

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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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Center for Substance Abuse Treatment

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2 Screening Issues

Physical, sensory, and cognitive disabilities affect far more clients than many treatment providers realize. Because so many people in treatment programs for substance use disorders have coexisting disabilities, the Consensus Panel recommends that every new client be screened for disabilities. In the screening process, each client's level of ability in various areas of functioning should be evaluated. The screening described here is not and should not be seen as an additional task to be performed only with people who have an obvious physical or cognitive disability.

Persons with disabilities also may require modifications in the way treatment personnel perform screening and assessment for substance use disorders. As with any stage of treatment, providers will need to make accommodations for people with disabilities in their screening procedures. Because both these forms of screening will occur at roughly the same time, both will be discussed below.

"Disability Etiquette"

It is important that providers be sensitive to the feelings as well as the needs of people with disabilities from their first contact onward. Providers who have never worked with someone with an obvious disability may feel awkward, unsure of what to say, or what help to offer. Sensitivity and openness will help ease this discomfort, as will the following guidelines.

In planning and providing treatment to people with disabilities, the importance of asking questions cannot be overemphasized. "Disability etiquette" involves maintaining an awareness of intrusion into an individual's personal space. Asking before rendering any service is a basic principle. "May I help?" should be followed by "How may I help?" For example, if a person is struggling to put a wheelchair into a car, it is important to first ask if help is needed and then to ask how the wheelchair should be placed in the car so that the person can later remove the wheelchair unassisted.

Some providers may feel embarrassed to ask certain questions or may worry about giving offense, even when the answers are critical to the treatment planning process. It may be helpful to preface such questions by requesting permission to ask them. "May I ask you about..." or "It would help me to know more about..." are ways of beginning to ask more direct questions. It is, however, important for staff members to be able to be honest and acknowledge that they may not know the appropriate way to ask a question.

Although resources regarding disability etiquette are available from organizations such as Easter Seals and the American Foundation for the Blind, it is always best to ask each person what he wants, thus ensuring that cultural, gender, and personal preferences are met. (See Appendix C for information on how to refer to people with disabilities.)

People With Sensory Disabilities

The majority of people who are blind use a cane; fewer use guide dogs. Either way, people who are blind or visually impaired will require assistance in orienting themselves to a new environment. Treatment providers should try to describe or guide a person through a new environment. Instead of stepping back and allowing the person to fumble, the counselor should offer “sighted guide” assistance, during which the person who is blind holds the sighted person’s arm just above the elbow and they walk in tandem. Pulling a person by his arm is not appropriate.

People who are blind live in a more touch-oriented world than the sighted population. It is acceptable for the counselor to put the blind person’s hand on the back of the chair she is to use. A service animal, however, should not be distracted from its job; the animal should not be touched or petted, nor should one even ask permission to do so.

Word use is important. The counselor must use more descriptive and detailed language and strive to avoid phrases like “over there” or “like this.” There is no need to avoid words like “see” and “look”—they are part of everyone’s daily language.

Finally, more than 80 percent of people considered “blind” have some residual vision. This remaining vision is typically light- or glare-sensitive. It is helpful to ask if the lighting in the current environment is uncomfortable. Figure 3-6 in the next chapter presents these and other suggestions for working with people who are blind in the form of an easy-to-follow list of suggestions.

Communication is the key issue when dealing with individuals who are deaf and hard of hearing. 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 so he can see facial expressions and has the option of lip-reading. When interviewing a person who is deaf with an interpreter, it is still important to look directly at the client. Speak directly to him just as if there was no interpreter present.

People With Physical Disabilities

Persons with disabilities that limit their mobility can encounter situations like sidewalks without curb cuts or front doors that cannot be opened from a wheelchair. They are understandably annoyed if they are stymied by these barriers and then hear those responsible for the facility explain, “We hardly ever get someone with a wheelchair here.” Providers should not assume that someone in a wheelchair is unusually resistant to treatment just because she expresses anger at not being able to enter the facility through the same entrance or use the same restroom as other clients.

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 or touch any other adaptive equipment without permission.

Screening for Disabilities

Treatment providers are not expected to become experts in disabilities or to diagnose disabilities themselves. However, functional limitations and symptoms of disability are likely to become apparent as clients with disabilities participate in treatment, and a provider should recognize certain signs and symptoms.

It is the level of abilities and of the functioning of the individual—not the simple determination of whether a disability 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. State vocational rehabilitation (VR) programs may be a good source for referral.

Functional limitations associated with a disability, whether apparent or not, can undermine treatment if they are not recognized and addressed. For example, a person's lack of progress in treatment may be mistakenly attributed to a lack of motivation, when in reality a functional limitation, such as an inability to read, is impeding her ability to understand or participate in treatment. Such an individual may seem indifferent to achieving her treatment goals, when she is actually having difficulty processing or retaining information.

Treatment providers should be careful not to make determinations about a person's disability when they are not qualified to do so. Initial screening is encouraged, but an expert on the particular disability should conduct any further assessment. Of course if a client is being referred from a disabilities expert, staff should ask for a full evaluation that includes specific client strengths and weaknesses.

Initial Screening

Through the screening process, the provider can begin to understand the circumstances in a client's life that are likely to have a bearing on treatment. All such circumstances, whether or not they are disabilities, should be incorporated into the treatment plan.

Questions relating to disabilities can and should be incorporated as seamlessly as possible into a comprehensive screen, rather than treated as an altogether separate subject. After discussion of the substance use disorder, the interviewer can bring up visibly obvious impairments, such as those requiring the use of a wheelchair or cane. The questions can be framed by the program's desire to respond to individual needs: "Do you need any accommodations to participate in this

program?" This question should be posed to everyone, not only to those the interviewer thinks have a disability.

The possibility of hidden impairments can be explored subtly during the conversation. For example, during a routine medical history, a question about past hospitalizations can elicit information about a previous brain or head injury, thus alerting the interviewer to the possibility of traumatic brain injury (TBI). Similarly, a client's answers to routine questions about past and current medications may point to the possibility of cognitive or affective impairments (see Case Study below). A client's referrals from other service providers such as VR services can also offer insights into less obvious impairments.

Setting always influences the screening process; this is especially true when testing or interviewing for disabilities. An individual's problems with mobility, for example, may make it necessary for the interviewer to travel to his home, where there may be distractions of children or other family members. However, a person might not be willing to speak openly in front of other family members, even if they already know about her disabilities. Wherever the interview takes place, it is important to create a sense of privacy in talking with the client.

Figure 2-1 presents a basic screening instrument for identifying impairments and functional limitations that can be handed to a client preceding an interview. The text can be used verbatim (with the instructions given at the top of the figure) as a form all clients would receive before a screening and assessment session. In the answers to questions such as these, the interviewer should be looking for things such as the history and symptoms of diseases or disorders that can provide clues to impairments and disabilities. If the questions and discussions based on the screen indicate an

Figure 2-1 Educational and Health Survey

Please answer the following questions keeping in mind that we are trying to get to know you better and to identify areas that may create difficulty for you in treatment if we don't know about them.

1. Do you have a disability or have you ever been told that you have a disability?
 Yes No
2. Are you currently under the care of a doctor or other medical care professional?
 Yes No
3. Do you take medications?
 Yes No
4. Do you have difficulty hearing in group settings (e.g., theaters, classrooms, family dinners)?
 Yes No
5. Do you frequently need people to repeat what they have said to you?
 Yes No
6. Have people complained that you don't hear or don't listen to them?
 Yes No
7. Do you wear glasses or contact lenses?
 Yes No
8. Do you have difficulty seeing things that are far away or very close?
 Yes No
9. Do you have frequent eye pain or headaches?
 Yes No
10. Have you ever hit your head and lost consciousness?
 Yes No
11. Have you ever received health or disability benefits?
 Yes No
12. Have you ever been unemployed for a long period of time?
 Yes No
13. Have you ever been fired from a job, asked to leave a job, or passed over for a promotion?
 Yes No
14. Did you ever have special classes or tutoring in school?
 Yes No
15. In a school or work setting, do you like to learn or learn best by
 Listening to someone talk
 Watching someone perform a task
 Reading on your own
 Performing tasks yourself
 Discussing things with another person
 Discussing things with a group of people

Figure 2-1
(continued)

16. Have you had problems or difficulty with any of the following?
- Getting your point across to others
 - Sitting still
 - Focusing on the task at hand for more than several minutes at a time
 - Understanding the point that others are making to you or what others are saying to you
 - Communicating your feelings or thoughts to others
17. Have you ever had problems with or been bothered by any of the following?
- Controlling anger
 - Remembering things
 - Following instructions (verbal, written, or demonstrated)
 - Concentrating
 - Becoming tired easily
 - Getting along with others
18. Have you ever had problems or been bothered by any of the following?
- Depression
 - Anxiety
 - Forgetfulness
 - Sleep problems
 - Nervousness
 - Muscle tension or soreness
 - Uncontrolled worry
 - Excessive worry
 - Irritability
 - Restlessness (feeling on edge)
 - Mind "going blank"
 - Rapid heart rate
 - Pounding in chest
 - Heart burn or stomach pain
 - Uncontrolled feelings of happiness or euphoria

impairment, the client should be referred to a disabilities expert for a more in-depth screening.

Figure 2-2 presents the questions from Figure 2-1 in the manner they might be asked during a spoken (or signed) interview, with the numbers of the relevant questions provided in parentheses. This figure also provides further questions that might be asked and ideas for how the information gained in the interview could be used in followup treatment planning.

Throughout the screening interview, it is important for the screener to pay attention to the individual's affect and behavior in order to pick up on possible cognitive or affective impairments. Screening for psychiatric disorders is discussed in TIP 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (CSAT, 1994).

Figure 2-2 Impairment and Functional Limitation Screen		
Questions	Further Questions	Followup Treatment
Do you have a disability, or have you ever been told that you have one? (1)	It may be useful to ask what a typical day is like to gain a better understanding of how these accommodations affect the person's daily life. Ask client to specifically describe the activities and events of the day. Her answer may indicate problems in functional areas such as self-care, learning style, mobility requirements, or reveal her participation in a work program. If the person uses an assistive device, inquire how long it has been used.	Refer to vocational rehabilitation. Consult with disability professionals.
Are you currently under the care of a doctor or other medical care professional? (2)	Inquire as to how a condition affects the person's daily life (e.g., what accommodations and precautions he takes).	Consult and communicate with physician. Obtain medical records.
Are you taking any medications (prescribed or over-the-counter)? (3)	If the client takes medications, does she understand what they are being taken for? What side effects from medications has she experienced? A recent medication history should be taken.	Provide medication education. Use charting or a pill case to organize medications and ensure proper use. Remind client when she should take medication. Use timers or pagers to remind client of when to take medication. Set up appointment for medication check with physician.
Do you have difficulty hearing in group settings (e.g., theaters, classrooms, family dinners)? Do you frequently need people to repeat what they've said to you? Have people complained that you don't hear or don't listen to them? (406)	Ask if client has had his hearing tested recently (or ever). Look for nonverbal signals that he is having difficulty hearing (e.g., looking at lips instead of eyes, thinking a long time before answering questions, ignoring questions, not directly answering questions). Some attempt should be made to determine if problems are attentional in nature rather than due to a hearing impairment.	Administer hearing test and language or communication test. Have client sit in front during classroom type sessions. Place client nearer to the speakers when movies or tapes are being used. Have sessions with client in the room with the best acoustics. Meet with client after group sessions to discuss what occurred as a way to determine whether he heard everything that was said. Arrange the room so that outside noise is minimal and so that clients can all see each other. Develop a cueing system to let client know when he is being spoken to and so client can signal when he cannot hear. Repeat the points or questions of group members often. Use an interpreter when appropriate. Use a microphone in a large group setting. Use other assistive devices like a radio amplification system. Frequently check in with client to make certain that he is following what is being said.

Figure 2-2 (continued)

Questions	Further Questions	Followup Treatment
Have you ever hit your head and lost consciousness? (10)	Further investigate any occurrences even if the client was not sure whether he sustained an injury (sometimes issues of inebriation and the loss of consciousness due to trauma are mixed together). Ask client if he has ever been in a car accident or a fight. Ask about the length of time unconscious, the circumstances surrounding the accident, whether alcohol or drugs were involved, and any changes in functioning dating from the time of the injury.	Obtain results of any previous neuropsychological exam. If none has been done, arrange to have one administered (if funds are available). Consult with a psychologist about the neuropsychological test results and about possible accommodations. Administer a short, simple memory test.
Have you ever received health or disability benefits? (11)	Ask client why she received these benefits and if that influenced her work or search for a job.	Request records. Consult with client's case manager or benefits coordinator. Help client to get assistance that she is entitled to.
Have you ever been unemployed for a long period of time? Have you ever been fired from a job, asked to leave a job, or been passed over for promotion? (12-13)	Ask if the client feels unsatisfied with the work he's been able to find. Ask if he's ever had a job where he didn't understand the tasks he was asked to perform or felt unable to perform them. Ask how he obtained his most recent work, and whether he has ever been involved in a vocational rehabilitation program.	Obtain vocational rehabilitation records if applicable. Refer to vocational rehabilitation. Use self-administered interest inventories. Design assignments and treatment goals relating to employment and/or vocational rehabilitation.
Did you ever have special classes or tutoring in school? (14)	Ask whether the person has ever had a past diagnosis of a learning disability. Ask questions such as, "Is English your first language? Can you read English? Do you like to read? What do you like to read? How often do you read and for how long generally?" For a client who is blind, ask, "How do you read? Audiotapes? Braille? Any other method?" Unless the person states that she cannot read, find an opportunity—later in the interview, so that it is not connected with the question—to have her read something aloud. This should be something brief, such as a sentence in a release statement or a standardized screening questionnaire for substance use.	Use audio- and/or videotapes. Use murals, art activities, role-playing, etc., instead of written assignments. Use feelings chart or other picture tools during session. Take frequent breaks. Confer with client periodically to find out if she is understanding material. Arrange for extra help/tutoring from peers or counselor.
In a school or work setting, do you like to learn or learn best by listening to someone talk, watching someone perform a task, reading on your own, performing tasks yourself, discussing things with another person, discussing things with a group of people? (15)	While many clients will not be able to answer this question very easily, those that can will be able to provide information that can prove to be very valuable in developing a treatment plan. Ask for details concerning positive and negative learning experiences. Find out if any accommodations have been made in the past in order to help the client learn most effectively.	Attempt to utilize client's preferred means of learning as much as possible.

Figure 2-2 (continued)

Questions	Further Questions	Followup Treatment
<p>Do you ever have difficulty sitting still, focusing on a task for more than several minutes, understanding what people are saying to you, or communicating your thoughts and feelings to others? (16)</p>	<p>Anything but an unqualified “no” should be followed up since it could point to a possible attention deficit. Ask under what circumstances the person has had these problems and what kinds of distractions he has had, such as environmental (noise) or physical (pain). Observe whether he is able to sit still during the interview. The sensory aspects of understanding speech need to be addressed separately (see above).</p>	<p>Take frequent breaks. Allow client to stand or alternate standing and sitting. Use shorter sessions. Have an agenda for each session which clients can follow. Stagger client participation during a session to keep him involved (for example, every ten minutes after each key point or after each group member shares). Use cues to let client know when he is getting off track. Use other refocusing techniques like summarizing what has happened or using quick response activities (“everyone tell me how you are feeling right now”). Limit the number of key points per session. Alternate types of activities throughout the session.</p>
<p>Do you ever have problems controlling your anger, remembering things, following instructions (either verbal, written, or demonstrated), concentrating, becoming tired easily, or getting along with others? (17)</p>	<p>Ask about friendships and relationships with others; find out if the client has problems with friends, family, or being a “loner.” Ask if she is getting tired or having trouble concentrating during the interview.</p>	<p>Use relaxation techniques. Use memory books. Provide client with a schedule that is in short increments. Adhere to regular scheduling. Give client as much notice (and reminders) as possible if schedule will change. Use written and/or pictorial instructions. Use audio and/or video instructions. Involve the client in role-playing. Use mock sessions to prepare client for what will happen. Arrange field trips. Use cues to keep client on track. Take frequent breaks. Determine client’s most alert times and attempt to schedule key activities during those times. Begin treatment plan utilizing individual counseling only and work towards group involvement. Allow client to observe group before engaging. Include anger management activities in treatment plan. Expect to repeat key points often.</p>
<p>Have you ever been bothered by any of the following: depression, anxiety, forgetfulness, sleep problems, nervousness, muscle tension or soreness, uncontrolled worry, excessive worry, irritability, restlessness (feeling on edge), mind “going blank,” rapid heart beat, pounding in chest, heartburn or stomach pain, uncontrolled feelings of happiness, or euphoria? (18)</p>	<p>Ask the client if he is in or has ever been in counseling. If he has, ask how often he visited a mental health professional and what problems were most often discussed. Find out if the client currently has or has ever had any suicidal ideation. Ask what his normal sleeping and eating patterns are, and what a typical day is like. Look to see if he appears sad or depressed, and if his grooming is adequate.</p>	<p>Obtain medical records or mental health records if possible. Refer for mental health assessment. Use relaxation techniques. Use recreation therapy. Refer for a physical therapy or occupational therapy assessment. Refer for a medication check. Have client keep a journal or log about his symptoms to see if there is a pattern to them. Use memory book or other memory techniques. Have client practice memorizing short slogans or phrases.</p>

Screening for sensory disabilities

A treatment provider need not conduct an assessment of hearing loss when working with people who are deaf or hard of hearing. The

provider should, however, note the individual’s apparent adjustment to the hearing loss and psychosocial factors related to it. This information could be used in determining the

type of program to which to refer the client (a mainstreamed program or an all-deaf program) and could be useful to the treatment provider in developing a treatment plan. Clinicians who conduct screenings should consult with a professional who is experienced in working with people who are deaf and can assist the clinician in developing an appropriate referral to treatment.

Background information to consider when screening an individual who is deaf or hard of hearing includes the following:

- Is the family of the client deaf or hearing?
- What is the nature of the client's relationship with family members?
- What is the extent of communication between the client and significant family members?
- What is the communication mode used by the client? If signing, what is the style used?
- What type of school program(s) did the client attend? How did he feel about the program and his experiences there?
- Is the client's primary peer group deaf or hearing? If hearing, what is the extent of communication with these peers (how fluent)?
- How does the individual feel about and cope with her hearing loss?

If a client uses sign language as her primary mode of communication, attended a residential school for the deaf, or socializes primarily with people who are deaf, it is likely that an all-deaf program is most appropriate for him. On the other hand, if she does not use sign language, grew up attending public schools without support services, and has no deaf peers, a mainstreamed program may better meet her needs.

Screening for cognitive and affective disabilities

Some cognitive impairments, while not readily apparent, may be revealed by subtle behavioral

cues. For instance, difficulty in attending to the questions being asked or fidgeting and restlessness during the interview may indicate an attention disorder.

Memory problems, such as those resulting from TBI, may also be hard to detect initially. A person might be quite conversationally skilled and appear to be comprehending a vast amount of new information but might not retain the information even until the following day. Given the significance of retaining treatment information, memory difficulties need to be detected early so that a more in-depth assessment can be conducted and treatment recommendations can be made.

A person's problem-solving and reasoning abilities may be impaired by head trauma and substance use. While this functional limitation can greatly affect decision making in high-risk situations, it might not emerge as problematic while the client is responding to questions about his personal background in a well-rehearsed fashion. For this reason, it may be important for the clinician to informally assess reasoning and problem solving with more novel questioning or a brief screening tool that does not solely target the individual's personal social history. One way to screen self-care and problem-solving capacities informally is by asking a person to complete some simple activities such as writing a check or performing a practical math problem.

Substance use disorders may elicit behaviors that could be mistaken for mental health concerns. For example, many substance-using clients display paranoid behaviors that may take time to dissipate even after detoxification. Looking at these cues as potential signals, rather than drawing conclusions from them, will help the interviewer avoid making false presumptions.

Interviewers also need to be aware that substance use disorders can obscure a disability. The use of cocaine and crack can mask clinical depression, and some individuals with severe,

chronic depression may self-medicate with crack or cocaine. Upon admission to a substance use disorder treatment facility, these individuals appear appropriate in affect. However, after detoxification, they plunge into a deep, intractable depression, requiring psychiatric intervention and medication. Individuals with mental retardation or developmental disabilities often use marijuana or alcohol to mask their disability—it is difficult to discern a drunk or high person with developmental disabilities from a drunk or high person without such disabilities.

Conversing with an individual with a cognitive disability about her disability can provide other information relevant to treatment. For example, asking someone how he became cognitively disabled may reveal a history of physical abuse, accidents, or illnesses resulting in head injuries in childhood. Asking how old someone was when she first realized she had a disability and what that felt like can reveal suicidal ideation in childhood and untreated pain over the disability, problems that may contribute to a substance use disorder in later life.

From Screening to Treatment

One of the challenges substance use disorder treatment programs face in providing services to people with disabilities is determining what the program can offer these clients to best meet their needs. The screening process can help to identify those areas where linkages with other services and agencies are needed. Changes to the program and its facilities may also be needed.

The aim of the initial screening for disability-related considerations is not a diagnosis, but rather a pragmatic exploration of the potential barriers to treatment that may arise from a disability and its associated functional

limitations. Individuals entering chemical dependency treatment do not always benefit from learning new, potentially stigmatizing terms that apply to them, but they may benefit from modifications to the treatment process. Which is not to say that staff and clients should avoid talking about disabilities, but that it is more important to focus on necessary modifications to treatment than on a specific label. Additionally, treatment personnel are unlikely to be qualified to make disability diagnoses; however, in a practical sense, they are likely to be more skilled than they realize in adjusting treatment approaches based on the needs of their clients.

Questions used to screen for the presence of disabilities can be asked verbally, or the client can fill out the written survey provided in Figure 2-1 before an interview begins. After the screening it may be useful to draw up a profile of the client that presents the person's strengths and needs, along with recommendations to address those needs. This profile can be drawn up as a chart listing the seven areas of functional limitations described in Chapter 1. Each of the seven areas of functional limitation used in this screening (self-care, mobility, communications, learning, problem solving, social skills, and executive functions) presents specific considerations that may be identified in the screening interview. In the example below, questions from Figure 2-1 are applied in an actual interview; an accompanying profile, for a person with TBI, is depicted in Figure 2-3. A discussion of how the information gathered can be applied in treatment planning follows.

Case Study

"John," a 26-year-old white male, was referred from a local criminal justice agency after an arrest for driving under the influence (DUI). A high-school graduate, he lived with his mother and had held a series of entry-level jobs, none for more than 8 months. He had no obvious

disabilities and stated that he is at the program because he “got into trouble.” The screening questions presented below reflect a portion of a lengthier interview; John’s answers to the questions will assist providers in planning his treatment program.

Q: Do you feel you have a disability, or has anyone ever told you that you have one?

A: No, nothing like that.

Q: Have you ever had to stay in a hospital overnight, or gone to an emergency room for any reason?

A: I’ve had some falls, and once I broke my arm. I went to the emergency room. But I never had to stay overnight.

Q: Have you ever seen a doctor for a long period of time, more frequently than just one visit or for routine check-ups?

A: Yes when I was in grade school.

Q: What was going on for you that you needed to see the doctor so often?

A: I’m not sure. I think I was overactive. I was on some kind of medicine.

Q: Do you know what kind of medication it was?

A: It was “rid-lin” [Ritalin] or something like that.

Q: Were you ever diagnosed with a learning disorder?

A: I don’t think so.

Q: Were you ever in special education classes in school or did you receive any kind of tutoring?

A: I had some tutoring for math.

Q: Have you ever been given a hearing test?

A: Yeah. When I was in school they did hearing tests. I always passed them with flying colors. I don’t have any hearing problems.

Q: Do you ever have to ask people to repeat what they’re saying? Or has anyone ever complained to you that you don’t listen?

A: Yeah, well my boss at work always says that I don’t listen. And my teachers at school

used to tell my mother that I don’t hear what people are saying to me.

Q: Did you ever need to wear glasses?

A: No.

Q: When was the last time that your eyes were checked?

A: Oh, about 2 years ago. I was having some problems at work because they have really bright lights in the building. That would give me a headache sometimes. The eye doctor said that my eyes looked good. I guess I just don’t like bright lights.

Q: Have you ever been hit on the head or had any blows to the head?

A: Now that you mention it, there was this one time in high school after football practice. Some of us were fooling around and I got into a fight. I don’t know what happened. But I had to get some stitches and I had a headache for a few days.

Q: Did you lose consciousness?

A: I don’t know. I guess there were some things I don’t remember that people told me about later.

Q: What’s the first thing you remember after the fight?

A: Riding in the ambulance.

Q: What did they do at the hospital?

A: I got some stitches in my forehead and they kept me around for a while to keep an eye on me.

Q: Did you notice any changes in your abilities since then?

A: No, not really.

Q: Have you had problems with bad or frequent headaches since the fight?

A: I guess sometimes I have headaches.

Q: Have you ever talked to a doctor about them?

A: No, not really.

[This is a problem that may need to be followed up with a physician visit. If neuropsychological testing was never done after

the accident, it should be performed now if funds are available.]

Q: Have you ever received benefits of any kind? Like from a government agency?

A: No.

Q: Let's talk about your work history for a while. How many jobs have you had in the past three years?

A: Oh, about four or five.

Q: What was the longest job that you held?

A: Last year I worked for 8 months as a grocer's assistant. I quit because the boss was getting on my case. I don't think he liked me very much.

Q: Why do you think that?

A: Well, he would yell at me or tell me that I didn't do my job right. I should have been given a better job there, but he would say that I couldn't figure out how to do the job I had. He said I was forgetful.

Q: Do you think that you are forgetful?

A: Yeah, I guess so. I just sometimes forget things at work. There's too much to remember all at once.

Q: How were you taught your job?

A: Well, I followed this guy around and did what he told me to.

Q: Did that work? Do you feel that you learned the job?

A: It was OK when we worked together. Then they gave me a big list of stuff and I was supposed to just follow the list, but it didn't make sense.

Q: Were you able to read the list OK?

A: I guess some of it I didn't understand.

Q: Were you able to ask someone to explain the tasks required?

A: No, I just kind of figured it out. I don't like to ask a lot of questions. People don't always understand what I'm asking about anyway.

Q: Do you ever have trouble controlling your anger?

A: Maybe when I'm drinking.

Q: Do you ever feel anxious or on edge?

A: Sometimes. When I'm bored.

Q: How about feeling depressed? Or really happy for no reason?

A: No.

Q: Is English your first language? Did you speak any other language when you were growing up?

A: No, I only speak English.

Q: Tell me about your reading habits. What kind of stuff do you like to read? How often do you read?

A: I don't really like to read. I mostly read the comics. Stuff like that. [The screener suspects a reading problem from this answer. Later on in the interview the client is asked to read a simple sentence from a Release of Information form, and he labors over it in a halting manner.]

Q: Do you ever have trouble paying attention or concentrating on things?

A: With things I like, I don't have a problem, no.

Q: What kinds of things interest you and hold your attention?

A: Sports and TV shows I like—mostly comedies.

[In the last portion of the interview, the screener has noticed that the client has been preoccupied; he keeps looking out the window, and the interviewer has had to repeat some questions.]

The results of this screening interview and how they pertain to the identification of areas in which John may have impairments and disabilities are presented in Figure 2-3. The interview with John and the accompanying

Figure 2-3 Profile of "John"			
Functional Area	Strengths	Needs	Recommended Followup
Self-Care			
Eating	OK		
Grooming	Well groomed		
Bathing	OK		
Dressing	OK		
Bowel and bladder management	OK		
Mobility			
Positioning	OK		
Walking, with or without assistive devices (e.g., walker, cane)	OK		
Use of wheelchair	No		
Use of stairs	OK		
Ability to operate motor vehicle		License suspended due to DUI	
Use of public transportation (or other access to transportation)			Check on the availability of transportation and the need for explicit directions to treatment site
Communication			
Reading		Apparent reading problem	Request school records; records should also indicate whether or not he took special education classes, received a regular high school diploma, or was diagnosed with a learning disability

profile may raise as many questions as they answer. However, after the interview the major issues become clearer, and the next steps are more evident. John may have had one or more

sources of compromise to his mental abilities. Regardless of the source, at this point the screening has raised questions about his reading, learning ability, problem-solving

Figure 2-3 (continued)			
Functional Area	Strengths	Needs	Recommended Followup
■ Writing			Writing skills need to be determined, but requirements are minimal in program
■ Speaking	Well-spoken		
■ Listening			Listening ability may be limited by attention problems
Learning			
■ Attention		Attention problems	Ritalin use in childhood may indicate the need for a referral to a psychiatrist for further evaluation
■ Comprehension	Comprehension appears to be good		
■ Retention and Application			May need formal assessment of retention and application abilities
Problem-Solving			
■ Awareness and recognition of problem		Statement that reason for being in treatment is he "got into trouble" may indicate lack of awareness of problem (DUI)	
■ Identification of alternatives			Screen problem-solving skills and anticipate possible consequences of various alternatives; then decide on optimal alternative
Social Skills			
■ Understanding of social mores and values	Statement that he "got into trouble" indicates awareness of social values		

Figure 2-3 (continued)			
Functional Area	Strengths	Needs	Recommended Followup
■ Impulse control		DUI and story of fight indicate impulse control problem; although they may be drinking-related	Further evaluation called for since substance use can cause a lack of impulse control
■ Intimacy			Explore relationships
■ Conversational skills	Conversational skills consistent with age, etc.		
■ Empathy; ability to identify with others			Need to further explore
Executive Functions			
<ul style="list-style-type: none"> ■ Planning and organization ■ Motivation and initiation ■ Monitoring and reviewing ■ Motivation, decision-making, disinhibition 			Explore basis of sporadic work history

ability, and social skills. Additionally, executive functions as they relate to vocational capability need to be further evaluated. There are two questions the treatment provider should consider at this point:

- How will these limitations affect John’s participation in our program?
- What additional information do we need to make sure he can get the maximum benefit from treatment?

The extent to which John’s needs will affect participation depends on the program. His reading problems will only limit participation if written materials are a pivotal part of the program. Attention problems will be more of a difficulty in group treatment, extended sessions,

or treatment that occurs at the end of the day. His possible difficulties with awareness and problem solving will be more limiting if the treatment program requires higher levels of insight and abstraction, particularly if there are not opportunities for individualized attention to assist with understanding and recognition. Finally, limitations in social skills may limit participation in a residential program or other treatment that involves significant peer interaction.

If the nature of the treatment program is such that John’s needs will limit his participation, then more aggressive steps to seek additional information and assistance may be necessary. For instance, consultation with a rehabilitation psychologist might be called for to help

ascertain John's optimal learning style and ways in which problem-solving abilities and social skills can be mediated. On the other hand, if there appear to be few ways in which John's participation in the program will be hindered by his functional limitations, then treatment might be initiated with the intention that if problems emerge additional information or consultation will be sought.

Intake

Admissions Procedures

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 what 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 an assessment for substance use disorders and refer the client for treatment elsewhere.

Some treatment programs allow only 1 hour for the intake interview. Persons with certain physical or cognitive disabilities may require a longer interview, and rest periods may need to be scheduled. Flexibility should be built into interview scheduling. Some residential or inpatient treatment programs have found it effective to schedule an interview over 2 hours, before and after lunch. Facilities with in-house meal programs can offer the person a meal ticket when the intake is scheduled, which may provide an additional incentive to stay to complete the interview. In other programs, the interviewer can encourage the individual to bring a bagged lunch. For some people, the informality of a shared lunch may encourage the disclosure of issues that might not come up in a formal interview session.

Admissions procedures for people with sensory disabilities

While treatment providers should try to use qualified sign language interpreters for communicating with people who are deaf or hard of hearing, there may be times when the program is not prepared for such a client. If a person who is deaf or hard of hearing shows up unannounced at the treatment center's door, the program will need to cope as best it can. If no one at the agency knows sign language and there is no interpreter available to come in, paper and pencil is probably the best way to communicate to the person that she cannot be helped today.

Due to the wide range of reading abilities among people who are deaf, paper and pencil should never be utilized to gather detailed screening information. Written English forms and questionnaires should be interpreted into sign language for these clients. Some programs use a videotape in ASL, or with captioning to ensure understanding. The client who is deaf may have questions after watching the video, so an interpreter should be available to interpret any questions and the answers from the counselor.

If there are forms to be completed, people who are blind must have the option to complete them in the medium of their choice (Braille, large print, audiocassette, or sighted assistance). Admission to substance use disorder treatment can be a stressful process that will be made more uncomfortable by forced adherence to an uncomfortable modality. Individuals who are both deaf and blind will need to have a tactile interpreter to translate for them during the admissions process and afterward.

Admissions procedures for people with cognitive disabilities

A program should examine its written forms, from intake and screening forms to treatment plans, to determine whether they adequately address the needs of people who are cognitively

impaired. Intake forms should either be simple enough for a cognitively impaired person to understand or else someone should be available to assist the client in completing them.

It may prove useful for clients with cognitive disabilities if the informed consent form has a clause that allows the program to go to a collateral source, such as a family member or significant other, for information. (However, it should be kept in mind that information obtained from these sources may not be reliable, and that they may not have an accurate perception of a person's functional abilities.) It is a good idea to get background information from as many sources as possible, but to interview the person alone if possible. Having others present often distorts the quality of the interview.

Admissions procedures for people with physical disabilities

Persons with disabilities that affect their fine or gross motor skills may not be able to fill out self-report questionnaires because the boxes are too small; large print forms can assist persons with mobility limitations as well as some individuals with visual impairments. Computers can also be used to respond to questionnaires, as keyboards are sometimes less cumbersome than writing by hand (Moore and Siegal, 1989).

Intake Interview

A supportive, nonconfrontational intake interview is critical to engaging the client. Often, it is the pivotal meeting during which a client makes a short-term commitment to "check out" treatment. Depending on the treatment program, various approaches are used to help a client admit that he needs help in overcoming addiction. The Consensus Panel recommends that intake interviews of persons with coexisting disabilities be conducted by the most qualified staff members—those who have been specifically trained to understand their needs. The interviewer must have the skills to ask

difficult questions in ways that are not offensive and maintain a good rapport with the client. Most important, such an interviewer will be more likely to detect subtle or hidden disabilities not previously identified that may make a significant difference in treatment outcome. If the intake interviewer does not have expertise or knowledge about disabilities and she knows that the individual being interviewed for admission has a particular disability, a professional who is knowledgeable about that disability should be included in the intake interview.

One of the first tasks of the interviewer is to reduce the anxiety of the client, which may be high. Many intake interviewers begin an interview by asking a very open and friendly question. Questions such as "What led you here?" or "What happened to bring you here today?" are usually nonthreatening. It is recommended that this type of question be asked initially rather than a question about the person's disability. Even when a person has an obvious disability, an initial question about it is inappropriate. However, an individual with a disability may also be very sensitive to others being uncomfortable and unwilling to talk about his disability. Thus the interviewer must judge whether it will make the client more comfortable to introduce questions about the disability during the introductory or the intermediate stage. The interviewer must remember the focus is the person, not her disability.

Intake interviews for people with cognitive disabilities

As in any interview with someone who has a cognitive disability, it is important to find the optimal setting, one that has a minimal number of distractions. The interviewer should allow for breaks in the interview and be sensitive to the client's attention span and restlessness.

Questions for people with TBI should be structured to provide concrete landmarks (e.g., "What were you doing 3 weeks before your automobile accident?"). Working backward in

time while using specific events will assist the client to structure his responses. For any person who is cognitively impaired, keep questions concrete and avoid abstract concepts.

For people with cognitive impairments, it is important to remember to ask simple questions; to repeat questions; and to ask the client to repeat back, in her own words, what's been said. The counselor may need to periodically check whether the person is understanding what is being asked. If the question is not understood it will need to be repeated in a different manner. However, it is important to not talk to people with cognitive disabilities below their own level of communication or as if they were children. They will be highly insulted, and will probably not come back.

Along those same lines, the interviewer should give specific examples to illustrate words or phrases which may be too abstract or sophisticated, such as "abstinent" or "withdrawal symptoms." Such rephrasing is appropriate for a wide range of clients—not only the cognitively disabled but also clients from different cultural backgrounds.

Some interviewers find it useful to ask a client to write a few sentences describing his activities over the past few days or weeks, or to read a sentence from the informed consent form. Some high-functioning individuals may simply never have learned how to read and write, and the interviewer should not make assumptions about a disability based on the lack of this ability.

The interviewer should end the interview by summarizing the information learned. Recognizing a person's difficulties by providing feedback is an important way to let her know that she has been understood. The interviewer should present an overview of the services the program offers that meet the client's individual needs, as well as express the program's willingness to accommodate her disability

needs, in hopes of obtaining her commitment to return.

Intake interview with people with sensory disabilities

An intake interview should address the eye condition and blindness adjustment skills of people who are blind or visually impaired. The counselor should know the pathology of the loss of vision (if it was congenital, adventitious, or traumatic), and precisely how much vision remains. Each situation will affect the treatment plan differently.

It is important to know how well a person who is blind can maintain independence. Some considerations are

- What travel aid is used?
- What communications modality is used?
- How does the person maintain clothing organization?
- What are the person's skills in food preparation and hygiene?

The counselor must ask direct questions because the person who is blind may be ashamed of his lack of skills and unknowingly lie. For example, do not assume because someone has a white cane that it is used properly. Programs can consult with a local disability service provider who has experience working with people who are blind to find out what are good and/or acceptable levels of ability. Questions such as, "Tell me how often you've used Braille in the last 2 weeks," can then be used to assess each individual's level of ability. If the person who is blind has limited knowledge and skills about blindness, the counselor may need to arrange some form of training. This lack of knowledge and skills could be a factor in the person's substance use.

When interviewing people who are deaf, treatment programs should contact an interpreter referral service in their area to ensure that sign language interpreter services will be available when needed. 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. Family and friends often cannot be neutral and unbiased, which is the interpreter's responsibility. Use only qualified interpreters as determined by either a chapter of the Registry of Interpreters for the Deaf or a state interpreter screening organization. Ideally, the interpreter will have had previous experience working in treatment settings or will have at least attended workshops related to addiction treatment settings. However, it is not always possible to obtain an interpreter with this specialized training. In any case, prior to the session, the staff should try to meet with the interpreter to clarify the purpose of the interview and the meaning of the terminology and the questions to be asked.

Intake providers and counselors at any stage of the treatment process should realize that sign language interpreters have varying skill levels. If an interpreter has difficulty interpreting for a particular individual, the counselor should ask questions to determine if the problem lies with the skill level of the interpreter or the cognitive processing or language style of the client who is deaf. This is a critical piece of information for the counselor to have during the intake process so that the counselor does not misdiagnose the client or assign a level of functioning to him that is not correct.

Some of the questions during the intake process may be difficult to interpret into sign language. For example, some assessments include questions to test orientation to reality and cognitive functioning. In order for the interpreter to interpret these questions correctly, she could give away the answers. In these instances, the interpreter will need to discuss the question with the counselor to determine how the question can best be asked to obtain the information needed. Much of the language used

in substance use disorder treatment will not be familiar to clients who are deaf and will need to be explained.

Additionally, some individuals who are deaf or hard of hearing may have limited communication skills. They may not have even been exposed to any formal system of sign language. In these cases, an interpreter may not know how to communicate questions to the person who is deaf. The screener can try to use props or pictures to help make the message understood in a different way. It may also help to hire a deaf interpreter to work along with the hearing interpreter. The deaf interpreter would be a native sign language user and thus is likely to have a better understanding of how to communicate with a deaf person who has minimal communication skills. If these methods do not work, it may not be possible to make the screener's questions understood by the client.

Intake interview with people with physical disabilities

When conducting an interview 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. Interviewers should try to place themselves so that they are no higher than the person being interviewed. They should be aware of the pace of the interview, and attempt to gauge when clients are becoming fatigued. In addition, some forms of chronic pain make lengthy interviews excruciating. Periodically inquire how the individual is doing and offer to take breaks in order to make the experience more tolerable.

It is important to consider whether an individual's physical disability may influence his responses in ways which portray him inappropriately. A person with a long-term back injury may, in fact, wish to return to work, but still respond that he doesn't "intend on working in the future." He may neglect to inform the interviewer that working even part-

time in the future may jeopardize his disability benefits, including medical services.

Adapting Substance Use Disorder Screening for Persons With Coexisting Disabilities

As stated above, the more information a provider has about a client's disabilities and functional limitations, the more she can tailor treatment to the client. As with any person with a substance use disorder, details about the patterns of abuse and dependence are also critical to effective treatment. This section presents modifications to screening and assessment questions for people with coexisting disabilities.

Drug and Alcohol History

It is important to understand the relation of drug use to an acquired disability. Some people begin using substances in response to an acquired disability; for others their substance use may have caused or contributed to the coexisting disability. Some people may not even be aware that their disability is substance-related. The use of prescription medication in combination with alcohol and the use of other people's prescription medications, are common for some persons with physical disabilities (Moore and Polsgrove, 1991). Consequently, make certain that this aspect of the drug history is well discussed.

Screening people with cognitive disabilities

Rather than asking generally about "abstinence," take a history of use. Ask, "Did you get high today?" or "What about yesterday?" Try to ask concrete questions, perhaps using time markers such as the 4th of July. It may be helpful to ask the person to relate his whole life story; opportunities to ask

about substance use will occur during the telling of the story.

A client's understanding of "alcohol" may be different than the interviewer's. Be as specific as possible with clients—rather than asking if they "use alcohol," ask if they like to drink beer, wine, wine coolers, etc. Remember that wine coolers may not be the same as wine to many people. It may help to use props such as different glass or bottle sizes rather than asking how many ounces were consumed.

Do not assume people with cognitive disabilities understand the terminology being used; explain or define it and ask them to repeat back their understanding of the words. Instead of asking if they have had a blackout, describe a situation that would explain what this means. For example, ask, "Have you ever gone to a party and drank and the next thing you know you wake up and can't remember anything from the night before?" (It may also be necessary to ask if this problem ever occurred when the person was sober, or is still happening now, in order to check for dissociated symptoms.)

Psychosocial History

This history should look at an individual's work record, residential life, educational background, family, employment status, mental health history, and history of past abuse (since many people with disabilities have been victims of physical, emotional, and/or sexual abuse). It is also important that the assessment of a person with a disability gather information about involvement in vocational, physical, or social rehabilitation. The history should determine whether a person has had skills training, where she received it, and how long ago it was completed. The interviewer should determine when the training took place relative to the history of the substance use disorder. If the client was undergoing personal adjustment training and using substances at the same time, it is reasonable to assume that he will need to

repeat at least some elements of the adjustment training.

Use of Screening Information

Treatment providers should not feel the need to be experts on all disabilities or disability issues. Instead, providers should view the task of screening for disability symptoms as a benefit for individualizing and developing appropriate

treatment goals. Treatment should be more beneficial to clients if their limitations are considered in the development of their treatment goals. This in turn should make the counselor's job less frustrating and difficult. Chapter 3 of this TIP discusses how screening information can be applied in treatment planning and counseling and the alterations that will need to be made for clients with coexisting disabilities.

Appendix A

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