective strengthened program design, ensured disability- and culturally responsive approaches, and grounded the project in real-

word practice. We are grateful for their collaboration and commitment to improving recovery-oriented support for adults with intellectual and developmental disabilities.

PROJECT MANAGER CONSULTANT POSTING

Posting Date: July 25, 2023
Closing Date: August 25, 2023

Agency Description

Westside Regional Center (WRC) is a state-funded, private, non-profit agency dedicated to serving individuals with developmental disabilities in Western Los Angeles County. WRC offers service coordination, health education, and provision of resources and support to people with developmental disabilities (e.g., intellectual disability, autism, cerebral palsy, epilepsy).

Position Description

To lead implementation of a grant-funded project focusing on interventions to improve substance use disorder (SUD) services for individuals with intellectual/developmental disabilities (I/DD) and mental health concerns. The goals are to develop (1) e-learning Certification Program to increase capacity of providers working with individuals with I/DD dually diagnosed with SUD, and (2) Peer Mentoring Program for individuals with I/DD and SUD to support their immediate needs and facilitate social connections as well as links to local recovery groups.

Key Duties and Responsibilities:

- Lead coordination and administration of all project implementation activities, including literature reviews, needs assessments, development of curricula, evaluation tools, data collection and management,
- Identify local drug and alcohol programs and assist in referrals and linkage,
- Support development and implementation of culturally competent e-learning training curriculum and Peer Mentoring Program's design,
- Draft correspondence on project-related issues and prepare and update periodic reports, briefing notes, and other documentation,
- Monitor project outcomes and contribute to ongoing strategic planning to meet grant deliverables,
- Lead the quarterly Grant Advisory Council's meetings.

Qualifications:

- Certified Alcohol Drug Counselor (CADC) or other counselor certification in alcohol and other drugs, or equivalent work experience in public health, social work, psychology, or other related fields preferred. Candidates in the process of obtaining their Master's degrees are encouraged to apply.
- Excellent verbal, interpersonal, and written communication skills.
- Demonstrate compassion, competency, and professional accountability for interactions with individuals served by WRC, their circles of support and other stakeholders.
- Have background and/or experience in the fields of substance use prevention, treatment, and recovery, mental health and/or developmental disabilities.

This is a remote, hourly ($35/hour; up to 20 hours per week) contracted position with flexible hours and secured funding from Mental Health Services Act grant in partnership with the California Department of Developmental Services.

Contact Information

For consideration, please email a cover letter and resume to Aga Spatzier, MPH, Wellness Manager at agas@westsiderc.org. Please call Aga at 310 258 4254, if you have any questions.

APPENDIX A

RESEARCH ASSISTANT CONSULTANT POSTING

Posting Date: July 25, 2023
Closing Date: August 25, 2023

Agency Description

Westside Regional Center (WRC) is a state-funded, private, non-profit agency dedicated to serving individuals with developmental disabilities in Western Los Angeles County. WRC offers service coordination, health education, and provision of resources and support to people with developmental disabilities (e.g., intellectual disability, autism, cerebral palsy, epilepsy).

Position Description

To support implementation of a grant-funded project focusing on interventions to improve substance use disorder (SUD) services for individuals with intellectual/developmental disabilities (I/DD) and mental health concerns. The goals are to develop (1) e-learning Certification Program to increase capacity of providers working with individuals with I/DD dually diagnosed with SUD, and (2) Peer Mentoring Program for individuals with I/DD and SUD to support their immediate needs and facilitate social connections as well as links to local recovery groups.

Key Duties and Responsibilities:

- Perform literature reviews on best practices in identification and supports in treatment of SUB among people with I/DD into curricula development,
- Assist in development and implementation of needs assessments of local service providers/vendors and lead focus groups/listening sessions with individuals served by WRC,
- Support development and implementation of culturally competent e-learning training and peer program curricula/program design, recruitment materials, and evaluation tools,
- Collect and analyze data to monitor process and outcome measures,
- Draft correspondence on project-related issues and prepare and update periodic reports, briefing notes, and other documentation (e.g., presentations and/or manuscripts),
- Assist in development of agendas for the quarterly Grant Advisory Council's meetings.

Qualifications:

- Bachelor's degree, or equivalent work experience, in public health, social work, psychology, or other related fields preferred. Candidates in the process of obtaining their Master's degrees are encouraged to apply.
- Excellent verbal, interpersonal, and written communication skills.
- Familiarity with Microsoft Office and data entry (STATA, SAS, or SPSS).
- Demonstrate compassion, competency, and professional accountability for interactions with individuals served by WRC, their circles of supports, and other stakeholders.
- Have background and/or experience in the fields of mental health, substance use prevention, treatment, and recovery, and/or developmental disabilities.

This is a remote, hourly ($30/hour; up to 10 hours per week) contracted position with flexible hours and secured funding from Mental Health Services Act grant in partnership with the California Department of Developmental Services.

Contact Information

For consideration, please email a cover letter and resume to Aga Spatzier, MPH, Wellness Manager at agas@westsiderc.org. Please call Aga at 310 258 4254, if you have any questions.

WESTSIDE REGIONAL CENTER

APPENDIX A

Request for Proposals (RFP)

Westside Regional Center (WRC) is seeking Data Collection and Evaluation Consultant.

SUMMARY: In partnership with Frank D. Lanterman Regional Center, WRC aims to improve substance use disorder (SUD) services for individuals with intellectual/developmental disabilities (I/DD) and mental health concerns by developing: (1) e-learning Certification Program to increase capacity of providers working with individuals with I/DD dually diagnosed with SUD, and (2) Peer Mentoring Program for individuals with I/DD and SUD to support their immediate needs and facilitate social connections as well as links to local recovery groups. In order to accomplish those goals, WRC is looking for a well-qualified Evaluation Consultant to develop and implement needs assessments, perform consultations and program progress evaluations, including:

- development and implementation of surveys to identify the scope of substance use disorders among people with intellectual/developmental disabilities (I/DD) served by WRC and Lanterman Regional Center, number of providers supporting this population, as well as needs of both of those groups,
- development of standardized protocols for data collection as well as tools to monitor outcomes, and fidelity of implementation of the e-learning and peer mentor programs,
- assistance in development of tools to evaluate Peer Mentoring Program on access, delivery of services, program efficiency, as well as cost analysis for funding sustainability,
- final program evaluation with service providers and people served or supported under this project.

TARGET AUDIENCE: The primary target audience of this work will be individuals with I/DD served by WRC and Lanterman Regional Center, regional center staff and vendored service providers working with individuals with I/DD dually diagnosed with mental health and substance use disorders.

SERVICE DELIVERY: Successful proposal to be selected and contact to be finalized by September 25, 2023. This is a 3-year project with flexible consulting hours and quarterly deliverables.

DATE POSTED: July 25, 2023

RFP DUE DATE: August 25, 2023

HOW TO SUBMIT PROPOSALS: Interested subject matter experts should send a statement of interests, background and qualifications, including CV, and proposed scope of work to agas@westsiderc.org.

APPENDIX A

WESTSIDE REGIONAL CENTER

Request for Proposals (RFP)

Westside Regional Center (WRC) is seeking Subject Matter Experts in the fields of Mental Health and Intellectual/Developmental Disabilities (I/DD), Substance Use Prevention, as well as Motivational Interviewing (MI).

SUMMARY: WRC is looking for up to three (3) well-qualified subject matter experts in the fields of mental health and I/DD, substance use prevention, as well MI to develop training curricula for a series of e-learning courses (including instructional design/script writing). The subject matter experts must be experienced in:

- Working with individuals with I/DD and their circles of support,
- Developing and delivering culturally competent training curricula for service providers assisting individuals with I/DD,
- Utilizing evidence-based techniques to quip target audiences with skills in identification and understanding of substance abuse issues, trauma-informed care, Motivational Interviewing as well as provide tools to encourage and support population in treatment.

TARGET AUDIENCE: The primary target audience of this work will be regional center staff and vendored service providers working with individuals with intellectual/developmental disabilities dually diagnosed with mental health and substance use disorders.

SERVICE DELIVERY: Successful proposal to be selected and contact to be finalized by September 25, 2023. Training curricula to be completed on or before February 28, 2024.

DATE POSTED: July 25, 2023

RFP DUE DATE: August 25, 2023

HOW TO SUBMIT PROPOSALS: Interested subject matter experts should send a statement of interests, background and qualifications, including CV, and proposed scope of work to agas@westsiderc.org.

WESTSIDE REGIONAL CENTER

Summary of the Project

Posting Date: August 25, 2023
Service Type: E-learning Courses Design and Development
Specialization: E-Learning Instructional Design
Funds Available: $100,000.00
E-learning Location: Learning Management System (LMS)
Timeline: Work to begin in December 2023 and be completed by May 1, 2024
Proposal Submission Deadline: September 25, 2023.

REQUEST FOR PROPOSALS

PURPOSE

Westside Regional Center, in partnership with Frank L. Lanterman Regional Center, is requesting proposals to design and develop a series of e-learning courses for service providers. This project is a multi-regional center project approved by the California Department of Developmental Services in partnership with Mental Health Services Act (MHSA) funding for fiscal years 23/24 through 25/26

SCOPE OF WORK

Westside Regional Center (WRC) and Frank L. Lanterman Regional Center (Lanterman RC) will work on initiatives to improve substance use disorder services for individuals with developmental disabilities receiving services from regional centers. The development of Certification Program to increase capacity of service providers, is a focus for this Request for Proposals (RFP) and will be achieved by contracting with consultant to develop and design a series of e-learning courses as well as a custom, branded template in Articulate Storyline 360.

WRC and Lanterman RC will be responsible for providing content and subject matter expertise for the courses. The consultant will be responsible for converting the content into an online format that will effectively deliver the instruction with a high level of quality, look and feel and interactivity. The consultant will design and develop e-learning courses, as part of the Certificate Program, including, but not limited to, a full course instructional design, storyboarding, scripting, audio/video editing, professional voice-over narration, AA 508-compliance, quality assurance/testing, and project management. The number of courses will be determined by the contractor based on the standard course length and 180 hours of instruction. We anticipate the minimum length of each course to be between 15 to 20 min. The contractor is to utilize best practices in Instructional Design to gauge learners' retention and knowledge. The consultant will also provide course integration and support for the hosting Learning Management System (LMS). The consultant will conduct testing of the courses prior to implementation to ensure that they will operate properly in the LMS environment and to make final adjustments to both content and technology. The consultant will also provide support to

the regional centers' system administrator staff and assist them in their support of the end users.

At a minimum, the e-learning courses to be developed under this contract must meet the standards outlined in the Association of Regional Center Agencies Statewide Training and Information Group approved guidelines and the following specifications:

- Provide 15 to 30 minutes of online learning time per course.
- Offer ease of navigation, including clear screen layouts and the ability to move back and forth, exit and resume or complete as necessary through the course modules.
- Be interactive, incorporating such learning tools as quizzes and knowledge checks, and provide immediate feedback on them.
- Incorporate interactive case studies and problem-solving exercises.
- Be capable of supporting pre- and post-course assessments of user knowledge.
- Feature a mix of text, voice and graphics and/or still photos. If video clips are not available, consultant will specify the additional cost.
- Be easily modified to accommodate changing/evolving content.
- Be developed using software authoring tools available to WRC and Lanterman RC.
- Incorporate the ability to print a certificate of completion for learners completing the course. The ability to work with Thinking Cap to design custom for an additional cost associated with this feature in the LMS.
- All courses will be 1.2 or 2004 SCORM compliant.

PROPOSAL FORMAT

Please include the following information in your proposal:

General Information: The proposal should provide the name of the agency, address, phone number, email address, and website. The name and email address of any team members assisting with the project should also be included.

Work Plan: The proposal should include a brief description of all the proposed components of the design and development of the interactive courses using Articulate Storyline 360, including content scripting phase, professional voice-over narration, AA 508-compliance, quality assurance/testing, and any projected kickoff calls/meetings and their goals.

Assumptions: Based on the extensive experience, the proposal should include assumptions regarding proposed project including content/scrip, revisions, project management, narration, media use, and any updates to scope of work.

Timeline and Budget: The project timeline and budget should include tasks, responsible parties, estimated time for completion, corresponding fees/projected costs, and invoicing schedules.

References: Information regarding past projects (could be limited to the ones relevant to this RFP) including references. Please include the individual's name, address, phone number and email address.

SCORING

Proposals will be reviewed and evaluated on the following criteria:

1. Qualifications
2. Scope of Proposal
3. Work Plan
4. Budget

PROCESS FOR PROPOSAL SUBMISSION AND EVALUATION

Instructions for submission:

1. **Closing Submission Date**
   Proposals are due by 5:00pm on Monday, September 25, 2023.

2. **Inquiries**
   Inquiries concerning this RFP should be directed to: Aga Spatzier, MPH, Wellness Manager via email agas@westsiderc.org.

3. **Conditions of Proposal**
   All costs incurred in the preparation of a response to this RFP are the responsibility of the bidder and will not be reimbursed by WRC and Lanterman RC.

4. **Submission Instructions**
   All submissions must be submitted through email to: agas@westsiderc.org
   - FAX copies will NOT be accepted.
   - Submissions will NOT be returned.

   An email acknowledgement of each submission received will be sent to the applicant.

   All proposals received by the deadline will undergo a preliminary screening. Late or incomplete applications will not be accepted for review and rating. Any proposal may be disqualified if it deviates from the submission instructions in the RFP.

5. **Reservation of Rights**
   WRC and Lanterman RC reserve the right to request or negotiate changes in a proposal, to accept all or part of a proposal, or to reject any or all proposals. WRC and Lanterman RC may, at their sole and absolute discretion, select no provider for these services if, in their determination, no applicant is sufficiently responsive to the need. WRC and Lanterman RC reserve the right to withdraw this Request for Proposals (RFP) and/or any item within the RFP at any time without notice. WRC and Lanterman RC reserve the right to disqualify any proposal which does not adhere to the RFP guidelines. This RFP is being offered at the discretion of WRC and Lanterman RC. It does not commit the regional centers to award any grant.

6. **Confidentiality**

If the bidder deems any material submitted to be proprietary or confidential, the bidder must indicate this in the relevant sections of the response.

7. **Ineligibility**
   Under the following conditions, an individual or entity is ineligible to be a regional center vendor, and therefore may not submit a proposal.

   Conflict-of-Interest: Any individual or entity that has a conflict-of-interest as established in DDS Regulations, Title 17, Sections 54314 and 54500 et seq., unless a waiver is permitted and obtained, including WRC and Lanterman RC employees and Board members, and their family members.

8. **Notification of Selection and Timeline**
   WRC and Lanterman RC will seat the RFP Selection Committee. The evaluation process will include individual committee member evaluation and rating of each proposal, followed by committee discussion and ranking of proposals. After preliminary rating and ranking of proposals, interviews may be scheduled with finalists, particularly if two or more proposals are closely rated and/or more information is needed. References might be contacted for all finalists.

   Additional information may be required from the selected applicant prior to the awarding of the project. Any information withheld or omitted, or failure to disclose any history of deficiencies or client abuse shall disqualify the applicant from award of the project and/or contract. WRC and Lanterman RC reserve the right not to select an applicant for project implementation if, in their determination, no qualified applicant has applied or is sufficiently responsive to the service need.

   If no proposal is selected, WRC and Lanterman RC may elect to either not develop the service pending further analysis of alternatives to meet the expressed need, or to issue a new RFP to attempt to expand the pool of potential respondents.

Completed RFP submissions including all elements listed above are due to **Westside Regional Center by 5:00pm on Monday, September 25, 2023**. Please email submissions to: **agas@westsiderc.org.**

WESTSIDE REGIONAL CENTER

Announcement of Request for Proposal (RFP)
Fiscal Year 2023-2024

Summary of Project: Westside Regional Center (WRC) is soliciting proposals for a substance use treatment peer mentoring contracted service.

Posting Date: October 16, 2023

Mental Health Services Act (MHSA) Funds Available: The MHSA, approved by voters in 2004, assists counties and state agencies in providing increased funding, personnel, and other resources to support county mental health programs. The Department of Developmental Services (DDS) has been receiving MHSA funding for regional centers to develop and oversee innovative projects. WRC, in collaboration with Frank D. Lanterman Regional Center, received MHSA funds to improve substance use disorder services for individuals with intellectual/developmental disabilities (I/DD) and mental health concerns. This project is called "Substance Use Delivery Expansion Project" and it aims to: (1) develop an E-learning Certification Program to increase the capacity of providers working with individuals with I/DD who are dually diagnosed with substance use disorders (SUD), and (2) develop a Peer Mentoring Program for individuals dually diagnosed with I/DD and SUD, or at risk for dual diagnosis, to support their immediate needs and facilitate substance recovery, social connections, as well as links to local recovery groups. The second goal, development of a Peer Mentoring Program, is the focus for this RFP and will be achieved by contracting with an individual, a group of individuals, or a not-for-profit agency (501-C3), or a proprietary, for-profit entity. Funds identified in this RFP are solely for activities integral to development and program delivery. For example, administrative component, personnel recruitment, program design development (including screening, intake, individual and program evaluations), staff training, mentor recruitment and training. Funds are not intended to cover 100% of the development costs.

Location: WRC and Frank D. Lanterman Regional Center's catchment areas and other adjacent communities.

Development Timeline: The program should be ready to provide services no later than June 30, 2024, unless otherwise specified.

Service Description: WRC is soliciting proposals for a substance use treatment peer mentoring contracted service to train and support adult individuals with I/DD and SUD, and those who are at risk for dual diagnosis of substance use and mental health conditions, to serve as peer mentors for other clients in substance use recovery. Individuals participating in this program may need support in some or all the following areas: substance abuse prevention and treatment, mental health challenges, anger and aggression management, medication management, health care and access to mental

health/substance use services, and forensic concerns and/or risk of criminal involvement. The agency might offer or arrange comprehensive substance abuse prevention and/or treatment, mental health counseling, trauma-focused therapies, social skill development, competency training, and crisis intervention services. The agency will also develop a peer-delivered outreach program to individuals supported by the regional centers who are in substance use recovery and create linkages between those clients and mentors.

Potential providers must have prior experience/knowledge in the following:

- Supporting individuals with developmental disabilities, mental health, and forensic backgrounds.
- Working with substance abuse prevention and/or treatment.
- Working with the mental health care system.
- CA valid license (i.e., LMFT, LSW, PsyD, PhD, LPC) or at the very least, a certification as a Substance Use Counselor.

A provider must be able to work collaboratively with others in a multi-agency, interdisciplinary configuration (e.g., other regional centers, courts, mental health systems, probation).

Goals should be individualized to program participants, and possible outcomes may include the following:

- Improved knowledge, attitudes, and coping skills surrounding substance use and harm reduction.
- Reductions or eliminations of substance use.
- Increases in self-efficacy and motivation to change.
- Increases in knowledge and access to local health and recovery support services.
- Development of positive mentee and peer mentor relationships (increased utilization of social/peer support).
- Active implementation of strategies to decrease mental health symptoms identified by the counselor (e.g., depression, anxiety).

Deadline for Submission: Proposals must be received at WRC by **December 15th, 2023.** This RFP does not commit WRC to procure or contract for services or support. WRC may elect to fund all, part, or none of the project, depending on funding availability as approved by DDS and the quality of the proposals received.

MHSA funding will be negotiated. MHSA funds have been approved by the DDS under WRC's "Substance Use Delivery Expansion Project" for the Peer Mentoring Program and are set as following:

Fiscal Year (FY): 2023-24: up to $75,000
FY 2024-25: up to $150,000
FY 2025-26: up to $150,000

The applicant agency should propose to use funds to bring in consultation for development of the service, and for recruitment of staff and consultants to establish the service.

The applicant agency:

- Will be required to meet all Title 17 requirements, as applicable to this service model as prescribed by DDS.
- Will provide a plan for recruitment, thorough background check, i.e., Live-scan, pre-service and ongoing training, and provision of consultative support to supported living staff that will best assure that the outcomes of the service and life goals of individuals are met.
- Will provide a plan for security and response to emergencies.
- Will develop a plan for evaluation of service success and quality of life outcomes by an objective third party.
- Must adapt toward individual service recipients and a commitment to have a creative and flexible approach to service, and to modify support to ensure continued stability without requesting additional funding from the regional center.
- Must agree to a minimum of quarterly monitoring by WRC. Families will be evaluated by a separate process and on a more frequent schedule.
- Must keep financial data for 5 years from the date of contract. It is required to keep receipts and cancelled checks for 5 years from the date of contract.
- Must disclose any potential conflicts of interest (Title 17, §54500). Proposals will NOT be accepted from employees of the State of California, employees of the regional center system, or their immediate family members. Eligible applicants may be either a non-profit corporation (501-C3) or proprietary, for-profit entities.

Additional Requirements:

- Development of Program/Service Design: The selected applicant will be required to complete a service design within thirty (30) days of award of the contract.
- Proof of Liability Insurance: The selected applicant will be required to maintain general and professional liability insurance for all work performed on behalf of regional center clients and their families and to name the regional center as an additional insured on all such policies.

Costs for Proposal Submission: Applicants responding to the RFP shall bear all costs associated with the development and submission of a proposal.

SUBMISSION INSTRUCTIONS

Please submit a single PDF file with all information in the same order as listed below:

Application/Proposal Coversheet – Attachment A

Table of Contents

Professional Resumes and References – Attachment B

Statement of Obligation – Attachment C

Sample Financial Statement – Attachment D

Budget Summary – Attachment E

Mission, Vision, and Value Statements: Provide any agency MVV statements and how these were developed for your agency.

Background and Experience: Summarize education, experience, and knowledge of key personnel in providing services to the target populations. Describe how the documented education, knowledge, and experience will be a good fit for developing this program.

Development Experience: Briefly summarize your current and previous development of services and programs. Highlight similarities between current or previous program(s) developed and your proposed program for this RFP.

Agency Outcomes: Describe anticipated outcomes of proposed service and how achievement of outcomes will be measured.

Assessment and Planning: Briefly describe the planning process. Discuss how individual goals and objectives will be determined and progress measured. Describe the outcomes for each target population involved (e.g., individuals working as mentors as well as those being mentored).

Administrative/Consultant Roles: Describe roles of Administrator, additional staff, and proposed involved consultants. Provide qualifications of any certified or licensed staff or consultants. Attach resumes.

Methods and Procedures: Applicants will describe the substance use treatment peer mentoring service including how they will address:

- Substance use and mental health treatment needs of participants, as well as therapeutic approaches/modalities to be utilized.
- Education approaches for substance abuse treatment and prevention to prepare program participants to mentor their peers, tools to monitor competencies, and any proposed processes to reimburse mentors for working with mentees.
- Participant motivation issues using incentive systems to promote cooperation and participation in the treatment and educational aspects of the services.
- Entrance/exit criteria for program participants.

Staff Recruitment and Retention: Describe your plan to recruit and retain quality staff. Include the following:

- Desired characteristics for all staff positions.
- Health and criminal background screening procedures.
- Initial and ongoing training, including required certifications. Include any specialized training for providing behavior support and crisis intervention to individuals who have potentially dangerous behaviors.
- Discuss what typical staff turnover is for your organization/agency.
- Provide information on salary levels and benefits. Direct care staff must be paid at a set minimum.
- Attach an organization chart that includes this project and maps the supervisory hierarchy.
- Provide job descriptions and qualifications for the primary staff and consultant positions.

Staffing Schedule: Provide a sample one-week staffing schedule including the administrative staff, direct support professionals, consultant(s), and program prep time.

Transportation: Describe how participants' transportation will be addressed for appointments and program activities.

Communication: Describe how participants' diverse communication styles will be addressed (including any translation, interpretation, ASL needs).

Financial Resources: Discuss what financial resources you bring to the project (e.g., line of credit, cash, or fluid capital reserves, etc.).

Continuous Quality Improvement (CQI): Describe how the service agency will use data, such as agency outcomes, stakeholder satisfaction, or other existing data (e.g., incident reports, medication logs) to identify service problems pursuant to corrective changes such as revised staff training curriculums, staff training procedures (e.g., supervision, medication management, recruiting, etc.). Providers shall describe the feedback loop by which problem procedures will be identified, corrective through revised practices, and further monitored to measure the effectiveness of those changes in agency practice.

DS 1891 Applicant/Vendor Disclosure Statement: Complete and include this document:
http://www.dds.ca.gov/Forms/docs/DS1891.pdf

Formatting Requirements: All submissions must be emailed to **RFP@WestsideRC.org.** Electronic submissions cannot exceed 15 megabytes per email. Multiple emails per RFP submission can and will be accepted. An email acknowledgement of each submission received will be sent to the applicant.

Attachments/Forms must be type written. Include additional pages as needed, please note that **proposals should be no longer than 10 pages total.** All proposals must be complete, typewritten, collated, and page numbered. Please save and email the attachments/forms as a single PDF file.

The "Application/Proposal Coversheet" (see Attachment – A) must be the first page of the proposal.

The proposal must include a Table of Contents.

As applicable, include appendices for documents, such as resumes, certificates, curricula, schedules, letters of recommendation, letters of support from agencies, consultants expected to provide program services, etc. Those will not be counted towards the maximum 10-page submission.

Fax copies will NOT be accepted.

Submissions will NOT be returned.

Proposals will NOT be accepted after the deadline.

Inquiries/Requests for Assistance: Technical assistance is limited to the information on the requirements for preparing the application packet. Applicants are expected to prepare the documentation themselves or retain someone to provide such assistance. If an applicant chooses to retain assistance from another party, the applicant must be able to thoroughly address all sections of the proposal during the interview process and/or demonstrate that the party assisting with the application will have a continuing role in the ongoing operation of the program.

Inquiries Contact: Westside Regional Center
Attn: Aga Spatzier, Wellness Manager
5901 Green Valley Circle, Ste. 320
Culver City, CA 90230
agas@westsiderc.org

Timeline requirements:

- October 16, 2023---Request for proposals release
- November 16, 2023---RFP Zoom orientation meeting (optional)
- **December 15, 2023**---RFP submission deadline
- January 8-12, 2024---Evaluation of proposals by selection committee
- January 22-26, 2024---Interviews with highest-ranking applicants, if applicable
- January 31, 2024---Notice of selection mailed to applicants
- February 2, 2024---Notification of Project Award posted on WRC website
- March 1, 2024---Contract signed

An RFP orientation meeting will be held on
Thursday, November 16th, 2023, at 11:00 a.m. via Zoom.
Please submit questions about the RFP to agas@westsiderc.org prior to the orientation meeting.

Register in advance for Peer Mentoring Program RFP Orientation.

After registering, you will receive a confirmation email with information about joining the meeting.

Attachment – A

APPLICATION/PROPOSAL COVERSHEET

Name of Applicant or Organization Submitting Proposal
Name of parent corporation, if applicable
Applicant's mailing address
Contact person for project

Contact phone number	Contact fax number	Contact e-mail address

Author of proposal or consultant assisting with proposal	Author/consultant phone number

List all Regional Centers with which you have vendored programs or services

Reg. Center	Name of Program/Service	Type of Program/Service	Vendor Number

List all Regional Centers with which you have programs/services in development

Reg. Center	Type of Program/Service in Development	Service Start Date

Application submitted by:

Signature (person must be authorized to bind organization) _____ Date _____

Attachment – B

PROFESSIONAL RESUMES AND REFERENCES

Name of Applicant/Organization: _____

Submit a professional resume for all staff and consultants identified or referenced in application, including individuals who will be administrator, if known.

List all staff and/or consultants for whom a resume is **attached**	
Name	Job Title/Type of Consultant

List three references, including job title and agency affiliation, who can be contacted in regard to applicant's qualifications, experience and ability to implement this proposal. References must be professional in nature. References from members of the applicant's governing board and/or applicant's family members are excluded from consideration.

Name: _____ Phone: _____

Job Title: _____

Agency Affiliation: _____

Name: _____ Phone: _____

Job Title: _____

Agency Affiliation: _____

Name: _____ Phone: _____

Job Title: _____

Agency Affiliation: _____

Attachment – C

STATEMENT OF OBLIGATION

1. The applicant is presently providing social services to regional center consumers or other members of the community.
   [ ] No [ ] Yes
   If yes, indicate name, location, type and capacity of service(s).

2. The applicant is currently receiving or planning to apply for grants/funds from any source to develop social service programs.
   [ ] No [ ] Yes
   If yes, indicate name, location, type and capacity of service(s).

3. The applicant is planning to expand existing services (with or without grant funds) from a source other than Westside Regional Center during Fiscal Year 2023-2024 and/or fiscal year 2024/2025.
   [ ] No [ ] Yes
   If yes, indicate funding source and scope of grant project.

4. The applicant or member of the applicant's organization or staff has received a citation from any agency for abuse (verbal, physical, sexual fiduciary, neglect).
   [ ] No [ ] Yes
   If yes, explain in detail.

5. The applicant or any member of the applicant's organization received a Corrective Action Plan (CAP), sanction, notice of immediate danger, or an "A" or "B" citation, or any other citation from a regional center or state licensing agency.
   [ ] No [ ] Yes
   If yes, explain in detail.

6. Describe other professional/business obligations held by the Licensee and Administrator, including name, location, type, and capacity (time commitment) of each obligation. Do not include services you propose to provide through this proposal.

Signature of Applicant or Authorized Representative Date

Attachment – D

SAMPLE FINANCIAL STATEMENT

1. CURRENT ASSETS:
   Cash in banks
   Accounts receivable
   Notes receivable
   Equipment/vehicles
   Inventories
   Deposits/prepaid expenses
   Life insurance (cash value)
   Investment securities (stocks and bonds)

2. FIXED ASSETS:
   Buildings and/or structures
   Real estate holdings
   Long-term investments
   Potential judgments and liens

3. CURRENT LIABILITIES:
   Accounts payable
   Notes payable (current portion)
   Taxes payable

4. LONG-TERM LIABILITIES:
   Notes/contracts
   Real estate mortgages

5. OTHER INCOME
   Wages/revenues or other sources

6. LINE OF CREDIT
   Amount available (specify)

Attachment – E

BUDGET SUMMARY

Name of Applicant/Organization: _____

Submit budget projections using estimates that are both reasonable and realistic uses of funds.

	Care and Services	**Start-up Expense**	**Ongoing Monthly**
1.	Food		
2.	Household Supplies		
3.	Personal Supplies		
4.	Program Equip/Recreation		
5.	Total Board & Supply (add lines 1-4)		
	Physical Plant	**Start-up Expense**	**Ongoing Monthly**
6.	Lease/Insurance (3 months lease)		
7.	Utilities (gas, electric, water, phone/media)		
8.	Vehicle Lease		
9.	Vehicle Maintenance/Gas/Insurance		
10.	Furnishings/Maintenance		
11.	Total Physical Plant (add Lines 6-10)		
	General Administration	**Start-up Expense**	**Ongoing Monthly**
12.	Admin Overhead		
13.	Office Supplies/Equipment/phone		
14.	Insurance(s)		
15.	Other-CCL fees		
16.	Staff recruitment		
17.	Training & Staff Development		
18.	Total Gen. Administration (add lines 12-17)		
	Staffing	**Start-up Expense**	**Ongoing Monthly**
19.	Salary – Administrator		
20.	Direct Staffing		
21.	Program Consultants		
22.	Employee Benefits		
23.	Payroll Taxes		
24.	Worker's Compensation		
25.	Total Staffing Expenses (add lines 19-24)		
26.	Total Start-up Expenses (add lines 5,11,18 & 25)	$	
27.	Total Mo. Rate Per Person (divide Line 26 by 4)		$

MHSA's Substance Use Delivery Expansion Project: E-Learning Design and Development RFP Scoring Criteria

Name of Agency Submitting RFP:	
Date of Review:	
Reviewer's Name:	

Proposals will be reviewed and evaluated based on 4 sections: Qualifications, Scope of Proposal, Work Plan, and Budget. For each section, a point value of 1-10 should be entered in the Points column (in green) based on the following scale:

0: Failed to address any RFP section criteria (grossly negligent or misaligned)
1-2: Does not meet RFP section criteria
3-4: Meets some of the RFP section criteria
5-6: Meets many of the RFP section criteria
7-8: Meets almost all of the RFP section criteria
8-9: Meets all RFP section criteria
10: Notably exceeds minimum section criteria

After you enter the points, the score for each section will auto-calculate in the Score column (in blue). This is calculated by multiplying the number of points by the percent weight assigned to each section. The total score is out of 100%. The total point value is 40 (max 10 points per section). You may include notes for each criteria listed in sections 1-4 to help you determine the number of points per section.

Section 1: Qualifications (Weight 15%)	**Points (max 10 pts)**	**Score (weight*points)**	**Notes**
The developer has extensive experience in instructional design and development.		0	
The proposal includes contact information (the agency's name, address, phone number, email address, website, and name and address of assisting team members).			
The proposal includes references (reference's name, address, phone number, email address) and information regarding past projects.			

Section 2: Scope of Proposal (Weight: 35%)	**Points (max 10 pts)**	**Score (w*p)**	**Notes**
The proposal includes assumptions regarding the proposed project including the content/script, revisions, project management, narration, media use, and any updates to scope of work.		0	
The project timeline includes tasks, responsible parties, and estimated time for completion.			

Section 3: Work Plan (Weight: 35%)	**Points (max 10 pts)**	**Score (w*p)**	**Notes**
The proposal includes a brief description of the following components in the design and development of the interactive courses using Articulate Storyline 360: A full course instructional design Storyboarding Content scripting phase Professional voice-over narration Audio/video editing AA 508-compliance Quality assurance/testing Any projected kickoff calls/meetings and their goals		0	
The proposal includes a brief description of all the proposed components of the design and development of the interactive courses using Articulate Storyline 360.			
The proposal demonstrates plan to conduct testing of the courses prior to implementation to ensure proper operation of courses in LMS.			

Section 4: Budget (Weight: 15%)	**Points (max 10 pts)**	**Score (w*p)**	**Notes**
The proposal includes the corresponding fees/projected costs and invoicing schedules related work plan and scope of proposal.		0	
The proposal demonstrates how the budget will be met (funds available: $100,000.00).			

Total:	**0**	**0%**	**Comments:**

Westside Regional Center

APPENDIX A

MHSA's Substance Use Delivery Expansion Project: Substance Use Treatment Peer Mentoring Contracted Services

PROPOSAL REVIEW/EVALUATION CRITERIA

Applicant /Agency _____ Reviewer_____ Date_____

Proposal Section	Scoring Criteria	Proposal Score
A. Qualifications (weight 29%)		
The applicant/agency has education/experience in providing services to the target population. Key personnel and their resumes, roles and qualifications are listed in the RFP, including any CA valid licenses (i.e., LMFT, LSW, PsyD, PhD, LPC) or at the very least, a certification as a Substance Use Counselor).	1 pt: Meets some of the RFP section criteria 2 pts: Meets many of the RFP section criteria 3 pts: Meets almost all of the section criteria 4 pts: Meets all RFP section criteria	
The applicant/agency has prior experience in the successful development of services and programs, describes those experiences in the RFP, and highlights similarities between current/previous programs and proposed program for this RFP.	1 pt: Meets some of the RFP section criteria 2 pts: Meets many of the RFP section criteria 3 pts: Meets almost all of the section criteria 4 pts: Meets all RFP section criteria	
The applicant/agency is (or will be) able to work collaboratively with others in a multi-agency, interdisciplinary configuration. Examples of collaborative partners include substance use prevention/treatment systems, mental health systems, probation, courts, other regional centers.	1 pt: Meets some of the RFP section criteria 2 pts: Meets many of the RFP section criteria 3 pts: Meets almost all of the section criteria 4 pts: Meets all RFP section criteria	
B. Implementation Plan (weight 51%)		
The applicant/agency proposes a feasible plan for the substance use treatment peer mentoring service including: (1) therapeutic modalities/approaches to address participants' substance use and mental health treatment, (2) education approaches to prepare participants to mentor their peers and tools to monitor competencies, (3) incentive systems to promote cooperation and participation in treatment services (4) any proposed reimbursement models for mentors, (5) entrance/exit criteria for program participants.	1 pt: Meets some of the RFP section criteria 2 pts: Meets many of the RFP section criteria 3 pts: Meets almost all of the section criteria 4 pts: Meets all RFP section criteria	
The applicant/agency successfully describes the assessment and planning processes including setting and measuring individuals' goals and objectives as well as the anticipated outcomes of the proposed services, and any outcome evaluation methods to be used.	1 pt: Meets some of the RFP section criteria 2 pts: Meets many of the RFP section criteria 3 pts: Meets almost all of the section criteria 4 pts: Meets all RFP section criteria	
The applicant/agency successfully describes continuous quality improvement methods including utilization of data to identify service problems and implementation of corrective changes.	1 pt: Meets some of the RFP section criteria 2 pts: Meets many of the RFP section criteria 3 pts: Meets almost all of the section criteria 4 pts: Meets all RFP section criteria	
The applicant/agency has an organizational structure that can provide adequate staffing to partner with WRC for successful project development and completion. Staff (administration, consultants, direct support professionals) recruitment and retention plan is well described including job descriptions,	1 pt: Meets some of the RFP section criteria 2 pts: Meets many of the RFP section criteria 3 pts: Meets almost all of the section criteria 4 pts: Meets all RFP section criteria	

qualifications, screenings, trainings, compensation, organizational chart. A sample of a one-week staffing schedule is provided.	APPENDIX A	
The applicant/agency includes feasible plans for recruitment and retention of peer mentors including qualifications, screenings, trainings, and any compensations.	1 pt: Meets some of the RFP section criteria 2 pts: Meets many of the RFP section criteria 3 pts: Meets almost all of the section criteria 4 pts: Meets all RFP section criteria	
The applicant/agency includes information on participants' transportation and communication needs and how they will be addressed by this program.	1 pt: Meets some of the RFP section criteria 2 pts: Meets many of the RFP section criteria 3 pts: Meets almost all of the section criteria 4 pts: Meets all RFP section criteria	
Overall, the proposal indicates thorough knowledge of the processes and procedures needed to complete the project. The proposal indicates demonstrates ability to follow directions and is an appropriate response to the RFP.	1 pt: Meets some of the RFP section criteria 2 pts: Meets many of the RFP section criteria 3 pts: Meets almost all of the section criteria 4 pts: Meets all RFP section criteria	
C. Budget and Finances (weight 20%)		
The project budget demonstrates candidates' knowledge of costs. The budget is reasonable and includes all costs required for start-up as well as ongoing operations. The applicant demonstrates an appropriate understanding of costs associated with the project.	1 pt: Little understanding of costs associated/budget is somewhat reasonable 2 pts: Some understanding of costs associated/budget is reasonable 3 pts: Good understanding of costs associated/budget is quite reasonable 4 pts: Clear understanding of costs associated/budget is very reasonable	
The applicant/agency financial statement(s) reflects sound fiscal practices. Assets are sufficient to undertake the proposed project and there are sufficient financial assets in reserves.	1 pt: Assets are not sufficient 2 pts: Assets are somewhat sufficient 3 pts: Assets are sufficient and there is some assets in reserves 4 pts: Assets are sufficient and there is sufficient assets in reserves	
Total Score		

Recommended to invite for an interview: ■ yes ☐ no

Follow up questions to ask at the interview: (enter here any questions that you may have for this applicant/agency)

1.
2.
3.

Westside Regional Center
FY 2023-2024 Peer Mentoring RFP Interview Scoring

Applicant/Agency:	Reviewer:	Date:

Likert Scale to be used while scoring the quality of answers provided: **5 – excellent, 4 – good, 3 – fair, 2 – poor, 1 – very poor**

Questions	Notes	Max Score	Interview Score
1. Tell us about your agency and its experience supporting individuals with developmental disabilities and describe your service approaches.		5	
2. Tell us about your experiences with development and implementation of programs supporting people with substance use disorders and mental health conditions.		5	
3. Describe your process for recruiting, training, and retaining staff to be working on this project.		5	
4. Describe your process for recruiting, training, and retaining mentors to be involved in this project.		5	
5. Could you elaborate on the organizational structure for this project? Have you identified the project lead? How many positions will need to be developed and hired? Would the project staff have needed certifications or licenses to work with people with mental health and substance use disorders?		5	
6. Describe the services you plan to provide, how you plan on including the individual's choice and the utilization of community resources specific to substance use.		5	
7. Describe how the agency develops a project budget for this program and this service.		5	
8. Would this project be fully funded by the grant funding or will you be able to match with revenues from other sources?		5	
Total		40	

Applicant:

Interview Date:

MHSA – Project Manager

Interview Scoring Criteria

WESTSIDE REGIONAL CENTER

APPENDIX A

Section A: Work Experience	Skills/ Qualifications Expected	Max 9 pts
1. Tell us about yourself and walk us through your resume.	☐ Strong communication skills (clear, prepared, confident) ☐ Experience working with non-profits; social work/public health/related fields	
2. Tell us about your experience in the fields of substance use prevention, treatment and recovery and/or mental health.	☐ Experience working in the field of SUD ☐ Experience working in the field of MH	
3. What do you know about the regional center system?	☐ Knowledge of the regional center system (ex. what we do, who we serve) ☐ Able to identify and knowledge of other systems	
Section B: Project Management	**Skills/ Qualifications Expected**	**Max 9 pts**
4. Tell us about your project management experience. Have you led any projects on your own? What was your role and how did you manage the project?	☐ Ability to develop a project plan/ timeline/process to reach outcomes/goals ☐ Has led a project independently with large responsibilities	
5. Describe your experiences with research, data collection and monitoring of project's outcomes and any report writing.	☐ Experience with correspondence with grant funders / subcontractors ☐ Experience with quantitative/qualitative data, software for analyzing data (ex. SPSS, Excel), and the ability to translate data into graphs / narrative reports	
6. What presentations of project's findings or lessons learned have you done? Can you tell us more about the audience and your experiences?	☐ Experience and comfort presenting in front of diverse audiences	
Section C: Development	**Skills/ Qualifications Expected**	**Max 9 pts**
7. Describe your experiences of any multi-agency collaborative building. What was your role in this?	☐ Experience with development and implementation of multi-agency partnerships / collaborative / task force groups ☐ Strategies to engage agencies into sustainable collaborative	
8. Can you tell us about your experiences developing or supporting development of needs assessments, project's protocols, program designs, and any accountability or communication plans?	☐ Developed and implemented needs assessments (e.g. surveys, focus groups) ☐ Developed other materials: program designs, protocols, accountability or communication plans	
9. Have you ever worked on e-learning courses design and development? Or any other mode of professional development? Do you remember the software platform used?	☐ Worked on projects focused on professional development ☐ Worked on e-learning course design and development (e.g. Articulate 360 suite or others)	
Wrapping Up		**No Score**
10. This position will start off as telework but it might transition into office work. Will this be an issue for you if offered the position?	☐ Able to telework and work in the office (Culver City), if needed.	Yes/ No
11. If this position is offered to you, what is your availability?	☐ Able to start within 2 weeks	Yes/ No
12. Would you be able to email us a writing sample?	☐ Sample provided	Yes/ No
13. Do you have any questions for us?	☐ Thoughtful questions asked	

Final Score:_____(out of 27 points max)

Applicant:

Interview Date:

MHSA – Research Assistant

Interview Scoring Criteria

WESTSIDE REGIONAL CENTER

APPENDIX A

Section A: Work Experience/Systems Knowledge	Skills/ Qualifications Expected	Max 9 pts
1. Tell us about yourself and walk us through your resume.	☐ Strong communication skills (clear, prepared, confident) ☐ Experience working with non-profits; social work/public health/related fields	
2. Tell us about your experience in the fields of substance use prevention, treatment and recovery and/or mental health.	☐ Experience working in the field of SUD ☐ Experience working in the field of MH	
3. What do you know about the regional center system?	☐ Knowledge of the regional center system (ex. what we do, who we serve) ☐ Able to identify and knowledge of other systems	
Section B: Research Experience	**Skills/ Qualifications Expected**	**Max 9 pts**
4. How would you conduct literature reviews on best practices in identification and supports in treatment for substance use disorders among people with I/DD?	☐ Ability to develop a plan including research questions, synthesis of results of what is known, areas of controversy in literature, gaps in knowledge/research ☐ Has led a project independently with large responsibilities	
5. Describe your experiences with data collection and setting up process and outcome evaluations. How did you analyze quantitative vs. qualitative data?	☐ Experience with evaluations (pre/post tests, process evaluations, monitoring) ☐ Experience with quantitative/qualitative data, software for analyzing data (ex. SPSS, Excel), and the ability to translate data into graphs / narrative reports	
6. How were the findings presented in the projects you worked on? Can you tell us more about the audience and your experiences?	☐ Experience and comfort presenting in front of diverse audiences ☐ Experience with report writing	
Section C: Development	**Skills/ Qualifications Expected**	**Max 9 pts**
7. Describe your experiences of any multi-agency collaborative building. What was your role in this?	☐ Experience with development and implementation of multi-agency partnerships / collaborative / task force groups ☐ Strategies to engage agencies into sustainable collaborative	
8. Can you tell us about your experiences developing or supporting development of needs assessments including survey development, recruitment materials and leading focus groups?	☐ Developed and implemented needs assessments (e.g. surveys, focus groups) ☐ Developed other materials: program designs, recruitment materials and evaluation tools	
9. Have you ever worked on e-learning courses design and development? Or any other mode of professional development? Do you remember the software platform used?	☐ Worked on projects focused on professional development ☐ Worked on e-learning course design and development (e.g. Articulate 360 suite or others)	
Wrapping Up		**No Score**
10. This position will start off as telework but it might transition into office work. Will this be an issue for you if offered the position?	☐ Able to telework and work in the office (Culver City), if needed.	Yes/ No
11. If this position is offered to you, what is your availability?	☐ Able to start within 2 weeks	Yes/ No
12. Would you be able to email us a writing sample?	☐ Sample provided	Yes/ No
13. Do you have any questions for us?	☐ Thoughtful questions asked	

Final Score:_____(out of 27 points max)

WRC/FDLRC:
Supporting People with Substance Use Concerns:
Provider Survey

Welcome!

Westside Regional Center and Frank D. Lanterman Regional Center received a grant to expand services for *people with developmental disabilities who are dually diagnosed (or at risk of dual diagnosis) with mental health and (or at risk of) substance use disorder(s).*

This funding will also support the service provider community….and we would like to involve you in this process.

How many people do you support with substance use/misuse issues and how can we help you support them?

This survey will take approximately 10 minutes to complete and your input will better inform how we can support you, our provider community, and the people you serve who may have co-occurring mental health and substance use disorders..

Provider Background

1) Can you please tell us what services and supports you are contracted with to provide on behalf of WRC and/or FDLRC? *(please select all that apply)*

[ ] ILS - Independent Living Services
[ ] SLS - Supported Living Services
[ ] Adult Day Program
[ ] Employment Program
[ ] Other - Write In

2) Can you please tell us which of the following best describes you?

( ) I am an owner or administrator of an agency (CEO, CFO, President, Manager)
( ) I am a program manager or case manager
( ) I am medical staff
( ) I am a direct support professional
( ) I am a parent provider
( ) Other - Write In: _____

3) Which zip codes do you provide the above regional center services to?

_____

4) Which regional center(s) are you vendored with or provide supports to? *(please select all that apply)*

[ ] Frank D. Lanterman Regional Center
[ ] Westside Regional Center
[ ] Other - Write In: _____

The People You Serve

For the purposes of this survey,

- Mental health disorders are conditions that affect a person's thinking, mood, and/or behavior, often referred to as mental illness. Examples include anxiety, depression, schizophrenia, Attention-Deficit/Hyperactivity disorder.

- Substance use disorders are characterized by a problematic pattern of use of a substance or substances leading to impairments in health, social function, and control over substance use. Examples of substances include legal or illegal drugs, alcohol, tobacco products, inhalants.

5) To the best of your ability, can you please enter the number of people you/your agency served *in the past year* in each category identified in the table below.

How many people...

	18 - 22	23 - 55	56+
Has your agency served in the following age ranges?			
Have, or you suspect of having, both developmental disability AND mental health disorder(s)?			
Have, or you suspect of having, both mental health disorder(s) AND substance use disorder?			
Could benefit from substance use disorder intervention (e.g. recovery support, peer mentoring)?			
Could benefit from substance use disorder prevention services? (e.g. education, screening, referrals)			

6) What type of mental health disorder(s) are the people you serve experiencing? *(please check all that apply)*

[ ] Anxiety Disorders (e.g., Social Anxiety, Panic Disorder, Obsessive-Compulsive Disorder)
[ ] Impulse Control Disorders (e.g., Impulsivity, Inattention, Explosive Behaviors)
[ ] Mood Disorders (e.g., Depression, Bi-Polar)
[ ] Thought Disorders (e.g., Schizophrenia, Psychosis, Paranoia, Delusions/Hallucinations)
[ ] I don't know

[ ] Other - Write In: _____

7) What type of substances are being used or what type of addictions are the people you serve experiencing?

_____
_____
_____
_____

Supporting People with Developmental Disabilities, Mental Health and Substance Use Disorders.

8) Overall, how knowledgeable do you consider you/your staff to be about mental health disorders?

( ) Very knowledgeable
( ) Highly Knowledgeable
( ) Somewhat knowledgeable
( ) Not very knowledgeable
( ) Not at all knowledgeable

9) Overall, how knowledgeable do you consider you/your staff in general to be about substance use disorder?

( ) Very knowledgeable
( ) Highly Knowledgeable
( ) Somewhat knowledgeable
( ) Not very knowledgeable
( ) Not at all knowledgeable

10) Do you/your staff have a mental health or substance use disorder/addiction treatment counselor you consult with when needed or appropriate?

( ) Yes, we have a mental health consultant we utilize
( ) Yes, we have a substance use expert we utilize
( ) Yes, we use both
( ) No, we don't have either of these resources
( ) We have not needed either of these resources

11) How do you/your staff identify if the people you serve have substance use disorder?

_____
_____
_____
_____

12) What is/are the source(s) of your / your staff's knowledge about supporting those with substance use disorder? *(please check all that apply)*

[ ] Formal university or college education
[ ] Certification Program
[ ] Training (regional center or other)
[ ] Personal experience
[ ] Relationship with a person with mental illness
[ ] Work- related experience
[ ] Personal interest in learning about mental illness
[ ] News and media (TV, books/audiobooks, podcasts, social media, and newspapers/magazine articles)
[ ] Other - Write In: _____

13) What substance use disorder resources are you/your staff aware of and/or refer people to?

_____
_____
_____
_____

14) What challenges do you/your staff or organization encounter when supporting people with developmental disabilities, mental health disorder(s) AND substance use disorder?

_____
_____
_____
_____

15) What training or supports do you/your staff need to help people with developmental disabilities, mental health disorder(s) AND substance use disorder?

_____
_____
_____
_____

16) What risk factors for substance use disorder(s) do see impacting the people you serve? (*please check all that apply)*

[ ] Relationship stress (family support and dynamic, friendship, etc.)
[ ] Medical condition (Vision loss, Hearing Loss, Chronic Pain)
[ ] Social isolation
[ ] Medication use/access to prescription pain medication
[ ] Low socioeconomic status
[ ] Limited education and awareness of risks of substance use
[ ] Limited communication skills
[ ] Family history of substance use disorder
[ ] Trauma (adverse childhood experiences, PTSD, history of abuse/sexual abuse)
[ ] Co-occurring mental health disorders
[ ] Other - Write In: _____

17) To what degree do you believe you/your staff and organization is prepared/ capable of providing informed care related to:

	Very Prepared/ Capable	Highly Prepared/ Capable	Prepared/ Capable	Less Prepared/ Capable	Significantly Less Prepared/ Capable
Individual's Racial Ethnicity – (e.g., Asian, Black/African American, Caucasian, Hispanic, Middle Eastern)	[ ]	[ ]	[ ]	[ ]	[ ]
Religion (e.g., Buddhism, Catholic, Christian, Jewish, Muslim, Pagan, etc.)	[ ]	[ ]	[ ]	[ ]	[ ]
Sexual and/or gender identities (LQTBQIA+ or other)	[ ]	[ ]	[ ]	[ ]	[ ]
Economic Diversity (Income Level, Occupational Status, Education Level, etc.)	[ ]	[ ]	[ ]	[ ]	[ ]
Environmental Diversity (Living Conditions, Access to Resources, Cultual Capital, etc.)	[ ]	[ ]	[ ]	[ ]	[ ]

18) If you or your organization would like to receive additional information on substance use prevention and treatment services, please feel free to leave us a contact email.

_____

Thank You!

Your feedback will help us improve resources and services for individuals with developmental disabilities, mental health and substance use disorders, including those who are at risk of for substance use disorders.

WESTSIDE REGIONAL CENTER

2023-26 Mental Health Services Act (MHSA) Grant: Co-Occurring Developmental Disabilities, Mental Health and Substance Abuse: Provider Survey: *Executive Summary*

BACKGROUND

Within California's developmental disabilities services system, the need for substance abuse treatment programs, resources and supports has long been recognized, though little "official" data on the number of people impacted by co-occurring intellectual and or developmental disabilities and addiction issues has not been established.

Through a Mental Health Services Act (MHSA) 2023-26 Mental Health Services Act (MHSA) Grant: Co-Occurring Developmental Disabilities, Mental Health and Substance Abuse grant application, Westside Regional Center (WRC), with Frank D. Lanterman Regional Center (FDLRC), is taking a lead within Los Angeles County to:

1. Assess the number of people served/supported by the regional center(s) that are impacted by substance Use disorder (SUD) or substance abuse issues (SAI);
2. Design and Develop E-Learning Resources for the Service Provider Community
3. Work to create peer mentoring program(s)
4. Assess the impact of the e-learning program, peer mentoring program, and program supports on people served

OBJECTIVE

The *2023-24 Mental Health Services Act (MHSA) Grant: Co-Occurring Developmental Disabilities, Mental Health and Substance Abuse: Provider Survey (Provider Survey)* focuses on quantifying and better understanding people served with dual (DD/MH) service needs who are also dealing with substance use/abuse issues/disorder and the needs of the providers that support them.

FRANK D. LANTERMAN REGIONAL CENTER

Kinetic Flow Corp.

WESTSIDE REGIONAL CENTER

2023-26 Mental Health Services Act (MHSA) Grant: Co-Occurring Developmental Disabilities, Mental Health and Substance Abuse: Provider Survey: *Executive Summary*

METHODOLOGY

Population and Sample. The target population for the *Provider Survey* are providers that support adults with developmental disabilities, including Day/Employment Services, Independent and/or Supported Living Services. Given available data, ***the potential respondents is likely to be ~398 service providers.***

Questionnaire: 36 data points

Questionnaire. The questionnaire for the *Provider Survey* includes 36 data points addressing: Service Provider Background, People Served, and Supporting People with Developmental Disabilities, Mental Health and Substance Use Disorders.

Data Collection: Fielded: 12/08/23-02/02/24

Completes: 149

Data Collection Methodology. Between December 8th, 2023 – February 2nd, 2024, WRC and FDLRC collected online data for the *Provider Survey*. Potential respondents were invited to participate via an email invitation from either WRC or FDLRC (or both), and were also sent 1-3 reminder emails. **In total, 149 respondents of an estimated 389 potential respondents participated, yielding a 38.3% response rate.**

PROVIDER BACKGROUND

In total 147 service providers participate in the *Provider Survey*. Respondents represented 194 service categories, as some providers offer multiple services:

Service Type	Count
Adult Day Program	47
Adult Residential	4
Employment Program	23
ILS - Independent Living Services	17
SLS - Supported Living Services	45
Other	58

Responding service providers are vendored with Westside Regional Center (73.7%), Frank D. Lanterman Regional Center (53.9%) and other California regional centers (38.2%).

WESTSIDE REGIONAL CENTER

2023-26 Mental Health Services Act (MHSA) Grant: Co-Occurring Developmental Disabilities, Mental Health and Substance Abuse: Provider Survey: *Executive Summary*

THE PEOPLE YOU SERVE

The *Provider Survey* focused on quantifying the number of people served by the regional center who have, or who provider suspect have developmental disability(ies), mental health *AND* substance abuse disorder(s). Utilizing the data provided by responding service providers and a multi-step data analysis, it is possible to project the occurrence and co-occurrence of people with developmental disabilities and mental health and substance abuse disorders. Using the top question, "Has your agency served in the following age ranges?" as a base number, the precent of the population impact for each category:

Support Need	18 - 22	23 - 55	56 +
1) Has your agency served in the following age ranges?	624	1949	555
2) Have, or you suspect of having, both developmental disabilities AND mental health disorder(s)?	66.3%	51.2%	41.1%
3) Have, or you suspect of having, both mental health disorder(s) AND substance use disorder?	6.3%	3.8%	8.1%
4) Could benefit from substance use disorder *intervention* (e.g. recovery support, peer mentoring)?	21.2%	19.0%	17.1%
5) Could benefit from substance use disorder *prevention* services (e.g. education, screening, referrals)?	3.7%	2.4%	3.6%

Overall, the percent of people experiencing mental health disorder(s) include:

- Mood Disorders (88%)
- Anxiety Disorders (85%)
- Impulse Control Disorders (79%)
- Thought Disorders (76%)
- Other (8%)

FRANK D. LANTERMAN REGIONAL CENTER

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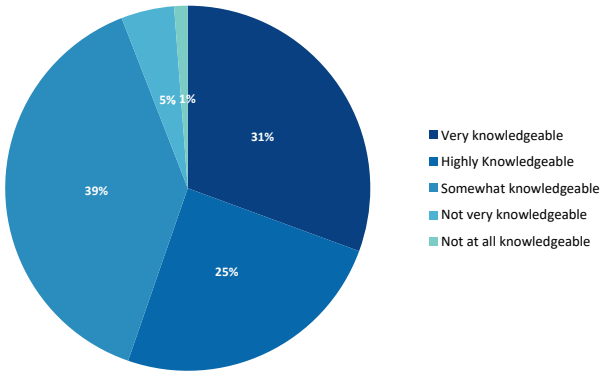
SUPPORTING PEOPLE WITH DEVELOPMENTAL DISABILITIES, MENTAL HEALTH AND SUBSTANCE USE DISORDERS

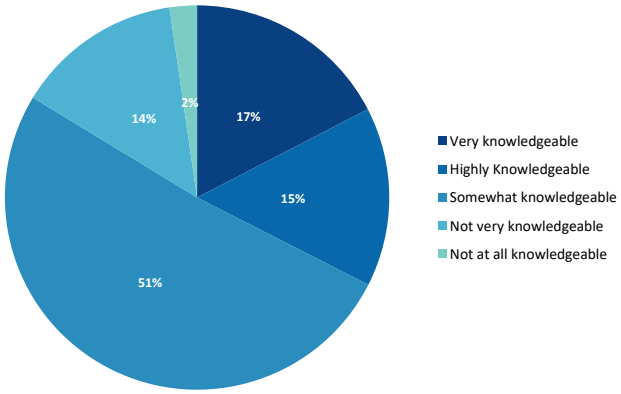
Overall, how knowledgeable do you consider you/your staff to be about mental health disorders?

Overall, responding providers rated their staff's knowledge a 3.77 on a5-point balanced Likert-scale, with 55% of providers stating they/their staff are Very or Highly Knowledgeable. In total 6% of responding providers rated their staff Not Very or Not At All Knowledgeable.



Overall, how knowledgeable do you consider you/your staff in general to be about substance use disorder?

Overall, responding providers rated their staff's knowledge a 3.31 on a5-point balanced Likert-scale, with 32% of providers stating they/their staff are Very or Highly Knowledgeable. In total 16% of responding providers rated their staff Not Very or Not At All Knowledgeable.



Primarily, staff knowledge comes from Work-Related Experience (67%), Training (61%), Personal Experience (52%), Relationships with a person with a mental illness (51%) and personal interest in learning about mental illness (41%).

WESTSIDE REGIONAL CENTER

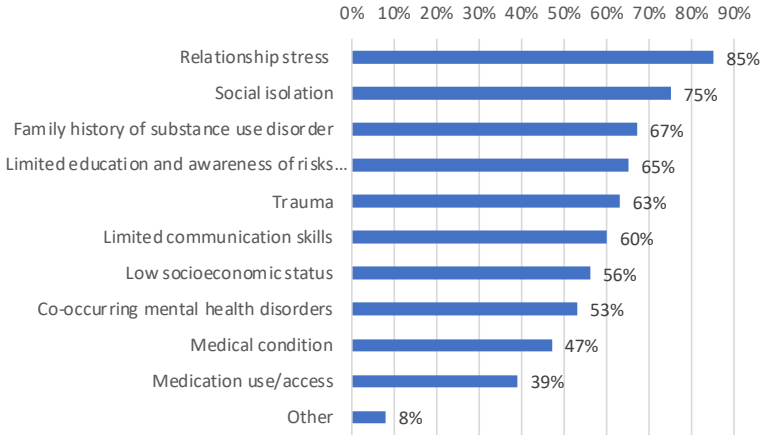
2023-26 Mental Health Services Act (MHSA) Grant: Co-Occurring Developmental Disabilities, Mental Health and Substance Abuse: Provider Survey: *Executive Summary*

SUPPORTING PEOPLE WITH DEVELOPMENTAL DISABILITIES, MENTAL HEALTH AND SUBSTANCE USE DISORDERS

To what degree do you believe you/your staff and organization is prepared/ capable of providing informed care related to:

	Very Prepared/ Capable	Highly Prepared/ Capable	Prepared/ Capable	Less Prepared/ Capable	Significantly Less Prepared/ Capable
Individual's Racial Ethnicity – (e.g., Asian, Black/African American, Caucasian, Hispanic, Middle Eastern)	27.9%	27.9%	38.4%	5.8%	0.0%
Religion (e.g., Buddhism, Catholic, Christian, Jewish, Muslim, Pagan, etc.)	22.4%	23.5%	43.5%	7.1%	3.5%
Sexual and/or gender identities (LQTBQIA+ or other)	27.7%	24.1%	39.8%	6.0%	2.4%
Economic Diversity (Income Level, Occupational Status, Education Level, etc.)	28.9%	25.3%	38.6%	6.0%	1.2%
Environmental Diversity (Living Conditions, Access to Resources, Cultual Capital, etc.)	26.3%	26.3%	40.0%	7.5%	0.0%

As part of providing informed care, the risk factors providers see impacting people served often include:



Do you/your staff have a mental health or substance use disorder/addiction treatment counselor you consult with when needed or appropriate?

Thirty-eight percent (38%) of responding providers have access to some resources – a substance use expert or mental health consultant, though 46% do not have access to these resources.

Qualitative insights on resources, provider challenges and support needs can be found in the full report.

FRANK D. LANTERMAN REGIONAL CENTER

Kinetic Flow Corp.

Literature Review Guide

1. Scope and Objectives:

Scope (What are we looking at?)

- To explore research on Intellectual/Developmental Disability (I/DD) populations with substance misuse and best practices in the identification and treatment of Substance Use Disorder (SUD) among individuals with I/DD.

Objectives (What do we want to achieve?)

- Identify research on **I/DD population with substance misuse**; identify questions for survey, pilot questions and develop recruitment strategy for data collection, collect and analyze data and present findings (activities fulfill objective 2.1)
    - Identify & synthesize empirical studies on the **prevalence** of substance misuse among individuals with I/DD
    - Examine existing research on **risk factors** associated with substance use in the I/DD population
    - Utilize literature review findings to help inform the development of the **needs assessment survey** for WRC and Lanterman RC service providers to help identify the scope of SUD among people with I/DD, and tools for service improvement.
- Identify research on **best practices in identification and treatment of SUD among people with I/DD** into curriculum development in combination with findings from local needs assessment; develop list of resources and evaluation tools of the training curriculum (activities fulfill objective 3.1)
    - Evaluate the effectiveness of **current interventions of treatment approaches** for individuals with co-occurring I/DD and SUD
    - Identify **gaps** in the literature and areas requiring further research in the field of I/DD and substance misuse

2. Protocol:

- **To Do's**
    - Begin literature review:
        - 1) Search articles/studies using relevant keywords/terms
        - 2) Screen abstracts and titles to identify potentially relevant articles per inclusion/exclusion criteria
        - 2) Check the Zotero library for any duplicate articles before adding to the library.
        - 3) Add relevant articles to the Zotero library.

        - 4) Conduct full-text review of selected articles.
            - Extract relevant data from selected articles into the **data extraction sheet**.
        - 5) Conduct quality assessment for the selected article per the checklist.
        - 6) Consult with Subject Matter Experts (SMEs) on as-needed basis during lit review (**or** until data saturation is achieved with lit review search, then collectively gather findings for cross-validation of information)
            - Cross-validate information provide by SMEs with existing literature to ensure consistency and reliability
            - Highlight SME insights that complement or extend existing research findings
            - Document any information collected from SMEs
            - Include SMEs in the peer-review process to ensure the final version of literature review reflects the highest standards of expertise
        - 7) Meet with team to report on summary of literature review findings and discuss synthesis of extracted data
        - 8) Create an outline based on synthesis of findings.
            - Identify and take notes on patterns, trends, and gaps in the literature.
            - Incorporate findings from service provider needs assessment and synthesize with literature review findings.
        - 9) Assign sections/topics to team members for writing.
- **Literature review deadlines**
    - Research on I/DD population with substance misuse
    - Research on best practices in identification and treatment of SUD among people with I/DD
    - Complete synthesis of data findings
    - Outline of literature review
    - First draft of literature review
    - Complete literature review edits
    - Complete final draft of lit review on I/DD population with substance misuse
    - Complete final draft of lit review on best practices

3. Literature Search:

- **Search criteria and keywords**
    - Intellectual/Developmental Disability
    - Developmental Disorders
        - Autism Spectrum Disorder (ASD)

        - Attention-Deficit/Hyperactivity Disorder (ADHD)
        - Cerebral Palsy
        - Specific Learning Disorder (SLD)
        - Communication Disorders (Speech Sound Disorder, Language Disorder, Childhood-Onset Fluency Disorder (Stuttering)
        - Epilepsy
        - Down Syndrome
        - Motor Disorders (Developmental Coordination Disorder/DCD, Stereotypic Movement Disorder)
        - Tic Disorders
    - Dual diagnosis
    - Comorbidity
    - Disabilities
    - Mental illness
    - Mental health
    - Peer support
    - Service delivery
    - Substance Use Disorder
    - Opioid Use
    - Treatment models
    - Interventions
    - Barriers to treatment
    - Best practices
- **Databases and Journals**
    - Google Scholar: https://scholar.google.com/
    - PubMed: https://pubmed.ncbi.nlm.nih.gov/
    - APA PsycINFO: https://psycinfo.apa.org/journal/browse-all
        - *Frontiers in Psychiatry* https://psycinfo.apa.org/journal/explore/111635
        - *Disability and Rehabilitation: Assistive Technology* https://psycinfo.apa.org/journal/explore/110620
        - *Disability and Health Journal* https://psycinfo.apa.org/journal/explore/111060
        - *Journal of Intellectual and Developmental Disability* https://psycinfo.apa.org/journal/explore/1094
        - *Disability & Society* https://psycinfo.apa.org/journal/explore/3083
        - *Journal of Intellectual Disability Research* https://psycinfo.apa.org/journal/explore/1429
        - *Disability and Rehabilitation: An International, Multidisciplinary Journal* https://psycinfo.apa.org/journal/explore/3671
    - Scopus: https://www.scopus.com/
    - Web of Science: https://www.webofscience.com/wos/alldb/basic-search

    - List of relevant databases & resources: https://simmons.libguides.com/c.php?g=830722&p=5964570
- **What to Look for**
    - Identify research on **I/DD population with substance misuse**
        - **Prevalence and Incidence Studies:** Search for studies that aim to understand prevalence and incidence of substance misuse among individuals with I/DD
        - **Risk Factors and Protective Factors:** Explore research that identifies and analyzes risk factors associated with substance use in the I/DD population. Search for studies that highlight protective factors that may mitigate the risk.
        - **Comorbidity Studies:** Examine studies that delve into the comorbidity of I/DD and SUD—aim to better understand the intersection of these conditions. What challenges exist in accurately diagnosing and assessing substance misuse among individuals with I/DD?
    - Identify research on **best practices in identification and treatment of SUD among people with I/DD** into curriculum development
        - **Treatment Outcomes and Effectiveness:** Evaluate studies that assess the outcomes and effectiveness of different treatments and interventions for SUD in individuals with I/DD (e.g., behavioral interventions, pharmacological treatments, counseling)
        - **Barriers to Treatment Access:** Investigate literature that discusses barriers to accessing treatment for individuals with I/DD and SUD.
        - **Quality of Life and Wellbeing:** Explore any research that examines the impact of substance use on the overall quality of life and well-being of individuals with I/DD. This may help inform holistic approaches to intervention.
        - **Cultural Considerations:** Explore studies that address cultural considerations in the identification and treatment of SUD among individuals with I/DD. Search for interventions addressing cultural competence.
        - **Family and Caregiver Perspectives:** How do family members and caregivers perceive and experience the challenges of addressing substance use among individuals with I/DD? What role do family and caregivers play in supporting interventions and treatment?
        - **Policy and Program Evaluations:** Explore literature that assesses the impact of policies and programs aimed at addressing SUD among individuals with I/DD. What gaps exist in current policies and programs, and how can they be improved?

        - **Longitudinal Studies:** Search for longitudinal studies with I/DD over time to understand the long-term effects of substance use and the effectiveness of existing interventions.

5. Screening and Selection:

- **To Do:** Conduct an initial screening based on titles and abstracts.
- **Inclusion and Exclusion Criteria**
    - **Inclusion criteria:**
        - Studies focused on I/DD population with substance misuse or SUD
        - Research articles, systematic reviews, meta-analyses, and empirical studies.
        - Publications in English.
        - Studies published within 2013-2023.
    - **Exclusion criteria:**
        - Studies unrelated to I/DD or SUD.
        - Non-English publications.
        - Dissertations, conference abstracts, non-peer-reviewed sources.
        - Studies older than 2013.

6. Data Extraction:

- **Identify relevant data per article for synthesis of findings.**
    - Systematically extract relevant information from each source and input it into the data extraction sheet.
    - Ensure consistency in data extraction across team members.

7. Quality Assessment:

- **Evaluate the quality and credibility of each source.**
- Use the checklist below as a guideline to help you assess the quality of each article.

Study Design and Methodology:

Research Design:

☑ Is the study design appropriate for the research objectives (e.g., randomized controlled trials, cohort studies, systematic reviews)?

Sample Size and Representativeness:

☑ Is the sample size adequate for the study's objectives?

☑ Are participants representative of the broader I/DD population?

Sampling Methods:

☑ Are the sampling methods clearly described and appropriate for the study design?

Data Collection Methods:

- ☑ Are data collection methods well-defined and appropriate for the study's objectives?
- ☑ Is there transparency regarding how data were collected?

Measurement Tools:

- ☑ Are standardized and validated measurement tools used to assess variables of interest?

Quality of Reporting:

Clarity of Reporting:

- ☑ Is the study clearly and transparently reported?
- ☑ Are the methods, results, and conclusions clearly articulated?

Publication Source:

- ☑ Is the study published in a reputable, peer-reviewed journal?
- ☑ Consider the impact factor of the journal.

Author Credentials:

- ☑ Are the authors qualified and experienced in the field?
- ☑ Check for conflicts of interest.

Study Results and Analysis:

Statistical Analysis:

- ☑ Are appropriate statistical methods used in data analysis?
- ☑ Are statistical results adequately reported?

Discussion of Limitations:

- ☑ Does the study acknowledge and discuss its limitations?
- ☑ Is there a clear awareness of potential biases?

Generalizability of Findings:

- ☑ To what extent can the study findings be generalized to the broader I/DD population?

Relevance to Research Objectives:

Alignment with Research Objectives:

- ☑ Does the study directly address the research questions and objectives of your literature review?

Applicability to Intervention Strategies:

- ☑ For intervention studies, does the research explore practical and evidence-based strategies for addressing SUD among individuals with I/DD?

Consideration of Ethical Standards:

Ethical Considerations:

- ☑ Are ethical standards adhered to in the study's design and implementation?
- ☑ Is there evidence of informed consent and ethical review board approval?

Additional Criteria:

Temporal Relevance:

- ☑ Is the study recent enough to be considered relevant, given the dynamic nature of research in the field?

Peer Review Status:

- ☑ Is the study peer-reviewed? Peer-reviewed studies are generally considered more reliable.

Biases:

- ☑ Be cautious about potential sources of bias:
  - ➢ Consider the study design—E.g., RCTs are generally less prone to bias than observational studies.
  - ➢ Evaluate the methodology, sampling methods, data collection techniques, and statistical analysis—all methods used should be transparent and rigorous.
  - ➢ Conflict of interest—Do the authors declare any conflicts of interest? Financial or non-financial conflicts of interest may influence the study design, conduct, or reporting.
  - ➢ Examine funding sources—Research funded by entities with a vested interest may introduce bias.
  - ➢ Review acknowledgments—The acknowledgements for any affiliations, relationships, or support that could introduce bias.
  - ➢ External validation—Are the study findings consistent with other research in the field?
  - ➢ Selective Citation—Examine the references in the study. If the authors selectively cite studies that support their viewpoint, it may indicate bias.

8. Data Analysis & Synthesis:

- Refer to data extraction sheet to do the following:
  - Summarize key findings from each source.
  - Identify common themes, patterns, and gaps in the literature.
  - Analyze the literature–identify and discuss strengths, weaknesses, and limitation of studies.
  - Identify areas of consensus and disagreement among the literature
- Can consider creating diagrams and other mapping tools like concept mapping or thematic analysis to aid with data synthesis.

9. Report Writing:

- Develop a structured and well-organized literature review summary.
- Include an introduction, methodology, findings, discussion, and conclusion.
- Clearly articulate the implications of the literature for the research question/objectives.

10. Peer Review:
    - Conduct peer reviews within the team, SMEs, etc. for quality assurance.
    - Ask for constructive feedback and address any discrepancies.
    - Ensure that the review is comprehensive and unbiased.

11. Revision and Finalization:
    - Incorporate feedback from team members.
    - Revise the literature review accordingly.
    - Finalize the report and ensure consistency.

12. Documentation and Citation:
    - Keep detailed records of the literature review process.
    - Use a citation management tool to manage references.
    - Ensure accurate and consistent citation throughout the report.

13. Communication and Meetings:
    - Schedule regular team meetings for updates and discussions.
    - Foster open communication and collaboration.
    - Address any challenges or concerns promptly.

Literature Review Summary

Course module ideas:

1. Overview of content; knowledge of SUD/dual diagnoses/common co-occurring mental health conditions impacting our client population
    a. Scope of developmental disabilities and understanding the different disabilities in this category and mental health concerns
2. Skills in identifying and understanding substance misuse/SUD in clients (e.g., screening/assessment/evaluation tools)
    a. Recognizing signs of substance abuse, behavior, emotional regulation, adaptive skills
3. Knowledge of how to navigate systems of care/how to access interdisciplinary services in local communities for dually diagnosed individuals.
    a. Include list of relevant/recent resources/treatment interventions
    b. Providers need to understand how to collaborate with systems
4. Guiding principles Any tools/skills for service providers to use to help support their clients in initiation and treatment compliance
    a. Stigma/discrimination
    b. Trauma-informed care
    c. Person-centered care
    d. Motivational interviewing
5. Actual skills, implementation or putting into practice the skills
    a. Motivational interviewing
    b. Refusal skills
    c. Coping skills
    d. Mindfulness

Themes to keep in mind throughout the modules:

- Empowering the providers, understanding that they can't control the behaviors of clients

Literature Review Scope: To explore research on Intellectual/Developmental Disability (I/DD) populations with substance misuse and best practices in the identification and treatment of Substance Use Disorder (SUD) among individuals with I/DD.

Literature Review Keywords & Summary

Keywords for important themes in the literature
(related to facilitators to/adaptations for treatment):

- Person-centered care
- Trauma-informed care

- Support systems
- Medication treatment
- Navigational supports
- Coordinated care
- Integrated care
- Access to diverse treatment modalities
- Peer Support
- Accessible design: universal design principles
- Alcohol and drug refusal skills
- Coping strategies/skills
- SBIRT training - motivational interviewing
- Booster/refresher training

Summary:

The literature on the intersection of disability and substance use reveals key patterns and themes. Individuals with developmental disabilities, spanning autism spectrum disorder (ASD) and intellectual disabilities (ID), exhibit heightened susceptibility to substance use and addiction, with risks escalating based on factors like comorbid mental health conditions and ADHD. Barriers to treatment include stigma, discrimination, lack of information, and inaccessible settings, while facilitators involve peer support, tailored interventions, and person-centered approaches. Adaptations in treatment, such as simplified communication and individual therapy, are crucial for addressing diverse cognitive profiles. Furthermore, the literature underscores the need for coordinated care, navigational support, diverse treatment modalities, and the identification of Substance-Related and Addictive Disorders as markers for complex conditions. These findings highlight the need for targeted interventions that recognize the intersectionality of disability and substance use, addressing barriers and leveraging facilitators to enhance treatment efficacy.

General Disability and Substance Use (Prevalence):

- Substance use and addiction among people with disabilities is higher compared to people without disabilities (Reif et al., 2023).

- 26% of the U.S. population has some type of disability, and one in every six children in the U.S. ages 3-17 has an intellectual or developmental disability (Roux et al., 2022).

- Adults with any disability have increased odds of drug (aOR = 2.7) and alcohol use disorder (aOR = 1.8) compared to those without disabilities (Aram et al., 2023).

Autism Spectrum Disorder (ASD) and Substance Use:

- Varied rates of SUD in individuals with ASD, potentially influenced by limited social contacts and literal interpretation of social rules (Arnevik & Helverschou, 2016; Ressel, et al., 2020).

- Autistic traits, depression, anxiety, and social anxiety associated with hazardous alcohol consumption (Bowri, et al., 2021)

- Gender and the level of autistic traits are significant predictors of alcohol use in autistic adults (VanDerNagel, et al., 2017; Bowri et al., 2021)

- In a cohort study of of 6599 individuals with ASD and 26,396 controls without ASD, a diagnosis of autism was associated with an increased risk of substance use disorder, and the risk was much higher in those who had behavioral comorbidities and those who did not receive psychotropic agents (Huang et al., 2021)... These findings suggest that patients with ASD are vulnerable to the development of SUD. Comorbid ASD and SUD were associated with an increase in mortality risk.
    - Autistic people are more likely to develop addiction compared to the general population—**twice as likely to develop alcohol addiction and three times as likely to develop drug addiction** (Huang et al., 2021).

- SUD prevalence increased yearly across disability groups (ASD group, ID group, and ASD & ID group) to 1-2.2%, increasing most quickly among those with ASD. (Roux et al., 2022)

- Alcohol abuse was the most common SUD among those with ID-only (57%) versus **cannabis abuse among the ASD-only group (41%)** (Roux et al., 2022)

Intellectual Disabilities and Substance Use:

Individuals with mild to borderline intellectual disabilities are at a higher risk of developing SUD.
SUD prevalence varies with intellectual disability severity.
Substance use problems may increase with cognitive function and community integration.

- A systematic review of research between January 2000 and June 2018 on the prevalence, assessment, and treatment of SU(D) among children, adolescents, and adults with mild to borderline intellectual disability (MBID) found that **individuals with MBID are likely to be at higher risk for developing SUD** compared to those without MBID (van Duijvenbode & VanDerNagel,
2019).

- **Alcohol abuse was the most common SUD among those with ID-only** (57%) versus cannabis abuse among the ASD-only group (41%) (Roux et al., 2022).

- Prevalence rates of SUD vary in people with intellectual disability. SUD are almost exclusively observed in individuals with moderate to MID or BIF (Didden et al., 2020).
    - MID = mild intellectual disability; BIF = borderline intellectual functioning

- Substance use problems among people with intellectual disability may increase with cognitive function and as they are more fully integrated into the community, perhaps linked to increased access to and opportunity to use substances (Reif et al, 2023).

Youth with Disabilities and Substance Use:

- Higher prevalence of tobacco and alcohol use and lower prevalence of cannabis use in adolescents with MBID (van Duijvenbode & VanDerNagel, 2019).
- The goal of minimizing the early onset alcohol consumption among [high school] students [with disabilities] remains essential for prevention specialists, as **early onset alcohol use has been linked to increased substance use disorder risk later in life** (Ryding et al., 2022).

Patterns (in types of substance use)

- Adults with disabilities were significantly more likely than adults without disabilities to experience **past year prescription opioid use** (52.3% for those with disabilities compared to 32.8% of those without), **misuse** (4.4% compared to 3.4%), and **use disorders** (1.5% compared to 0.5%). (Lauer et al., 2019).
    - People with disabilities were significantly more likely to **misuse opioids for pain** (Risk Ratio = 1.5, $p < 0.001$) and to receive opioids from a healthcare provider (Risk Ratio = 2.0, $p < 0.001$).

- People with disabilities who reported **multiple tobacco product use** were significantly more likely to show signs of nicotine dependence than those who reported only using one tobacco product. Multiple tobacco use was not uncommon in this sample: about one-sixth of the participants reported currently using multiple types of tobacco products. (Soule et al., 2015)

Risk Factors

Comorbid mental health concerns increase the risk of substance misuse/SUD.
ADHD is a significant predictor of substance misuse.
Co-occurring psychiatric disorders (e.g., depression) increase SUD risk.

- Many people reported that their **anxiety, depression, and trauma** were the core of why they used opioids and that it was critical that it was acknowledged and treated during SUD treatment (Ledingham et al, 2022).
- **ADHD** increased the risk of alcohol abuse, cannabis abuse, and other illicit substance abuse compared to individuals without ADHD (Ottosen et al, 2016)

    - In the overall estimates, no gender differences were found—ADHD increased the risk of all SUD outcomes. Among individuals with ADHD without comorbidities, **females had a higher SUD risk than males**, as did females with ADHD and conduct disorder (CD). **Comorbid CD, depression, bipolar disorder, and schizophrenia** further increased the risk of SUD in ADHD, compared to non-ADHD (Ottosen et al, 2016).
- Risk of SUD was higher among those with [disabilities with] co-occurring psychiatric disorders—notably, **depression** (Roux et al, 2022).
- On average, individuals with **intellectual disability** have similar risk factors compared with their peers without intellectual disability but **are more vulnerable for the adverse effects of SUD** (Didden et al., 2020).
- Factors contributing to the increased risk of alcohol and other drug problems in **ID include cognitive and adaptive functioning limitations, including deficits in causal reasoning, insight and self-regulation**. Furthermore, ID-related social adaptive functioning deficits, including **susceptibility to peer pressure, amenability, credulity, poor risk awareness and difficulty reading social signs of untrustworthiness** increase their likelihood of being pressured or manipulated into using alcohol and other drugs (Copersino et al., 2022).
    - **Individuals with mild ID have compounded risks** associated with social adaptive functioning deficits, because their relatively higher level of functioning frequently accompanies greater independence in the community, which increases the chances of environmental exposure to substances and potentially exploitative social interactions (Copersino et al., 2022).
- Risk of substance use problems may also be **higher [among those with ID]**, as with the general population, when there are co-occurring psychiatric problems, trauma history, or severe behavioural problems (Reif et al., 2023).

- Various risk factors for substance use, such as low social support, late ASD diagnosis, psychological distress, lack of daytime activities, modeling, and executive functioning deficits (VanDerNagel et al., 2017).

Protective Factors

- The diagnosis of ASD can be a protective factor when comorbid with intellectual disability (Ressel, 2020).

- Protective factors such as low sensation-seeking traits and limited access to drugs in individuals with ASD (Ressel, 2020).

Barriers to Treatment

- Individuals with MBID face barriers to initiating, engaging in, and completing SUD treatment, leading to higher dropout rates (van Duijvenbode & VanDerNagel,2019).

- Respondents reported numerous challenges with treatment, including **not having a sufficient number of programs accessible**, a **lack of specialized programs** for people with dual-diagnoses and diverse populations, **affordable/consistent transportation**, **lack of access to affordable quality care**, and **stigma/shame** (Ledingham et al., 2022).
    - Some mentioned that **having medical complexity** (e.g., disability, asthma, mental health) could be a barrier, with one respondent describing treatment centers being hesitant to take them on because of their physical health problems.
    - In spite of the evidence that medication treatments are effective for OUD in reducing deaths and relapse, **stigma and misunderstanding about medication treatments remain common even in SUD treatment programs and have resulted in its underuse**.

- Reif et al., 2023: Summary of barriers to accessing treatment for SUD (Note: **stigma** and **discrimination** due to disability are major concerns and may manifest across all barriers listed).
    - **Table of Barriers to Accessing Treatment for Substance Use Disorders:**

Barriers to accessing addiction treatment	Examples of these barriers
Not ready to seek help	Lack of motivation Do not recognize a problem
Don't know where to go	Lack of information regarding addiction treatment Lack of information regarding accessible treatment
Transportation	Cost, accessibility of transportation Access in rural areas
Financial resources	Income restrictions and higher poverty rates affect out-of-pocket payments and other costs
Health insurance	Providers who do not accept public insurance

Addiction treatment beliefs	People always relapse Stigma about addiction medications, by individuals and providers
Stigma related to disability	Ableism, focus only on disability Beliefs that disabled people don't use substances, will be noncompliant, make others uncomfortable Beliefs that disabled people don't belong due to differences in communication, learning styles, or adherence to social norms
Inflexible addiction treatment	Lack of accommodations Group therapy not ideal for some types of disability
Addiction treatment policies	Medications or personal care assistants not allowed Missed appointments seen as noncompliance regardless of reason (e.g., transportation)
Communications	Materials not available for visually, hearing, or cognitively impaired, lack of interpreters
Physical barriers	Inaccessible buildings (e.g., no elevators, narrow hallways, poor lighting, no braille signage)

Facilitators to Treatment

Having a strong support system with caring individuals facilitates engagement in treatment—a person-centered approach.
Various types of SUD treatment is necessary to serve people with I/DD and SUD, including medication treatment (e.g., buprenorphine).
There is a need for more welcoming, minority-led services/counselors/providers, including more explicit ways to increase visibility of providers who identify as, for example, LGBTQ+ friendly providers.

- Several respondents talked about the difficulty of seeking treatment and the need for support because it is a “scary” thing to go through. Having a **support system** and “**someone that really cared**” was described as a facilitator to treatment (Ledingham et al, 2022).
    - Several others discussed how **medication treatment (e.g., buprenorphine)** has been a central part of their recovery.
    - Respondents suggested a more **person-centered approach** to working with people with disabilities.
    - People with disabilities **need access to various types of SUD treatment**, including medication treatment, alternative modalities, and treatments that address co-occurring needs in a way that minimizes stigma.
    - The **need for a personal care attendant or other designated support staff** was also a common issue, particularly among those with a physical disability.
    - Respondents highlighted experiences related to belonging to a stigmatized group (e.g., gender, race, LGBTQ+) as impacting their OUD or broader SUD recovery journey.
        - Another respondent mentioned the **need for more minority-led recovery centers and counselors**.
        - Another respondent who self-identified as being part of the LGBTQ+ community said they have been in treatment settings that “aren't welcoming to the LGBTQ+ community” and expressed the **need for better ways to identify LGBTQ+ friendly providers and centers such as “signage on the doors.”**

Adaptations for Treatment

- Recommendations for treatments focusing on time management, organization, problem-solving, and emotional regulation (Kronenberg, et al., 2014)

- Integrated cognitive-behavioral therapy, atomoxetine, and methylphenidate found effective for SUD + ADHD individuals (Kronenberg et al., 2014).

- Identification of Substance-Related and Addictive Disorders (SRAD) as a marker for complex conditions and the need for coordinated care (Lin et al., 2016).

- Navigational supports critical for coordinating across health, mental health, housing, and public health services for individuals with IDD and SRAD (Lin et al., 2016).

- Adaptations for ASD clients, including plain language, structured sessions, and involvement of family (Brosnan & Adams, 2022).

- Tailoring treatment to the characteristics and personality profile of the client (Gosens et al., 2021).

- A few respondents discussed how having access to a **variety of complementary and integrative health treatments** was useful for them (e.g., swimming, peer support), in addition to **diverse, trauma-informed care** (Ledingham et al., 2022).
    - **Peer support**, a mentoring and support service typically provided by people in recovery from SUD, was consistently mentioned as an integral part of OUD recovery journeys. Several respondents talked about how peer support provides value by providing “non-judgmental” support, feeling comradery that they are “in the same boat,” learning from “each other's past experiences,” offering “solidarity,” helping “navigate” services/treatment, and someone to “listen” when needed.
    - Several respondents mentioned that one of their first experiences with treatment was in prison, giving them access to therapists and treatment programs that they did not have access to before. Some mentioned how the opportunity to participate in drug treatment programs during their prison sentence was impactful because it “**has structure ... education” and helps people be around others who “want help and are willing to do the work**.

- People with **arthritis, a leading cause of disability,** may be prescribed long-term opioid therapy to manage chronic pain. Regular use of opioids can increase risk of overdose and opioid use disorder (OUD). The purpose of our research was to **validate an instrument to screen for harmful opioid use in people with disability and chronic pain due to arthritis (PWDA)** (Mallery Lankford et al., 2022)
    - The COMM 11-PWDA is a valid instrument for screening for and monitoring harmful opioid use in PWDA. (People With Disability due to Arthritis)
        - The COMM 11-PWDA is a shortened and validated version of the COMM that will be useful to primary care providers and other clinicians who treat adults living with chronic pain and arthritis-related disabilities.

- Reif et al., 2023: Summary of approaches that are promising for addressing substance use or addiction among people with intellectual disability, autism, and cognitive disabilities including brain injury.
    - **Table of Selected Adaptations in Addiction Treatment:**

Adaptation	Type of disability	Rationale	Examples

Simplified materials	Intellectual, cognitive	Limited knowledge or ability to abstract information More likely to respond yes when do not understand	Use simple sentences, pictures, graphics, colloquial terms (e.g., weed, not cannabis) Avoid negative phrases or confrontational items
Simplified communications	Autism	Concrete or inflexible thinking	Be direct and unambiguous Minimize nonverbal communication, metaphors
Reduced information shared at one time	Intellectual, autism, cognitive	Challenges in executive functioning	Provide less information at one time Use simpler language, repeat information Provide time for comprehension Take breaks, minimize distractions
Assess or enhance comprehension and retention	Intellectual, autism, cognitive	Cognitive functioning and processing speed variations	Use visual tools Have patient summarize or role-play Structured homework, routines Written summaries

Motivational interviewing	Intellectual, autism	Lack of knowledge or reasoning to participate in own behavior change	Educate around substance use and specific harms or negative outcomes Increase insight and engage around reasons for treatment
Problem-solving skills	Intellectual, autism, cognitive	Reduced insight or motivation to change	Build skills to refuse substance use, address cravings, anticipate impulses, practice alternatives Identify constructive and rewarding activities to replace substance use
Individual therapy (vs. group-based sessions)	Intellectual, autism, cognitive	Group sessions require greater attention span, social and communication skills	Use individual therapy to tailor treatment to individual needs and functioning Incorporate cognitive-behavioral approaches adapted to level of functioning
Supervised medication use	Intellectual	Addiction medications may not be taken correctly or regularly	Supervised administration by family, treatment providers, or others

Tailored & Effective Interventions

- Motivational interviewing techniques show effectiveness in increasing readiness for change in individuals with MBID (van Duijvenbode & VanDerNagel,2019).

- Mindfulness-based and other cessation programs demonstrate efficacy in behavior change and reducing substance use (van Duijvenbode & VanDerNagel, 2019).

- Exploration of minor adaptations in communication to enhance the effectiveness of interventions (van Duijvenbode & VanDerNagel, 2019).

- Copersino et al. (2022) examined clinical utility of an **alcohol and other drugs refusal skills intervention for adults with intellectual disability** (ID); intervention was appropriate for people with mild ID.
    - The Refusal Skills Group is developmentally appropriate for people with mild ID in that: (1) **they can learn and demonstrate refusal skills** and (2) their **skill acquisition is predicted more strongly by exposure to the intervention than by individual differences in learning characteristics**.
        - Delivering refusal skills in DDS settings familiar to clients increased their access to services and minimized disruption to their usual routines and schedules.
    - The intervention [10-session alcohol and other drug refusal skills group] is innovative because it **combines clinical elements of evidence-based CBT with principal objectives of DDS services provision by promoting greater independence and community inclusion** and brings delivery of these specialized services directly to DDS community residential and day habilitation settings.
    - Curriculum content was drawn from source material on general education about alcohol and other drugs, motivational strategies for SUD recovery in ID, assertiveness training for people with ID, and coping strategies of ID individuals for stressful social interactions.
        - The core alcohol and other drug refusal strategies (i.e., “NO-GO” and “NO-Suggest-GO”) were adapted from The James Stanfield Company Life Facts Series, Substance Abuse and Smart Trust volumes, and National Institute on Drug Abuse (NIDA) Therapy Manual 1: A Cognitive-Behavioral Approach to Treating Addiction.
            - The James Stanfield Company Life Facts Series is a seven-volume set of modifiable slide presentations designed to augment basic health education and social skills training with mentally disabled students.
        - Visual aids were adapted from the Life Facts Substance Abuse and Smart Trust materials, and from NIDA for Teens: Drug Facts: What Are They?
    - The refusal skills group is comprised of ten sessions of about 45 min in duration organized into modules of increasing complexity.
        - The introductory module is dedicated to identifying visual images of alcohol and other drugs, and learning and practicing assertiveness (i.e., body language, gaze, tone of voice).
        - The second module introduces the core refusal skills strategy (“NOGO”), which involves making an assertive refusal and removing oneself from the situation. The “NO-GO” strategy is the foundation on

which the remaining modules are added. Participants are taught that the “NO-GO” strategy is appropriate in all situations.
    - For example, the subsequent module introduces the “NO-Suggest-GO” strategy, which is intended to be used with individuals the participant knows and trusts. In “NO-Suggest-GO,” participants are taught that it is okay to recommend an alternative activity with a trusted person but removing oneself from the situation without recommending an alternative activity is okay too.
  - The last module introduces the concepts of “checking ahead” to recognize and avoid risk in new social situations (e.g., asking who will be at a party before attending), but being prepared to use refusal skills if necessary.

- Collings et al. (2022) examined a **modified residential SUD treatment program for individuals with cognitive impairment**, including accessible design and person-centered care; found treatment completion rates for people with cognitive impairments.
  - Environmental adaptations, including a combination of conventional treatment modalities with accessible design and person-centred principles, removed barriers to treatment for residents with cognitive impairment. Creating a climate where respect, tolerance and peer support were normalised was likely to have been particularly beneficial for these residents.
    - **Treatment completion was up to five times higher for residents with cognitive impairment after the new program was implemented.** The pilot program provided **simplified written and visual materials and concrete examples and introduced a daily virtues program to embed new learning and support behaviour change**. Resources to allow staff to engage more intensively with residents and provision of ongoing staff training were viewed as essential for program success.
  - A key finding was that the implementation of **universal design principles** made the program materials inclusive of all rehabilitation residents, which extends knowledge about the use of these techniques to remove communication barriers for people with disability by applying them to learning within a treatment context.
    - **Modified psycho-educational materials were incorporated into the program**. A workbook developed in Canada for use with clients living with acquired brain injury and substance misuse issues as part of the SUBI Bridging Project (see https://www.subi.ca) was adapted by Author B in consultation with its author.
      - The workbooks were used to support **a staged change process** in which residents gained awareness of the impacts of substance misuse, knowledge of their own triggers and new skills to support mastery for relapse prevention.

Potential Outline for Lit Review:

1. **Introduction:**
    a. Overview of the prevalence of substance use in individuals with I/DD (e.g., MBID, ASD, ADHD, etc.)
    b. Identification of common barriers to SUD treatment in populations with intellectual and developmental disabilities.
    c. Importance of tailored interventions for individuals with I/DD.
2. **Prevalence of Substance Use in Different Populations:**
    a. Comparative analysis of substance use prevalence in adolescents, adults, and individuals receiving residential ID care.
    b. Exploration of factors influencing substance use initiation, including gender, age, and social modeling.
    c. Differences in caregiver burden and expressed emotion.
    d. Themes in personal recovery for individuals with SUD, ADHD, and ASD.
    e. Impact of hospitalization, medication, and family therapy on recovery
3. **Risk Factors and Protective Factors:**
    a. Examination of specific risk and protective factors for substance use in individuals with I/DD.
    b. Importance of cognitive impairment screening in individuals with SUD and IDD.
4. **Screening and Assessment Challenges:**
    a. Discussion on the lack of systematic screening and assessment for SUD in populations with IDD and MBID.
    b. Implications of undetected substance use due to insufficient screening practices.
5. **Reduction in Substance Abuse:**
    a. Case studies illustrating successful reduction in substance use following engagement in treatment.
6. **Intervention Strategies and Personal Recovery:**
    a. Effectiveness of interventions on different substances.
    b. Themes of personal recovery.
    c. Development and outcomes of the "Take it Personal!" treatment.
    d. Overview of e-learning and classroom-based prevention programs.
    e. Impact of modified CBT programs on substance use.
    f. Challenges and recommendations for individuals with dual diagnoses of SUD and ADHD or ASD.
    g. Effective treatments and interventions for executive functioning impairments.
    h. Effectiveness of motivational interviewing and mindfulness-based programs.
7. **Adaptations in Treatment:**
    a. Challenges in therapist-client communication and recommended adaptations.
    b. Tailoring treatment to the characteristics and personality profile of the client.
8. **Peer Support:**
    a. Role and significance of peer support in the recovery process.
    b. Recommendations for peer specialist training and matching.
9. **Complex Conditions and Navigational Supports:**
    a. The significance of SRAD as a marker for complex conditions.

   b. The need for navigational supports in coordinating care for individuals with IDD and SRAD.

10. Conclusion:

   a. Summary of key findings.
   b. Recommendations for future research and practice.

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Data Extraction for Research on I/DD Population with Substance Misuse

REVIEWER & DATE	REFERENCE & PURPOSE			PARTICIPANTS/POPULATION STUDIED			DATA	SUBSTANCE MISUSE	IDENTIFICATION & DIAGNOSIS	VARIABLES			OUTCOME MEASURES	RESULTS & FINDINGS	RELEVANCE	QUALITY ASSESSMENT				COMMENTS
Name of Reviewer + Date of Data Extraction	Citation: Author(s), Title, Journal, DOI/URL, etc. (AMA format)	Publication Year	Research Objective(s)/Question(s)	Recruitment Methods & Sample Size	Participant Characteristics (Age Range, Gender, Type of Disability, etc.)	Type of Study, Research Design, & Analysis Used	Year Data Collected	Types of Substances Misused, Prevalence/Incidence of Substance Misuse, etc.	Methods used for Identifying Substance Misuse, Tools/Instruments Used for Assessment, etc.	Treatment and Intervention: Types of Interventions/Treatments Studies, Duration of Intervention, Adaptations for I/DD population, etc.	Control	Intervention	Primary, Secondary, Long-term Outcome Measures (if available)	Main Findings Related to Substance Misuse/ Intervention Effectiveness	Relevance to Research Objectives: How Well Does the Study Address Research Q's & Objectives? Applicability to Best Practices for I/DD and SUD Population?	Overall Quality Rating (High, Moderate, Low)	Strengths of Study	Weaknesses & Limitations	Ethical Considerations	Any Additional Notes/Relevant Info
Lianne W., 10/4/23	Aram J, Slopen N, Arria AM, Liu H, Dallal CM. Drug and alcohol use disorders among adults with select disabilities: The national survey on drug use and health. Disability and Health Journal. 2023;16(3):101467. doi:10.1016/j.dhjo.2023.101467	2023	"Using national data, this study quantifies the association between disability and drug and alcohol use disorders among US adults."	Audio computer-assisted self-interviewing for the National Survey on Drug Use and Health/NSDUH (2018-2019), n=83,439	Age=18 or older; Sex=52.8% F, 48.2% M; Hearing, Vision, Cognitive, Mobility, and Complex Activity Limitations	**Observational/Cross-Sectional Study.** Logistic regression was used to estimate adjusted odds ratios (aORs) controlling for potential sociodemographic confounders.	2018 and 2019	Broadly examines drug use disorder—including stimulants (i.e., methamphetamine and cocaine), and tranquilizers (i.e., benzodiazepine) - alcohol use disorders. Adults with disabilities make up approximately 37% of adults with past year drug use disorder and 25% of adults with past year alcohol use disorder.	NSDUH survey questions about disability recommended by the US Dept. of Health and Human Services. For this analysis, disability was assessed as: 1) any disability versus no disability (dichotomous); 2) seven mutually-exclusive types of specific disabilities: 1) no disability (the reference group); 2) hearing disability only; 3) vision disability only; 4) cognitive disability only; 5) mobility disability only; 6) complex activity disability only; 7) two or more types of disabilities. The NSDUH drug and alcohol use disorder categories were based on the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders 4th Revision (DSM-IV).	N/A	N/A	N/A	N/A	Adults with any disability had increased odds of drug (aOR = 2.7; 95% CI = 2.5–3.0), and alcohol use disorder (aOR = 1.8; 95% CI = 1.6–2.0), compared to adults without disability. Examining specific types of disabilities, adults with cognitive limitations only had increased odds of drug (aOR = 3.1; 95% CI = 2.6–3.6), and alcohol use disorders (aOR = 2.2; 95% CI = 1.9–2.5), compared to adults without disability. Adults with two or more types of limitations had increased odds of drug (aOR = 3.7; 95% CI = 3.3–4.3), and alcohol use disorders (aOR = 2.3; 95% CI = 2.0–2.6).	Highlights scope of substance misuse among disability population in the US in recent years, specifically those at risk of increased odds for drug and alcohol use disorder.	Moderate-High	Findings align with much of the existing literature which shows elevated burden of drug and alcohol misuse among persons with any reported disability. This analysis uses more recent NSDUH data than most published studies and examines broad drug and alcohol misuse measures. Most prior studies have utilizes binary disability measure or focused exclusively on one type of disability, while this study examined which disability types and combinations are associated with the greatest risk for drug and alcohol use disorders, and evaluated the strength of these associations after controlling for known sociodemographic covariates and considering potential effect modification by sex, which is an especially salient characteristic in disability and substance	Cannot determine whether SUD preceded and contributed to disability, or vice versa. There is a need for further longitudinal research which distinguishes between cognitive disabilities of different etiologies. Other limitations: the potential for misclassification of alcohol and/or drug use disorders among adults with certain disabilities. The exclusion of individuals residing in institutional group quarters from the NSDUH sample might omit a portion of the disabled population and differentially excludse adults with more severe disabilities—this limits the generalizability of the present study to non-institutionalized persons with disabilities.	No conflicts of interest and no funding was received for this research.	
Lianne W., 10/14/23	Huang JS, Yang FC, Chien WC, et al. Risk of Substance Use Disorder and Its Associations With Comorbidities and Psychotropic Agents in Patients With Autism. JAMA Pediatrics. 2021;175(2):e205371. doi:10.1001/jamapediatrics.2020.5371	2021	Do patients with autism have a higher risk of substance use disorder than the general population, and is this risk associated with psychotropic treatment, comorbidities, or mortality?	Data collected by the Taiwan National Health Insurance Research Database (NHIRD) from Jan. 1, 2000 - Dec. 31, 2015. Over 23 million/99.9% of Taiwan's population data is in this database. Included participants attended at least 3 outpatient visits withint he 1-year study period for symptomatic ASD as determined by the ICD-9-CM diagnostic codes. Sample size = 6599 patients with ASD.	Total participants w/ ASD: 6599 - Mean age 11.9 years. 5,094 boys (77.2%), 1,505 girls (22.8%). Control group w/o ASD: 26,396 - Mean age 12.1 years. 20,376 boys (77.2%). Patients w/ ASD and non-ASD controls were matched 1:4 by age, sex, and index date. 8 psychiatric comorbidities that often occur w/ ASD were examined: intellectual disability, ADHD, OCD, epilepsy, tic disorder, mood disorder, anxiety disorder, and impulse control disorder.	**Retrospective, population-based, matched cohort design** - included outpatient & inpatient Longitudinal Health Insurance Databse of the NHIRD. Multivariable Cox proportional hazards regression analysis was used to calculate Hazard ratios w/ 95% CIs (to calculate the risk of SUD and mortality between both groups.	Jan. 1 2000 - Dec. 31 2015	Alcohol Use Disorder (AUD) and Drug Use Disorder (DUD) were examined and classified as SUD subgroups.	ASD identified according to ICD-9-CM codes and catastrophic illness card. In Taiwan, patients w/ several mental disorders may be issued this card in order to reduce their financial burden. Individuals diagnosed with ASD before 2000 were excluded. Those diagnosed with SUD before the first visit for ASD, and those with missing data, were also excluded. A combination of diagnostic code criteria, statistical matching, and multivariable-adjusted analysis used to measure the risk fo SUD, AUD, and DUD in individuals w/ ASD.	N/A	N/A	N/A	Adjusted hazard ratios (aHRs) with 95% CIs for SUD, including AUD and DUD, and the risk of mortality were calculated. Data were analyzed from March 1 to July 13, 2020.	In this cohort study of 6599 individuals with autism spectrum disorder (ASD) and 26 396 controls without ASD, a diagnosis of autism was associated with an increased risk of substance use disorder, and the risk was much higher in those who had behavioral comorbidities and those who did not receive psychotropic agents. The mortality risk was higher in patients with autism and co-occurring substance use disorder than in non-ASD controls with or without substance use disorder. These findings suggest that patients with ASD are vulnerable to the development of SUD. Comorbid ASD and SUD were associated with an increase in mortality risk.	Important insights into the associations between ASD and substance misuse/SUD, but it is centered on ASD. More explicit study on those with I/DD is needed.	Moderate	Study includes a large cohort of individuals w/ ASD. Matching ASD individuals w/ non-ASD controls in a 1:4 ratio helps control of potential confounding variables and increase statistical power. Analysis differentiates between AUD and DUD, and examines associations w/ comorbidities, psychotropic agents, and mortality.	Generalizability of findings to the broader I/DD population is limited as the study primarily focuses on ASD. The study covers data from 2000 2015, and trends in substance use and diagnostic practices may have changed since then. Data is from the Taiwan NHIRD, and findings may not be applicable to populations in other countries. The NHIRD also did not include the severity of ASD (therefore, could not examine the association of ASD severity w/ the risk of SUD). Although the study screened a sample of 1936512 people w/ 16 years of follow-up, only 6599 people w/ ASD were enrolled in the analysis. The study only identified 4 cases of tobacco use disorder, so the associated outcomes for this disorder had limited statistical power.	Participant information kept confidential, no conflicts of interest, fundersa hd no role in the design and conduct of the study, and transparency in research methodology.	The study investigates the association between ASD and SUD, emphasizing a higher risk of comorbid SUD in individuals with ASD compared to the general population. Notably, those with ASD and comorbid SUD exhibited a significantly increased risk of mortality. The study spans a 16-year follow-up, involving a large sample size of 6599 patients with ASD. Subgroup analyses revealed a reduced risk of SUD in ASD patients receiving psychotropic agents (PAs), suggesting a potential protective effect. The study explores neurobiological and behavioral science perspectives, emphasizing shared neural circuits and molecular pathways between ASD and SUD. Abnormalities in the cortical motor system are implicated, suggesting motor cognition commonalities in ASD and SUD. The findings underscore the importance of ASD treatment in reducing the risk of SUD and prompt further exploration of mechanisms, nonpharmacotherapies, and psychosocial outcomes in this population.
Lianne W., 10/14/23	Lauer EA, Henly M, Brucker DL. Prescription opioid behaviors among adults with and without disabilities – United States, 2015–2016. Disability and Health Journal. 2019;12(3):519-522. doi:10.1016/j.dhjo.2018.12.001	2019	To examine prescription opioid use, misuse, and use disorder, reason and source for last prescription opioid misuse, and receipt of prescription opioid treatment among people with and without disabilities.	The data comes from the 2015 and 2016 US National Survey on Drug Use and Health (NSDUH). Information was collected through in-person household interviews about substance use and mental health among the U.S. noninstitutionalized, civilian population ages 12 and over. After restricting the sample to civilian, noninstitutionalized adults ages 18 and over and removing participants with missing responses, 84,633 individuals remained from both years (N = 42,742 and 41,891).	Included civilian, noninstitutionalized adults ages 18 and over, and those with disability status. Disabilities were defined as having vision, hearing, ambulation, cognition, self-care, or independent living difficulties from standardized disability questions recommended by the DHHS.	**Stratified analysis** of prescription opioid use, misuse, and use disorders; primary reason and primary source for last prescription opioid misuse; receipt of prescription opioid treatment; and disability status among civilian, noninstitutionalized adults (ages 18+) using data from the 2015-2016 NSDUH.	2015-2016	Opioids included prescription opioids (oxycodone, tramadol, codeine, morphine, fentanyl, buprenorphone, oxymorphone, demerol, hydromorphone, and methadone products).	Prescription opioid behaviors were defined as (1) any use (using a drug in the past year), (2) use only (use without misuse, using a drug, excluding misuse, abuse, or dependence, in the past year), (3) misuse only (misuse without use disorder, using a drug in any way not directed by a doctor, excluding abuse or dependence, in the past year), and (4) use disorder (dependence or abuse in the last year, with dependence defined as meeting at least three of seven dependence criteria and abuse defined as meeting at least one of four abuse criteria and no dependence). 2015 and 2016 NSDUH abuse and dependence definitions for use disorders were based on American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) criteria.	N/A	N/A	N/A	N/A	Adults with disabilities were significantly more likely than adults without disabilities to experience past year prescription opioid use (52.3% for those with disabilities compared to 32.8% of those without), misuse (4.4% compared to 3.4%), and use disorders (1.5% compared to 0.5%). People with disabilities were significantly more likely to misuse opioids for pain (Risk Ratio ¼ 1.5, p < 0.001) and to receive opioids from a healthcare provider (Risk Ratio ¼ 2.0, p < 0.001). Among people with opioid use disorder, people with disabilities were less likely to receive treatment for prescription opioid use (Risk Ratio ¼ 0.6, p ¼ 0.067).	The focus is on disabilities broadly and provide a broad overview/picture, but the study does not specify the nature of disabilities, so this lack of detail may limit the applicability of findings to specific disability subgroups. The study does, however, acknowledge heterogeneity within the disability population and calls for further research to examine this.	Moderate	The large-scale analysis of national data increases the generalizability of findings to the broader US population. The study identifies disparities in prescription opioid use, misuse, and treatment between adults w/ and w/o disabilities, which is important for addressing the specific needs of individuals w/ disabilities in the context of opioid use. Also, despite the possibility of underreporting opioid use and misuse, there is no evidence that underreporting of opioid misuse would be related to disability status. Further, the NSDUH administration mode was designed to increase reporting honesty and substance use measures were found to have good validity and reliability.	The NSDUH is a cross-sectional, self-reported survey that is subject to several biases (selection, observation, response, and nonresponse bias). Opioid behaviors and drug treatment may be underreported due to stigma, social desirability, and because people who are members of the active-duty military or living in institutions are not included. n this analysis, dependence and other abuse variables are treated as mutually exclusive, with dependence taking precedence such that an individual will not be classified as abusing a substance if they are already classified as dependent.	No ethical concerns - no conflicts of interest and funding sources were transparently disclosed.	During 2015-2016 in the U.S., adults with disabilities were more likely to use and misuse opioids than adults without disabilities. Adults with disabilities have an increased risk of opioid use disorders, yet national, state, and local efforts to address the opioid epidemic often overlook this subpopulation. The data analyzed here suggests that pain is the primary reason for opioid misuse and that healthcare providers are the primary source of prescription opioids for both persons with and without disabilities.
Lianne W., 10/15/23	Ottosen C, Petersen L, Larsen JT, Dalsgaard S. Gender Differences in Associations Between Attention-Deficit/Hyperactivity Disorder and Substance Use Disorder. Journal of the American Academy of Child & Adolescent Psychiatry. 2016;55(3):227-234.e4. doi:10.1016/j.jaac.2015.12.010	2016	To examine gender differences in the association between attention-deficit/hyperactivity disorder (ADHD) and substance use disorder (SUD), and to explore the impact of comorbid psychiatric conditions.	Data derived from the Danish Civil Registration System (CRS), the Danish Medical Birth Register (MBR), the Integrated Database for Labour Market Research (IDA), the Danish Psychiatric Central Research Register (DPCRR), and the Danish National Patient Register (DNPR). Using the CRS, they identified all children born in Denmark to Danish-born parents between 1990 and 2003 (n = 729,560) and identified their parents and siblings. All individuals born in Denmark are assigned a unique identification number (the CPR number) at birth. This identification number was used to identify individuals across registers and to obtain and accurately merge information from the 5 registers. **Total of 713,393 children included in the study cohort (51% males and 49% females).**	Within the study cohort, we identified 19,645 individuals with ADHD. Of these, 5,144 (26.2%) were females. The mean age of ADHD diagnosis was 13.02 years (SD ¼ 4.4) for females and 11.03 years (SD ¼ 4.11) for males. The most prevalent comorbidities among females with ADHD were anxiety disorder (13.6%), ODD/CD (13.1%), and ASD (11.7%), whereas the most prevalent comorbidities among males with ADHD were ASD (19.3%), ODD/CD (18.4%), and mental retardation (9.8%).	**Registered-based, prospective cohort study of all children born in Denmark in 1990 to 2003.** Crude incidence rates of SUD for covariates in the total cohort was calculated. Cox regression was used to estimate the gender-specific hazard ratios (HRs) and 95% CIs for each of the 3 subgroups of SUD, in females and males with ADHD, compared to females and males without ADHD, respectively.	Prior to 2016?	For the main analyses, they collapsed SUD outcomes according to the 3 most prevalent types of substances into 3 groups: alcohol (ICD-10: F10), cannabis (ICD-10: F12), and other illicit substances (ICD-10: F11, 13–16, and 18–19). For additional analyses, they divided SUD into 3 severity groups: use (ICD-10: F1x.0), abuse (ICD-10: F1x.1, F1x.8, and F1x.9), and dependence (ICD-10: F1x.2, F1x.3, F1x.4, F1x.5, F1x.6, and F1x.7). Nicotine was not included in any of these analyses, as its prevalence is highly underestimated in the registers.	ICD-10 diagnostic criteria	N/A	N/A	N/A	N/A	ADHD increased the risk of alcohol abuse (HRfemales ¼ 1.72 [95% CI ¼ 1.42–2.08], HRmales ¼ 1.57 [1.37–1.79]), cannabis abuse (HRfemales ¼ 2.72 [2.12–3.47], HRmales ¼ 2.24 [1.86–2.70]), and other illicit substance abuse (HRfemales ¼ 2.05 [1.54–2.73], HRmales ¼ 2.42 [1.98–2.96]), compared to individuals without ADHD. In the overall estimates, no gender differences were found. Among individuals with ADHD without comorbidities, females had a higher SUD risk than males, as did females with ADHD and conduct disorder (CD). Comorbid CD, depression, bipolar disorder, and schizophrenia further increased the risk of SUD in ADHD, compared to non-ADHD. Autism spectrum disorder in males with ADHD lowered the SUD risk.	Focus is on ADHD and its associations with substance use/misuse, but does not specifically examine I/DD. However, provides insight into developmental disabilities broadly.	Moderate	Large sample size, longitudinal follow-up, use of various nationwide health registers - provides comprehensive info and minimizes selection bias, explores substance use severity, and meticulous methodology and gender-specific analysis used.	Lack of generalizability - study is based on data from Denmark.	None	ADHD increased the risk of all SUD outcomes. Individuals with ADHD without comorbidities were also at increased risk, and some comorbid disorders further increased the risk. Females and males with ADHD had comparable risks of SUD, although females had higher risk of some SUDs than males. Females with ADHD may be perceived as less impaired than males, but they are at equally increased risk of SUD.
Lianne W., 10/16/23	Reif S, Mitra M. The complexities of substance use disorder and people with disabilities: Current perspectives. Disability and Health Journal. 2022;15(2, Supplement):101285. doi:10.1016/j.dhjo.2022.101285	2022	To address these gaps in research and evidence, research articles were solicited and peer-reviewed to expand the knowledge base on prevalence and identification of disability-related disparities, perspectives of people with lived experience of disability, and adaptations to substance use measures and interventions.	N/A	N/A	N/A	2022 and prior	N/A	N/A	N/A	N/A	N/A	N/A	Article highlights 3 major themes among the 11 articles reviewed: 1) Prevalence of substance use/misuse/treatment, treatment disparities, and protective factors in relation to people w/ disabilities; 2) Experience of people w/ disabilities and their providers 3) The need for adaptations to measures and interventions	The article is short but a good summary of some recent research characterizing substance use and SUD among people w/ disabilities. It also highlights perspectives of people with disabilities, which is lacking in the literature. .	Low-Moderate	N/A	Not an actual study but a review of 11 articles.	N/A	**Theme 1: Prevalence, Treatment Disparities, and Protective Factors:** Hinson-Enslin et al.: Association between vision/hearing loss and drug use; increased likelihood of drug use, but no increase in treatment for those with sensory disabilities. Ryding et al.: Parental listening associated with lower likelihood of early alcohol initiation for youth with disabilities; however, this doesn't fully explain younger age of alcohol initiation among youth with disabilities compared to non-disabled youth. Richard et al.: Pregnant women with certain disabilities prescribed more opioids, leading to increased risk of adverse birth outcomes. Roux et al.: Prevalence of Substance Use Disorder (SUD) increased, more rapidly among autistic people; types of substances misused varied by specific disability types; co-occurring depression increased the risk of SUD. Reif et al.: Disability associated with reduced odds of current alcohol use but higher odds of drug use, prescription drug misuse, and nicotine use; chronic pain accounted for significant proportions of these associations. **Theme 2: Experiences of People with Disabilities and Providers** Ledingham et al.: People with disabilities face barriers to substance use disorder (SUD) treatment related to their disability, including stigma and systemic barriers. Paez et al.: People with chronic pain due to arthritis and their providers frustrated with new barriers to opioid prescribing set by states and insurers. **Theme 3: Adaptations to Measures and Interventions** Mallery et al.: Adaptation of an instrument to measure opioid misuse among people with disabilities and chronic pain due to arthritis; validated for screening and monitoring harmful opioid use. Copersino et al.: Examined clinical utility of an alcohol and other drugs refusal skills intervention for adults with intellectual disability (ID); intervention was appropriate for people with mild ID. Collings et al.: Examined a modified residential SUD treatment program for individuals with cognitive impairment, including accessible design and person-centered care; found treatment completion rates for people with cognitive impairments
Lianne W., 10/17/23	Roux AM, Tao S, Marcus S, Lushin V, Shea LL. A national profile of substance use disorder among Medicaid enrollees on the autism spectrum or with intellectual disability. Disability and Health Journal. 2022;15(2, Supplement):101289. doi:10.1016/j.dhjo.2022.101289	2022	This study aimed to estimate prevalence of SUD among Medicaid enrollees with ASD, ID, or ASD & ID; characterize these groups and types of SUDs; and identify risk of SUD by demographic and clinical characteristics within groups	Utilized administrative data that all states and Washington D.C. submitted to the CMS for production of Medicaid Analytic eXtract (MAX) files. The sample utilized for this study required at least 9 months enrollment in any calendar year to ensure sample quality and account for administrative churning in Medicaid eligibility. **ASD only, n = 209,795; ID only, n = 790,719, ASD & ID, n = 123,705; No ASD/ID, n = 1,768,499**	Included Medicaid enrollees who were ages 11-64 at some point within the study data years (2009-12 and used ICD-9 codes in use during these data years to construct 3 disability groups: 1) individuals with ASD-only as identified with codes 299.XX, and with no ID diagnosis identified with codes 317.XX-319.XX, 2) individuals with ID-only and no ASD, and 3) those with both ASD & ID diagnoses. identified six co-occurring psychiatric conditions based on at least one inpatient or two non-drug claims for: ADHD, anxiety, bipolar disorder, personality disorder and schizophrenia; and identified depression using any claim, using ICD-9 codes and guidelines obtained from the CCW.	Used descriptive statistics to characterize enrollee groups and types of SUDs, calculated SUD prevalence, and used modified Poisson regression to examine adjusted relative risk of SUD within disability groups.	2008-2012	Primary categories of substance abuse included in data: alcohol, amphetamines, cannabis, cocaine, drug-induced mental disorders (e.g., drug-induced psychosis, delirium, or mood disorder), hallucinogens, opioids, and other/mixed (e.g, sedatives, hypnotics, anxiolytics, tranquilizers, barbiturates; and combined drug dependence).	Used categorized ICD-9 diagnostic codes from the CCW and the Clinical Classifications Software (CCS) of the Agency for Healthcare Research and Quality (AHRQ) related to drug, alcohol or opioid use disorders. They defined individuals with SUD as those with at least one claim or two non-drug claims associated with a direct SUD diagnosis code, as per CCW criterion. Also, included individuals with a claim associated with an indirect code for a medical event connected with substance misuse, such as drug-induced mental disorders or poisoning due to alcohol, as suggested in prior research seeking to identify individuals with SUD within populations that may be subject to under-reporting of SUD.	N/A	N/A	N/A	N/A	SUD prevalence increased yearly across disability groups to 1-2.2%, increasing most quickly among those with ASD. Alcohol abuse was the most common SUD among those with ID-only (57%) versus cannabis abuse among the ASD-only group (41%). Risk of SUD was higher among those with cooccurring psychiatric disorders - notably, depression.	Provides good insights into ASD and ID populations and substance misuse/SUDs, including an important section on implications for clinical treatment.	High	Is the largest known investigation of SUD in youth and adults with ASD and/or ID in the US given the Medicaid-enrolled ASD and ID populations in 2008-2012. Also, explored multiple psychiatric conditions as co-occurring clinical characteristics.	Not generalizable beyond Medicaid enrollees with ASD or ID during the 2008-12 data years. Also, because the prevalence of SUD was low among those with disabilities, elevated relative risks based on specific characteristics may not be practically meaningful. it is possible that this study under-represents SUD needs within the ASD-only population given the potential for underestimation of SUD in individuals with ASD when using ICD-9 criteria to identify ASD. Could not examine severity levels of ASD or ID with the given data.	None	"Adults with ID who used substances also appeared to have elevated risk for conversion to SUD. Specific risk factors for SUD among individuals with ID include having friends who drink and low parental supervision." "Risk factors for SUD among those with ASD include history of SUD in immediate family members, early smoking onset, and adverse families histories." "...because SUD and ASD share common co-occurring psychiatric disorders, it is possible that the same neurobiologic pathophysiology contributes to SUD risk." "Use of pharmacotherapy to treat co-occurring conditions appeared to be a protective factor in adolescents with ASD." "While opioid disorders were more frequent among those without ASD or ID, we did find evidence of opioid use among those with disabilities. This finding points to an imperative need to monitor data for evidence of how the opioid crisis is affecting youth and adults with ASD or ID." "Adults with disabilities of all types are 1.5 times more likely to misuse opioids for pain and 40% less likely to receive treatment when they have OUD." "Those with ASD-only were more likely to have elevated risk associated with co-occurring psychiatric diagnoses - having over two times the risk of SUD if they had either depression, bipolar, or schizophrenia/other psychotic disorder, compared to no other psychiatric disorders. **These findings are notable as depression and other psychiatric disorders may be more potent clinical indicators of risk of SUD among people with ASD than ADHD.**"
Lauren, 10/20/2023	McKowen, J., Berger, A., Towbin, J., Yule, A. M., Woodward, D., Nowinski, L., Forchelli, G., Meyers, R. J., Joshi, G., & Wilens, T. E. (2023). A manualized behavioral therapy intervention for youth with autism spectrum disorder and substance use disorder. Case Reports in Psychiatry, 2023, 1–9. https://doi.org/10.1155/2023/8998160	2023	Case report on manualized behavioral intervention that utilizes individual therapy to evidence improvement in ASD and SUD	N/A	Case A: 17.5 y/o Caucasian male with diagnosis of ASD: Case B: 17 y/o Caucasian male with social communication disorder	N/A	2022	Case A: Heavy binge use of alcohol (6-8 standard unites per binge), marijuana (5-7 days of cannabis use w/ unknown potency but 1-2 joints at a time). Misuse of cough medication (900 mg of Delsym); Case B: met criteria for DSM-V cannabis use disorder and alcohol binge drinking 1-2 days per week, 3-4 standard units per occasion	Self-reported during intake interviews	Protocol consisting of 12 youth modules (designed for youth 26 y/o and younger), 7 parent modules, and 3 joint modules. Modules defined here as cognitive behavior therapy sessions faciliated by licensed practitioners with at least 5-10 years of experience working with SUD or ASD youth. Sessions with practioner 45-50 minutes weekly. Exercises for youth include identifying triggers, functional analysis of healthy activities, goals for abstinence trials, and grounding techniques	N/A	N/A	N/A	Both cases demonstrated a reduction in substance abuse. Case A continued to smoke cannabis, but fewer times per week. Cough medicine and binging alcohol no longer occurred once treatment began. Case B demonstrated a 50% reduction in cannabis use and did not engage in binge drinking once engaged int treatment.	Provides insights into content and exercises utilized to support individuals with comorbid ASD and SUD that resulted in the reduction of substance abuse	Low	Intervention that integrates parent engagement to support families of youth with SUD and ASD with fostering independence and adaptive functioning. The case reports also provide evidence to support the impact of CBT on individuals with SUD and ASD.	The protocol had a small sample size and focused on two individuals and their families.Generalizability is limited in that no quantitative sales measuring SUD or ASD were implemented. In order to limit the number of sessions, topic areas such as executive functioning strategies, job training, support services, etc. were not included which could have provided support for ASD symptoms. Issues around race, ethnicity, gender, gender identity, or sexual orientation were not addressed.	N/A	
Lauren, 10/20/2023	van Duijvenbode, N., & VanDerNagel, J. E. L. (2019). A systematic review of Substance use (disorder) in individuals with mild to borderline intellectual disability. European Addiction Research, 25(6), 263–282. https://doi.org/10.1159/000501679	2019	This systematic review aimed to summarize the research on the prevalence, assessment, and treatment of SUD among individuals with ID	N/A	N/A	N/A	2018	Among children and adolescents with MBID, prevelance rates ranged from 0.0-49.8% for tobacco use, 15.6-75.4% for alcohol use, 2.4-13% for cannabis use. Across articles on adults with MBID, prevalance rates ranged from 6 to 98.4% for tobacco use and 2.5-97.3% for alcohol use. Cannabis use centered around 50% and stimulant use was around 19.2%	Systematic review conducted by identifying articles from 2000-2018 through electronic search of Web of Science, PsycInfo, PubMed, and Eric. Search limited to published and peer reviewed full-text articles in English. 207 articles met the inclusion criteria	N/A	N/A	N/A	N/A	Data suggests a higher prevalence of tobacco and alcohol use and a lower prevelance of cannabis use in adolescents with MBID compared to those without. The prevalance of cannabis and stimulant use among adults with MBID was similar to and higher than, respectively, adults without MBID. For individuals receiving residential ID-care,there was a SUD prevelance rate of up to 46%. Individuals with MBID experience barriers to SUD treatment. Individuals are less likely to initiate and engage in SUD treatment and are more likely to drop out	Provides an overview of the research on prevention, screening/assessment, treatment, and prevalance of SUD in individuals with MBID	High	Provides an overview of articles included the population, method of intervention, substances, and outcomes	N/A	N/A	"With minor adaptations in communication, interventions based on motivational interviewing techniques seem effective in increasing the readiness to change of individuals with MBID and their motivation to enter into SUD treatment" "Mindfulness-based and other cessation programs seem effective in eliciting behavior change and reducing SU." "Within MBID populations, it appears that because of a lack of systematic screening and assessment of SUD, SUD is often overlooked and remains undetected."
Lauren, 10/20/2023	Arnevik, E. A., & Helverschou, S. B. (2016). Autism spectrum disorder and co-occurring substance use disorder – A systematic review. Substance Abuse: Research and Treatment, 10. https://doi.org/10.4137/sart.s39921	2016	A systematic review to 1) assess the estimated frequency of the co-occurrence of these two conditions (ASD + SUD) 2) explore the particular characteristics of this group of patients 3) obtain a better undersanding of the function of substance use in this population 4) summarize data on current tratement interventions available	Studies were divided into five sections: 1) studies of substance abuse in clinical populations with ASD 2) studies of ASD in clinical populations with SUD 3) studies of characteristics of individuals with ASD who have SUD 4) studies of the functions and/or consequences of SUD in individuals with ASD 5) studies of intervention strategies		Systematic review of 18 empirical articles highlighting the prevalence of SUD in individuals with ASD and intervention approaches	March 2014-January 2016							11 studies reported the frequency of SUD in patients with ASD but the rates ranged from .7% to 36% SUD generally lower in ASD samples potentially due to limited social contacts and/or literal interpretation of social "rules"	Insights into subgroup within I/DD and the prevelance of SUD	Moderate	Summarizes studies across a 10 year period related to SUD in individuals with SUD Discusses limitations in research and finidings across empirical articles Behavioral therapies delivered by trained clinicans helped reduce SU by strengthening motivation to change. This change was delivered by incentives for abstinence, building skills to resist and refuse substances, deal with triggers or craving, replacing drug use with constructive and rewarding activies, improving problem-solving skills, and facilitating better interpersonal relationships	Variable sample sizes across studies Age, intellectual level, and gender of participants varied across samples Definitions of SUD ranged between studies + few studies had formal diagnostic criteria for SUD Low generalizability of information due to inclusion of few studies with different methodologies	N/A	"This change was delivered by incentives for abstinence, building skills to resist and refuse substances, deal with triggers or craving, replacing drug use with constructive and rewarding activies, improving problem-solving skills, and facilitating better interpersonal relationships." "Studies including persons with ASD and comorbid pyschiatric disorders indicate that cognitive behavioral treatment approaches adapted to the individuals' level of functioning are most frequently recommended for this group."
Lauren, 10/20/2023	Bowri, M., Hull, L., Allison, C., Smith, P., Baron-Cohen, S., Lai, M.-C., & Mandy, W. (2021). Demographic and psychological predictors of alcohol use and misuse in autistic adults. Autism, 25(5), 1469–1480. https://doi.org/10.1177/1362361321992668	2021	1) What are the proportions of participants who abstain from, use and misuse alcohol in our sample of autistic adults? 2) What are the associations between gender, relationship and employment status and alcohol use and misues in autistic adults? 3) What is the association between autistic trait severity and alcohol use and misues in autistic adults? 4) What are the associations between levels of depression, generalised anxiety, social anxiety, and mental well-being and alcohol use and misues in autistic adults? 5) What is the association between levels of social camouflaging and alcohol use and misues in autistic adults?	n= 237 adults with autism diagnosis participated in the study. Participants were recruited voluntarily from social media platfoms (Twitter and Facebook), Internet forums, the Cambridge Autism Research Database, and through Brighton Housing Trust, Dv8 vocational college, and Autism Sussex charity.	Over 18 years of age, fluent in English, and self-reported an official autism diagnosis from a qualified healthcare professional Demographic information such as autism diagnoses/severity and co-occurring psychiatric/medical conditions, age, gender, nationality, relationship status, occupation, and education level Autistic traits measured with Broad Autism Phenotype Questionnaire to measure variability in autistic traits of autistic individuals. Scores of 3.55 and 3.17 were taken as cut-off values for males and females, respectively Depression, generalised anxiety, social anxiety, social camouflaging, alcohol use, and mental well-being were measured using relevant scales	One-way analysis of variance (ANOVA) was performed to test for gender differences in depression, generalized anxiety, social anxiety, mental well-being, autistic traits, and social camouflaging. Mann-Whitney tests were used to examine association between relationship status and AUDIT scores. Kruskal-Wallis tests were used to examine the association between alcohol use and gender and employment status. Spearman's correlation was used to examine associations between alcohol use, autistic traits, depression, generalized anxiety, social anxiety, mental well-being, and social camouflaging.	2017-2018	Study explored psychological and demographic predictors of alcohol use and misuse	Alcohol use was measured using the Alcohol Use Disorders Identification Test (AUDIT)	N/A	N/A	N/A		Autistic traits, depression, generalized anxiety, and social anxiety were associated with increased likelihood of hazardous alcohol consumption An individual's gender and level of autistic traits may be the most significant predictors of alcohol use in autistic adults	Demonstrates the relationship between autistic trait severity, mental health variables, and alcohol use/misuse	Moderate	Associations and analysis across multiple variables. Comparison of hazardous drinkers and non-drinkers. Highlight factors contributing to autistic adults abstaining from alcohol or becoming hazardous drinker Most participants in the study identified themselves as having Asperger syndrome or high-functioning autism Recommendations based on the study to increase screening and intervention for autistic individuals with SUD	Excluded individuals with lower intellectual ability who may not be able to complete the survey Reliance on self-reported autism diagnoses	N/A	Screening for alcohol use should be a routine part of healthcare and mental health assessments for autistic adults An individualized approach should be utilized to explore the unique combination of factors involved in alcohol misuse Autistic adults may be using alcohol for self-medication and to cope with sensory overstimulation Alternative coping strategies should be discussed to minimize hazardous alcohol use

APPENDIX B

Lauren, 11/1/2023	Gosens, L. C. F., Otten, R., Didden, R., & Poelen, E. A. P. (2020). Evaluating a personalized treatment for substance use disorder in people with mild intellectual disability or borderline intellectual functioning: A study protocol of a multiple baseline across individuals design. Contemporary Clinical Trials Communications, 19, 100616. https://doi.org/10.1016/j.conctc.2020.100616	2020	Evaluating the effectiveness of Take it Personal!+ in decreasing SU in individuals with MID-BIDF and SUD	Participants recruited from healthcare organizations for people with MID-BIF and behavioral problems. N=10	Inclusion criteria: 1) diagnosed with MID-BIF with an IQ between 60 and 85 and deficits in adaptive skills 2) diagnosed with SUD with cannabis, alcohol, XTC, cocaine, or speed 3) substance use at least 3 days a week	Non-concurrent baseline across individuals design. Participants randomly assigned to different baselines	2019-2020	See 17F.	The Substance Use Risk Profile Scale is used to allocate participants to one of four personality profiles	Participants are randomly allocated to one of the five baseline lengths varing from 7 to 11 days Take it Personal!+ is designed to last 11 weeks but can be adjusted based on the needs of the participants Session A involves individual sessions; Session B the participant brings a confidant	N/A	N/A	The primary outcome is the frequency and quantity of SU	SU will be assessed using daily diary measures during the various phases of the treatment program. The daily diary will be applied using a mobile app. The questionnaire will include 15 questions related to the frequency of SU and the quantity of SU. This will provide additional context ahead of the baseline phase	Provides ideas of how to gather information from participants ahead of engaging in a prevention program.	Moderate-Low	Highlights first SUD treatment program for individuals with MID-BIF that is based on theoretical frameworks that have shown positive results on individuals with SUD Treatment program that is responsive to the needs of individuals with MID-BIF Direct replications and systematic replications + descriptions of the characteristics of the participants that increase generalizability Daily diary method provides additional data points that could be utilized in treatment sessions	Outcome data is based on self-reports which can lead to response bias The study is the first to apply daily diary method for longer periods of time so there is no point of comparison	N/A	
Lauren, 11/8/2023	Oliva, F., Mangiapane, C., Nibbio, G., Berchialla, P., Colombi, N., & Vigna-Taglianti, F. D. (2021). Prevalence of cocaine use and cocaine use disorder among adult patients with attention-deficit/hyperactivity disorder: A systematic review and meta-analysis. Journal of Psychiatric Research, 143, 587–598. https://doi.org/10.1016/j.jpsychires.2020.11.021	2021	Estimating the lifetime prevalence of cocaine use and cocaine use disorder among adult patients with ADHD	N/A	Inclusion criteria were studies involving: adults, patients diagnosed with adult ADHD, reporting cocaine use and/or cocaine use disorder	Sytematic review and meta analysis of 12 studies involving 3357 patients	N/A	Cocaine	N/A	N/A	N/A	N/A	N/A	An average prevalence of 26% of cocaine use was found. The lifetime prevalence of cocaine use disorder is similar to that of patients with other psychiatric disorders. Psychosocial interventions have been found to be effective treatments An improvement in ADHD symptoms with the use of stimulants appeared to precede cocaine abstinence	Highlights the prevalence of substance use and misuse in individuals with ADHD across research and also summarizes treatments despite limited previous research	Moderate	Search strategy did not restrict study publication date or language Sample was large and included studies from different countries Diagnosis of individuals with ADHD was based on standardized assessment scales	A number of studies were excluded because they did not measure cocaine or cocaine use but focused on broad drug use of SUD whichcould have lead to the underestimation of prevalence It was sometimes difficult to understand how the authors calculated prevalence	N/A	"Abstience from cocaine use can be achieved by reducing impulsivity, increasing cognitive control, and decreasing the need to self-medicate"
Lauren 11/8/2023	Kronenberg, L. M., Slager-Visscher, K., Goossens, P. J., van den Brink, W., & van Achterberg, T. (2014). Everyday life consequences of substance use in adult patients with a substance use disorder (SUD) and co-occurring attention deficit/hyperactivity disorder (ADHD) or autism spectrum disorder (ASD): A patient's perspective. BMC Psychiatry, 14(1). https://doi.org/10.1186/s12888-014-0264-1	2014	What are the everyday life consequences of substance use in adult patients with a SUD and co-occurring ASDor ADHD from a patient's perspective?	Patients recruited from an outpatient, dual-diagnosis, treatment facility. n=11, SUD +ADHD; n= 23, SUD + ASD	Inclusion criteria: outpatient treatment for SUD, age 18-65, IQ >80, current DSM-IV diagnosis of SUD and current DSM-IV diagnosis of ADHD or ASD	Qualitative study using in-depth semi-structured interviews	2011-2012	Primary substances of use included: alcohol. Alcohol was used with cannabis, cocaine, amphetamines, ecstasy, medication, heroine, and XTC	Semi-structured interviews	N/A	N/A	N/A	N/A	Everyday life consequences of a dual disorder can create a cycle of symptoms and substance use. For SUD+ ADHD, substance use typically leads to increased impulsiveness. For SUD + ASD, substance use leads to increased passivity SUD increases ADHD + ASD and interferes with self-management A dual diagnosis can mean an accumulation of executive functioning impairments	Provides insight into the daily impact of a dual diagnosis and also the the impact of executive functioning impairments on daily functioning	Moderate	Interviews conducted by multiple researchers Analysis of data was performed independently and coding was based on a consensus between the researchers	Researchers did not use cross-over blind coding SUD + ASD group included only males and co-occurring conditions outside of ASD and ADHD were not assessed.	N/A	To assist individuals with dual diagnosis and executive functioning impairments, treatments should focus on time management, organization, problem solving, self-control, motivation, and emotional regulation. An integrated cognitive behavior therapy in combination with atomoxetine and methylphenidate have been effective in SUD + ADHD individuals
Lauren, 11/8/2023	VanDerNagel, J. E., Kiewik, M., Didden, R., Korzilius, H. P., van Dijk, M., van der Palen, J., Buitelaar, J. K., & de Jong, C. A. (2017). Substance use in individuals with mild to borderline intellectual disability: An exploration of rates and risks in the Netherlands. Advances in Neurodevelopmental Disorders, 1(4), 283–293. https://doi.org/10.1007/s41252-017-0035-3	2017	1) Determine lifetime and past month rates of alcohol, tobacco, cannabis, and stimulant use 2) Assess whether age at initiation of SU differs between current users vs. users who desisted SU and participants with mild IQ versus borderline IQ 3) Assess the contribution of SU related factors to a model based on demographical, contextual, and diagnostic factors	Individuals from 22 organizations of the Dutch Association of Healthcare Providers were invited to participate. 16 organizations chose to participate. They were asked to randomly select 10% of individuals with MBID. n=419	Inclusion criteria: received care from one of these organizations, were > or equal to 18 years old, had MBID, and had no language or communications problems	Cross-sectional design utilizing structured interviews	2010-2011	Substances included: alcohol, tobacco, cannabis, and stimulants	The Substance use and misuse in Intellectual Disability Questionnaire (SumID-Q) assessed lifetime and recent SU. Administration takes 45-60 minutes.	N/A	N/A	N/A	N/A	Rates of current smoking (62%), current cannabis and other illict drug use (15%) SU initiation typically occcurred in adolescence, with several participants initiating SU at primary school age Gender, age, and lack of daytime activities were associated with SU, yet independent living and level of ID were not SU modeling and related positive attitudes were associated with an increse in SU likelihood	Describes onset of SU for MBID individuals and some of the risk factors that contribute to to SU	Moderate-High	Large sample size, explores SU onset, analysis across risk facctors, recognition and attitudes toward SU, and SU rates	Risk of recall bias and causality between risk factors and SU status can't be established Unable to claim that the sample is representative of MBID population and selection bias can't be ruled out	N/A	Lifetime use of both cannabis and stimulants was related to male gender and younger age Lifetime stimulant use was also related to lack of daytime activities For current tobacco and alcohol use, SU picture recognition, attitude, and modeling were related to use
Lauren, 11/9/2023	Lin, E., Balogh, R., McGarry, C., Selick, A., Dobranowski, K., Wilton, A. S., & Lunsky, Y. (2016). Substance-related and addictive disorders among adults with intellectual and developmental disabilities (IDD): An ontario population cohort study. BMJ Open, 6(9). https://doi.org/10.1136/bmjopen-2016-011638	2016	Describe the prevalence of substance-related and addictive behaviors (SARD) for adults with IDD and compare the sociodemographic and clinical characteristics of adults with IDD and SARD to adults that just have IDD or SRAD	Health administrative records and disability income support administrative data were used to recruit individuals for the study. n=66,484	Participants were ages 18-64 years old with a developmental disability or IDD.	Population-based cohort study. Crude percentages were used to report sociodemographic characteristics. Effect size was utilized to determine if observed or adjusted differences were meaningful.	Prior to 2016	N/A	N/a	N/A	N/A	N/A	N/A	The prevalence of SRAD was 6.4% compared with 3.5% in those without IDD. Individuals with both IDD and SRAD had psyhchiatric co-morbidities such as anxiety disorders (67.6%), affective (44.6%), psychotic (35.8%), and personality disorders (23.5%). They also tended to be younger and more likely to live in the poorest neighborhoods compared to individuals that are IDD or SRAD only.	Demonstrates the prevalence of individuals with SRAD and IDD in a large sample size emphasizing the need to provide support and intervention for this population.	Moderate	Data caputes the entire population of a geopolitial jurisdiction and avoids the biases that may be present in smaller clinical samples Allows comparisons to groups drawn from the same population and uses consistent operational definitions	Definition of IDD was not externally validated Administrative data is not usually collected for research or clinical purposes which leaves important variables to not be captured May be difficult to generalize to other jurisdictions that have different health and social service systems	N/A	SRAD is a marker for even more complex conditions and a need for close attention to engagement, intervention, and cross-sector care coordination Demonstrates the need for increased staff training Highlights the need to link to social services due to risk factors associated with poverty Navigational supports are critical for coordinating across health, mental health, housing, and public health services to help someone with IDD and SRAD
Lauren, 11/10/2023	Ressel, M., Thompson, B., Poulin, M.-H., Normand, C. L., Fisher, M. H., Couture, G., & Iarocci, G. (2020). Systematic review of risk and protective factors associated with substance use and abuse in individuals with autism spectrum disorders. Autism, 24(4), 899–918. https://doi.org/10.1177/1362361320910963	2020	1) Examine ASD and substance abuse diagnostic measures 2) reporting on the prevalence of co-occurring ASD and substance abuse 4) identifying risk, protective, and positive treatment factors	2321 studies were initially screened and four raters assessed the articles for inclusion. 26 studies were deemed to have met the inclusion criteria	All studies published in English or French reporting on co-occurring ASD and SUD either as a main focus or by-product published between 2008 and 2020. Both adult, child, qualitative, quantitative, and mixed-methods studies were included.	Sytematic review and analysis of 26 studies	2008-2020	In studies that focused on clinical levels of substance abuse prevalance rates of ranged from 1.3% to 36% Of articles reporting on substances used, tobacco followed by alcohol and then cannabis were reported the most often as the substance of choice in individuals with ASD	Mixed-Methods Appraisal Tool (MMAT) was used to assess the methodological quality of all included studies, particularly methodological strength and risk of bias.	N/A	N/A	N/A	N/A	Risk factors were related to three categories: individual psychiatric, individual cognitive, and environmental factors Individuals with ASD were susceptible to common risk factors that impact the general population such as familial history of substance abuse, adverse family events, early tobacco use, psychological distress, co-occurring internalizing and externalizing disorders Protective factors included if an individual with ASD has low sensation seeking traits, co-occurring intellectual disability, and limited access to drugs	Provides risk and protective factors from thoroughly vetted and analyzed empirical studies	High	Conducted quality assessments of the studies identified Had multiple raters and studies went through three stages of inclusion review Inter-rater reliability was 95.13% Included studies published in multiple languages	Since studies focused on ASD and SU generally instead of specifically, the MMAT may not have adequately captured methodological concerns Data from the included studies was cross-functional so it is not possible to estable causal direction of risk and protective factors	N/A	Risk factors that may be more specific to individuals with ASD are low social support, disengaging behaviors, late ASD diagnosis, and weak executive functioning A diagnoses of ASD was a protective factor when comorbid with intellectual disability, but a risk factor when the individual had average or above-average intelligence Substance use may be used as an aid for social engagement when young people or adults with ASD experience loneliness or a desire for social interaction Psychological distress, negative cognitions, and executive functioning deficits increase the risk of substance use for some individuals with ASD
Lauren, 11/10/2023	Ledingham E, Adams RS, Heaphy D, Duarte A, Reif S. Perspectives of adults with disabilities and opioid misuse: Qualitative findings illuminating experiences with stigma and substance use treatment. Disability and Health Journal. 2022;15(2, Supplement):101292. doi:10.1016/j.dhjo.2022.101292	2022	The purpose of this study was to illuminate the perspectives of individuals who have both opioid misuse/OUD and another disability, focusing on their experiences accessing and engaging in SUD treatment. Using a CDT (Critical Disability Theory) lens, we investigated whether individuals' unique identities, or experiences with stigma and barriers, influenced their OUD/SUD treatment experiences or their addiction.	Recruited adults who had lived experience with both disability and an "opioid use problem." We conducted 17 individual interviews and facilitated two focus groups with 11 participants. Individual interviews conducted between October 2019 and August 2020: 6 in person, 5 by phone, and 6 by videoconferencing after the COVID-19 shutdown in March 2020. Worked with leadership at homeless shelters to recruit 2 focus groups, which were held in 2020 prior to the COVID-19 shutdown, with 5 and 6 participants.	Respondents were, on average, 49 years old (range 30e66 years), and the majority were female (53.6%). Mental disabilities were most commonly reported (46.4%), followed by physical and mental disability (28.6%), and physical only (25.0%). Almost half reported being White/non-Hispanic (46.4%), with 3 identifying as African American or Black/non-Hispanic (10.7%), 2 identifying as 2þ races (7.1%), and 1 identifying as Hispanic. Nine individuals (32.1%) did not report a race/ethnicity.	Qualitative study using individual interviews & focus groups	2019-2020	Opiods/prescription opioids	Recruited adults who self-identified as having lived experience with both a disability and an "opioid use problem," not requiring OUD or specifying opioid use/misuse as prescribed versus illicit, for inclusion in an effort to encourage participation.	N/A	N/A	N/A	N/A	Stigma is a barrier to treatment in terms of opportunity/access and how clinicians interact with those who have both a disability and SUD—lack of representation for those with multiple marginalized identities (e.g., gender/sexuality, racial/ethnic minority). Many reported pathway to opioid misuse/OUD was related to experiences with chrnoic pain and/or mental health conditions, which are known risk factors for prescription opioid misuse and more common among people with disabilities. Access to equitable care that provides appropriate acommodation is a facilitator to treatment. **Trauma-informed, person-centered services that address/accommodate co-occurring needs are necessary.**		High		Relied on purposeful sampling in one state; not generalizable to all populations of individuals w/ disabilities and OUD/SUD. Most respondents reported mental health and/or physical disabilities; may not reflect experiences of those w/ other types of disabilities (e.g., intellectual disabilities). Social desirability bias may have occured (due to shame/stigma) since most interview were conducted face-to-face. Some respondents were in SUD recovery, this may have introduced recall bias in terms of their substance use experiences. Study used broad definition of having an "opioid problem" and could miss more nuances associated w/ illicit vs prescribed opioid misuse.	No conflicts of interest, IRB approved	"Disability is a stigmatized trait, and many participants did not strongly identify with having a disability. Within our study population, many respondents reported many barriers to treatment. However, they often attributed the barriers to other factors, rather than suggesting that these challenges may be impacted by having a disability. Over half of the respondents in our study had a mental health disability, **yet many did not use language to suggest that they identified as having a disability due to their mental health condition.**" Many respondents described **peer support services** as a source of non-judgmental assistance while navigating the treatment system and appreciated the individualized support. Overall, participants noted there **needs to be more work to destigmatize OUD/SUD and disability,** so people are able to seek treatment when needed and receive quality, equitable care targeted for their needs. People with disabilities need access to various types of SUD treatment, including medication treatment, alternative modalities, and treatments that address co-occurring needs in a way that minimizes stigma. In spite of the evidence that medication treatments are effective for OUD in reducing deaths and relapse, **stigma and misunderstanding about medication treatments remain common even in SUD treatment programs and have resulted in its underuse.** There needs to be **more person-centered care delivered that is accessible, including assistance with transportation, course content, physical accessibility, and provision of personal care attendants. Better representation of people with disabilities and OUD/SUD from diverse backgrounds is needed** within the treatment and peer supports systems and to improve targeted programs for these populations... There are no simple one-size-fits-all solutions to address the multifaceted needs of this population.
Lauren, 11/19/2023	Ko, K. Y., Ridley, N., Bryce, S. D., Allott, K., Smith, A., & Kamminga, J. (2021). Screening tools for cognitive impairment in adults with Substance Use Disorders: A systematic review. Journal of the International Neuropsychological Society, 28(7), 756–779. https://doi.org/10.1017/s135561772100103x	2022	Describe types of cognitive screening measures used in adults with SUDs, identify specific substance use populations and settings these tools are utilized in, review diagnostic accuracy of these screening measures in detecting CI versus an accepted objective reference standard, and evaluate methodology of these studies for risk of bias	Searches of electronic databases identified 5,135 studies and after removing duplicates and screening the titles and abstracts, n=14	Inclusion criteria: original empirical article, published or prepared for publication; in English; reported on a tool designed for cognitive functioning or the tool was used for this purpose, examined or provided data that supported inferences regarding criterion validity of the screening tool compared to an accepted standard criterion of cognitive functioning; participants were adults; participants were reported to have some form of SUD	Systematic review of 14 empirical articles	2019-2020							Alcohol was the most common susbtance used and majority of the studies were conducted in an inpatient setting Sample sizes tended to be small across the studies Across the 14 studies, 10 different cogntive screening tools were evaluated. The majority of studies examined only one measure and all were pen and paper tasks. The MoCA was the most studied and most consistent tool that provided classification accuracy for this population The MoCA is brief,evaluates a range of cognitive domains and is used widely throughout healthcare settings	Identification of screening tools that can be utilized in populations of individuals with congitive impairment and SUD	High	First systematic review of cognitive screening tools utilized in adult SUD Broad inclusion critieria (range of aetiologies and client populations included) Wide range of index measures and reference standards used	Bias could have been potentially introduced in the recruitment and exclusion of participants in the sudies A more comprehensive grey literature search would have increased the evidence base by including findings from a wider variety of sources	N/A	Given the prevalence of cognitive impairment in individuals with SUD, cognitive impairment should be screened for on treatment entry and periodically throughout treatment
Lauren, 11/20/2023	Braatveit, Kirsten. J., Torsheim, T., & Hove, O. (2018). The prevalence and characteristics of intellectual and borderline intellectual disabilities in a sample of inpatients with substance use disorders: Preliminary clinical results. Journal of Mental Health Research in Intellectual Disabilities, 11(3), 203–220. https://doi.org/10.1080/19315864.2018.1469701	2018	Investigate the prevalence of ID/BID in a population of inpatients with SUD. Investigate the similarities and differences between ID/BID and non-ID among SUD inpatients with regard to education, access to public support systems, childhood learning difficulties, comorbid mental disorders, and substance-related factors	Recruited from 3 inpatient adult health service institutions for SUD. N=91	Individuals attending treatment facilities for SUD who were over the age of 18. Mean age for participants was 33.27. Anxiety, behavioral, and affective disorders were among the most prevalent mental disorders. 29 participants were classified with definite, probable, or possible ID/BID	Descriptive analyses were used to analyze the demographic information, factors associated with ID, and ID prevalence								A substantial number of inpatients in SUD facilities may qualify for ID or BID; prevalence rate of 30%. This suggests that individuals receiving SUD services have developmental delays may require attention during the treatment or post-treatment. Many individuals with ID who are receiving SUD services may be going undiagnosed which may be a result of the focus on SUD and not comorbidity, time-consuming assessments, or fear of stigmatizing patients	Emphasizes the importance of having screening for both ID/SUD to improve the effectiveness of treatment, to inform the development of treatment, and ensure awareness of both conditions for providers.	Moderate	The study applies three diagnostic criteria for ID/BID and the use of standardized and validated instruments to measure both IQ and adaptive skills Six weeks of abtinence was ensured before IQ testing to minimize effects.	Utilized a self-report questionnaire to understand childhood learning difficulties Study of inpatient SUD individuals may differ from other populations of SUD There was no information regarding the type of substance used Given that this is an international study, there could be differences in who is admitted to SUD in-treatment facilities	None	Supports the increased knowledge of ID providers to understand the nature of SUD to increase the services and quality of services provided to individuals with ID/SUD
Lianne, 11/24/2023	Ryding R, Scales MJ, Brittingham R, Holz D. Are you listening? Parental protective factors and early onset drinking among students with disabilities in Delaware. Disability and Health Journal. 2022;15(2, Supplement):101287. doi:10.1016/j.dhjo.2022.101287	2022	To explore the relationship between parental listening and the age of substance use initiation among students with disabilities.	Used 2933 observations of unweighted data from the 2017 Delaware high school youth risk behavior survey (YRBS). Based on self-report by students. YBRS is administered to a random sample of classes drawn by the CDC among all public high schools in Delaware.	Among the students who participated in the 2017 high school YRBS in Delaware, approximately 80% were between the ages of 15 and 17 years old.	Retrospective/cross-sectional study. Logistic regression used to analyze the data	2017	Alcohol	To operationalize the outcome variable of interest, we used the YRBS question asking students how old they were when they had their first drink of alcohol (other than a few sips). Students were given seven possible response choices: I have never had a drink of alcohol other than a few sips; eight-years-old or younger, nine or 10-years-old; 11 or 12years-old; 13 or 14-years-old; 15 or 16-years-old; or 17-years-old or older.	N/A	non-disabled students	disabled students	Age of onset of alcohol use, parental listening (how often they feel that their parents listen to them when they talk), disability (yes/no diagnosed w/ emotional or learning disability)	Both disability status and feeling that parents listened to them were statistically significant predictors of the odds of reporting alcohol use prior to age 15. Compared to students without emotional or learning disabilities, students with these disabilities had 1.60 times the odds of drinking alcohol before age 15, while the odds of students drinking before 15 when their parents always or almost always listened to them were 0.70 compared to students whose parents did not always listen.	Not generalizable to I/DD population but still addresses importance of understanding and addressing substance use patterns among adolescents/youth given the association between substance use at a young age and the risk of developing a SUD later in life.	Moderate	Data clearly shows that students with emotional and learning disabilities are initiating alcohol use at younger ages on average, and that parental listening has a significant effect in decreasing the average age of onset among students.	Differences in parental listening did not explain all of the variation in age of onset between students with these disabilities and students w/o. Sample is only from Delaware HS students & self-report data. Study was unable to explore specific subtypes of disabilities. The YRBS collected data from students in GE classes attending public schools for face-to-face instruction, does not explore non-traditional school environments.	None	When looking at the interaction between having an emotional or learning disability and parents who listen, students with no disability and parents who listen to them have the lowest probability of drinking before age 15 (30.4%), while **students with these disabilities whose parents do not listen to them have the highest probability of early onset drinking (45.7%)**. The goal of minimizing the early onset alcohol consumption among students remains essential for prevention specialists, as **early onset alcohol use has been linked to increased substance use disorder risk later in life**.
Lianne, 11/24/2023	Didden R, VanDerNagel J, Delforterie M, van Duijvenbode N. Substance use disorders in people with intellectual disability. Current Opinion in Psychiatry. 2020;33(2):124. doi:10.1097/YCO.0000000000000569	2020	To provide an overview of studies on substance use and substance use disorder (SUD) in individuals with mild intellectual disability or borderline intellectual functioning (MID–BIF).	This is a narrative review providing an overview of studies published between 2017-2019	Individuals with mild intellectual disability or borderline intellectual functioning (MID–BIF)				Hayes Ability Screening Index (HASI; Substance use and misuse in Intellectual Disability Questionnaire (Sum-ID-Q);					Prevalence rates of SUD vary in people with intellectual disability. SUD are almost exclusively observed in individuals with moderate to MID or BIF. On average, individuals with intellectual disability have similar risk factors compared with their peers without intellectual disability but are more vulnerable for the adverse effects of SUD.	High relevance to ID population	Moderate/Low				The validity of the **Hayes Ability Screening Index (HASI)** was investigated in three facilities for the treatment of SUD. The HASI had acceptable validity for use in screening MID–BIF in SUD samples. **SUMID-Q** was developed to assess type and frequency of lifetime and current alcohol and drug use, risk factors for and consequences of problematic substance use in individuals with MID–BIF. Both self-report and proxy-report (information provided by someone else—e.g., caregiver, family member—using SUM-ID-Q are reliable in assessing substance use among this population.
Lianne, 11/25/2023	Soule EK, Pomeranz JL, Moorhouse MD, Barnett TE. Multiple tobacco use and increased nicotine dependence among people with disabilities. Disability and Health Journal. 2015;8(2):258-263. doi:10.1016/j.dhjo.2014.09.004	2015	The purpose of this study was to examine nicotine dependence among a sample of PWD who use multiple types tobacco products. We hypothesized that individuals who used multiple forms of tobacco would have higher levels of nicotine dependence.	A tobacco survey was administered to clients who use tobacco and receive services from an organization that provides independent living services to PWD. The self-report brief survey included measures of nicotine dependence and items indicating the types of tobacco products participants used. N = 113 male and female participants w/ disabilities.	Mean age = 51.7; 40.4% female 49.5% White/Caucasian, 41.3% Black/African American, 2.8% Latino(a), 0.9% Asian/Asian American, 4.6% American Indian/Alaskan Native, 0.9% other; majority have a high school diploma or less than a diploma with few having a college and graduate degree. Disability type: 33.3% physical; 4.5% sensory; 1.8% cognitive; 19.8% mental; 40.5% combination.	Cross-sectional study. Frequency analyses, chisquared tests, and Fisher's exact tests used to examine associations between tobacco use and nicotine dependence.		Tobacco (in multiple forms—e.g., cigarettes, cigars)	The survey instrument included items examining demographics, types of tobacco products used, and a nicotine dependence measure informed by the **Fagerstrom Nicotine Dependence Test**.	N/A	N/A	N/A		PWD who reported **multiple** tobacco product use were **significantly more likely to show signs of nicotine dependence** than those who reported only using one tobacco product. Multiple tobacco use was not uncommon in this sample: about one-sixth of the participants reported currently using multiple types of tobacco products.	Does not explore ID population specifically but broadly covers it (in the category of cognitive disability different types of disabilities. Authors also cite that to the best of their knowledge, this is the first study to examine nicotine dependence and multiple tobacco use among the PWD popuatlion.	Moderate	Data was collected over multiple days over the course of 3 months to help capture a more representative sample; included multiple types of disabilities; used a measure based off of the gold standard measure of nicotine dependence among PWD	Small sample size; Participants not randomly selected; Analyses did not control for other variables (e.g., demographic characteristics that may be associated with nicotine dependence). This is also an older study, may not reflect recent data	None	This study provides further evidence of the need to include people with disabilities in tobacco cessation interventions. This study shows that PWD may face greater challenges still regarding tobacco cessation due to increased levels of nicotine dependence. PWD may have greater difficulties with tobacco cessation. There is a lack of tobacco cessation intervention programs that target PWD; when developing these programs, authors suggest counselors consider multiple tobacco use as a potential barrier for clients to overcome. **Multiple tobacco product use may be a warning sign of greater nicotine dependence that counselors can use to determine who is at greatest need for tobacco cessation intervention.**
Lianne, 11/25/2023	Umucu E, Lee B. Examining the impact of COVID-19 on stress and coping strategies in individuals with disabilities and chronic conditions. Rehabilitation Psychology. 2020;65(3):193-198. doi:10.1037/rep0000328	2020	This study aimed to describe the perceived stress levels and coping mechanisms related to COVID-19, and whether coping is related to well-being in people with self-reported chronic conditions and disabilities.	Participants recruited from Amazon MTurk (a crowdsourcing tool that enables participants w/ a MTurk account to access and complete a variety of Human Intelligence Tasks (HITs) such as online surveys for academic research. MTurk reported to be a reliable, valid, diverse, cost-effective & large data collection tool. **N = 269 individuals w/ self-reported disabilities and chronic conditions.**	Mean age = 39.37, SD age = 12.18; only residents in the US. 56.1% men, 43.9% women; 84% white, 27% black/african american, 6% AI/AN, Asian/AA 13%, 5% other	Cross-sectional study; correlation analysis used to examine th erelationships among COVID-19 stress and COVID-19 coping strategies; hierarchial regression analysis used to examine what COVID-19 coping strategies are associated w/ well-being after controlling participant demographic & psychological characteristics			N/A	N/A	N/A	N/A		The findings related to substance use found that the second least used coping strategy was substance use, indicating that participants with self-reported chronic conditions and disabilities were not very likely to use substance to cope w/ COVID-19. The study cites that this is consistent with prior research that substance use (and denial) were identifed as less frequently used coping strategies in people w/ disabilities.				Convenience sample with self-reported crhnoic conditions and disabilities; Sample comprised of mainly Whites, highly educated, and only English-speaking individuals—not as generalizable to broader population.		
Lianne, 11/25/2023	Virtanen S, Sidorchuk A, Fernández de la Cruz L, et al. Association of Tourette Syndrome and Chronic Tic Disorder With Subsequent Risk of Alcohol- or Drug-Related Disorders, Criminal Convictions, and Death: A Population-Based Family Study. Biological Psychiatry. 2021;89(4):407-414. doi:10.1016/j.biopsych.2020.09.014	2021	Study investigated the association between ICD diagnoses of TS/ CTD and substance misuse outcomes, accounting for psychiatric comorbidity and familial factors. TS = Tourette syndrome CTD = Chronic tic disorder	N = 14,277,199 individuals, of whom 7832 had a TS/CTD diagnosis (76.3% men, 23.7% women)	Examines the Swedish population-based registers and identified one of the world's largest cohorts of prospectively followed patients with TS/CTD	Retrospective cohort study (population-based family study)	Cohort included all individuals living in Sweden at any time between January 1, 1973, and December 31, 2013	Broadly examines substance misuse outcomes, i.e., any substance misuse, alcohol-related disorder, any drug-related disorder, and substance-related convictions, in Individuals With Tourette Syndrome or Chronic Tic Disorder, Compared With Unaffected Individuals From the General Population, Excluding Psychiatric Comorbidities						Individuals with TS/CTD were at increased risk of subsequent alcohol-related disorders, drug-related disorders, substance-related criminal convictions, and substance-related deaths, even after controlling for unmeasured familial confounders and accounting for psychiatric comorbidities.	Provides insight into SUD among a specific type of disability		Large, population-based sample of individuals w/ TS/CTD; long follow-up spanning up to 31 years; high validity of diagnostic codes; use of nationwide registers w/ prospective & uniformed data collection (minimizes the risk of selection, recall, and report biases)	Results may not be generalizable to individuals w/ milder or transient forms of tic disorders; the coverage of the alcohol- and drugr-related disorders cases is incomplete because the patient register only captures individuals with a severe enough clinical presentation to require treatment in specialist inpatient and outpatient services;		**TS/CTD are associated with subsequent alcohol and drug use disorders, and related outcomes, independently of psychiatric comorbidity and familial factors shared between siblings.** Compared with the unaffected general population, individuals with TS/CTD had nearly a **7-fold increased risk of any drug-related disorder (including cannabis, opioids, sedatives, and stimulants)**, **over a 3-fold increased risk of alcohol-related disorder**, and a **2.5-fold increased risk of both substance-related criminal convictions and substance-related deaths**. For the subcohort followed from birth, the expected cumulative incidence of alcohol-related disorders in individuals with TS/CTD exceeded 20% by 41 years of age (end of the follow-up period), reached 26% for drug-related disorders, and was 20% for substance-related convictions. While substance-related deaths were rare in the TS/CTD cohort (about 1%), they were still significantly more common than in the general population. Higher incidence of alcohol- or drug-related disorders and criminal convictions in individuals with TS/CTD was already evident by 16 years of age.

APPENDIX B

Data Extraction for Research on Best Practices in ID & Treatment of SUD among people with I/DD

REVIEWER & DATE	REFERENCE & PURPOSE			PARTICIPANTS/POPULATION STUDIED			DATA	SUBSTANCE MISUSE	IDENTIFICATION & DIAGNOSIS	VARIABLES			OUTCOME MEASURES	RESULTS & FINDINGS	RELEVANCE	QUALITY ASSESSMENT				COMMENTS
Name of Reviewer + Date of Data Extraction	**Citation: Author(s), Title, Journal, DOI/URL, etc.**	**Publication Year**	**Research Objective(s)/Question(s)**	**Recruitment Methods & Sample Size**	**Participant Characteristics (Age Range, Gender, Type of Disability, etc.)**	**Type of Study, Research Design, & Analysis Used**	**Year Data Collected**	**Types of Substances Misused, Prevalence/Incidence of Substance Misuse, etc.**	**Methods used for Identifying Substance Misuse, Tools/Instruments Used for Assessment, etc.**	**Treatment and Intervention: Types of Interventions/Treatments Studies, Duration of Intervention, Adaptations for I/DD population, etc.**	**Control**	**Intervention**	**Primary, Secondary, Long-term Outcome Measures (if available)**	**Main Findings Related to Substance Misuse and Intervention Effectiveness**	**Relevance to Research Objectives: How Well Does the Study Address Research Q's & Objectives? Applicability to Best Practices for I/DD and SUD Population?**	**Overall Quality Rating (High, Moderate, Low)**	**Strengths of Study**	**Weaknesses & Limitations**	**Ethical Considerations**	**Any Additional Notes/Relevant Info**
Lauren, 10/20/2023	Schijven, E. P., Hulsmans, D. H., VanDerNagel, J. E., Lammers, J., Otten, R., & Poelen, E. A. (2020). The effectiveness of an indicated prevention programme for substance use in individuals with mild intellectual disabilities and borderline intellectual functioning: Results of a quasi-experimental study. Addiction, 116(2), 373–381. https://doi.org/10.1111/add.15156	2020	The study is aimed at measuring the effectiveness of a prevention program aimed at reducing SUD among experimental to problematic substance users.	66 adolescents (47 male) from 11 treatment centers in the Netherlands	Inclusion criteria: life-time prevalence of alcohol, cannibis, or illicit drug use; belonging to one of the four personality high-risk groups (sensation-seeking, negative thinking, anxiety sensitivity, and impulsivity); mild intellectual disability or borderline intellectual functioning	Quasi-experiment with two arms Descriptive analyses was perfomed to examine baseline distributions of age, gender, total IQ, and outcome measures Mixed-effects regression models were used to test the effectiveness of the prevention program on SUD frequency, severity, and binge drinking. Time, condition and time x condition interaction were fixed effects in the models.	2015-2017	Substances included alcohol, cannabis, or illicit drugs	One item from the Substance Use and Misuse in Intellectual Disability Questionnaire (SumID-Q) was used to measure the frequency of SU The Alcohol Use Disorders Identification Test (AUDIT) and the Drug Use Disorders Identification Test (DUDIT) were used to determine frequency and quantity of use, dependency, and problems related to use.	Take it personal! prevention program that includes psycho-education about personality profile and problematic coping behavior, training of behavioral copy skills, and training of cognitive coping skills to cope with personality-related thoughts and behavior. MI, CBT, and Psychomotor therapy utilized to deliver components	Treatment care as usual that was not standardized or protocolled and had freedom to attend other programs based on their individual needs	5 45-minute group sessions, 5 30 minute individual sessions within 6-week time-span with psychologist or psychomotor therapists	Substance use frequency, substance use severity, binge drinking	24% of adolescents were frequent alcohol users reporting weekly or daily alcohol consumption at baseline, 41% used cannabis weekly or daily and 20% used illicit drugs weekly or daily. There was a stronger decrease in SU frequency in the intervention condition compared to the control condition, a stronger decrease in binge drinking for adolescents in the intervention condition, and a stronger decrease in the severity of alcohol use. There was not a decrease in the severity of cannabis or illicit drug use frequency.	Highlights intervention aimed at SU reduction and details the impact on individuals with mild intellectual disability	Moderate-High	Utilized different questionnaires to attain information on substance use Effective reduction in SU Peer support throughout program to mirror daily life situations and ensure safety Administration of questionnaires modified for participants (included visuals, researchers read questions aloud + provided extra clarification)	Participants assigned to intervention and control condition based on treatment center Only short-term intervention effects were investigated so it is hard to discern long-term effects of the program Participants dropped out due to lack of motivation to complete follow-up questionnaires.	N/A	Addressed individual needs of participants instead of relying on a uniform approach
Lianne, 10/27/23	Collings S, Allan J, Munro A. Improving treatment for people with cognitive impairment and substance misuse issues: Lessons from an inclusive residential treatment program pilot in Australia. Disability and Health Journal. 2022;15(2, Supplement):101295. doi:10.1016/j.dhjo.2022.101295	2022	Approximately half of the substance dependence treatment population is estimated to have a cognitive impairment, which reduces participation, retention, and post-treatment outcomes. **Cognitive behaviour change approaches are less effective for this population and cognitive remediation strategies have been found to improve outcomes.** Evidence on modified programs to remove environmental barriers for treatment seekers with disability does not exist. A modified residential substance misuse treatment program in New South Wales, Australia, was piloted and evaluated to address this knowledge gap.	Convenience sampling was used to recruit resident and staff participants. The Addenbrooke's Cognitive Examination (ACE R) was used as a screening tool to identify residents w/ cognitive impairment. Residents voluntarily agreed to the program. N = 33.	Of 67 residents who received treatment during the evaluation period, 33 (50%) were screens as having cognitive impairment. 12 residents were interviewed and 10 staff were invovled in a focus group to understand their view of the pilot program. 6 female, 27 male. Majority betwen ages 18-42. 10 = Aboriginal and Torres Strait Islander; 23 = Non-aboriginal.	Pilot program intervention. Thematic analysis was undertaken to identify common and divergent perspectives of the program (interviews and focus groups used to collect data)	2016-2017	Methamphetamine, alcohol, cannabis. Methamphetamines were the main drug of concern for residents with cognitive impairment (50%), whereas alcohol was the main drug of concern for residents without cognitive impairment (47%).	Assessment tools for substance misuse not explicitly stated but most likely information made available by the residential rehab unit that participants were from	REPIN pilot program intervention recognized the relationship between rehabilitation environment and the functioning of individual residents as key to a person-centered practice. **This is the first study to describe participants' experiences of a substance treatment setting designed to be inclusive and accessible for people with cognitive impairment.**	N = 34, residents without cognitive impairment	N = 33, residents with cognitive impairment		A key finding was that the implementation of universal design principles made the program materials inclusive of all rehabilitation residents, which extends knowledge about the use of these techniques to remove communication barriers for people with disability by applying them to learning within a treatment context		Moderate-High	Effective implemention of program due to implementing universal design materials to make program materials inclusive for all residents. Used a disability-informed approach in a rehab setting. High approval among both staff and residents, indicating implemented strategies were well-received. Person-centered and strength-based design successful in fostering culture of collaboration among residents and staff.	The evaluation was conducted over a short timeframe with a small number of residents and in the context of real time implementation of the pilot program. A key limitation was the quality of data collected on individual outcomes such as relapse prevention. Incomplete data reduced reliability and made reporting individual treatment outcomes unwise. The use of a convenience sample introduced sample bias, and a decision by particular residents and staff not to take part may have influenced results. It is noted that fewer than half of eligible residents took part in an interview and the views of residents without cognitive impairment were not sought.	None. Received ethics approval to conduct evaluation by UNSW Human Research Ethics Committee. No conflicts of interest declared.	Typically, residential substance treatment programs use a one-size-fits-all model Three themes were identified: 1) practising inclusion; 2) gaining confidence and skills; and 3) resourcing intensive support.
Lianne, 10/27/23	Copersino ML, Slayter E, McHugh RK, Shedlack KJ, Lukas SE, Weiss RD. Clinical utility of a hybrid secondary and relapse prevention program in adults with mild intellectual disability in community residential and day habilitation settings. Disability and Health Journal. 2022;15(2, Supplement):101293. doi:10.1016/j.dhjo.2022.101293	2022	This study examined the clinical utility of an alcohol and other drug refusal skills intervention designed to be cognitively accessible to adults with ID. Hypothesis: there would be a significant pretest versus posttest improvement in refusal skill competency (i.e., refusal skill acquisition), and that developmental appropriateness of the intervention would be demonstrated in that the amount of intervention exposure would be a stronger predictor of skill acquisition than individual differences in verbal learning ability or efficiency	30 individuals at high risk for or in recovery from a SUD in developmental disability services (DDS) community residential and day habilitation settings participated in the two-week refusal skills group. Participants were initially approached to inquire about their interest in participating in research opportunities by clinical providers known to them at Bay Cove, Inc. or CLASS, Inc.	Study participants from Bay Cove (n = 10; age range 36-60) were significantly older than participants from CLASS (n = 20; age range 24-55). There were no other statistically significant differences in demographic variables. Across groups, participants were predominantly male and Caucasian. There was a between-cohort difference in current tobacco cigarette smoking status, but no differences in self-reported lifetime alcohol and other drug problems or past-month use of substances, history of SUD treatment, or the proportion of participants currently under guardianship or residing in a sober residence	Alcohol and other drugs refusal intervention study; A a comparison of refusal skill competency was conducted before and after the 10-session intervention via repeated-measures analysis of variance (ANOVA)	?	Specific substances not mention; study broadly measured rates of "lifetime alcohol or drug problem"	Following receipt of informed consent, medical chart and baseline interviewer-administered assessment data were collected. These data included demographics, self-efficacy measures; and substance use history, characteristics, knowledge and attitudes. The timeline follow-back (TLFB) method, in which a printed calendar and other aids are used to facilitate participant recall of events during the reporting period, was used to collect substance use data.	This study examined the benefits of a ten-session therapy group aimed at building confidence, assertiveness and measurable skills around refusing alcohol and other drugs that was designed to be cognitively accessible to adults with ID.	None	Intervention applied to all participants involved in study	The primary outcome measure is refusal skill acquisition, which was measured using a modified version of the situational competence test (SCT).	Results showed a strong effect for refusal skill acquisition ($p < .001$); and the magnitude of skill acquisition was predicted by group attendance ($p < .001$) and not by individual differences in verbal learning ability ($p = .074$) or efficiency ($p = .35$).	Relevant to our client population: "The Refusal Skills Group is developmentally appropriate for people with mild ID in that: (1) they can learn and demonstrate refusal skills and (2) their skill acquisition is predicted more strongly by exposure to the intervention than by individual differences in learning characteristics. Delivering refusal skills in DDS settings familiar to clients increased their access to services and minimized disruption to their usual routines and schedules.	High	Addresses a gap in the literature; includes curriculum tailored to the needs of adults with ID; high retention (83%) of participants maintained abstinence from pretest to posttest; high participation of client to attend refusal skills group despite busy schedule with various activities and therapies	Bias from the same investigator for both delivering the intervention & administering performance measures; absence of videorecording & independent raters for roleplays at pretest & posttest may limit objectivity of results; short assessment period following participation in the group (within 12 hours of completing the intervention)	None of concern	The main focus of the curriculum is teaching refusal skills, an adaptive skill set aimed at providing individuals with wellrehearsed and assertive responses to people who pressure them to use, hold, or obtain alcohol and other drugs. The main purpose of the group is to teach a common skill set supporting healthy decision-making around substances in a way that promotes greater independence, self-determination and community inclusion.
Lianne, 10/30/23	Kelley HH, Aller TB, Wappett M. A Systematic Review of Mental Health Focused Training Programs for Direct Support Professionals Working with Individuals with Intellectual and Developmental Disabilities. Journal of Mental Health Research in Intellectual Disabilities.:1-32. doi:10.1080/19315864.2023.2198491	2023	By integrating more recent data, and through an intentional focus on training programs specifically for DSP, **we aim to deepen the understanding of the current strengths and needs of programs that increase DSP knowledge and skills in addressing the mental health aspects of clients with I/DD.** **RQ1: What training programs have been used or are currently available that work to improve DSP's knowledge of and skills in addressing mental health aspects of individuals with I/DD?** **RQ2: What methods and measures are being used to assess the effectiveness of these programs?** **RQ3: What do we know about the effectiveness of these training programs?** **RQ4: What is the impact of the identified studies on the field as a whole, as measured by location and citation metrics?**	To be included in this review, four requirements needed to be met. Specifically, the study needed to include (1) direct support professionals (DSPs) who were working with (2) individuals with I/DD. The study also needed to include a (3) training that was empirically tested and that focused on improving DSP understanding of (4) mental health issues among individuals with I/DD or that aimed to improve the overall mental health or specific mental health concerns (e.g., depression, anxiety, etc.) Note: DSP defined and included any studies where the training was applicable to employed staff who were caring for individuals w/ I/DD and who were not required to hav eany specific degree/certification (e.g., nurses excluded).	N/A	Systematic review of 15 empirical articles that assessed the outcomes of training rograms for DSPs that addressed aspects of mental health among individuals with I/DD.	Initial search conducted on March 21, 2022	N/A	N/A	N/A	N/A	N/A		Wide diversity in the trainings, including both staff and individuals with I/DD focused trainings, workshop formats and intervention formats, and trainings varying in length. Each article found benefits of the training improved knowledge and confidence for the DSP and/or decreased mental health issue symptoms or behaviors for individuals with I/DD.	Relevant to understanding the scope of existing training approaches among service providers who support those with I/DD + this is a recent review of the literature. Although it does not discuss training relevant to substance misuse/SUD, it does provide insight into understanding the current landscape of training for those with I/DD and other mental health concerns.	Moderate	Provides insightful overview of MH focused trainings and interventions for DSP working w/ individuals w/ I/DD	Lacks the ability to distinguish which programs are more effective than others or to identify specific factors (e.g., demographic characteristics) that increase the effectiveness of the training for intervention. Further, the studies reviewed failed to assess metrics of staff turnover, a salient issue in the field - future research should utilize long follow-up periods and include measures of staff turnover.		The studies reviewed found that implementing trainings w/ a MH focus was consistently associated with at least some positive outcomes for either DSPs and/or individuals w/ I/DD. - Positive outcomes included: increased staff knowledge, confidence, and skills, while individuals w/ I/DD showed improvements in relationships, reduced incidence of problem behaviors, decreased depression & anxiety, and improved quality of life. The most commonly utilized frameworks guiding the trainings designs were the **biopsychosocial model** and **cognitive behavioral therapy**-based interventions. It may be that the exact modality and duration is less important than **finding ways to directly support the mental health of individuals with I/DD**, a commonly overlooked, but crucial component of well-being for individuals with I/DD. One of the most pervasive concerns in providing quality care for individuals with I/DD is high rates of staff turnover, and **previous research has found that meaningful and applicable trainings can help reduce the rates of staff turnover.**
Lauren, 10/31/2023	Brosnan, M., & Adams, S. (2022). Adapting drug and alcohol therapies for autistic adults. Autism in Adulthood, 4(3), 214–223. https://doi.org/10.1089/aut.2021.0047	2022	1) Explore the skills, experience, and confidence of drug and alcohol providers and what adaptions they are making for autistic participants 2) Members of autistic communities reflected on adaptions made by therapists	Survey participants: Invitations to participate were include in a local magazine *(Drink and Drug News), and webpages related to the* National Autistic Society. N=122 Focus groups: Participated in National Autism Wales Conference and ran two focus groups. N=11 (individuals with autism, n=3; families/advocates, n=4; professionals n=4)	Of 122 therapists, 61% worked in community drug and alcohol services, 8% worked in local authority social services, 7% worked in a hospital setting, 7% worked in outreach services, 4% in residental rehab centers, 14% in other services. 60% worked with adlts aged 18-65, 29% with adults 65+ and 11% with under 18.	Cross-sectional online survey for therapists and thematic analysis for focus groups/	N/A	N/A	Survey that assessed therapists' demographics, training and experience, adaptions made for autistic service users, and therapist confidence. The Therapist Confidence Scale for Intellectual Disabilities adapted for individuals with Autism was used to assess confidence.					Therapists that participated were community drug and alcohol service providers with at least 10 years of experience. Many had autistic clients without formal training on how to support autistic clients. Therapists found that a lack of adaption to meet the individual needs of autistic clients resulted in disengagement with the service. Therapists also reported difficulty when clients with autism are less expressive or responsive or demonstrate difficulty in group therapy. Clients with autism can present with inflexibility to suggestions from the therapist. Therapists reported that family therapy, CBT, and systematic approaches was most helpful with autistic clients.	Addresses the need for individualized therapy to support individuals with SUD and autism. It also supports the need to provide training to susbtance abuse service providers related to individuals with autism.	Moderate-High	Data from therapists with wide ranges of expertise + experience related to the target population Adaptations that were made to therapy sessions provided in study	The online nature of the sample making it difficult to generalize to drug and alcohol therapists as a whole. Requesting a response to a survey about autistic clients could have created biased responses. The sample was based in the UK so there may be different issues across cultures. Some questions had more responses than others. The members of the focus groups were convenience samples	N/A	Lack of a shared perspective between the therapist and the autistic client as to the intended outcomes of the theraputic process could have posed a challenge to therapy. Therapists need to be trained in a wide range of adaptations for autistic clients and not adopt a one-size-fits-all approach Adaptations included: using plain language more frequently, more structured approach, shorter sessions, avoiding metaphors, discussing hobbies and interests, more written and visual information, involving a family member or partner, behavioral or cognitive strategies to introduce change, psychoeducation about emotions, longer sessions
Lauren, 11/1/2023	Kronenberg, L. M., Goossens, P. J., van Etten, D. M., van Achterberg, T., & van den Brink, W. (2014). Need for care and life satisfaction in adult substance use disorder patients with and without attention deficit hyperactivity disorder (ADHD) or autism spectrum disorder (ASD). Perspectives in Psychiatric Care, 51(1), 4–15. https://doi.org/10.1111/ppc.12056	2014	1) What are the nursing care needs of SUD patients with a co-occuring diagnosis of ADHD or ASD and do these nursing care needs differe from each other and from those of patients with SUD but no co-occurring diagnosis of ADHD or ASD?	Patients were recruited from mental health and addiction treatment services on the basis of clinical screening and diagnostic procedures. N=73 with dual diagnosis, n=51 patients with addition	Patients consisted of a) SUD b) SUD w/ comorbid ADHD or ASD Inclusion: inpatient or outpatient treatment, age 18-65, IQ>80, DSM-IV diganosis of SUD w/ or w/o ADHD or ASD	A cross-sectional study of treatment seeking patients with SUD and a comorbid diagnosis of ADHD or ASD.	N/A	Primary drugs: alcohol, heroin, cocaine, amphetamines, cannabis, and multiple	Diagnoses were based on semi-structured interviews including the Mini International Neuropsychiatric Interview, Diagnostic Interview for Social and Communicative Disordrs, Autism Diagnostic Interview, Rimland, Diagnostics Interview for ADHD in adults. To assess care needs: European Addiction Severity Index, Camberwell Assessment of Needs, and Manchester Short Assessment of Quality of Life					Patients with SUD +ASD were more likely to live alone or in a protected setting than patients with SUD or SUD + ADHD. Patients in the SUD + ADHD group reported needed care in the domains of alcohol/drugs, psychiatric health, unemployment, physical health, and finance where the SUD + ASD group reported needed support in the alcohol, unemployment,daytime activity, sexual life, looking after the home, family/social relationships, and psychiatric health domains. The group with solely SUD reported needs in the domains of alcohol, psychiatric health, and unemployment.	Demonstrates the quality of life for individuals with intellectual or learning disabilities that are comorbid with SUD vs. individuals with solely SUD	Moderate	Includes perspectives of individuals with ASD + ADHD Looks at multiple domains related to quality of life Standardized questionnaires representing self-perceived quality of life in addition to care needs Gathering of real-life examples through semi-structured interviews	The relatively small sample size of the patient groups which could result in type 1 errors There may be biases in data due to diffculty understanding how to resond for individuals with ASD + SUD Participants at different phases of treatment (outpatient, no longer in treatment, clinical detoxification)	None. Received ethics approval to conduct evaluation.	Given social and communicative impairments, SUD + ASD group was more likely to attain alcohol since it requires less complex social skills to attain Individuals with ADHD/ASD + SUD are likely to have more care needs yet there is limited guidelines for supporting those with a dual diagnosis
Lauren, 11/1/2023	Kronenberg, L. M., Verkerk-Tamminga, R., Goossens, P. J. J., van den Brink, W., & van Achterberg, T. (2015). Personal recovery in individuals diagnosed with substance use disorder (SUD) and co-occurring attention deficit/hyperactivity disorder (ADHD) or autism spectrum disorder (ASD). Archives of Psychiatric Nursing, 29(4), 242–248. https://doi.org/10.1016/j.apnu.2015.04.006	2015	1) Understand the main elements in the process of recovery for patients with SUD and comorbid ASD or ADHD 2) Understand the coping mechanisms and care needs	Participants recruited by professionals working at a dual diagnosis, outpatient, treatment facility. Clinicians were informed about personal recovery and were encouraged to select patients who could talk about the process of recovery. N=21, patients diagnosed with SUD + ADHD, n=9; diagnosed with SUD + ASD, n=12	Inclusion criteria: outpatient treatment for SUD; age 18-65; estimated IQ>80; current DSM-IV diagnosis of SUD and current DSM-IV diagnosis of ADHD or ASD, currently in the process of recovering according to both patient and clinician.	Qualitative apporach using semi-structured interviews. Interviews were coded and analyzed	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Four themes related to personal recovery were identified: 1) crisis and diagnosis, 2) dealing with agitation, symptoms, and burden 3) reorganization of life 4) meaningful life Across both groups, substance use served the purpose of stopping the jumble of thoughts and emotions in their heads which eventually lead to substance use crisis and tratement. Hospitalization was helpful for both groups, but for different reason. For individuals with SUD + ADHD, medication allowed them to pause their thoughts and emptions and work towards goals. Their personal recovery process included gaining hope, pride, and faith in their capabilities. People with SUD + ASD describe their recovery as an ongoing struggle. Controlled substance use is sometimes helpful for social participation and helpful for personal recovery.	Highlights the impact of treatment and intervention on the quality of life of individuals with comorbid diagnoses	Moderate	Data analyzed by multiple researchers to ensure the accuracy of the themes identified and the coding Validating the results by the patients	Limited number of women included in the study, impacting generalizability Homeless or disenfranchised patients were not included and their recovery process may look different	N/A	Period of addiction almost twice as long for those patients diagnosed with SUD + ADHD than those with SUD + ASD The aspects of personal recovery found across research and practice are: connection, hope, identity, meaning in life, and empowerment SUD + ADHD patients were more likely to be active agents of change in their recovery, where SUD + ASD patients experienced considerable difficulty due to limited hope and empowerment
Lauren, 11/1/2023	Gosens, L. C. F., Otten, R., de Jonge, J. M., Schellekens, A. F., VanDerNagel, J. E. L., Didden, R., & Poelen, E. A. (2021). Development of a personalised substance use disorder treatment for people with mild intellectual disabilities or borderline intellectual functioning: An intervention mapping approach. Journal of Intellectual & Developmental Disability, 47(2)	2021	The article highlights the development of a personalized SUD treatment for individuals with Mild Intellectual Disorder or Borderline Intellectual Functioning as it relates to Intervention Mapping	N/A	N/A	Individual Mapping framework consists of 1) conducting a needs assessment 2) determining objectives 3) selecting theory-based interventions 4) developing interventions 5) implementing interventions 6) evaluating the interventions	N/A	N/A	N/A	N/A	N/A	N/A	N/A	The study describes the development of Take it Personal! a personalized SUD treatment. Content and format of treatment was adapted to the needs of individuals with MID-BIF. Treatment is tailored to the characteristics and personality profile of the client.	Describes the process taken to develop a prevention program for the target population from the needs assessment to evaluation stage which mirrors our work	Moderate-High	Creates strong collaboration for professionals in addiction and ID care	Screening is needed to determine whether the program is appropriate for those with comorbid diagnoses Drop-out rates for SUD programs is typically high so maintaining motivation is key	N/A	Adaptations taken for the target population were repetition of content during and in between sessions , support of a confidant/peer, and flexibility of sessions (duration, amount, etc.) Ensuring information is provided in multiple modalities is also key Ensuring that both therapists and clients were involved in the developmental process so that the program is an accurate reflection of needs and information is clear and appealing
Lauren, 11/2/2023	Helverschou, S. B., Brunvold, A. R., & Arnevik, E. A. (2019). Treating patients with co-occurring autism spectrum disorder and substance use disorder: A clinical explorative study. Substance Abuse: Research and Treatment, 13, 117822181984329. https://doi.org/10.1177/1178221819843291	2019	1) Ways of improving services for individuals with ASD and SUD by enhancing competence of professionals in SUD outpatient clinics 2) Understand the outcome of individually focused CBT for individuals with SUD and ASD	Therapists were recruited from an SUD outpatient clinic. therapists, n=3. Patients were referred by their family doctor to the clinic to overcome their problems with alcohol or drugs. To increase the patients with ASD, the project was advertised through websites and flyers at SUD outpatient clinics, ASD services, and user organizations.	Therapists: Extensive clinical experience with SUD patients and training in CBT. Inclusion criteria for patients: previous diagnosis of ASD, intellectual ability within normal range, age over 16 years, and able to attend weekly outpatient sessions	Interviews were conducted to highlight the experiences of treating patients with ASD and SUD. Pre- and post-treatment questionnaires were provided to patients.	N/A	Substances used by patients: stimulants, alcohol, opioids, cannabis, and sedative, hypnotic, or anxiolytics	Wechsler Abbreviated Scale of Intelligence (WAIS-III) assessed IQ, the Hopkins Symptom Checklist-25 (HSCL-25) was used to assess psychiatric comorbidity, the Drug Use Disorder Identification Test and Alcohol Use Disorders Identification Test were used to assess drug and alcohol use before and after treatment and positive and negative experiences with intoxication. The Global Assessment of Functioning (GAF) assessed psychosocial functioning before and after treatment. The Motivational Interview was used to identify the patients' goals for and anticipations of therapy and to develop an individualised plan in collaboration with patients. Post-treatment, the Patient Satisfaction Questionnaire assessed patients' own evaluation of treatment.	CBT included psychoeducation, cognitive restructuring, relaxation strategies, exposure, and response prevention. CBT was offered over a minimum of 10 sessions. Treatment was modified to meet the communication and comprehension difficulties associated with autism and expanded to ASD-related characteristics.	N/A	N/A	N/A	By the end of treatment, 2 participants had ended their drug and alcohol abuse, one had reduced abuse, and one was heavily dependent on alcohol. Psychological well-being was reported as being the most positive aspects of drug/alcohol abuse with social interactions being the most negative. Therapists noted that the therapy took longer than recommended because the patients with ASD required several sesions to complete assessments and establish goals. Therapists also experienced difficulty communicating with the patients. Therapists obtained support from other therapists for strategies to support the patients.	Describes some of the successes and challenges of developing a treatment for individuals with ASD and SUD. It also indicates some of the modifications that were needed for the population of individuals with comorbidity.	Moderate-Low	The therapy was evaluated was satisfactoy suggesting that CBT is a promising treatment option for individuals with ASD and SUD. Study showed the impact of monthly ASD education and group supervision for therapists in SUD outpatient clinics. Highlighted the adaptations needed to make therapy more individualized for the population Demonstrated that patients with ASD also needed social training and support with housing, employment, and leisure activities	Sample size was very small and does not include a control group so interpreting the results requires caution Homogeneity of ethnicity, sex, and intellectual ability	N/A	

APPENDIX B

Lauren, 11/6/2023	Nicholson, J., Valentine, A., Ledingham, E., & Reif, S. (2022). Peer support at the intersection of disability and Opioid (mis)use: Key stakeholders provide essential considerations. International Journal of Environmental Research and Public Health, 19(15), 9664. https://doi.org/10.3390/ijerph19159664	2022	Explore and elaborate essential considerations for adapting peer supports for individuals at the intersection of disability and opioid misuse. Identify potential barriers and facilitators to implementing supports	N=16 using snowball approach to reflect varied domains and interests	Participants incldued those with lived experience as a disabled peson, advocate, family member or provider with personal or professional knowledge of the intersection of disability and opiod misues. Participnats also had personal or professional experience in human services, as service providers, peer specialists, or service recipients.	Exploratory, developmental design and qualitative methods	2019-2020	N/A	N/A	N/A	N/A	N/A	N/A	Participants indicated difficulty accessing relevant peer supports, willingness to access services, and the capacity to take advantage of relevant resources Participants indicated wanted to be matched to a peer specialist not only on the basis of functioning or diagnosis, but on identity based on how they define and see themselves Participants described the importance of building trust in the peer support relationship through shared experiences, offering the hope that change is possible, and serving as a role model and source of motivation to make changes Providing peer support gives individuals a sense of purpose, a reason to stay clean and sober Participants indicated that certified peer specialist training must be disability informed and accommodate different needs	Highlights the relationship between peer supports and individuals that have comorbid disabilities and SUD. It indicates the significance of peer support and allows for first-person perspectives on the adaptations and acccommodations necessary for this population.	Moderate-High	Participants described challenges and made recommendations for meeting the diverse needs of individuals at the intersection of disability and SUD. Participants reflected diverse training, roles, and disciplines from years of experience in the field Participants had experience building models or services to meet the needs of individuals at the intersection of disability and SUD	The study was exploratory and the data was qualitative though obtained from a selected sample of experts. Small sample size	N/A	Participants recommended the importance of materials and resources in diverse formats addressing issues of cognitive, sensory, information procesing, or attentional impairments, and language or health literacy challenges A key characteristic of peers is having similar lived experiences "Individuals with disabilities may have experiences of having been assigned labels or to groups or having been compared with people presumed to be peers, rather than being allowed to build identities or relationships of their own choosing." Peer specialists need to question their assumptions and recognize what they don't know about other types of disabilities "Peer training should focus on how to question assumptions; how to be respectful of, sensitive to, and make practical adaptations for physical, cognitive, and sensory needs, and challenges, and how to inquire about needs that may not be readily observable."
Lauren, 11/8/2023	Kronenberg, L. M., Goossens, P. J., van Busschbach, J. T., van Achterberg, T., & van den Brink, W. (2015). Burden and expressed emotion of caregivers in cases of adult substance use disorder with and without attention deficit/hyperactivity disorder or autism spectrum disorder. International Journal of Mental Health and Addiction, 14(1), 49–63. https://doi.org/10.1007/s11469-015-9567-9	2015	1) What is the relative burden of caregivers of adult SUD patients with or without co-occurring ADHD or ASD? 2) What is the relative perceived EE of caregivers of adult SUD patients with or without a co-occurring ADHD or ASD according to caregivers themselves and patients? 3) Does perceived caregiver EE from the patient's perspective versus the caregiver's perspective differ for the three groups of patients? 4) Does perceived caregiver EE correlate with caregiver burden in the three groups of patients?	Patients were recruited from mental health and addiction treatment services. Patients had also previously participated in a study by the researchers. N=60	Inclusion criteria: outpatient treatment of SUD, age 18-65, IG> 80, current diagnosis of SUD either with or without current DSM-IV diagnosis of ADHD or ASD	Cross-sectional study with caregivers and treatment-seeking SUD patients. The Involvement Evaluation Questionnaire was used to measure caregiver burden. The Level of Expressed Emotion (LEE) assesses expressed emotion and was administered during a face to face interview. Caregivers received both questionnaires mailed to the home. Chi2 tests were used for categorical data like kind of relationship between caregiver + patient and weekly contact hours. One-way ANOVA's were used on research questions 1-2, paired t-tests, and Pearson correlation coefficients were utilized on questions 3-4	2015	N/A	N/A	N/A	N/A	N/A	N/A	The co-occurrance of ADHD-ASD in addition to SUD was not significantly associated with greater caregiver burden or more expressed emotion when compared to SUD alone The caregivers for patients with only SUD showed higher levels of caregiver burden, but also expressed emotions when compared to SUD + ASD. More contact hours between caregiver and patient were associated with higher levels of caregiver burden, higher levels of perceived stress, and greater perceptions of expressed emotion.	Supports the impact of comorbid I/DD + SUD on caregivers	Moderate-High	First study to compare caregiver burden in SUD patients with or without comorbid ADHD or ASD	Limited samplesize Data was obtained using self-report questionnaires		Number of contact hours may be a indicator of caregiver burden
Lauren, 11/13/2023	Walhout, S. J., Zanten, J. van, DeFuentes-Merillas, L., Sonneborn, C. K., & Bosma, M. (2022). Patients with autism spectrum disorder and co-occurring substance use disorder: A clinical intervention study. Substance Abuse: Research and Treatment, 16, 117822182210855. https://doi.org/10.1177/11782218221085599	2022	Introduce and evaluate manualized group intervention by evaluating current drug and alcohol use, coping strategies, and patients experience of control over their alcohol and drug use and experience of recovery.	Patients were referred by their general practitioner for drug or alcohol use problems. N=57 completed assessment, n=27 that completed second follow-up 3 months after treatment	Inclusion criteria: previous diagnosis of ASD according to DSM-5, diagnosed with SUD according to DSM-5, aged over 18 years, able to attend weekly outpatient sessions. Exclusion criteria were low intellectual disability, psychiatric comorbidity, or recent diagnosis of ASD	CBT based group intervention. Descriptive statistics were performed on demographic variables. Multiple paired t-tests were conducted to compare the variables at different points in time. Data was analyzed using SPSS.	2017-2019	Primary substances: Alcohol 42.1%, Cocaine 8.8%, Cannabis (29.8%), Amphetamine (5.3%), Ecstacy, GHB, Medication (1.8% each)	Measurement of addication for triage and evaluation (MATE): Used to assess the severity of addiction and psychiatric comorbidity, the social functioning and treatment history. Also Used for assessing care needs and evaluating treatment. Utrecht Coping List (UCL): is a self-report measure assessing different dimensions of coping one uses when encountering daily life struggles Mental Health Recovery measure (MHRM): measures the recovery process Rumination Reflection Questionnaire (RRQ): measures the extent to which a patient generally ruminates or reflects Depression Anxiety Stress Scales (DASS-21): measures symptoms of depression, anxiety, and stress	An adaption of CBT for SUD that includes components of psychoeducation, response prevention and cognitive restructing tailored to the needs of patients with ASD with co-occurring SUD 12 sessions with each session lasting 2 hours long. Initial 6 sessions are provided to all and the remaining sessions can be chosen dependent on the specific problem areas of the individuals.				Participants reported lower levels of alcohol use and craving following the group intervention and the effect was stronger even 3 months after completion of the intervention. Participants reported a change in social support as a coping style and used passive coping styles less frequently. Participants had more control over their recovery process and fewer symptoms of anxiety, stress, and depression.	Related to intervention programs that support individuals with ASD and SUD. Demonstrates the positive results of group intervention to support this population.	High	Suggests positive outcomes for adapted group intervention and demonstrates impact 3 months after completion of intervention	The sample size was small and did not include a control group. The study population was heterogenous in terms of time betweeen the first diagnosis of ASD and the start of intervention which may have impacted the results.	N/A	27 out of the 57 participants that were initially referred dropped out which is comparable to SUD treatment in general. It is recommended to include a buddy during tratement which can improve the generalizability of the skills learned during the intervention Group intervention introduced mindfulness as a way of coping with stress caused by ASD and/or SUD Alcohol use in clients decreased significantly while cannabis use remained unchanged
Lianne, 11/19/2023	Martin JL, Cimini MD, Longo LM, Sawyer JS, Ertl MM. Equipping mental health professionals to meet the needs of substance-using clients: Evaluation of an SBIRT training program. Training and Education in Professional Psychology. 2020;14(1):42-51. doi:10.1037/tep0000258	2020	With funding from SAMHSA for a 3-year training grant, we sought to address the addictions training gap for professional psychology trainees by implementing and evaluating a two-part SBIRT training program for students in mental health counseling, clinical, counseling, and school psychology graduate programs at one institution. More specifically, we **evaluated students' satisfaction with the training as well as the impact of the training on students' knowledge of motivational interviewing (MI) and SBIRT and their self-efficacy to implement SBIRT. We hypothesized that completion of the training would be associated with increases in students' knowledge of MI and SBIRT and self-efficacy to implement SBIRT.**	Recruited via email invitation to participate in face-to-face training. There were no exclusion criteria. In total, 89 graduate students attended the in-person training (described below), and 87 chose to complete the associated surveys.	Graduate students across six nationally accredited master's and doctoral degree programs in professional psychology sampled from one large, public institution in the northeastern US (PhDs in counseling psychology, clinical psychology, and school psychology; Masters in mental health counseling & school psychology). Majority of participants identified as female (80%); 82% identified as White, 8% as Black/African American, 7% as Asian, 2% as Latina/o, and 1% as American Indian. The mean age = 26.64 years. ~56% of participants reported not seeing clients in a practice setting. Those who were seeing clients were completing practicums in training clinics (14.6%), schools (11.3%), college counseling centers (10.1%), community mental health centers (9%), hospitals (4.5%), drug/alcohol treatment facilities (3%), Department of Veterans Affairs (2.2%), and other (5.6%). The majority of participants (82%) reported they had never completed a formal course on substance use, 53% reported completing zero hours of lectures or workshops devoted to substance use, and 51% reported zero hours of training in MI.	SBIRT intervention training program. Descriptive analyses assessed **participants' satisfaction** and **perceived utility** of the SBIRT training programs. Separate repeated-measures (RM) one-way ANOVAs were used to examine changes in **MI knowledge and SBIRT self-efficacy across the six time points. Only participants who provided data at all three time points for each training were included in analyses, resulting in sample sizes of n = 71 and n = 17 for the face-to-face and booster knowledge analyses, respectively.**		N/A						The majority of participants were satisfied or very satisfied with their overall training experience (88.6% and 96.4% for the face-to-face and booster trainings, respectively). Most agreed or strongly agreed that the trainings boosted their SBIRT skills (86.4% and 100% for the face-to-face and booster trainings, respectively). Finally, nearly all participants found the trainings to be useful or very useful (90.9% and 100% for the face-to-face and booster trainings, respectively), and greater than half of each group of participants used at least some of what they learned with their clients in the 30 days following the training (51.7% and 75% for the face-to-face and booster trainings, respectively).	Not directly related to substance use but SBIRT could be adapted for screening people with disabilities.	High	"the most encouraging finding was the increase in self-efficacy scores that resulted from the initial and booster trainings and was maintained over time"	Results are limited to five graduate psychology programs from one university. A sharp decrease in participants who completed the booster training is a limitation of the study that resulted in the inability to analyze SBIRT behaviors over time. Another limitation is use of author-generated measures to assess SBIRT knowledge, self-efficacy, and behaviors. Although not uncommon in SBIRT program evaluation research, the use of measures unique to our study prevents comparison of our findings with those of other studies. The use of self-reported rather than observed or documented use of SBIRT in clinical notes represents another limitation. Study did not assess competency in delivering SBIRT.		Using χ2 tests, **there were statistically significant associations between type of training program and sex in relation to completion of the face-to-face training versus the booster training**, such that **the sample that completed the booster training was comprised of fewer men, a larger proportion of counseling psychology students, and smaller proportions of school psychology students.** **The 4-hr online booster training utilized an online module titled, "SBIRT for Behavioral Health Specialists," developed by University of Missouri Kansas City (http://www.sbirt.care/training.aspx).** The booster training covered similar topics as the face-to-face training (e.g., background and utility of SBIRT, MI, and SBIRT skills) and utilized interactive games, case scenarios, and quizzes to guide participants through the process of learning and practicing SBIRT skills. Participants did not engage in role plays or receive feedback on SBIRT skills. Ideally, all didactic training should be followed by supervised practice with feedback to build and maintain competence in implementing SBIRT... Students were informed they could use **freely available SBIRT simulation programs (e.g., www.drugabuse.gov/blending-initiative/cme-ce-simulation) to practice skills and obtain feedback on their choice of interventions.**
Lauren, 11/20/2023	VanDerNagel, Joanne E., van Duijvenbode, N., Ruedrich, S., Ayu, A. P., & Schellekens, A. F. (2017). The perception of substance use disorder among clinicians, caregivers and family members of individuals with intellectual and developmental disabilities. Journal of Mental Health Research in Intellectual Disabilities, 11(1), 54–68. https://doi.org/10.1080/19315864.2017.1390712	2017	Explore the perceptions and attributions of clinicians, caregivers, and family members of IDD toward SUD	Respondents to the survey were invited to participate via information posted on the website of National Association for the Dually Diagnosed. n=165, of which 88 were clinicians, 58 were caregivers, and 19 were family members	Respondents were primarily female (n=120, 72.7%), the mean age was 49.5 years old which respondents ranging from 21-74. Caregivers had an average of 19.5 years of work experience and clinicians had an average of 21 years of work experience	Descriptive analyses measured demographic information, the background of the respondent, and perceptions of SUD.			Illness Perception Questionnaire Revised: IPQ-R was used to explore the perception of clients and professionals on a range of illnesses and disorders The IPQ-R was also used to assess perceptions of SUD and explore respondents' opinions of possible causes of SUD					Generally, respondents believed they understood SUD and its consequences. Social factors and personal factors were largely belived to be the most important causes of SUD. Social causes include negative life experiences, social isolation, lack of support, situational stressors, socioeconomic status, etc. Personal causes included mood, anxiety, trauma, lack of coping skills, etc. Risk factors such as psychological and emotional stress may be more prevalent in individuals with IDD and increase risks for SUD. Increased susceptibility to peer pressure and the desire to fit in also contributed to the development of SUD. Interventions for SUD/IDD individuals should be adapted to the needs of the individuals with IDD and also reduce psychosocial stressors, increase emotional and coping skills and promote a life with social support and interpersonal	Perceptions from clinicans, caregivers, and families can aid us in seeing gaps to inform the development of our training.	Moderate-High	Affirms that SUD is a chronic condition and the need to screen for SUD in this population to allow for early intervention Understanding the perceptions and knowledge (or lack thereof) could support the detection and diagnosis and aid in the elimination of lack of access to adequate interventions and services.	Small sample size and the information gathered about respondents was limited Unsure for those that were family members, how they were related to the person with IDD Due to the relationship with the NADD, it is hard to know whether the results would apply to other populations Perceptions and attributions toward SUD in non-IDD populations was not assessed.	None of concern	"Improving access to SUD treatment adapted to the need of these individuals, but also reducing psychosocial stressors, improving coping and emotional skills, and promoting a healthy, fulfilling life with adequate support and interpersonal connection." Perceptions of SUD shape attitudes towards working and interacting with individuals with SUD and affect access to care, quality of care, and treatment outcomes making it a critical element of both treatment and recovery
Lauren, 11/21/2023	Didden, R., VanDerNagel, J., van Duijvenbode, N., Delforterie, M., Otten, R., & Poelen, E. (2020). Treatment of substance abuse in dual diagnosis. Handbook of Dual Diagnosis, 549–563. https://doi.org/10.1007/978-3-030-46835-4_32	2020	Provide a short overview of the interventions that have been adapted to indivduals with dual diagnosis of ID and SUD. Developments regarding personalized treatments is also described and screening, assessment, and collaboration between organizations is indicated.											A study conducted by VanDerNagel et.al (2017) developed an e-learning prevention program with games, vidoes, and quizzes in order to increase students' substance knowledge and strengthen ability to make own choices. The study showed that a classroom-based e-learning program is feasible for individuals with ID, but did not impact their intention to use substances. CBT has been shown to have a positive impact on the use of substances for individuals with SUD. Kouimtsidis et al., modified a CBT program to include a workbook with easy language and visual cues, reduced number of sessions with therapist, and peers were involved in alternate sessions. Another study modified the CBT program by including visual aids, repetition, role-play, and homework to complete with their support staff.	This review indicates both the treatments for ID/SUD across various studies and adaptations to treatments to increase access for individuals with ID	High	Detailed overview of adaptations, treatments, personalized treatments, and prevention programs for indivdiuals with ID/SUD	N/A	N/A	Adaptations of treatment programs included reduction of language complexity, inclusion or real-life exercises, and utilization of a less information dense program with increased repetition. Individuals with ID were noted to need more support generalizing information and skills in their daily life Other adaptations noted included: increasing motivation to change, using short sentences that contain a single concept, minimize switching between tasks, prevent distractions, and use memory aids Supporting individuals with SUD/ID often requires collaboration between organizations, but often staff report a lack of expertise to support these clients. Cross-system collaboration could be beneficial as it involves multiple services for the prevention, care, and treatment of individuals with SUD/ID. This would require organizations that typically support ID or SUD to shift their mindsets regarding how to treat these conditions to increase the support provided to individuals with comorbid conditions.
Lianne, 11/23/2023	Reif S, Lee MT, Ledingham E. The Intersection of Disability With Substance Use and Addiction. In: Oxford Research Encyclopedia of Global Public Health. ; 2023. doi:10.1093/acrefore/9780190632366.013.491	2023	Summarizes what is known about the prevalence of substance use and addiction; the role of substance use in the developing or worsening of certain disabilities and symptoms; facilitators and barriers to addiction treatment access, including stigma and ableism; and accommodations and best practices.	N/A	NA	N/A		Substance use and addiction among people with disabilities is higher compared to people without disabilities. There are associations between substance use and addiction by specific types of disability: spinal cord injuries, traumatic brain injury, intellectual disabilities, autism, hearing and visual impairments.						Article concludes with important call to actions: 1) need to develop appropriate screening tools to screen & assess PWD, 2) a universal approach to accommodations ensures physical barriers are removed + materials & treatment made accessible, 3) need for training about disability, ableism, and effective accommodations **Person-centered** approach to care should decrease stigma & discrimination	Highly relevant to population with recent data. Provides summary of barriers to addiction treatment for PWD + provides exemplar adaptations in addiction treatment for people w/ ID, autism, & cognitive disabilities incl. brain injury	High				Importance of **improving comprehension & retention** in treatment by using simplified communication and materials/visual aids. Would need to be taken a step further for certain disabilities (E.g., people w/ ID may be more likely to say "yes" to questions they do not understand, thus avoid negative phrasing or confrontational questions). Also important: **enhance problem recognition & problem-solving skills, provide individual therapy** (rather than group therapy)**, social supports (**providers can provide concrete definitions of healthy relationships & strategies for improving relationships)**, peer supports** (i.e., digital-based peer support has particular appeal bc it eliminates barriers e.g., transportation & physical inaccessibility)**, cross-system collaboration** (i.e., among both treatment and service providers)
Lianne, 1/23/2024	Presnell, J., Keesler, J. M., & Thomas-Giyer, J. (2022). Assessing Alignment Between Intellectual and Developmental Disability Service Providers and Trauma-Informed Care: An Exploratory Study. Intellectual and Developmental Disabilities, 60(5), 351–368. https://doi.org/10.1352/1934-9556-60.5.351	2022																		
Lianne, 1/23/2024	Rich, A. J., DiGregorio, N., & Strassle, C. (2021). Trauma-informed care in the context of intellectual and developmental disability services: Perceptions of service providers. Journal of Intellectual Disabilities, 25(4), 603-618. https://doi.org/10.1177/1744629520918086	2021																		

"Supporting Adults with Developmental Disabilities and Substance Use Challenges" – 3-month Follow-Up Provider Survey

Thank you for taking the time to complete this survey. The purpose of this survey is to assess the effectiveness of the training you recently completed on supporting individuals with intellectual and developmental disabilities (I/DD) who may also have co-occurring mental health and/or substance use disorders.

Your feedback is important and will help us improve future training programs to better support your work and the individuals you serve.

All responses are confidential. Your answers will be compiled and reported in a way that does not identify individual participants.

PROVIDER BACKGROUND

1) What services or supports are you contracted to provide on behalf of regional centers? (select all that apply)

- Independent Living Services (ILS)
- Supported Living Services (SLS)
- Adult Day Program
- Employment Program
- Other / Not contracted with regional centers (please specify): _____

2) Which cities do you provide services to? Write In: _____

3) Can you please tell us which of the following best describes you?

- I am an owner or administrator of an agency (CEO, CFO, President, Manager)
- I am a program manager or case manager
- I am medical staff

- I am a direct support provider
- I am a parent provider
- Other (please specify): _____

4) Which regional center(s) are you vendored with or provide support to? (select all that apply)

- Frank D. Lanterman Regional Center
- Westside Regional Center
- Other/Not vendored with regional centers (please specify): _____

Impact on Practice, Service Delivery, & Outcomes

5) Before taking the training, how confident were you in your ability to support individuals with I/DD who have (or at risk for) mental health and/or substance use disorders?

- Likert scale: 1 = Not at all confident, 2 = Not very confident, 3 = Neutral, 4 = Very Confident 5 = Extremely confident

6) Since completing the training, how confident are you in your ability to support individuals with I/DD who have (or are at risk for) mental health and/or substance use disorders?

- Likert scale: 1 = Not at all confident, 2 = Not very confident, 3 = Neutral, 4 = Very Confident 5 = Extremely confident

7) Please reflect on your experiences since completing the training. For each statement below, select the response that best represents your level of agreement.

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable

a. I have changed the way I approach supporting individuals with I/DD who have (or may be at risk for) co-occurring mental health and/or substance use disorders.	☐	☐	☐	☐	☐
b. I feel more confident communicating with individuals with I/DD who have (or may be at risk for) co-occurring mental health and/or substance use disorders.	☐	☐	☐	☐	☐
c. I feel more confident in making referrals to mental health or substance use treatment services since completing the training.	☐	☐	☐	☐	☐
d. I feel more confident applying trauma-informed and culturally responsive practices.	☐	☐	☐	☐	☐

8) Since completing the training, how often have you applied the following concepts or strategies in your work? Please indicate your response for each item below.

Statement	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
a. I have applied cultural humility (e.g., respecting language and cultural differences).	☐	☐	☐	☐	☐
b. I have used refusal skills (e.g., practicing saying no, role-playing).	☐	☐	☐	☐	☐
c. I have applied strengths-based approaches (e.g., treating people as resourceful and resilient)	☐	☐	☐	☐	☐

Statement	Never	Rarely	Sometimes	Often	Always
d. I have applied person-centered care (e.g., co-creating care plans, showing compassion, supporting independence and decision-making)					
e. I have used mindfulness techniques (e.g., breathing, 5-4-3-2-1 method, STOP strategy).	☐	☐	☐	☐	☐
f. I have applied coping strategies (e.g., crisis intervention planning, identifying triggers).	☐	☐	☐	☐	☐
g. I have supported self-advocacy (e.g., helping people understand their rights, communicate their needs).	☐	☐	☐	☐	☐
h. I have used Motivational Interviewing principles (e.g., expressing empathy, supporting autonomy, rolling with resistance).	☐	☐	☐	☐	☐
i. I have used OARS strategies (Open-ended questions, Affirmations, Reflective listening, Summarizing).	☐	☐	☐	☐	☐
j. I have helped people identify their own goals or ambivalence.	☐	☐	☐	☐	☐
k. I have supported people to explore change talk.	☐	☐	☐	☐	☐

9) Since completing the training, have you referred an individual with I/DD to any of the following services related to mental health and/or substance use treatment? (Select all that apply)

☐ Regional Center services (e.g., case coordination, crisis response)
☐ Medi-Cal primary care provider
☐ Los Angeles County Department of Mental Health (LACDMH) or ACCESS Line
☐ SASH: LA County Substance Abuse Service Helpline
☐ Private or residential substance use treatment centers

☐ SAMHSA Treatment Locator or Helpline
☐ Crisis services (e.g., 988 Lifeline, LACDMH Help Line)
☐ Other (please specify): _____
☐ None

10) Have you observed any of the following outcomes among individuals you support since completing the training? (Select all that apply)

☐ Increased willingness to seek help

☐ Improved engagement with mental health or substance use treatment
☐ Increased self-reported satisfaction or well-being
☐ Greater confidence or self-efficacy in navigating care systems
☐ Increased independence or self-advocacy
☐ Other (please specify): _____
☐ No noticeable changes
☐ Not applicable to my role

11) Please share any challenges and/or success stories you have faced when supporting this population since completing this training. (Open-ended)

12) We are considering adding a monthly community of practice around skill-building, resource sharing, and reflections around mental health and substance use. Would you be interested in attending those?

- Yes, in-person
- Yes, over Zoom
- Not at this time

Training Feedback

13) How satisfied are you with the training overall?

- Likert scale: 1 = Very dissatisfied, 2 = Dissatisfied, 3 = Neutral, 4 = Satisfied, 5 = Very Satisfied

14) Would you recommend this training to other direct services providers?

- Yes/No (If no, please explain)

15) What additional support or resources would help you apply what you learned in this program more effectively?

- Open-ended

BLUEPRINT

(December 2025)

By: Hilario Vazquez, MSW

Sober State, LLC

This Blueprint is funded by the Mental Health Services Act (MHSA) in partnership with the Department of Developmental Services. Westside Regional Center and Sober State, LLC are solely responsible for the content of this Blueprint. The Department of Developmental Services has not developed, reviewed, endorsed, or approved the contents of this Blueprint.

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MENTAL HEALTH SERVICES ACT (MHSA) "Substance Use Delivery Expansion Project": Peer Mentoring Program Substance Use Contracted Services with Westside Regional Center
CYCLE VI - FISCAL YEARS 23-24 THROUGH 25/26

MHSA: Peer Mentoring Program (PMP) Design

Program Goal: To provide recovery support though peer to peer mentorship by peers with lived experiences of intellectual and developmental disability (IDD) and substance use disorder (SUD) aimed at increasing self-efficacy, belonging and connection, self-confidence, and access to community resources.

1. Description of service (Peer Mentoring Program) emphasizing substance use and mental health treatment needs of participants.

   The Peer Mentoring Program (PMP) at Sober State, LLC. is designed to meet the unique substance use and mental health needs of individuals with intellectual and developmental disabilities (IDD) who are experiencing, or are at risk for, substance use disorder (SUD). The program integrates evidence-based therapeutic practices to strengthen participants' self-efficacy, sense of belonging, and self-confidence. Through structured education on substance use treatment and prevention, participants gain the knowledge and skills necessary to effectively mentor their peers.

   To support engagement and motivation, the PMP incorporates an incentive system that reinforces cooperation, pro-social behavior, and consistent participation. Both mentors and mentees complete pre- and post-program evaluations to measure progress, identify growth areas, and assess overall program impact. Program staff continuously monitor outcomes, maintain fidelity to the model, and ensure high-quality service delivery.

   Clear, measurable objectives guide all interventions and are reviewed regularly by subject matter experts and the Grant Advisory Council to promote ongoing program refinement and improvement. The PMP is designed not only to address immediate recovery needs but also to enhance social connectedness and strengthen linkages to local recovery and community support resources. Through structured training, ongoing support, and supervised practice, participants have the opportunity to advance into peer mentor roles and engage in meaningful peer-delivered outreach as part of their recovery and community integration journey.

2. Summary of the training curriculum and therapeutic approaches/methodologies utilized (i.e., CBT/MI). Include description of how to incorporate trauma-informed approaches to emphasize safety, trustworthiness, choice, collaboration, empowerment, and cultural competence.

   The training curriculum is a combination of group structures used in various evidenced based curricula: *Living in Balance, SAMHSA-Matrix, SAPC-Healthy Youth, Mindfulness for SUD, and DBT*. These curricula draw upon established practices, strategies, and research in behavioral risk-reduction interventions associated with health-promotion behavior change including cognitive behavioral therapy (CBT) and motivational interviewing (MI) techniques. Therapeutic approaches include psychoeducation and experiential learning. Incorporating trauma-informed approaches into substance abuse treatment involves using a bio-psycho-social screener form to identify past trauma as a risk factor to create a safe process for managing participant issues that may arise during their participation. Additionally, using trauma informed approaches promotes empowerment by validating experiences and supporting participants in their recovery journey. Cultural competence is also integral, ensuring sensitivity to diverse backgrounds and experiences, thus making the program more relevant and effective.

3. Education approaches for substance abuse treatment and prevention to prepare program participants to mentor their peers (e.g. Mentor vs. Menteer, step program, etc.)

   Counselors assist participants to mentor their peers through pre-group consultation where they can discuss roles, group structure, guidelines, interests, potential barriers, accommodations, and general expectations. Education is also provided in group format through a structure recovery community format. Group facilitation and leadership is the primary function of mentors. Mentor's secondary function is to provide one-on-one support to their assigned mentee via telephone outside of group. Mentee's primary function is to manage assigned service commitments such as group set up, snack table preparation, whiteboard group preparation, and clean up. Commitments are voluntary and chosen by mentees while they work towards advancing to a Mentor role. For more information on the Mentor advancement requirements, group structure, format, and content. Please see the PMP Curriculum.

4. Length of service (frequency and length of meetings/sessions)

Individual participant length of service is open to the duration of the grant. Groups at held weekly for a one-hour duration and an outing once a month without time limit (typically 2-3hrs).

Individual commitments such as where Mentor status has been sustained can last one year, thereafter a PMP “Alumni” status will be assigned with continued program involvement.

5. Staff to client/individual ratio

   PMP Staff are Sober State registered/certified drug and alcohol counselors with a ratio of 1 staff for up to 6 participants.

6. Location of service

   11930 Hawthorne Blvd,
   Hawthorne, CA 90250

7. Hours of operation

   The hours of operation for PMP are Tuesday’s 6-7pm. Those participants whose role requires them to arrive early or stay after will be encouraged to do so 30 minutes prior/after commencement e.g., greeters, set up, clean up, snacks etc. Outing hours vary depending on the event.

8. Describe plans to work collaboratively with others in a multi-agency, interdisciplinary configuration (e.g., other regional centers, courts, mental health systems, probation).

   The PMP welcomes participants from surrounding Regional Centers and works with those coming in with drug diversion mandates to provide a space for recovery to take place. Counselors maintain an active role in assisting participants with their long-term obligations whether it be court ordered, probation suggested, or voluntary. Sober State is dedicated to advocating for our client’s full recovery efforts.

9. Description of individuals to be served and entrance and exit criteria. Incentive systems to be used to promote cooperation and participation in the treatment and educational aspects of the services (i.e. include means to personalize the incentives, preference assessments to be done).

PMP entrance criteria:

- 18 years or older
- Commitment to living a healthy, sober lifestyle
- Individuals receiving Regional Center services.

There is no full exit criteria, all participants are free to participate in the program for the duration of the grant. When client sustain “Mentor” status for a year, they will graduate to “Alumni” status and will remain leaders of the recovery community.

Participants can earn incentives through their active engagement in PMP activities. Below are the requirements for incentives but are not limited to the following due to flexible adherence considering each individual’s ability:

Mentee to Mentor: Stage 1
Attend twelve (12) PMP groups.
Attend three (3) PMP outings.
Attend (5) AA/NA meetings.
Achieve a minimum of 30-days of sobriety at the 3-month mark (12 PMP groups)
Incentive: $100 gift card

Mentor maintenance: Stage 2
Attend twelve (24) PMP groups.
Attend three (6) PMP outings.
Attend five (10) AA/NA meetings.
Achieve a minimum of 90 days of sobriety at the 6-month mark (24 PMP groups)
Incentive: $200 gift card

Mentor to Alumni: Stage 3
Attend twelve (48) PMP groups.
Attend three (12) PMP outings.
Attend five (20) AA/NA meetings.
Achieve a minimum of 6 months of sobriety at the 1-year mark (48 PMP groups)
Incentive: $300 gift card

10. Define your referral and intake for PMP

Participants are referred by Regional Centers, community service providers, guardians, or self-referred and will need to provide PMP with a copy of their Regional Center Face Sheet to verify Regional Center eligibility pmp@sober-

state.com. The Face Sheet can be obtained from service coordinators or other direct service providers. PMP counselors verify eligibility and schedule an intake to enroll clients in PMP. During the intake process, PMP counselors go over the PMP Handbook which details program guidelines and expectations. Consent and photograph is obtained from participants and uploaded in HIPPA complaint electronic records system for safe guarding of client information, attendance, and evaluations.

11. Define roles of Peer Mentors

The following are average service commitments and its corresponding role:

Mentee: (1 - 3 months) The main goal for the Mentee is to learn about the coordination of the gatherings, including location, outreach, promotion, setup, preparation, format, and purpose. Additionally, Mentees will have the chance to serve in a role under the guidance of their Mentor. Certain service positions will be exclusively for Mentees, while others with more responsibility will be reserved for Mentors.

Mentor: (3-months to 1year) Mentors play a crucial role in leading PMP gatherings, ensuring the execution of meeting formats, assigning roles to mentees, and actively engaging all participants. During monthly staff-Mentor meetings, Mentors provide valuable input and ideas to enhance program effectiveness. Mentors play an essential role in guiding Mentees in their personal and professional growth within the program. Mentors will receive a complementary PMP shirt so that others can easily identify them.

Alumni: (1 year and beyond) Alumni are PMP graduates that like to be of service to the PMP group and remain part of the sober community.

12. Processes to reimburse mentors for working with mentees (e.g. stipends)

The plan is to incentivize participants based on consistent and active participation and role-modeling behavior towards their peers. Examples include books on personal development or recovery literature, journaling supplies to facilitate self-reflection, fitness equipment or gym memberships to promote physical well-being, art supplies for creative expression and therapy, and self-help resources such as meditation apps or relaxation tools. Additionally, participants can access items that foster a sense of belonging and connection, such as group activity materials, tickets to cultural events or outings, or memberships to community organizations. These items not only serve as tangible rewards but also empower participants to take ownership of their

recovery journey, strengthen their sense of community, and build confidence in their abilities. That can help increase self-efficacy, belonging, and improve self-confidence.

13. Program supervision (emphasize the peer mentoring supervision component)

Continual professional oversight is a priority within the program which means staff is always present during PMP gatherings. Staff members also participate in regular weekly case consultations for the identification of any issues or concerns regarding any participant, ensuring that the PMP maintains an appropriate standard of care. In addition, professional development training opportunities and requirements are already built into the job descriptions for each direct service staff for special incidents.

14. Ongoing training and support plan for Peer Mentors

A plan for support at the group level for Mentors will aid our efforts in providing ongoing support and training. This is a monthly meeting that consists of a discussion to address barriers and challenges allowing for peer input.

15. Invoicing procedure for the MHSA startup funds and updated budget

Invoicing is provided using an initial budget breakdown for the start-up funds through Sober State's fiscal department. Ongoing monthly updates ensure the responsible managing to support the PMP for its proposed duration and thereafter as well.

Program Outcomes

1. **Self-Efficacy Improvement:**
   - **Objective:** Increase participants' belief in their ability to overcome challenges related to substance abuse.
   - Measurable Outcome:
     - Conduct pre-and post-program surveys using a validated self-efficacy scale to measure changes in participants' confidence in managing substance use issues.
       - Percentage increase in self-efficacy scores measured through pre- and post-program assessments using a validated self-efficacy scale.
       - Number of participants setting and achieving personalized, substance-use-related goals during the program.
2. **Belonging and Connection**:
   - **Objective:** Enhance participants' sense of belonging and connection within the peer mentor program.

- Measurable Outcome:
    - Administer pre-and post-program surveys to assess participants' feelings of social connectedness, utilizing a Likert scale or open-ended questions to capture qualitative data on perceived changes.
        - Increase in reported feelings of social connectedness among participants, measured through pre-and post-program surveys using a Likert scale.
        - Number of peer support group activities attended by participants, reflecting engagement and connection.

3. **Self-Confidence Enhancement:**
   - **Objective:** Improve participants' self-confidence in maintaining a substance-free lifestyle.
   - Measurable Outcome:
    - Track participants' self-reported confidence levels through regular check-ins or surveys, focusing on their ability to resist substance use and utilize coping strategies when faced with challenges.
        - Percentage increase in self-confidence scores measured through pre-and post-program assessments focusing on coping with triggers and challenges.
        - Number of participants reporting increased confidence in making positive lifestyle choices related to their recovery.

4. **Skill Development:**
   - **Objective:** Enhance participants' skills in coping with stress, managing triggers, and making positive lifestyle choices.
   - Measurable Outcome:
    - Use pre-and post-program assessments to evaluate participants' acquisition of specific coping skills, stress management techniques, and healthy decision-making abilities.
        - Percentage increase in participants' self-reported mastery of specific coping skills and stress management techniques.
        - Number of participants demonstrating the use of learned skills in real-life situations, such as avoiding relapse triggers.

5. **Retention in the Program**: (attendance)
   - **Objective:** Ensure sustained engagement and participation in the peer mentor program.
   - Measurable Outcome**:**
    - Monitor the retention rate of participants throughout the program duration, identifying factors contributing to any dropouts and implementing strategies to address them
        - Retention rate of participants throughout the program duration, measured by the percentage of participants who complete the program
        - Identification and analysis of factors contributing to dropout or disengagement, with subsequent adjustments to the program based on feedback.

6. **Qualitative Feedback**:

- **Objective:** Gather qualitative insights on the overall impact of the program using part- 3 of the evaluation tool.
- Measurable Outcome:
    - Conduct interviews or focus group sessions with participants to obtain in-depth feedback on the development of the program, their experiences, identifying specific aspects of the program that contributed to their self-efficacy, sense of belonging, and self-confidence.
        - Themes identified from participant interviews or focus group sessions highlighting perceived improvements in self-efficacy, belonging, and self-confidence.
        - Anecdotal evidence showcasing specific instances where participants successfully linked to local recovery groups and experienced positive outcomes.
        - Themes related to client satisfaction with program and mentor/mentee relationship.

7. **Linkages to Local Resources**: (facilitate/attend health fair/conference); (12-step attendance cards)
- **Objective**: Facilitate connections between participants and local recovery groups and resources.
- Measurable Outcome:
    - Track the number of participants who attend local recovery group meetings or events and collect feedback on the relevance and effectiveness of these connections in supporting their recovery journey.

Participant Outcomes

- Participants will demonstrate a 60-70% increase in knowledge about substance use, harm reduction strategies, and coping skills.
- 60-70% of participants will report a reduction or elimination of substance use by the end of the program.
- Participants will demonstrate a 60-70% increase in self-efficacy and motivation to change their substance use behaviors.
- Participants will demonstrate a 60-70% increase in knowledge about and access to local health and recovery support services.
- Participants will demonstrate a 60-70% reduction in mental health symptoms identified by the counselor (e.g., depression, anxiety) through the implementation of coping strategies.

Group Format

1) Introduction (Leader)

Welcome to the Peer Mentoring Program weekly meeting where we gather to share our experience, strength, and hope with each other so that we may learn healthier ways of living.

My name is _____and I am a PMP Mentor. For those who wish to join, let us begin with the **Serenity Prayer**:

"God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference."

To ensure a supportive environment, let's remember to **S.H.O.W. U. P**.:

- **S: Safety First** - No physical or verbal aggression.
- **H: Honor Privacy** - what's shared here stays here.
- **O: Only One Mic -** avoid speaking over each other.
- **W: Words Matter** - speak respectfully.
- **U: Use "I" Statements** - share from your own perspective.
- **P: Participate properly** - stay on topic and focus.

Thank you for respecting our **S.H.O.W. U. P**. policy.

Now, let's introduce ourselves stating your **first name and your role**, starting on my left:

(Participant/Staff introductions)

This meeting is dedicated to supporting the wellness and recovery of Regional Center clients. We aim to boost our own self-efficacy, foster a sense of belonging, and build up our self-confidence. We achieve this by discussing life topics, practicing social skills, and engaging in fun substance free activities together.

Now it's time for **Staff Announcements**

2) Staff Announcements (Staff)

Staff shares important information regarding outings, introduction of new members, any information that may be needed to inform the group.

Lesson of Week (Staff)

My name is _____and I am a PMP Staff and I have today's lesson of the week.

(Psychoeducation section)

Thank you for letting me be of service. I will now turn it over to Mentors for the Word and Question of the Week.

3) Word & Question of the Week (Mentor)

My name is _____and I am a PMP Mentor, and I have today's Word and Question of the Week.

The Word of the Week is: (Read word and the definition).

(See word of the day and definition)

Today's Question of the Week is _____

(See question of the week)

I will go first and then I will pick some people to share.

Is there anyone else who would like to answer the Question of the Week?

Thank you for letting me be of service**. I will now turn it over to Staff** for the Coping Skill of the Week.

4) <u>Coping Skill of the Week</u> (Staff)

My name is _____, PMP Staff. In this section, we will learn a new coping skill to help us deal with difficult situations in a healthy way. Does anyone remember last week's coping skill, and did you use it? (Pick some people to share).

(if no one remembers say: "Last week's coping skills was…")

Is there anyone else who would like to share how they handled a difficult situation with a different coping skill they learned?

Thank you to those who shared. **The new skill we will learn today is...**

(See coping skill of the week.)

Thank you for letting me be of service. Now, a Mentor will take us through Getting Honest.

5) <u>Getting Honest</u> (Mentor)

My name is _____and I am a PMP Mentor. Getting Honest is a time to take accountability for relapses, risky behavior, or inappropriate conduct. In this section the audience does not clap, we only say *"Thank you for being honest"*. Who would like to Get Honest? (**We don't pick people in this section**)

Thank you to those who took accountability, now time for Shout-Outs!

6) <u>Shout-Outs!</u> (Mentor)

My name is _____and I am a PMP Mentor. Shout-Outs! is our chance to show others our appreciation.

Would anyone else care to give a Shout-Out! to someone?

That all the time we have for Shout-Outs! now time for Meaningful Milestones!

7) Meaningful Milestones (Mentor)

Hello, my name is _____and I am a PMP Mentor. We acknowledge meaningful milestones at this meeting starting with clean and sober time.

Does anyone want to share their clean and sober time?

Now would anyone like to share something else they are proud of?.

Congratulations to all the milestones, now time for the Quote of the week.

8) Quote of the Week

My name is _____and I am a PMP Mentor, and I have today's Quote of the Week. (**read quote**) I will go first and then I will pick some people to share their thoughts on the quote?

(If time turn it over to staff for the activity) or (back to the leader)

9) Activity (optional if time)

10) Closing

That concludes are PMP group meeting for the week. I hope you have found it useful to hear from your peers and staff. Let's take a moment to thank everyone who shared.

Thank you again for attending today's PMP group meeting. Next week we will have new topics to help us grow and teach us how to live good lives. Can I see the hands of the cleanup crew (thank you) and can I see the hands of some people willing to help (thank you).

We will now close the meeting with the **Serenity Prayer:**

"God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference."

Overview of Format Segments

The PMP group meeting format effectively integrates evidence-based practices, providing a structured and supportive environment for adults in recovery with disabilities. The incorporation of CBT, MI, Mindfulness, and psycho-education, along with elements from 12-step programs, offers a comprehensive approach to recovery and personal growth.

Therapeutic Techniques, Theories/EBP, and Similarities to 12-Step Programs:

1) Introduction (Leader)

- **Therapeutic Techniques:**
  - Serenity Prayer: Spiritual reflection.
  - Safety Guidelines (S.H.O.W. U. P.): Establishes structure and safety.
  - Introductions: Personal connection and community building.
- **Theories/EBP:**
  - CBT: Respectful communication and responsibility.
  - Person-Centered Therapy: Safe, non-judgmental space.
  - Mindfulness: Present-moment awareness.
- **Similarities to 12-Step Meetings:**
  - Serenity Prayer and confidentiality.
  - Emphasis on respect and safety.

2) Staff Announcements (Staff)

- **Therapeutic Techniques:**
  - Information Sharing: Keeps participants engaged and informed.
  - Psycho-education: Enhances understanding of substance abuse and refusal skills.
- **Theories/EBP:**
  - CBT: Understanding consequences and healthier coping.
  - MI: Encourages personal motivation.
  - Psycho-education: Knowledge empowerment.

    - Social Learning Theory: Learning through observation and interaction.
- **Similarities to 12-Step Meetings:**
    - Educational components about addiction and recovery.
    - Emphasis on making healthier choices.

3) Word & Question of the Week (Mentor)

- **Therapeutic Techniques:**
    - Focused Sharing: Reflection and sharing experiences.
- **Theories/EBP:**
    - Narrative Therapy: Processing experiences through stories.
    - MI: Exploring motivations and challenges.
- **Similarities to 12-Step Meetings:**
    - Guided sharing and personal reflections.

4) Coping Skill of the Week (Staff)

- **Therapeutic Techniques:**
    - Skill-Building: Teaching and reinforcing coping strategies.
    - Sharing Successes: Reflecting on and sharing coping skill use.
- **Theories/EBP:**
    - CBT and DBT: Developing effective coping skills.
    - Mindfulness: Stress reduction techniques.
- **Similarities to 12-Step Meetings:**
    - Practical tools for managing challenges.

5) Getting Honest (Mentor)

- **Therapeutic Techniques:**
    - Accountability: Taking responsibility for actions.
    - Non-Judgmental Support: Encouraging honesty without repercussions.
- **Theories/EBP:**
    - Behavioral Therapy: Accountability and behavior changes.
    - Person-Centered Therapy: Supportive self-disclosure environment.

- **Similarities to 12-Step Meetings:**
  - Admitting mistakes and personal inventories.

6) Shout-Outs! (Mentor)

- **Therapeutic Techniques:**
  - Positive Reinforcement: Recognizing positive behaviors and achievements.
- **Theories/EBP:**
  - Positive Psychology: Building resilience through strengths.
  - Social Learning Theory: Reinforcement through social recognition.
- **Similarities to 12-Step Meetings:**
  - Acknowledgement of progress and achievements.

7) Meaningful Milestones (Mentor)

- **Therapeutic Techniques:**
  - Celebrating Achievements: Sharing and celebrating successes.
- **Theories/EBP:**
  - Positive Psychology: Recognizing progress.
  - Self-Determination Theory: Supporting intrinsic motivation.
- **Similarities to 12-Step Meetings:**
  - Milestone recognition and celebrations.

8) Quote of the Week (Mentor)

- **Therapeutic Techniques:**
  - Reflective Sharing: Discussing the meaning of the quote.
- **Theories/EBP:**
  - Narrative Therapy: Reflective prompts for personal stories.
  - Mindfulness: Promoting reflection and awareness.
- **Similarities to 12-Step Meetings:**
  - Inspirational readings for motivation and insight.

9) Activity (optional if time)

- **Therapeutic Techniques:**
  - Engagement: Interactive elements for learning.
- **Theories/EBP:**
  - Experiential Therapy: Learning through activities.
  - CBT: Practicing new skills and behaviors.
- **Similarities to 12-Step Meetings:**
  - Interactive elements (e.g., workshops).

10) Closing (Leader)

- **Therapeutic Techniques:**
  - Group Cohesion: Positive and inclusive ending.
  - Mindfulness and Reflection: Encouraging reflection through the Serenity Prayer.
- **Theories/EBP:**
  - Group Therapy Principles: Enhancing group cohesion.
  - Mindfulness: Reflection and acceptance.
- **Similarities to 12-Step Meetings:**
  - Closing prayer and reflection.

Goals of the Group Segments

1) Self-Efficacy Improvement

Objective: Increase participants' belief in their ability to overcome challenges related to substance abuse.

- **Staff Announcements:**
  - Refusal skills and interventions (No! Go! & No! Suggest Go!) empower participants to make healthier decisions, enhancing their belief in their ability to manage substance-related challenges.
- **Coping Skill of the Week:**
  - Learning and sharing new coping skills reinforces participants' belief in their ability to handle stress and triggers effectively.
- **Meaningful Milestones:**
  - Celebrating milestones (e.g., clean and sober time) reinforces participants' confidence in their ability to maintain progress.

2) Belonging and Connection

Objective: Enhance participants' sense of belonging and connection within the peer mentor program.

- **Introduction:**
  - Welcoming participants and establishing guidelines for respectful interaction helps create a safe and inclusive environment, fostering a sense of belonging.
- **Word & Question of the Week:**
  - Sharing personal experiences and reflections on the weekly word and question promotes connection and understanding among group members.
- **Shout-Outs!**
  - Recognizing and appreciating each other’s contributions and achievements strengthens the sense of community and belonging.

3) Self-Confidence Enhancement

Objective: Improve participants' self-confidence in maintaining a substance-free lifestyle.

- **Coping Skill of the Week:**
  - Gaining new coping strategies and sharing successful use of these skills boosts participants' confidence in their ability to handle difficult situations without substances.
- **Getting Honest:**
  - Encouraging accountability in a supportive, non-judgmental setting fosters self-awareness and confidence in personal growth.
- **Meaningful Milestones:**
  - Acknowledging achievements (e.g., reaching sobriety milestones) boosts participants' confidence in their ability to sustain a substance-free lifestyle.

4) Skill Development

Objective: Enhance participants' skills in coping with stress, managing triggers, and making positive lifestyle choices.

- **Lesson of the Week:**
  - Lessons on refusal skills and interventions (No! Go! & No! Suggest Go!) directly contribute to skill development in making positive choices and managing substance-related triggers.
- **Coping Skill of the Week:**
  - Introducing and practicing new coping strategies enhances participants' skills in managing stress and triggers.
- **Activity (optional if time):**
  - Engaging in activities that promote skill-building can help participants practice and reinforce new coping and decision-making skills.

Summary

By aligning specific goals with the relevant group segments, the PMP group meeting format effectively addresses the objectives of improving self-efficacy, fostering

belonging and connection, enhancing self-confidence, and developing essential coping and decision-making skills among adults in recovery with disabilities. The structured approach ensures that each segment contributes to the overall purpose of the program, creating a comprehensive and supportive environment for participants.

Group Date_____

Sample PMP Topic

Word: (A recovery concept or principle)

Definition: (simplified for people with IDD)

Question: (open-ended thought provoking)

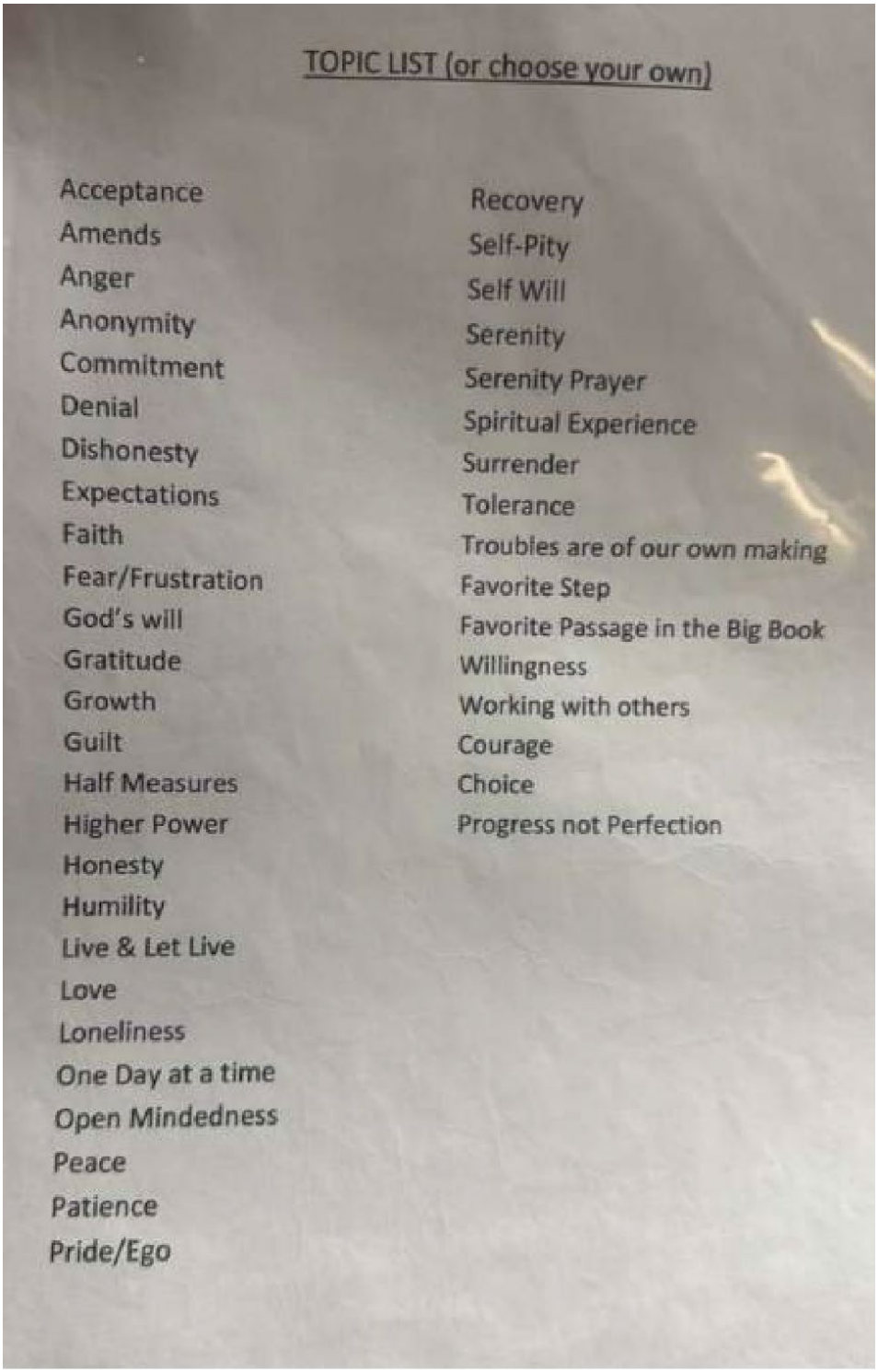
Lesson: (various SUD-related psychoeducation 10-15min lesson)

Coping Skill: (Seeking safety/DBT/Grounding)

Quote of the week: (relates to the word of the day)

Activity: (group focused for group bonding)

Sample Recovery Concepts/Principles



TOPIC LIST (or choose your own)

Acceptance
Amends
Anger
Anonymity
Commitment
Denial
Dishonesty
Expectations
Faith
Fear/Frustration
God's will
Gratitude
Growth
Guilt
Half Measures
Higher Power
Honesty
Humility
Live & Let Live
Love
Loneliness
One Day at a time
Open Mindedness
Peace
Patience
Pride/Ego
Recovery
Self-Pity
Self Will
Serenity
Serenity Prayer
Spiritual Experience
Surrender
Tolerance
Troubles are of our own making
Favorite Step
Favorite Passage in the Big Book
Willingness
Working with others
Courage
Choice
Progress not Perfection

Sample Coping Skills

DBT:

IMPROVE (Imagine, Meaning, Prayer, Relaxation, One Thing at a Time, Vacation, Encourage Yourself).

STOP (Stop, Take a Step Back, Observe, Improve Mindfully)

Grounding:

5,4,3,2,1 technique:

5 things you can see

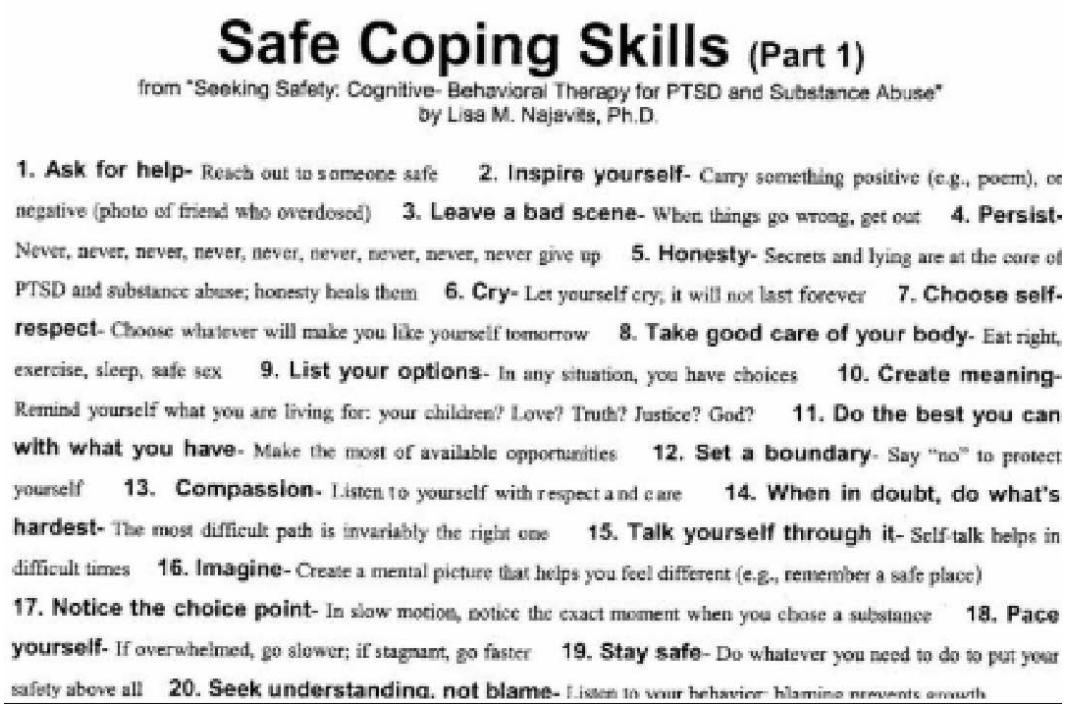
4 things you can touch

3 things you can hear

2 things you can smell

1 thing you can taste

Seeking Safety:



Safe Coping Skills (Part 1)

from "Seeking Safety: Cognitive- Behavioral Therapy for PTSD and Substance Abuse"
by Lisa M. Najavits, Ph.D.

1. Ask for help- Reach out to someone safe **2. Inspire yourself-** Carry something positive (e.g., poem), or negative (photo of friend who overdosed) **3. Leave a bad scene-** When things go wrong, get out **4. Persist-** Never, never, never, never, never, never, never, never, never give up **5. Honesty-** Secrets and lying are at the core of PTSD and substance abuse; honesty heals them **6. Cry-** Let yourself cry; it will not last forever **7. Choose self-respect-** Choose whatever will make you like yourself tomorrow **8. Take good care of your body-** Eat right, exercise, sleep, safe sex **9. List your options-** In any situation, you have choices **10. Create meaning-** Remind yourself what you are living for: your children? Love? Truth? Justice? God? **11. Do the best you can with what you have-** Make the most of available opportunities **12. Set a boundary-** Say "no" to protect yourself **13. Compassion-** Listen to yourself with respect and care **14. When in doubt, do what's hardest-** The most difficult path is invariably the right one **15. Talk yourself through it-** Self-talk helps in difficult times **16. Imagine-** Create a mental picture that helps you feel different (e.g., remember a safe place) **17. Notice the choice point-** In slow motion, notice the exact moment when you chose a substance **18. Pace yourself-** If overwhelmed, go slower; if stagnant, go faster **19. Stay safe-** Do whatever you need to do to put your safety above all **20. Seek understanding, not blame-** Listen to your behavior; blaming prevents growth

Sample Lesson Plans

Prescription medications vs over the counter Stimulants

Depressants

Hallucinogens

Inhalants Anger

Boredom

Negative peers

Special Events

Holidays

Internal triggers

External Triggers

Developing a support system

Step 1

Step 2

Step 3

Mentor Training Process Overview

1. **Mentee Phase:**
    - **Objective:** Participate in group meetings, develop group participation skills, and handle logistical commitments related to meeting setup.
    - Mentees assist with tasks such as preparing the room, organizing materials, and ensuring the meeting is ready to begin. They observe mentors during the facilitation of group segments, learning how meetings are led and structured.
    - **Key Focus:** Gaining familiarity with group dynamics, understanding mentor responsibilities, and developing an active presence in the group through participation.
2. **Observation & Preparation Phase:**
    - **Objective:** Learn from observing mentors as they facilitate group discussions and activities.
    - Mentees attend meetings regularly and observe the different facilitation styles of mentors. This gives them insight into effective leadership and group management skills.
    - **Key Focus:** Observing how mentors lead discussions, encourage participation, and manage group interactions.
3. **Commitment to Meeting Set-Up:**
    - **Objective:** Take responsibility for the practical aspects of group meetings.
    - Mentees are tasked with commitments such as setting up chairs, preparing meeting materials, and ensuring that the group environment is conducive to a productive session.
    - **Key Focus:** Building responsibility and ownership over essential group functions while learning about the structure and flow of meetings.
4. **Graduation to Mentor:**
    - **Objective:** Transition to a mentor role after mastering group participation and demonstrating reliability in handling commitments.
    - Once a mentee has completed the mentor requirements and has shown consistent participation and a strong understanding of group dynamics,

they may be considered for mentor training. At this stage, mentees begin to shadow current mentors, receive training on group facilitation, and prepare to co-facilitate group meetings.

- **Key Focus:** Preparing to lead, co-facilitate meetings, and support group members as a mentor.

Mentor Responsibilities

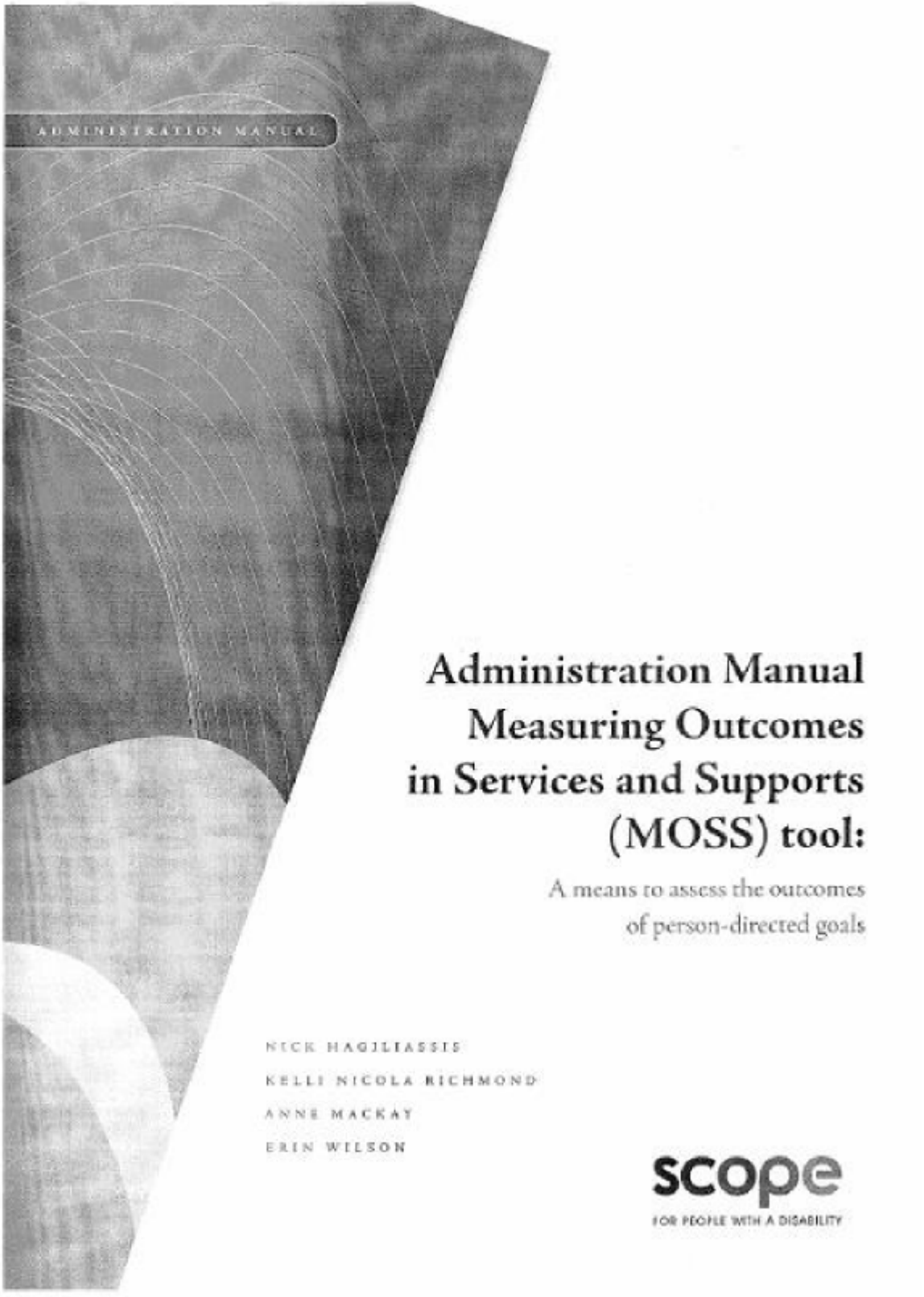
- **Co-Facilitation:** Mentors are responsible for co-leading group discussions and activities. This includes guiding all segments except the Staff Announcements, Lesson of the Week, and Coping Skill of the Week. Mentors also ensure that the meeting flows smoothly and that all participants have the opportunity to engage.
- **Supporting Participants:** Mentors serve as role models for group members, offering support and encouragement throughout the recovery journey.
- **Accountability:** Mentors help maintain the integrity of the group's principles, ensuring a respectful and productive environment for all participants.

Key Skills Developed Throughout Mentor Training:

- **Leadership:** Mentors learn to effectively lead group discussions, manage group dynamics, and encourage participant involvement.
- **Communication:** By co-facilitating meetings, mentors develop strong communication skills, including active listening, clear articulation, and respectful guidance.
- **Accountability:** Mentors uphold group rules, encourage accountability among participants, and model healthy behaviors.

By following this pathway, mentees transition from supportive roles within the group to active mentors capable of leading and supporting their peers in recovery.

Evaluation Tool Information



INTRODUCTION

The Measuring Outcomes in Services and Supports (MOSS) tool is an instrument for setting person directed goals and evaluating the outcomes associated with services and supports. It measures self rated 1) performance and 2) satisfaction levels prior to the delivery of a service and then again following service delivery. In this way, the roo! allows for tracking changes in association with a service or support. The MOSS was developed initially for use in the context of disability services, specifically at the level of therapy and psychology services. Through the course of its development it has become evident that the tool has application to a broader range of service environments and as such it has been reconfigured to have a much broader application. A key tenet of the tool is that it is person directed. That is, it allows for measurement of outcomes as identified by persons with a disability or service recipient, from their perspective. The tool has been developed primarily for use with adults with disability including people with communication and/or learning difficulties. It also has application for use when the 'client' is a group of people or an agency (e.g., when practitioners are providing services to a community organization). The background to the tool is described in Quilliam and Wilson (2011). This publication also provides a systematic review of selected measurement instruments against a set of criteria. These criteria relate to the type and level of outcome that is the focus, person-directedness, sensitivity, accessibility, ease of administration, and the extent to which tools allow for identification of enablers and barriers to goal attainment. This publication also sets out the set of criteria the MOSS tool was designed to meet.

Citation Hagiliassis, N., Nicola-Richmond, K., Mackay, A., & Wilson, E. (2011). Administration Manual- Measuring Outcomes in Services and Supports (MOSS) tool: a means to assess the outcomes of person-directed goals. Melbourne: Scope.

Evaluation Tool (Pre and Post Tests)

MEASURING OUTCOMES OF SERVICES & SUPPORTS (MOSS) TOOL

Client Name: _____ **ID:** _____

PRE-SERVICE GOAL-SETTING **Date:** _____

People Present:

- **Who is making the request?**
  - Person with a disability
  - Paid support person
  - Unpaid support person
  - Community representative

- **Whose needs are we meeting/whose capacity are we building?**
  - Person with a disability
  - Paid support person
  - Unpaid support person
  - Community representative

- **What is the request?** To participate in a **Peer Mentoring Program**.
- **Does PWD approve of this request?** (circle one) Yes or No.
- **Are there any key issues (e.g., sensitivities) around this request?**
- If so, specify:

Goals:

1. **Self-Efficacy Improvement:** To overcome challenges related to drugs/alcohol.
2. **Belonging and Connection:** Sense of belonging and connection within PMP.
3. **Self-Confidence Enhancement:** Confidence in maintaining a substance-free lifestyle.
4. **Skill Development:** Skills in coping with stress, managing triggers, and making positive lifestyle choices.

Notes:

Discipline(s) providing support: PT OT SP Psych Other_____

Client Name: _____ **ID: _____**

PART 1: PRE-SERVICE RATING **Date: _____**

Who is answering these questions?

- O Person with a disability
- O Paid support person
- O Unpaid support person
- O Community representative

1) Self-Efficacy Improvement (To overcome challenges related to drugs/alcohol.**)**

- **Question 1:** How good do you do it **now**?
  - O 5 Very Good
  - O 4 Good
  - O 3 Okay
  - O 2 Bad
  - O 1 Very Bad
- **Question 2:** How happy/satisfied are you with the way you do it **now**?
  - O 5 Very Happy/Satisfied
  - O 4 Happy/Satisfied
  - O 3 Okay
  - O 2 Unhappy/Unsatisfied
  - O 1 Very Unhappy/Unsatisfied

2) Belonging and Connection (Sense of belonging and connection to a group of peers**).**

- **Question 1:** How would you rate it **now**?
  - O 5 Very Good
  - O 4 Good
  - O 3 Okay
  - O 2 Bad
  - O 1 Very Bad
- **Question 2:** How happy/satisfied are you with the way you do it **now**?
  - O 5 Very Happy/Satisfied
  - O 4 Happy/Satisfied
  - O 3 Okay
  - O 2 Unhappy/Unsatisfied
  - O 1 Very Unhappy/Unsatisfied

3) Self-Confidence Enhancement (Confidence in maintaining a substance-free lifestyle.**)**

- **Question 1:** How would you rate it now?
  - 5 Very Good
  - 4 Good
  - 3 Okay
  - 2 Bad
  - 1 Very Bad
- **Question 2:** How happy/satisfied are you with the way you do it now?
  - 5 Very Happy/Satisfied
  - 4 Happy/Satisfied
  - 3 Okay
  - 2 Unhappy/Unsatisfied
  - 1 Very Unhappy/Unsatisfied

4) Skill Development (Coping with stress, managing triggers, and making positive lifestyle choices.**)**

- **Question 1:** How well do you do it now?
  - 5 Very Good
  - 4 Good
  - 3 Okay
  - 2 Bad
  - 1 Very Bad
- **Question 2:** How happy/satisfied are you with the way you do it now?
  - 5 Very Happy/Satisfied
  - 4 Happy/Satisfied
  - 3 Okay
  - 2 Unhappy/Unsatisfied
  - 1 Very Unhappy/Unsatisfied

Rating Tool Used (Circle One): Scale A: Scale B: Scale C:

Client Name: _____ **ID: _____**

PART 2: POST-SERVICE RATING **Date: _____**

Who is answering these questions?

- O Person with a disability
- O Paid support person
- O Unpaid support person
- O Community representative

1) 1) Self-Efficacy Improvement (To overcome challenges related to drugs/alcohol.**)**

- **Question 1:** How good do you do it **now**?
  - O 5 Very Good
  - O 4 Good
  - O 3 Okay
  - O 2 Bad
  - O 1 Very Bad
- **Question 2:** How happy/satisfied are you with the way you do it **now**?
  - O 5 Very Happy/Satisfied
  - O 4 Happy/Satisfied
  - O 3 Okay
  - O 2 Unhappy/Unsatisfied
  - O 1 Very Unhappy/Unsatisfied

2) Belonging and Connection (Sense of belonging and connection to a group of peers**).**

- **Question 1:** How would you rate it **now**?
  - O 5 Very Good
  - O 4 Good
  - O 3 Okay
  - O 2 Bad
  - O 1 Very Bad
- **Question 2:** How happy/satisfied are you with the way you do it **now**?
  - O 5 Very Happy/Satisfied
  - O 4 Happy/Satisfied
  - O 3 Okay
  - O 2 Unhappy/Unsatisfied
  - O 1 Very Unhappy/Unsatisfied

3) Self-Confidence Enhancement (Confidence in maintaining a substance-free lifestyle.**)**

- **Question 1:** How would you rate it now?
  - 5 Very Good
  - 4 Good
  - 3 Okay
  - 2 Bad
  - 1 Very Bad
- **Question 2:** How happy/satisfied are you with the way you do it now?
  - 5 Very Happy/Satisfied
  - 4 Happy/Satisfied
  - 3 Okay
  - 2 Unhappy/Unsatisfied
  - 1 Very Unhappy/Unsatisfied

4) Skill Development (Coping with stress, managing triggers, and making positive lifestyle choices.**)**

- **Question 1:** How well do you do it now?
  - 5 Very Good
  - 4 Good
  - 3 Okay
  - 2 Bad
  - 1 Very Bad
- **Question 2:** How happy/satisfied are you with the way you do it now?
  - 5 Very Happy/Satisfied
  - 4 Happy/Satisfied
  - 3 Okay
  - 2 Unhappy/Unsatisfied
  - 1 Very Unhappy/Unsatisfied

Rating Tool Used (Circle One): Scale A: Scale B: Scale C:

Client Name: _____ **ID: _____**

PART 3: POST-SERVICE RATING **Date: _____**

Who is answering these questions?

- O Person with a disability
- O Paid support person
- O Unpaid support person
- O Community representative

- **What is different about how you manage drug/alcohol problems compared to before PMP?**

  What are you doing/thinking/feeling that you weren't before?

  Have there been changes in the environment, resources, or other people connected to this goal?

  Did you achieve what you expected?

- **What is different about how you connect with others in recovery compared to before PMP?**

  What are you doing/thinking/feeling that you weren't before?

  Have there been changes in the environment, resources, or other people connected to this goal?

Did you achieve what you expected?

- **What is different about your confidence to stay clean and sober compared to before PMP?**

  What are you doing/thinking/feeling that you weren't before?

  Have there been changes in the environment, resources, or other people connected to this goal?

  Did you achieve what you expected?

- **What is different about how you cope (manage) with life stressors and triggers to drink or use compared to before PMP?**

  What are you doing/thinking/feeling that you weren't before?

  Have there been changes in the environment, resources, or other people connected to this goal?

  Did you achieve what you expected?

- **What things worked for you? What helped you achieve the 4 goals?** (People, activities, equipment/aids/resources, finances, environment, policies, time.)

  What else?

  What was the biggest help?

- **Did anything stop you from achieving the 4 goals? What made achieving the goals hard? (**People, activities, equipment/aids/resources, finances, environment, policies, time.

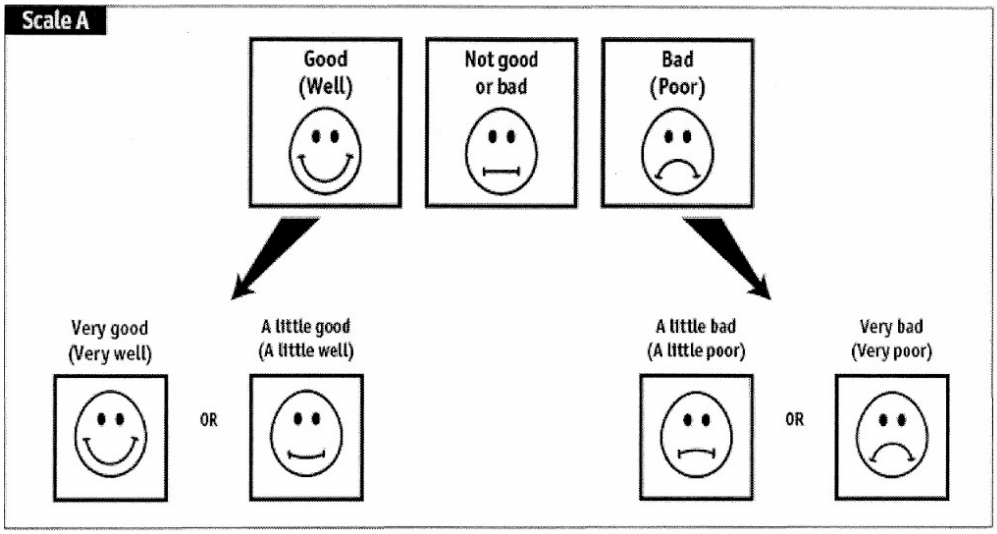
  What else?

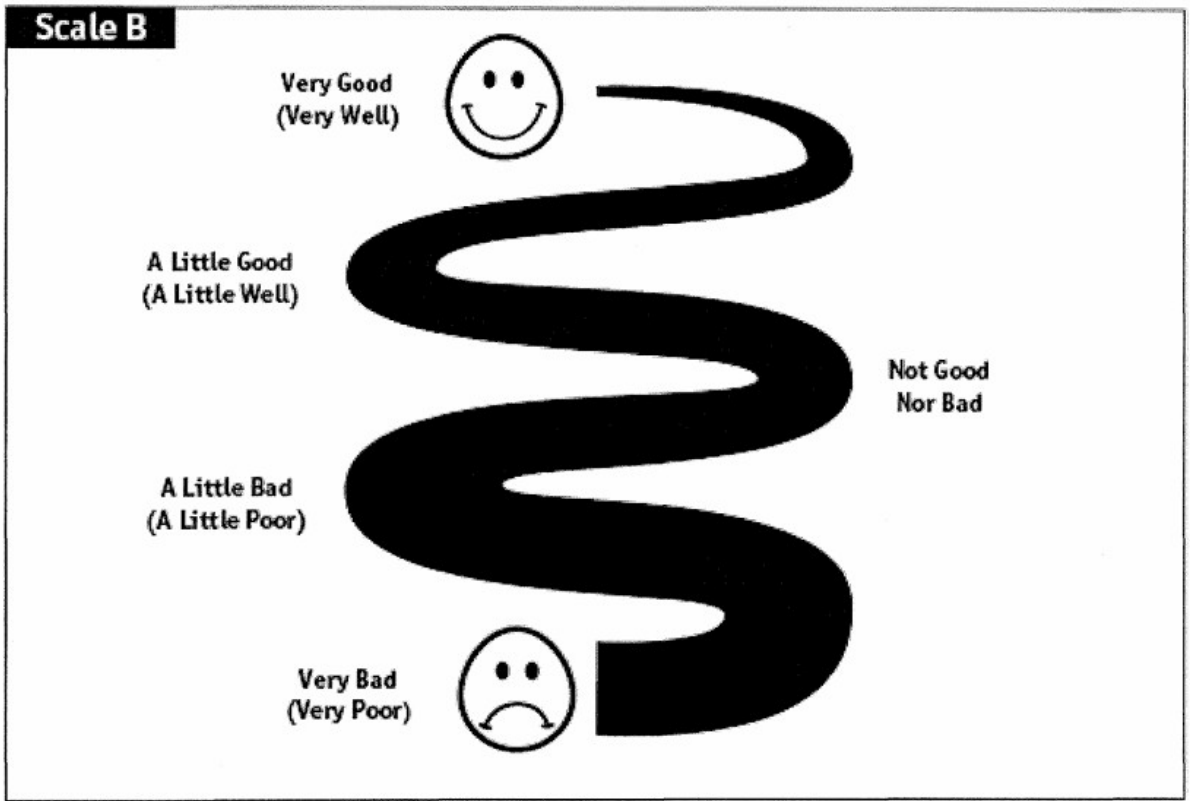
  Which of these was the biggest challenge?

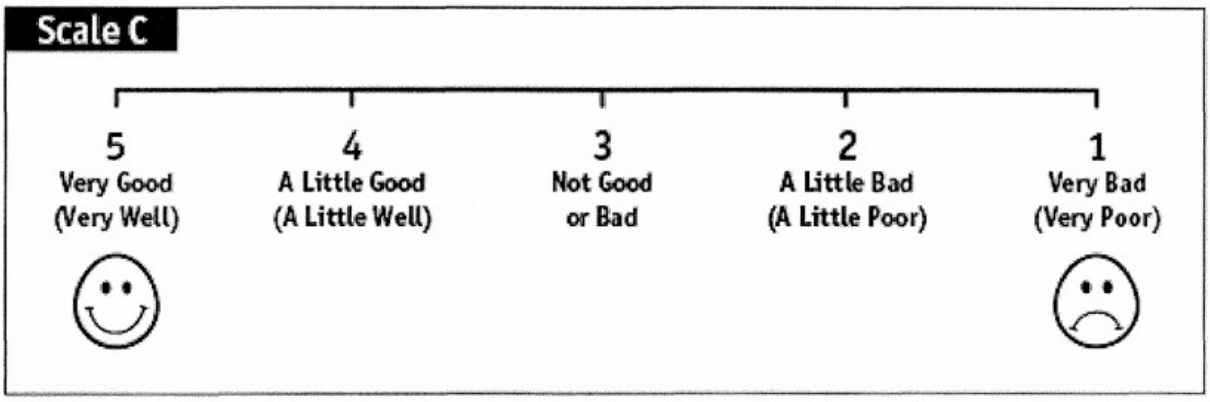
  Comments from person with a disability:

  Comments from others (please specify role, e.g. paid support worker, family):

Practitioner comments:






Scale C
5
Very Good
(Very Well)
4
A Little Good
(A Little Well)
3
Not Good
or Bad
2
A Little Bad
(A Little Poor)
1
Very Bad
(Very Poor)

Participant Handbook 2024

This handbook is funded by the Mental Health Services Act (MHSA) in partnership with the Department of Developmental Services. Westside Regional Center is solely responsible for the content of this presentation. The Department of Developmental Services has not developed, reviewed, endorsed, or approved the contents of this handbook.

OVERIVEW

The Peer Mentoring Program (PMP) offered by Sober State, LLC. is committed to fostering self-efficacy, sense of belonging & connection, self-confidence, the development of leadership skills among adults with intellectual/developmental disabilities (IDD) through education on substance abuse and healthy living practices.

The program includes group meetings and sober leisure activities/outings designed to support recovery, encourage social connections, and provide access to additional local recovery groups and community resources.

PARTICIPANT ELIGIBILITY

To participate in PMP, participants must meet the following criteria:

- 18 years or older
- Commitment to living healthy, sober lifestyle.
- Current Regional Center clients
    - Participants will need to provide PMP with a copy of their Face Sheet (ask your service coordinator to email it to pmp@sober-state.com

PROGRAM DETAILS

Weekly Meetings: Weekly group meetings are the foundation of the PMP program. During this time, participants are given the opportunity to Weekly Meetings foster safety and trust by creating a structured process for disclosure and handling of sensitive information. Additionally, this approach promotes empowerment by validating experiences and supporting participants in their recovery journey. Cultural competence is integral, ensuring sensitivity to diverse backgrounds and experiences, thus making the program more relevant and effective.

Weekly Meeting Location & Time:

Tuesday's 6-7pm

11930 Hawthorne Blvd

Hawthorne, CA 90250

Participants with commitments are encouraged to plan for approximately 30 minutes extra before or at the end of the meeting. Examples of such commitments include greeters, setup and cleanup crew, etc.

Monthly Group Outings: PMP organizes monthly group outings to enhance participants' social bonds, nurture their social skills, and bolster their confidence. Activities range from baseball games and museum visits to concerts and more. Eligibility to join these outings is determined by active participation in the program and/or the accumulation of Incentive Rewards points.

INCENTIVE GUIDELINES

Rewards Program: Participants can earn points through their active engagement in PMP activities. These points are redeemable for tangible rewards like gift cards, sports equipment, clothing, and more. It's important to note that rewards are not guaranteed without active involvement. Points can be earned through various means such as attendance, fulfilling service commitments, providing feedback, and more.

Mentee to Mentor: Stage 1
Attend twelve (12) PMP groups.
Attend three (3) PMP outings.
Attend (5) AA/NA meetings.
Achieve a minimum of 30-days of sobriety at the 3-month mark (12 PMP groups)
Incentive: $100 gift card

Mentor maintenance: Stage 2
Attend twelve (24) PMP groups.
Attend three (6) PMP outings.
Attend five (10) AA/NA meetings.
Achieve a minimum of 90 days of sobriety at the 6-month mark (24 PMP groups)
Incentive: $200 gift card

Mentor to Alumni: Stage 3
Attend twelve (48) PMP groups.
Attend three (12) PMP outings.
Attend five (20) AA/NA meetings.
Achieve a minimum of 6 months of sobriety at the 1-year mark (48 PMP groups)
Incentive: $300 gift card

SERVICE ROLES

Participants' duration of involvement will be determined by their level of active engagement in the PMP program. The following are average service commitments and its corresponding role:

Mentee: (1 - 3 months) The main goal for the Mentee is to learn about the coordination of the gatherings, including location, outreach, promotion, setup, preparation, format, and purpose. Additionally, Mentees will have the chance to serve in a role under the

guidance of their Mentor. Certain service positions will be exclusively for Mentees, while others with more responsibility will be reserved for Mentors.

Mentor: (3-months to 1year) Mentors play a crucial role in leading PMP gatherings, ensuring the execution of meeting formats, assigning roles to mentees, and actively engaging all participants. During monthly staff-Mentor meetings, Mentors provide valuable input and ideas to enhance program effectiveness. Mentors play an essential role in guiding Mentees in their personal and professional growth within the program. Mentors will receive a complementary PMP shirt so that others can easily identify them.

Alumni: (1 year and beyond) Alumni are PMP graduates that like to be of service to the PMP group and remain part of the sober community.

Role of Staff

Sober State staff will help Mentors prepare for weekly meetings, group outings and support the placement of service commitment that best utilizes each person's strengths.

Staff support includes being present at all PMP gatherings, hosting meetings/training for service role participants and addressing the progress of the PMP program.

PROGRAM RULES AND MEETING GUIDELINES

The following rules and guidelines are designed to promote a safe community in which to begin the recovery process. When one individual fails to comply with these rules, the entire community can be affected. Breaking rules will result in consequences ranging from incentive points deductions to possible discharged from the program.

THE BIG TEN

1. All Participants are to treat each other and Peer Mentoring Program (PMP) staff with dignity and respect.
2. No verbal or physical violence against participants or PMP staff.
3. Physical violence includes pushing, shoving, or hitting others. Verbal violence includes making threats, yelling, using profanity and name-calling.
4. A threat of violence is just as serious as an act of violence. Damaging any participant's property or PMP's property is not tolerated.
5. No sexual interaction with other participants.
6. Participants are expected to participate in all program activities.
7. No use of alcohol or drugs.
8. Social, romantic/sexual, financial and sponsorship relationships between participants and staff are strictly prohibited.
9. Any collusion with any other participant(s) (e.g., bringing drugs on the premises, or using drugs/alcohol in the program, or other rules violation) is prohibited.
10. Acts of self-harm (e.g., cutting) or suicidal ideation, homicidal ideation/threats will be taken very seriously and the appropriate course of action will be imposed (e.g., referral for psychiatric evaluation, higher level of care, or law enforcement).

CONFIDENTIALITY

1. You have a responsibility to protect the privacy of other participants receiving services at PMP.
2. You are not allowed to talk outside the program about who is here or about what is said in group.
3. Staff are allowed to discuss you (what you do and say) with other employees only. This is sometimes necessary so they can provide more effective help. Staff will not acknowledge your presence here or discuss you with anyone other than PMP staff without your written authorization.

GENERAL COMMUNITY RULES

1. No sexually explicit items (video, DVD, magazines, toys of any kind, internet, etc.) are allowed at PMP activities. Any items of this nature will be confiscated and returned upon discharge.
2. Drug/alcohol addictive behavior (e.g., gambling, binging/purging, sexual acting out, etc.) is not permitted and will be addressed by staff.
3. No alcoholic beverages or drugs including cannabis are allowed in the participant's possession or on PMP site. All paraphernalia will be confiscated and disposed of.
4. No medications are allowed in the possession of participants at the facility, including non- prescription and herbal preparations unless special arrangement is made with staff for clinical reasons.
5. Smoking, vaping, eating, or drinking at the facility is only allowed in designated areas. Absolutely no vaping/smoking during PMP meetings.
6. No smoking/vaping, eating, or open beverages in the PMP transportation vehicles.
7. No cameras or recorders of any kind are allowed during the meeting.
8. No weapons of any kind are allowed.
9. Appropriate attire is required at all times, as specified under Dress Code.
10. Participants are liable for any damage caused to floors, walls, furniture, etc. If caught defacing private or public property

REGARDING VISITORS

Visitors are not allowed without PMP staff approval.

REGARDING MONEY

1. No participant is to lend another participant money at any time for any purpose.
2. There is to be no buying, trading, or business transactions with other participants.

REGARDING GROUPS AND OUTINGS

1. Participants are expected to be on time.
2. Participants should follow dress code (below) and wear closed-toe shoes in case of an emergency.
3. Participants are expected to remain in the group/outing for the duration of the group/outing.
4. No cell phone or other electronic device may be used during group time.
5. Transportation will only be provided to Participants with the expressed understanding that Participant hereby releases liability for any harm or injury incurred during transportation.

DRESS CODE

1. Appropriate dress is required at all times.
2. Any article of clothing displaying vulgar/offensive language, drug/alcohol paraphernalia/ gang implications not allowed.
3. Shoes and shirt are required at all times.
4. See-through clothing and low-cut tops are not allowed.
5. It is at the staff's discretion if they choose to redirect your attire.

EXCLUSIVE RELATIONSHIPS

1. Being in a relationship, especially a romantic or physical one, can mess up your progress in the program.
2. After quitting drugs or alcohol, feeling empty and confused is normal, and seeking comfort in romance can be risky because it might stop you from asking for help.
3. Instead of focusing all your time and energy on just one relationship, it's better to spend time with all your friends.

PARTICIPANT GRIEVANCE PROCEDURE

It is the policy of Sober State, LLC to resolve any grievance matter in an expeditious and efficient manner the following steps outline the process used to resolve grievances:

Step One:
The aggrieved Participant shall present the grievance verbally to their counselor. If the counselor is the focus of the grievance, the procedure will move to the next step. Participant shall state that the grievance is official and formal. The program supervisor will attempt to resolve the problem. In any event, she or he shall record the grievance statement and respond in writing within five working days from the date of verbal grievance.

Step Two:
If the grievance is not settled in step two, the CEO shall offer to convene a meeting with the aggrieved participant and the program supervisor within ten working days to see if they can reach an acceptable solution.

Step Three:
In the event that the Participant is not satisfied by the proposed resolution by the CEO, the Participant can exercise the right to notify the **WESTSIDE REGIONAL CENTER** of the unresolved grievance at the following:

Westside Regional Center

777 S. Aviation Boulevard

Suite 105, El Segundo, CA 90245

(310) 258-4000 FAX: (310) 649-1024

www.westsiderc.org

Step four:

In the event that the Participant is not satisfied by the proposed resolution by the Westside Regional Center, the Participant can exercise the right to notify the **California Department of Developmental Services** of the unresolved grievance at the following:

Department of Developmental Services

Department of Developmental Services telephone number: (916) 654-1987

https://www.dds.ca.gov/general/appeals-complaints-comments/early-start-complaint-process/

I have read the PMP Program Rules and Meeting Guidelines and understand that any violation may result in the termination of my ability to participate in the program. ____

I understand I have no financial, legal, or moral obligations to participate in PMP. ___

I understand that I can leave the program at any time and after an absence from activities of 30 consecutive days or more my participation in the group will be considered a voluntary termination. ____

PMP Flyer

PMP
PEER MENTORING PROGRAM

11930 Hawthorne Blvd,
Hawthorne, CA 90250

Experience our Peer Mentoring Program (PMP) for adults with disabilities in recovery! Join a supportive community focused on sober & substance-free living. Gain support from a mentor and journey together towards becoming a mentor yourself!

Eligibility

- Adult 18+ in recovery
- Client of a local Regional Center
- Desire to live clean and sober!

sober-state.com

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FREE TO JOIN

PEER MENTORING PROGRAM

What You'll Get

- Leadership Training
- Weekly Group Meetings
- Monthly Sober Outings
- Community Resources
- And much more!

SIGN UP

For More Information email or call us!
pmp@sober-state.com

Sober State
424-269-0076