

Substance Use Disorder Treatment For People With Physical and Cognitive Disabilities

Treatment Improvement Protocol (TIP) Series

29



Blue Lines FPO
(for spine positioning)

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29

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services

Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed

to facilities and individuals across the country. Published TIPs can be accessed via the Internet at <http://kap.samhsa.gov>.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills the Substance Abuse and Mental Health Services Administration's (SAMHSA's) mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until

they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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Executive Summary and Recommendations

Nearly one-sixth of all Americans have a disability that limits their activity; countless others have disabilities (mostly cognitive in nature) that go unrecognized and undiagnosed. The Americans With Disabilities Act (ADA) was signed into law in 1990 to ensure equal access to all community services and facilities, including substance use disorder treatment facilities both public and private, for all people regardless of any disability they might have. People who are blind, deaf, paraplegic, and who have arthritis, heart disease, human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), mental illness, and substance use disorders are among those covered under this legislation.

People with physical and cognitive disabilities are more likely to have a substance use disorder and less likely to get effective treatment for it than those without such a coexisting disability. There are already many people in treatment who have a coexisting cognitive or physical disability. But, as many still go untreated, the number of people with coexisting disabilities entering treatment can only be expected to rise. Treatment programs have a legal and ethical responsibility to make treatment for these clients as effective as possible.

The ADA states that both public and private facilities be equally accessible for all. The law

requires the installation of ramps, elevators, proper lighting, and usable doorknobs, and the removal of other physical obstacles, but accessibility means more. Barriers to communications must be removed; discriminatory policies, practices, and procedures eliminated; and attitudes changed in order to not hold a person's disability against him. Accommodating people with coexisting disabilities in treatment for substance use disorders entails such things as adjusting counseling schedules, providing sign language interpreters, suspending "no-medication" rules, and often, overcoming people's fears and ignorance. This TIP presents simple and straightforward guidelines on how to overcome barriers and provide effective treatment to people with coexisting disabilities.

The topic of substance use disorder treatment for people with coexisting disabilities is a broad one. In creating this Treatment Improvement Protocol (TIP), the Consensus Panel focused its attention on the needs of adults in treatment who had a coexisting physical or cognitive disability (including those disabilities also classified as "sensory" in nature). While people who have an affective disability (i.e., mental illness) are mentioned in the TIP, the reader is referred to TIP 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (CSAT, 1994), for more

detailed information concerning the assessment and treatment of these clients.

In order to avoid awkward construction and sexism, this TIP alternates between “he” and “she” for generic examples. Since substance use disorders are considered a disability under the ADA, when people in substance use disorder treatment are referred to in the TIP as having disabilities it is understood that they have “coexisting” disabilities.

The Consensus Panel for this TIP drew upon its considerable experience in both the disability services and substance use disorder treatment fields. Panel members included providers as well as consumers of these services. Because of a lack of substantial research on the particular needs of people with coexisting disabilities in treatment for substance use disorders, the Panel often relied on clinical experience to develop the recommendations provided here. In the summary of recommendations listed below, recommendations that are supported by research literature or legislation (i.e., the ADA) are followed by a (1); clinically based recommendations are marked (2). Citations supporting the former are given in Chapters 1 through 5.

Summary of Recommendations

This TIP is organized into five chapters, the first of which presents an overview of the issues involved in providing substance use disorder treatment for people with coexisting disabilities. It provides important definitions, relevant research findings, and a discussion of barriers to treatment for people with coexisting disabilities. The second chapter presents methods of screening for disabilities and ways in which substance use disorder treatment may need to be modified for people with coexisting disabilities. Chapter 3 discusses treatment planning and counseling, and gives specific

recommendations concerning how treatment can be modified to be most effective for people with specific disabilities. Information on forming and maintaining linkages with other service providers is provided in Chapter 4. The final chapter is aimed at program administrators and discusses issues such as staff training, funding mechanisms, marketing, and demonstrating an organizational commitment to working with people who have coexisting disabilities. The recommendations that follow are, however, grouped thematically and not according to the chapters in which they are found.

Making Accommodations To a Program

- Providers should examine their programs and modify them to eliminate four fundamental groups of barriers to treatment for persons with disabilities: attitudinal barriers; discriminatory policies, practices, and procedures; communications barriers; and architectural barriers. (1)
- *Accommodation* does not mean giving special preferences—it does mean reducing barriers to equal participation in the program. (1)
- When barriers cannot readily be removed, a program must find alternative methods to make its services available. (1)
- Staff training is key to overcoming most barriers to treatment, especially attitudinal barriers. Such training should be ongoing and comprehensive. All program staff should be trained in understanding functional limitations, the wide variety of conditions that lead to them, and the barriers that treatment-as-usual may present for persons with specific disabilities. Training should strongly encourage and reward staff members who find creative ways to adapt treatment procedures for people with coexisting disabilities. Because they are the initial points of contact, receptionists and

other support staff should receive special training to prepare them to respond knowledgeably and sensitively to people with coexisting disabilities. (2)

- If there is any doubt on the part of the provider regarding the legitimacy of a person's request for accommodation, a disability expert should be consulted to evaluate the request. (2)
- In general, it is beneficial and feasible to integrate people with coexisting disabilities into already existing community-based services used by nondisabled individuals recovering from substance use disorders. However, there are a number of exceptions to this rule. In instances where a legitimate, documented reason exists, specialized services may be necessary. (2)
- For clients who are blind or visually impaired, keep pathways clear and raise low-hanging signs or lights. Use large letter signs and add Braille labels to all signs and elevator buttons. Make oral announcements; do not rely on a bulletin board. (2)
- People who are blind or visually impaired will require assistance to orient themselves to a new environment. The treatment provider should give clients who are blind a complete orientation to the facility the first time they visit; the client can be guided by holding her arm just above the elbow and walking with her through the rooms, explaining where the doors, furniture, and other features are. (2)

Screening for Disabilities

- Because many disabilities are not obvious, it is important to screen for them in every person, not just those with obvious functional limitations. Ask all clients entering treatment whether they require any accommodations in order to participate. (2)
- It is the level of abilities and of the functioning of the individual—not the simple determination of whether an impairment

exists—that must be assessed if screening is to lead to an effective treatment plan. In situations where a diagnosis of disability is needed (e.g., to qualify for special services) treatment providers should refer the client to a disabilities services professional. (2)

- Although it is a good idea to get background information from as many sources as possible, interview the person alone, if possible. Having others present often distorts the quality of the interview. (2)
- Intake interviews should begin with an open and friendly question, not one that is focused on the person's disability. (2)
- An intake interview should address the eye condition and blindness adjustment skills of people who are blind or visually impaired. The counselor should ascertain the pathology of the loss of vision (if it was congenital, adventitious, or traumatic), and precisely how much vision remains. (2)
- If there are forms to be completed as part of intake processing, people who are blind must have the option to complete them in the medium of their choice (Braille, large print, audiocassette, or sighted assistance). Individuals who are both deaf and blind will need a tactile interpreter to translate for them during the admissions process and afterward. (2)
- Due to the wide range of reading abilities among people who are deaf, paper and pencil should never be utilized to gather detailed assessment information. Written English forms and questionnaires should be interpreted into sign language for these clients. (2)
- When screening people with cognitive disabilities, be as specific as possible—rather than asking if they “use alcohol,” ask if they like to drink beer, wine, wine coolers, etc. It may help to use props such as different glass or bottle sizes rather than asking how many ounces were consumed. (2)

Treatment Planning

- For treatment to succeed, all clients must understand the particular strengths that they can bring to the recovery process. A strengths-based approach to treatment is especially important for people with disabilities, who, because they have so frequently been viewed in terms of what they cannot or should not attempt, may have learned to define themselves in terms of their limitations and inabilities. (2)
 - It is key to the treatment planning process for the treatment provider to learn where a person with a disability is on the spectrum of understanding and accepting his disability. (2)
 - No treatment plan should be static, and treatment providers must continually evaluate and revise the treatment plan with assistance from clients with disabilities. Treatment plans should be flexible enough to take into account changes in a person's condition or new knowledge gained during treatment. Clients with traumatic brain injury, for example, often show a dramatic recovery curve over the year to two years following their accidents. (2)
 - An individual with a disability may also need to explore several methods for learning something or fulfilling a goal before an accomplishable approach to the situation can be identified and implemented. (2)
 - The treatment plan should document all alterations to the usual treatment procedures that are being made. If an approach does not work, the outcome should still be carefully documented to prevent duplication of effort by other programs in the future. Similarly, details of what is successful for a person should be documented, particularly for persons with cognitive disabilities who may not be able to tell future caregivers which treatments have been effective and why. (2)
- Documentation of all efforts at accommodation is needed to verify ADA compliance. (1)
- It is helpful to identify early on any needed exceptions to the routines of the treatment program for a person with a disability and to explain to other clients that the accommodations for a person with a disability simply give her the help she needs to meet shared goals. If the client does not object, the exceptions and the rationale for these exceptions should be discussed openly in group meetings. (2)
 - Behavioral contracts with people with coexisting disabilities may need to be more explicit than those with other people, and the consequences for relapses in particular may need to be specifically tailored to what the individual is realistically capable of achieving. (2)
 - People who are deaf or hard of hearing (and probably those with other disabilities as well) generally know less about addiction and recovery when they enter treatment than nondeaf (or nondisabled) people, and therefore they will often require lengthier treatment. Treatment providers should be prepared to allow for longer treatment times for clients with disabilities. (1)
 - It is essential that all clients participate in planning leisure activities, and programs with rigid approaches that exclude clients from such participation should consider changing their policies. (2)
 - If a person with a disability has limited transportation options, conduct individual counseling by telephone, go to the person's house, or meet at a rehabilitation center or other alternative site. The Consensus Panel recommends that providers make home visits if necessary, which may be reimbursable under case management services. (2)
 - For people with coexisting disabilities, failure to achieve treatment goals may indicate that

the treatment plan lacks the discrete steps necessary to meet those goals. In setting a goal, the client and the counselor must work closely to understand all the physical and cognitive requirements of meeting a goal. (2)

- Early in treatment, a medical professional should conduct an assessment of all the client's medications—both prescribed and over-the-counter, including herbs and vitamins. In addition, the Panel recommends that a single medical professional try to monitor the client's medication regimen. Under no circumstances, however, should other treatment staff advise clients to take or not to take particular medications, vitamins, or herbs. (2)
- Lack of employment may be a factor in substance abuse; conversely, addressing and overcoming barriers to employment, with the aid of collaborative partners, may greatly enhance the prospect for recovery and should be addressed as a component of treatment planning. (2)

Counseling

- Counseling session times should be flexible, so that sessions can be shortened, lengthened, or more frequent, depending upon the individual treatment plan. (2)
- For people with cognitive impairments, it is important to remember to ask simple questions; to repeat questions; and to ask the client to repeat, in her own words, what has been said. Discussions should be kept concrete. People with mental retardation or traumatic brain injury may not understand abstract concepts; they should be asked to provide specific examples of a general principle. (2)
- The use of verbal and nonverbal cues will help increase participation and learning for people with cognitive disabilities and make the group sessions run more smoothly for all. The counselor and the person with a

disability together can design the cues but should keep them simple, such as touching the person's leg and saying a code word (e.g., "interrupting"). (2)

- Clients with cognitive disabilities will often benefit from techniques such as expressive therapy or role-playing. (2)
- Assignments that require the use of alternative media in place of writing may work best with clients who have cognitive disabilities as well as those who are deaf. (2) Clients who are blind will need assignments translated into their preferred method of communication (e.g., Braille, audiotope), but no matter what method is used they will require more time to complete reading assignments. (1)
- Regardless of the model of communication used by the person who is deaf or hard of hearing, the visual aspect of communication will be important. Therefore, it is important to look directly at the person when communicating. This will allow him to try to read the lips of the counselor and to see her facial expression. (2)
- Interpreters should usually be provided for people who are deaf or hard of hearing. (1) The interpreter should be a neutral third party hired specifically to interpret for the counselor and the person who is deaf; a family member or friend of the client should not be used as an interpreter. Use only qualified interpreters as determined by either a chapter of the Registry of Interpreters for the Deaf or a State interpreter screening organization. (2)
- If a person who is deaf is using an interpreter, group members will need to take turns during discussions. When addressing a person who is deaf the counselor or group members should speak directly to the person as if the interpreter is not present. (2)
- When working with an individual with a physical disability, make certain that table

surfaces are the correct height, and in particular that wheelchairs can fit beneath them. Counselors should try to place themselves so that they are no higher than the client. They should be aware of the pace of the interview, and attempt to gauge when clients are becoming fatigued. Counselors should periodically inquire how the client is doing and offer frequent breaks. (2)

- People who use wheelchairs often come to regard the chair as an extension of themselves, and touching the chair may be offensive to them. Never take control of the wheelchair and push the person without permission. (2)
- For individuals with cognitive disabilities, providers must systematically address what has been learned in the program and how it will be applicable in the next stage of treatment or aftercare. Some people are very context-bound in their learning, and providers cannot assume that the lessons learned in treatment will be applied in aftercare. (2)
- In planning and providing treatment to people with disabilities, the importance of asking questions cannot be overemphasized. Asking before rendering any service is a basic principle. (2)

Linkages

- Coordination with an agency providing case management services for people with disabilities should be a priority if those services are not already being provided by the substance use disorder treatment program. Treatment plans for people with coexisting disabilities should address problems such as unemployment, a lack of recreational options, social isolation, and physical abuse because they are more likely than the general population to experience these situations. (2)
- Service linkages are essential to provide effective substance use disorder treatment for people with coexisting disabilities. (2)
- Treatment providers need to be able to identify what ancillary services are available for their clients, and be able to access those services and funding sources. (2)
- Since a client having a substance use disorder and a disability may also be in a physical rehabilitation or other disability program, treatment professionals should be aware of the various approaches used by these other programs, and know how to collaborate with them. The Panel recommends cross-training between vocational rehabilitation or other disability service providers and substance use disorder treatment providers to help treatment professionals understand the impacts of both disability and substance use disorders. (2)
- In developing partnerships with referring agencies, the treatment program should ensure, through interagency agreements, that mechanisms are in place for exchanging client information. (2)
- It is not unusual for services to be duplicated or ineffective when a case manager is not utilized, and so a substance use disorder treatment provider may need to either case manage these services or find another organization or person to do so. A case manager can be a strong advocate for a person with a disability and help her locate appropriate and accessible services. (2)
- A substance abuse counselor may not have the time or the expertise to work on all the issues that arise because of a client's disability. If that is the case, a referral to a peer counselor at a Center for Independent Living, whose job it is to help disabled individuals come to terms with the limits of their disabilities, may be in order. The two counselors can work together as a team. (2)

- The treatment provider should investigate whether accommodations will be made for a client with a coexisting disability before sending him to an aftercare facility. (2)

Organizational Commitment

- Providers must be prepared to act as advocates for their clients when services and supports that are normally readily available and effective prove inaccessible for the client. (2)
- When treatment teams make the effort to accommodate individuals with coexisting disabilities, the quality of care improves for all clients. All clients can get more out of treatment that is individualized and that takes their specific functional capacities and limitations into account. (2)
- To ensure full organizational support for treating people with coexisting disabilities, the Consensus Panel recommends that a treatment program develop a policy statement that articulates the program's willingness to accommodate any individual with a disability who chooses to attend the program. (2)
- When a program makes a commitment to serving people with coexisting disabilities, board membership of people with disabilities may be implemented immediately or considered as a goal to be reached as the program begins to serve a greater number of people from these groups. A program should try to obtain regular input from the community it seeks to serve; creating a permanent task force or an advisory committee is an ideal way to address this need. (2)
- The organization must make a commitment to continually reexamine the program's effectiveness for people with coexisting disabilities. Such inquiry can take place both formally, using quality assurance methods and consumer satisfaction surveys, and

informally, through opportunities for individual and group feedback with program staff. (2)

- It is not enough for a program simply to be ready to serve people with coexisting disabilities. Rather, the program should be proactive in making the disability community aware of its services to ensure that disability organizations will support referrals to the program. (2)
- Another sign of organizational commitment is to hire people with disabilities to work in the treatment program. Hiring people with disabilities also benefits other staff members, who can learn from these coworkers. (2)
- The Consensus Panel recommends an "open door" policy that states that all clients are entitled to an assessment if they are presenting with a chemical dependency problem, regardless of whatever other problems they may appear to have. If the proper course of treatment is not available at the facility, it is still possible to perform a substance use disorder assessment and refer the client for treatment elsewhere. (2)

Improving Treatment for All Clients

Treatment that is planned and provided on a case-by-case basis will benefit everyone, not just those clients with coexisting disabilities. All people have different functional capacities and limitations, and an evaluation of these, as described and encouraged in this TIP, will help providers focus on individual needs. This TIP explores the treatment needs of people with particular types of disabilities, but the processes of assessment and evaluation it suggests can help all clients gain greater benefit from treatment.

There is a growing belief in the substance use disorder treatment field that treatment is more successful if it can respond to all the needs of an

individual, not just the need to stay away from alcohol and drugs. If treatment is to succeed for a client with a coexisting disability, a wide range of services may be required. For this reason, this TIP strongly encourages the use of case management services and service linkages. The TIP also aims to educate people in both the

disability services and substance use disorder treatment fields concerning the problems faced by people who have both a substance use disorder and a coexisting disability. A better understanding of the needs of these clients and the services available to them can be gained through reading this TIP.

1 Overview of Treatment Issues

In 1990, it was estimated that 36.1 million people in America (14.5 percent of the population) had a disability that limited their functioning in some manner (LaPlante, 1992). A great number of people with disabilities have struggled for years with barriers to employment, inaccurate and hurtful stereotypes, and inaccessible community services. In order to redress these barriers that affect millions of Americans, President Bush in 1990 signed into law the Americans With Disabilities Act (ADA), the most significant civil rights legislation in two decades. The legislation prohibits discrimination on the basis of disability, including substance use disorders (See Figure 1-1), and guarantees full participation in American society, including access to community services and facilities, for all people with disabilities. It makes provision for many accommodations that may be necessary in substance use disorder treatment, such as the use of large print materials, reading services, attended care, adaptive equipment such as listening devices, and flexible schedules to accommodate different physical needs. Because of this legislation, many people today are more aware of the problems faced by people with physical and cognitive disabilities.

Though the ADA is correcting the situation, many people with disabilities remain stigmatized and shut out. They are also at much higher risk than the rest of the population for substance abuse or dependence. A study of adult males receiving treatment for alcoholism,

for instance, revealed that 40 percent had a history indicative of learning disabilities (Rhodes and Jasinski, 1990). Another study indicated that at least one half of persons with a substance use disorder and a coexisting disability are not being identified as such by the systems providing them services (Rehabilitation Research and Training Center on Drugs and Disability [RRTC], 1996).

New York State maintains within their Office of Alcoholism and Substance Abuse Services (OASAS) some of the most comprehensive records in the country on substance use disorder services for persons with disabilities. The OASAS client services statistics for 1997 showed that of 248,679 clients served by licensed facilities in New York, a total of 55,719 (or 22.4 percent of the total clientele) were recorded as having a coexisting physical or mental disability. Of these clients, 58.9 percent had a disability not related to mental illness (e.g., mobility impaired, visually impaired, deaf) (OASAS, 1998). These records were generated by treatment staff personnel who were not necessarily trained in disability assessment or by client self-reports, which suggests that some disabilities (e.g., traumatic brain injury [TBI], learning disability, attention deficit/hyperactivity disorder [AD/HD]) may be greatly under-reported. Given that these “hidden” conditions affect more than half of all special education students, coexisting disabilities may actually affect up to 40 percent

Figure 1-1 Substance Use Disorders as a Coexisting Disability

Chemical dependency is called a disability and covered as such under the provisions of the Americans With Disabilities Act (ADA). Substance abuse is an illness that frequently results in serious functional limitations or death when not properly treated. If an individual has both a substance use disorder and a physical or cognitive disability, then he is really coping with coexisting disabilities. However, for the purposes of this Treatment Improvement Protocol (TIP), the term “disabilities” will refer to physical and cognitive disabilities and *not* substance use disorders. When the TIP refers to a person with a “disability,” therefore, it should be understood that it is a coexisting disability.

of all clients served by substance use disorder treatment programs.

Yet despite the prevalence of substance use disorders among people with disabilities, these individuals are less likely to enter or complete treatment (de Miranda and Cherry, 1989; Kirubakaran et al., 1986; Helwig and Holicky, 1994; Schaschl and Straw, 1989). This is because physical, attitudinal, or communication barriers often limit their treatment options or else render their treatment experiences unsatisfactory.

Fortunately today, substance use disorder treatment providers are better able to face the challenges of accommodating people with coexisting disabilities because they have already had the experience of making treatment modifications for other constituencies. Over the past decades, the substance use disorder treatment field has matured through the challenges of treating populations with specific needs, such as women, adolescents, people from various racial and ethnic minority groups, and gay men and lesbians. The effectiveness of treatment has improved as a result—it has become more developmentally and culturally specific, flexible, and holistic. Rather than placing a person in an established treatment “slot,” treatment providers are learning the importance of modifying and adapting services to meet an individual client’s needs. Thus, the knowledge and skills necessary to adapt a treatment program to meet the needs of people

with coexisting disabilities are a logical extension of existing principles.

Disabilities can be classified as physical, sensory, cognitive, or affective (see Definitions section below). This TIP addresses the problems that may arise when treating people with the first three types; providers treating people with affective impairments (often called dually diagnosed persons) are referred to TIP 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*. This TIP targets substance use disorder treatment providers with little or no experience treating people with physical, cognitive, or sensory disabilities. These providers may be prompted to address disability issues because of the ADA, or perhaps they are treating their first-ever client with deafness, TBI, spinal cord injury, or another disability. This TIP will help them screen, assess, refer, and treat this large and underserved population.

Definitions and Terminology

Physical and cognitive disabilities are very sensitive topics for discussion and providers need to pay attention to the language they use to discuss this issue. Appendix C presents specific guidelines on how to refer to persons with disabilities in a respectful, sensitive manner. As

a general rule, one should always put people first, before their disabilities, referring to “persons with disabilities” rather than “disabled people.” One should never refer to the disability in place of the person (not “the retarded” but rather “people who are retarded”). Nor should one call a person with a disability a “patient” or “case,” unless it is to refer to his relationship with his doctor.

Disabilities

Diseases, disorders, and injuries, whether congenital or acquired, can have various effects on organs and body systems. Conditions (and *diseases*) such as multiple sclerosis, TBI, spinal cord injury, diabetes, and cerebral palsy can lead to *impairments*, such as impaired cognitive ability, paralysis, blindness, or muscular dysfunction. These impairments in turn cause *disabilities*, which limit an individual’s ability to

function in various areas of life, such as learning, reading, and mobility. While diseases, impairments, and disabilities are distinct categories, they are often used interchangeably; to ensure clarity, they are defined in Figure 1-2.

The field of disability services has developed its own terminology to discuss physical and cognitive disabilities, and many substance use disorder treatment providers will not be familiar with these terms. The terms used throughout the TIP (and in the field of disability services) are defined below.

The World Health Organization (WHO) has devised a method for the classification of impairments and disabilities (World Health Organization, 1980). This complex system has been simplified here into four main categories:

1. *Physical* impairments are caused by congenital or acquired diseases and

Figure 1-2
Some Definitions

The definitions that follow explain the terms used in this TIP:

Disease: An interruption, cessation, or disorder of body functions, systems, or organs.*

Impairment: Any loss or abnormality of psychological, physiological, or anatomical structure or functions.**

Disability: Any restriction or lack (resulting from an impairment) of the ability to perform an activity in the manner or within the range considered normal for a human being. A disability is always perceived in the context of certain societal expectations, and it is only within that context that the disadvantages accruing from a disability (often called “handicaps”) can be properly evaluated.**

Functional capacities: The ability or degree of ability possessed by the individual to meet or perform the behaviors, tasks, and roles expected in a social environment.***

Functional limitations: The inability to perform certain behaviors, fulfill certain tasks, or meet certain social roles as a consequence of a disability. Those limitations can be anatomical (e.g., amputation), physiological (e.g., diabetes), cognitive (e.g., traumatic brain injury), or affective (e.g., depression) in origin and nature. They represent substandard performance on the part of the individual in meeting life activities and reflect the interaction between the person and the environment. (A list of the seven areas of functional capacities and limitations most often assessed follows on page 5.)***

*Source: Stedman, 1990.

**Source: World Health Organization, 1980.

***Source: Livneh and Male, 1993.

disorders or by injury or trauma. For example, spinal cord injury is a disorder that can cause paralysis, an impairment.

2. *Sensory* impairments include blindness and deafness, which may be caused by congenital disorders, diseases such as encephalopathy or meningitis, or trauma to the sensory organs or the brain.
3. *Cognitive* impairments are disruptions of thinking skills, such as inattention, memory problems, perceptual problems, disruptions in communication, spatial disorientation, problems with sequencing (the ability to follow a set of steps in order to accomplish a task), misperception of time, and perseveration (constant repetition of meaningless or inappropriate words or phrases).

4. *Affective* impairments are disruptions in the way emotions are processed and expressed. For the purposes of this discussion, affective impairments are considered to include problems caused by both affective and mood disorders, such as major depression and mania. These impairments include the symptoms of mental disorders, such as disorganized speech and behavior, markedly depressed mood, and *anhedonia* (joylessness).

Figure 1-3 categorizes various disabilities according to these four classifications; however, some conditions may be more difficult to categorize and some individuals may experience multiple conditions.

Figure 1-3 Disability Chart	
<i>Category</i>	<i>Disability</i>
Physical	Spina bifida Spinal cord injury Amputation Diabetes Chronic fatigue syndrome Carpal tunnel Arthritis
Cognitive	Learning disability Traumatic brain injury Mental retardation AD/HD
Affective	Depression Bipolar disorder Schizophrenia Eating disorder Anxiety Posttraumatic stress disorder
Sensory	Blindness Deafness Visual impairment Hard of hearing

Functional Capacities and Limitations

People may have the same disability without having the same functional capacities and limitations. It is, however, their capacities and limitations that will determine what accommodations should be made to the treatment plan. Treatment providers should look at each individual when determining the level and type of service needed rather than prescribing an approach or course of treatment based on the disability diagnosis. For example, one person with TBI may require a period of specialized services because of problems with attention span, unconstructive behaviors, or medical needs. Someone else with TBI may be stable enough to be integrated with nondisabled persons with minimal accommodation.

Though this TIP addresses accommodations and adjustments by disability, functional limitations are actually what will drive program modifications. There are seven categories of functional capacity and limitation that can impinge on a person's treatment. They are listed below with some of the specific functions that fall under each category.

1. Self-care
 - ◆ Eating
 - ◆ Grooming
 - ◆ Bathing
 - ◆ Dressing
 - ◆ Bowel and bladder management
 - ◆ Medication usage
2. Mobility
 - ◆ Positioning
 - ◆ Walking, with or without assistive devices
 - ◆ Use of wheelchair or other mobility aid
 - ◆ Use of stairs
 - ◆ Ability to operate motor vehicle
 - ◆ Use of public transportation (or other access to transportation)

3. Communication
 - ◆ Reading
 - ◆ Writing
 - ◆ Speaking
 - ◆ Listening
4. Learning
 - ◆ Attention
 - ◆ Comprehension
 - ◆ Retention
 - ◆ Application
5. Problem-solving
 - ◆ Awareness and recognition of problems
 - ◆ Identification of alternatives
 - ◆ Anticipation of possible consequences of various alternatives
 - ◆ Deciding on optimal alternative
6. Social skills
 - ◆ Understanding of social mores and values
 - ◆ Impulse control
 - ◆ Intimacy
 - ◆ Conversational skills
 - ◆ Empathy
7. Executive functions
 - ◆ Planning and organization
 - ◆ Motivation and initiation
 - ◆ Monitoring and reviewing
 - ◆ Decisionmaking

Disabilities and Chemical Dependency

Data from the Robert Wood Johnson Foundation indicate that about 10 percent of the population have a substance use disorder (Robert Wood Johnson Foundation, 1994). Yet studies have consistently found that 20 percent or more of all persons qualifying for State vocational rehabilitation services exhibit symptoms qualifying them for a diagnosis of substance abuse or substance dependence (Moore and Li, 1994; Schwab and DiNitto, 1993; RRTC, 1996). In the 1996 RRTC study, the disabilities

represented included those most prevalent within State vocational rehabilitation (VR) systems: mental illness, various orthopedic impairments, deafness/hearing impairments, blindness/visual impairments, learning disability, mental retardation, TBI, and chemical dependency. In a subsequent analysis, persons with the primary disability of chemical dependency were omitted from the sample. Yet the remaining VR consumers with other disabilities reported patterns of illicit drug use that were more frequent and heavier for every drug compared with a general population sample matched for age and geographic distribution (RRTC, 1996).

In 1988, the Wisconsin Department of Health and Social Services conducted a statewide study of alcohol use by people with disabilities (Buss and Cramer, 1989). It asked 3,216 consumers of VR or independent living services (people who had disabilities such as orthopedic impairments [including spinal cord injury and amputation], vision impairments, loss of hearing, arthritis, cerebral palsy, polio, brain trauma, heart disease, and multiple sclerosis) to report their use of alcohol. Alcohol use patterns were based on typologies established by Cahalan (Cahalan et al., 1969). The study found that respondents with a disability were more likely to be “heavy” or “moderate” drinkers (35 percent and 25 percent, respectively) than the general population. While heavy or moderate drinkers are not considered dependent, this heavy alcohol use puts them at higher risk for injury and other health consequences, as well as future risk of dependence. The results of this study suggest that people with disabilities may use alcohol at least as much if not more than the general population.

Not all people with disabilities are equally likely to have substance use disorders. Certain types of disabilities seem to have more impact than others on substance use behavior. For instance, research suggests that the rate of

substance abuse among people with mental illness may be twice as high as that of the general population, and over 50 percent of young people with mental illness report some kind of substance use (Kelley and Benshoff, 1997; Kessler and Klein, 1995; Regier et al., 1990; Brown et al., 1989). Substance use is often the major contributing factor to both spinal cord and traumatic brain injuries, and people living with the aftereffects of such trauma often continue to have substance use disorders (Heinemann et al., 1988; Sparadeo and Gill, 1989; Corrigan et al., 1995).

Both disability and chemical dependency service providers report increases in substance use disorders among people with disabilities. For example, State directors of alcohol and drug departments and directors of State VR agencies reported increases in coexisting disability and substance use disorders among recent referrals to their programs. Directors of both agencies predicted that these numbers would continue rising in the future (RRTC, 1996). Since many people with disabilities are not currently receiving the treatment for substance use disorders they require, the number of people with disabilities seeking treatment can only be expected to grow.

Life Problems Contribute to Substance Use Disorders

People with disabilities are more likely to use substances in part because they experience unemployment, lack of recreational options, social isolation, homelessness, and victimization or physical abuse more frequently than the general population (Susser et al., 1991; Vash, 1981; DeLoach and Greer, 1981; Marshak and Seligman, 1993). If they also have substance use disorders, such problems are further exacerbated.

Many adults with disabilities are underemployed or unemployed. Some 30 percent live below the poverty line, a rate

approximately 20 percent higher than that for people without disabilities (LaPlante et al., 1997). People with disabilities at all income levels generally spend a large proportion of their income to meet their disability-related needs. Like others who have been isolated or unemployed over a long period of time, some people with disabilities lack the social skills and familiarity with workplaces needed to succeed in a job.

For many reasons, people with disabilities may rely on a smaller social network. They may be isolated because of their families' efforts to protect them, the physical difficulty of getting out to social settings, lack of opportunities to practice social skills, lack of physical stamina, trouble finding activities and negotiating transportation, poverty, and nondisabled people's discomfort with people with disabilities. An altered body image can make those with a recent disability onset (e.g., people using a wheelchair for the first time) reluctant to socialize. Additionally, physical limitations make some people fear violence or exploitation. People with disabilities are at greater risk of being victims of sexual abuse and domestic or other violence (Glover et al., 1995; Varley, 1984). They are more likely to be victimized because they are perceived as unable to protect themselves. Depression and low self-esteem associated with their disabilities can also play a role in some individuals' victimization, and in turn their substance use.

Isolation and functional limitations leave many people with disabilities with few recreational options, yet they often have much unstructured time on their hands. For example, people who are blind or have a visual impairment may face increased isolation, excess free time, and underemployment (Motet-Grigoras and Schuckit, 1989; Nelipovich and Buss, 1989). Some people may perceive bars or other places where alcohol is consumed as the only social gathering places open to them and

drinking or drug use the only possible means of recreating or gaining social support (Greer, 1986).

Panel members report that employed assistants and caregivers for people with disabilities may often abuse their clients, steal from them, or otherwise exploit them. The caregiver for a substance-using client with a disability may purchase alcohol or drugs for the client or tolerate the client's self-destructive behavior.

Treatment implications

Each of these life problems increases the individual's risk of substance use disorder, makes treatment more complex, and heightens the possibility of relapse. Coordination with an agency providing case management services for people with disabilities should be a priority if those services are not provided by the substance use disorder treatment program. People with both a substance use disorder and a coexisting disability may need assistance and individualized accommodations to

- Escape from abusive situations
- Learn to protect themselves from victimization
- Find volunteer work or other means of gaining a sense of productivity in lieu of paid employment (although paid employment would always be preferred)
- Develop prevocational skills such as basic grooming, dressing appropriately, using public transportation, and cooking
- Learn social skills that may be missing because of both substance use disorders and disability-related problems
- Learn to engage in healthy recreation
- Become educated about their legal rights to accessible environments and services as well as employment
- Obtain financial benefits to which they are entitled
- Build new peer networks

Programs face procedural and other obstacles when they attempt to rectify such problems. For example, clients may be declared ineligible for some VR programs until they have remained sober for 6 months or more (even though such a requirement is counter-productive and can act to maintain a vicious cycle between a lack of vocational skills and substance use disorders). Some VR counselors resist working with people with substance use disorders, believing them too “difficult” and destined to fail. Furthermore, by the time a person with a disability attempts to access treatment, the level of her substance use disorder may be rather severe because of societal enabling, systems that do not identify early substance use and abuse, and the tendency among human service agencies to focus on disability rather than chemical dependency issues.

Obvious Versus Hidden Disabilities

Identifying hidden disabilities is the key to successful substance use disorder treatment. A patient who repeatedly fails at treatment may not understand what he is told, or may not be able to read or remember materials. Many people who have disabilities (e.g., people with multiple sclerosis, seizure disorders, cardiac problems) look healthy much of the time, but these conditions often cause significant fatigue or limitations on walking, driving, or other physical activities. Treatment staff members may not accept or believe a client has a disability based on what they see, regardless of what the client says. In some cases, people may have had a lifelong investment in hiding their cognitive disabilities and will not volunteer or admit to their conditions.

Disabilities can also be hidden from clients themselves. A substance use disorder treatment program may be where a person first discovers she has diabetes, a learning disability, or a

hearing loss. Even if a client knows he has a disability, he may not be aware of accommodations that could help him function better.

Whether they recognize it or not, treatment providers are already delivering services to a variety of people with disabilities. Some of these may be the same people who drop out of treatment, who do not seem to make progress, or who seem unmotivated. Such clients can be particularly frustrating for treatment providers; however, if functional limitations are recognized and treatment is modified accordingly, the program is likely to see better results.

The counselor must be especially sensitive when working with people who are not aware of or wish others to remain unaware of their disability. Chapter 2 elaborates some of the ways in which treatment staff can screen for cognitive disabilities that may not be readily apparent.

Hidden cognitive disabilities

Physical and sensory disabilities are generally more apparent than cognitive disabilities. Several studies have indicated that many people requiring chemical dependency treatment have cognitive, personality, or other conditions that affect their ability to learn or benefit from treatment (Corrigan, 1995; Brown et al., 1989; Rourke and Loberg, 1996). Provider experience bears out the fact that a number of persons present to the treatment setting with undiagnosed or misdiagnosed cognitive impairments. Treatment providers should look out for these potential hidden disabilities, because they may not have been documented by previous health care professionals, may not be fully appreciated by the client, or may have been misinterpreted in the past as “poor motivation” on the part of the client.

The majority of individuals with mental retardation is in the mild to borderline range (IQ up to 83) and can function well in many treatment situations with minimal adaptations.

However, people with mental retardation and other cognitive disabilities may have very good social and communication skills and yet still have serious problems with memory, decisionmaking, planning, or learning comprehension. Some highly functioning individuals go to great lengths to keep their disabilities a secret, even presenting with noncompliant or negative behavior to deflect attention from their areas of functional limitation.

Hidden physical disabilities

One cannot ascertain the nature of someone's limitations based on obvious physical impairments. A person who speaks slowly due to cerebral palsy may be able to read and process information quite well. On the other hand, someone who uses a wheelchair may in fact face a more serious impairment in an unrelated learning disability that dramatically limits his ability to read. Some persons with physical disabilities may have had to deal with so many disappointments that they have seriously lowered their own expectations of what they can do; in these situations, these individuals' physical disabilities may be less of an impediment to recovery than their lowered expectations.

Recognizing Barriers to Treatment

In spite of two recent Federal laws (the 1992 Amendments to the Rehabilitation Act of 1973 and the Americans With Disabilities Act of 1990), substance use disorder treatment programs continue to provide inadequate services for people with disabilities. Although this difficulty is most visible in inpatient or residential programs, statewide legal proceedings on behalf of people with disabilities have been initiated regarding access to outpatient settings as well. According to the ADA, programs must remove or compensate for

physical or architectural barriers to existing facilities when accommodation is readily achievable, meaning "easily accomplishable and able to be carried out without much difficulty or expense" (P.L. 101-336 §301). Providers should examine their programs and modify them to eliminate four fundamental groups of barriers to treatment for people with disabilities: (1) attitudinal barriers; (2) discriminatory policies, practices, and procedures; (3) communications barriers; and (4) architectural barriers. (For a more detailed explanation of what accommodations must be made, and answers to other, more specific, questions concerning ADA compliance and the best ways to overcome these barriers, see Appendix D).

Attitudinal Barriers

Attitudes about "disability" influence the ways nondisabled people react to people with disabilities, which can affect the latter's treatment outcomes. The stereotypes and expectations of others also influence the ways people think about their own disabilities.

Perceptions, stereotypes, or beliefs held by providers can hinder their ability to treat a person with a disability. Following are some examples of commonly held beliefs that can pose barriers to treatment:

- People with disabilities do not abuse substances.
- People with disabilities should receive exactly the same treatment protocol as everyone else, so that they aren't singled out as different. Being mainstreamed into society means that you should do exactly the same things as everyone else.
- A person is noncompliant when her disability prevents her from responding to treatment.
- A person with a disability will make other clients uncomfortable.
- People with disabilities will sue the program regardless of the services offered.

- Serving people with disabilities requires going to extremes.
- Every person with a disability requires hospitalization rather than a residential or outpatient program.
- People with cognitive disabilities are not capable of learning how to stay sober.
- People with disabilities make too many demands and use their disability as an excuse for not fully participating in treatment.
- People with disabilities deserve pity, so they should be allowed more latitude to indulge in substance use.

Staff members who hold such beliefs about people with disabilities may screen out those who would be well served by their programs or deny a client an appropriate accommodation for her disability. On the other hand, these staff members may unwittingly enable clients to use their disabilities to avoid treatment. (For examples of inappropriate responses, see Figure 3-1 on Denial, Enabling, and Accommodation.)

Staff training is key to overcoming attitudinal barriers. For more information on staff training, see Chapter 5 for the discussion of Provider Knowledge of People with Disabilities. To learn the appropriate terms to use in referring to people with disabilities see Appendix C: How to Refer to People With Disabilities.

Discriminatory Policies, Practices, and Procedures

Programs can inadvertently discriminate when their policies, practices, or procedures present barriers to the treatment of people with coexisting disabilities. For example, a program may establish a discriminatory policy such as the following:

- We do not serve clients who are taking medication (even if the medication is for a medical condition, such as epilepsy). (Such discrimination is also often seen against clients in opioid maintenance therapy or those who require psychoactive medications for a psychiatric condition.)
- People who miss appointments must pay fines (even though disability-related problems may make it impossible for a person to make a scheduled appointment)
- Fire and safety regulations require that all clients be able to walk out of the building independently (which precludes the participation of a person who uses a wheelchair).
- All clients must participate in house chores such as washing dishes and mowing the lawn (which precludes the participation of people with particular physical disabilities).
- Every person must read two chapters of a book per day (even if some people do not have the necessary reading skills).

Examples of discriminatory practices include the following:

- A client is excluded from the residential setting because he needs assistance in transferring from the wheelchair to the bed (even though this task is readily learned by program staff and is required only twice per day for 2 minutes at a time).
- A client is discharged from outpatient treatment for missing three sessions, when the client was actually delayed by waiting for a “handicapped-accessible” bus that does not run on a set schedule.

The ADA sets forth many requirements to protect people with disabilities from administrative barriers. Programs should periodically review their existing policies, practices, and procedures and adopt new ones as needed in order to avoid discrimination. Rules and treatment plans can be specifically tailored to meet the needs of each person, and consequently the specific treatment requirements will vary for some people. An individualized treatment approach permits

more latitude in assigning different types of chores or homework to individuals and in using different techniques or learning modalities (e.g., allowing a client who has great difficulty speaking in a group setting to turn in an oral report on audiocassette). Also, when all clients receive individualized treatment there will be less friction when one client is permitted to do an assignment differently.

Barriers to Communication

These barriers exist when a program's communications with people with coexisting disabilities are less accessible than its communications with others. To eliminate communications barriers, programs should have available a wide range of auxiliary aids and services.

Communications with people with physical disabilities

Persons with slow speech, significant respiratory problems, or other limitations in expression have a great deal of difficulty expressing their thoughts fully. Consequently, treatment staff has less information to guide its therapeutic actions. Ironically, this occurs most often with clients who need to be better understood by their counselors in order to progress in treatment. A counselor or clinician is confounding the potential success of treatment by not allowing clients who have delays in speech or cognition sufficient time to fully express their thoughts.

Speech impairments can result from a stroke or from a condition such as cerebral palsy. Auxiliary aids for individuals with speech impairments include telecommunication devices for the deaf (TDDs), computer terminals, speech synthesizers, and communication boards.

Communications with people with sensory disabilities

A person who is deaf and blind may require the use of a sign language interpreter trained in the

use of tactile communication. People who are blind or visually impaired use a wide range of communication techniques, and one should not assume that all people who are blind are Braille-literate. Providers should find out from the blind person her primary communication method and provide materials in that medium. The provider should be able to supply materials in Braille, large print, and audiocassette. Local, State, or private agencies for the blind can either transcribe or help arrange transcription of printed material into these media.

Inadequate communications are the major barrier to treatment for people who are deaf and hard of hearing. Without accommodation, people who are deaf, whether they use sign language or not, will experience barriers to communication that significantly reduce their ability to benefit from a treatment program and to receive services equivalent to those hearing clients receive. Various auxiliary services and devices can help a person who is deaf communicate with program personnel.

An individual who is deaf can experience his first barrier when he calls a program to apply for admission. A treatment program should have a TDD (also referred to as a TTY), which enables people to type and send messages over the telephone network. If a treatment program has a TDD, people who are deaf can call the program directly.

Once the individual who is deaf has been admitted to the program, someone will have to translate the spoken communication that comprises most of the program. Clients who are deaf and use sign language will need sign language interpreters in order to have access to communication. Individuals whose first language is American Sign Language (ASL) know written English as a second language, and may have the same difficulties with it that other nonnative speakers have. Interpreters should be available at all times so that clients who are deaf can fully participate in the program; if there are

no staff who use sign language then one or more outside interpreters will need to be hired.

Treatment programs can contact their State commission for the deaf and hard of hearing or the agency in their State that focuses on deaf and hard of hearing service provision. Most States also have a chapter of the Registry on Interpreters for the Deaf (RID), the professional association for sign language interpreters, to help people obtain the services of a qualified interpreter. As a general rule, an interpreter who is certified by the RID is considered qualified. However, in some States there is a screening system to determine if interpreters who have not yet received certification from the RID are able to provide quality interpreting services. In these States, a person who passes the evaluation, or receives a certain rating, may be qualified. The provider should speak with the organization overseeing the evaluation system to ensure that this is the case.

It is important for treatment providers to understand the parameters within which interpreters work. If an assignment (e.g., interpreting for a detoxification program) is 2 hours or less, an interpreter will usually take the assignment alone. He will probably need a break at some point during the 2 hours, however. Interpreting is taxing, and an interpreter's effectiveness diminishes over time. Well-placed breaks or hiring two interpreters will greatly reduce such fatigue and reduced performance.

Treatment programs may have deaf clients who do not use sign language. In this case, a program may need to get an oral interpreter (who mouths the words that people are saying) or Computer Assisted Realtime Transcription (CART) services. A CART reporter types everything that is said into a computer system, which a deaf person then reads on a monitor or laptop screen. Some individuals who are deaf or hard of hearing may request an assistive listening device to amplify sound. The client

who is deaf can provide advice to the program and should be provided the type of device he asks for. The State agency for people who are deaf or the State VR agency should know where to obtain these devices.

Communications with people with cognitive disabilities

Programs must be prepared to adapt basic treatment modalities for individuals with impaired communication (receptive and expressive), reading, or writing skills. The use of picture books, comic books, illustrated "flash cards," art therapy techniques, and audio and videotapes may help resolve some of these communication barriers.

Individuals with TBI may have decreased comprehension of both written and oral information, or may have difficulties speaking. In other cases, these abilities may be intact but social cognition is impaired, leaving those people functionally communicative and literate, but without the requisite judgment and social interaction skills to communicate meaningfully or appropriately with clinicians and peers.

People with *aphasia* lose the ability to convey and comprehend oral or written information. These individuals may be able to think clearly but may not be able to form their thoughts into coherent sentences without a struggle. In some cases, this condition can vary from day to day, causing counselors to suspect willful noncompliance or a mental/emotional problem unrelated to language comprehension.

Cognitive disabilities may limit people's understanding of basic concepts of treatment. Individuals with developmental disabilities may not have acquired abstract thought skills, and dealing with abstract concepts such as admitting their powerlessness over alcohol can be daunting. Those with learning disabilities may have trouble processing and using abstract information. Many will have limited vocabularies. And many individuals with a variety of disabilities—not necessarily cognitive

ones—have poor educational achievement due to negative school experiences. Bad experiences in school are also predictors of later substance use disorders (Jessor and Jessor, 1977).

Architectural Barriers

Physical barriers include the absence of elevators or ramps, narrow hallways, poor lighting, wall telephones too high for people in wheelchairs, deep pile carpets that interfere with wheelchairs or crutches, conventional doorknobs that impede access to people with limited manual dexterity, or even a lack of transportation from the property's boundaries (where public transportation may drop off a person) to the facility's entrance. Programs should consider other types of modifications as well in order to make their buildings safer for all participants.

A person who is blind or visually impaired can typically move safely within an environment once it becomes familiar. The treatment provider should early on give clients who are blind a complete orientation to the facility. Signage to accommodate people who are blind and visually impaired is widely available and includes signs and elevator settings that are properly color contrasted or have raised Braille words and numbers. In addition, loose rugs, wall-mounted fire extinguishers, and lighting that is too bright or too dim can create mobility problems for individuals who are visually impaired.

When barriers cannot readily be removed, a program must find alternate methods to make its services available. A program that offers counseling in an upstairs room must offer counseling downstairs when needed, if it is not able to add a ramp or elevator. If an onsite adjustment cannot be made, an outpatient program must find an alternate site where it can deliver the same level of care it provides at its nonaccessible site. A residential program may find it necessary to make an appropriate referral

as a temporary solution, while it takes the steps necessary to change its facilities for future clients.

Mainstreaming Versus Specialized Services

In general, it is beneficial and feasible to integrate people with disabilities into already existing community-based services used by other individuals recovering from substance use disorders (a process known as *mainstreaming*). However, there are a number of exceptions to this rule. In instances where a legitimate, documented reason exists, specialized services may be necessary.

People who are deaf and identify with Deaf Culture will usually prefer specialized treatment programs (see below). In addition, clients who have severe psychiatric disorders will benefit from specialized services that understand their medication and behavioral issues. People with mental retardation may find it easier to understand and participate in discussions that involve others with similar disabilities. They do not have to channel all their energy into "passing as normal" and are less ashamed to ask questions. Some clinicians find that even people with mild and borderline mental retardation, and with limited or no reading abilities, prefer to be placed with other nonreaders. Other disability conditions that may warrant some stand-alone services include TBI, spinal cord injury, or severe or multiple disabilities.

In some situations, however, grouping people with similar disabilities may be counterproductive. For example, persons who are grouped by disability may try to ignore the larger treatment population, or they may be at widely dissimilar stages of acceptance or adaptation to their disabilities. Depending on the personalities of the individuals involved, one person may keep another from going forward in treatment. While grouping generally

can produce positive outcomes, it is an adaptation that should be monitored once established.

Ideally, stand-alone services should be offered to an individual with a coexisting disability in concert with other community supports, thereby increasing the depth of the recovery plan and making the transition to sober community living more logistically possible. Such community supports could be attending an outpatient chemical dependency program in an area of the town where the client lives, becoming enrolled in vocational rehabilitation, attending support group meetings for head injury, or enrolling in a community college developmental English program.

Deaf and Hard of Hearing

Many members of the Deaf Community benefit from specialized services, which generally are better equipped to handle specific cultural, language, and communications issues that may arise. People who are deaf or hard of hearing and use sign language tend to identify themselves as part of a deaf community. Many will prefer to be served by programs that specifically address their needs and whose staff is fluent in sign language. Unlike many other people with disabilities, people who are deaf often do not identify with a medical model of disability and instead embrace a cultural model that emphasizes their abilities within the Deaf Community and their own language and values.

Most people who are deaf seeking substance use disorder treatment prefer segregated programs to mainstreamed programs. This allows clients who are deaf to participate in a group with deaf peers and a counselor who is fluent in sign language. Direct communication will facilitate greater participation by clients who are deaf than communication through an interpreter. Such a group provides an environment of peers who share similar life

experiences and a common language, generally considered important for the recovery process.

Yet having a group that is all deaf is not realistic for most programs. It is more likely that, on occasion, there will be only one client who is deaf in a program, and the rest of the clients will be able to hear. In this case, the program will need to hire one or more sign language interpreters to facilitate comprehensive communication among the client who is deaf, hearing clients, and hearing staff. In some instances, the program may want to refer the person to a specialized program serving people who are deaf and hard of hearing. If a sign language interpreter is not available, the leader of the group may try to communicate with the person through pencil and paper, trying to explain some of the issues. Without the presence of the interpreter, however, the individual who is deaf will miss much of the information shared during a therapeutic group.

Some individuals who are late-deafened or hard of hearing do not use sign language, did not grow up with other people who are deaf, and do not identify with Deaf Culture. This population is actually larger than the population who uses sign language (Minnesota Chemical Dependency Treatment Program for Deaf and Hard of Hearing Individuals, 1996). These individuals will generally prefer to be served by programs for the general population alongside clients who can hear. The types of accommodations they need will differ from what is needed to effectively treat clients who identify with Deaf Culture. These accommodations will usually consist of the use of devices either to amplify sound or to print what individuals in the program are saying. These people have grown up using English as a primary language and do not have the second language issues that are common to individuals who are deaf whose primary language is ASL.

Working With People With Disabilities

A significant number of the people currently seeking treatment for substance use disorders also have a physical, cognitive, sensory, or affective disability. Many others are or believe they are unable to access the treatment they desperately need, often because of the double stigma of having a substance use disorder and a coexisting disability. This TIP provides simple, practical guidelines to help treatment professionals provide services for people with coexisting disabilities, thereby improving the quality of treatment for a large number of persons whose needs are not being met. The TIP is organized to allow treatment providers to find information pertinent to clients who may have a particular disability. Even though these categories of disabilities are often artificial distinctions, this system of organization gives treatment professionals a baseline from which to modify treatment on a case-by-case basis for their clients with coexisting disabilities.

The TIP also aims to educate providers about the needs common to most (if not all) people with disabilities and the legal, ethical, and practical reasons to accommodate this significant client population. Information is provided concerning screening for the physical and cognitive disabilities of those seeking treatment (in Chapter 2), how treatment can be modified to work better for people with disabilities (in Chapter 3), establishing linkages with other types of agencies and programs (in Chapter 4), modifications to the program that

might need to take place at the administrative level (in Chapter 5), and ADA compliance (see Appendix D).

Many treatment providers have been reluctant to take on clients with disabilities because they assume difficulties that may not exist. The less one understands disabilities and their corresponding functional limitations, the more daunting accommodation appears. A useful parallel is the beginning of the acquired immunodeficiency syndrome (AIDS) epidemic in the 1980s, when many health care workers were afraid to treat patients with human immunodeficiency virus (HIV) and AIDS (a population also covered by the ADA). In that case, education and hands-on experience with AIDS patients countered the widespread apprehension better than anything else. Similarly, more information such as that provided in this TIP and the inclusion of clients with disabilities in treatment programs will help reduce barriers to treatment discussed above.

The process of education will help treatment providers discover that people with disabilities are more like than unlike other clients, and that they have already been treating people with disabilities without knowing it. The presence of people with disabilities in a treatment group can benefit all clients. Appropriate accommodation of a person with a disability fosters cooperation at the same time it enriches group diversity. By better serving people with identified disabilities, the treatment provider will improve care for a great many other clients as well, as providers learn to tailor treatment to each client's individual needs.

Appendix A

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