Substance Abuse and Mental Health Services Administration

*Center for Substance Abuse Treatment*

**Substance Use Disorder Treat ent For People ith Physical and Cognitive Disabilities**

*Treatment Improvement Protocol (TIP) Series*

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Public Health Service

Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment

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**3 Treat111ent Planning and Service Delivery**

onsidering the prevalence of people with physical, cognitive, and sensory disabilities who require substance use

disorder treatment, treatment providers should be better informed about the particular needs of this segment of the treatment population. They should also put that knowledge into practice, which may require changes to the treatment program. Successful treatment for all clients must involve all levels of the treatment staff; changes at the systemic level will be reflected at the organizational level and, most importantly, at the client-counselor level where recovery begins. When such systemic and organizational change does not occur, treatment personnel do not receive adequate support, and they and their clients feel isolated-repeating and maintaining the feelings of isolation that are often at the core of addiction.

In order to make treatment as effective as

possible, persons with coexisting disabilities will require specific accommodations. Treatment plans should be revised to accommodate the needs of people with coexisting disabilities, with recognition that not all clients respond equally well to the same types of treatment. If at all possible, treatment plans should be drawn up on a case-by-case basis; doing so will ensure better outcomes for all clients, not just those with disabilities. Understanding how an individual feels about her own disabilities will also enhance treatment.

# Understanding Client

**Attitudes in Treatment**

### Denial

Kubler-Ross identifies five stages in the grieving process: denial, anger, bargaining, depression, and acceptance (Kubler-Ross, 1969). Denial of a substance use disorder is a common client characteristic that must be addressed by treatment professionals. But as they face multiple losses (a loss of physical or cognitive functioning and the loss of a substance upon which they are dependent), some people with coexisting disabilities may experience two types of denial at once: denial of the substance use disorder and of the disability. The presence of a coexisting disability can alter how a person manifests denial of his substance use disorder or can cause his denial to be focused solely on the disability. For a person with a disability, substance use may also be a form of "bargaining." She may think of her substance use as something she is "allowed" to compensate for a disability she must face.

Recognizing her problem forces her to cope with

all the often painful emotions typically experienced by any person in recovery, in addition to those related to her disability. For most people with severe disabilities, adjustment to this condition is considered a lifelong process (De Loach and Greer, 1981).

Most substance use disorder treatment professionals already have extensive knowledge of the complex ways in which psychological denial and addiction are intertwined, and they have developed methods of working with clients whose denial presents a significant obstacle to treatment. However, for people with disabilities, denial has additional dimensions.

Some individuals may have used denial of their disability at various times in their lives as a legitimate coping mechanism to deal with the trauma of an accident or to push themselves toward a goal. Others will want to avoid the stigma and devaluation of being labeled. Other individuals may be cognitively unable to recognize their functional limitations, a problem that may only appear to be denial (see Figure 3-1 for some of the factors that influence a person's understanding of a coexisting disability). An addictions counselor may not have the time or the expertise to keep confronting the denial of

the disability; he should make a referral to a

peer counselor at a Center for Independent Living (CIL), whose job it is to help disabled individuals come to terms with the limits of their disability. The two counselors can then work as a team.

### Risk Avoidance and Risk Taking

Another important issue in treatment planning is the extent to which risk taking and risk avoidance may shape the daily life of a person with a disability . Some individuals with disabilities have been taught or have otherwise come to believe that they should avoid sources of risk (e.g., risk of embarrassment, risk of rejection, risk of failure). Avoidance may become such a favored strategy that it takes on the force of a personality trait, resulting in increased isolation. For example, a person who uses a wheelchair may miss seeing a much­ anticipated movie to avoid a situation in which she arrives at a theater and is unable to get in because of a physical barrier. A person with a

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| Figure 3-1  People's Understanding and Acceptance of a Coexisting Disability |
| People vary in how well they understand or accept their own disabilities. Some persons entering treatment for substance use disorders know what interventions their disabilities require. Others do not. Some people appreciate and benefit from accommodations to their disability, whereas others may be reluctant to acknowledge that some condition limits their functional capa city. The following are some of the factors that affect a person's willingness to accept the realities of her disab ility:   * The severity, duration, or specific functional limitations of the disability * Societal reaction to and expectations of the person with a disability * The developmental stage at time of the disability's onset * Access to resources and societal mobility * A history of risk-taking behaviors prior to the onset of the disability * A history of having used substances to cope with a disability * Recurring and episodic forms of personal grieving due to disability issues * The amount of independence resulting from a person's life s tyle and personality * Age (generally, younger people are more willing to eventually accept their disability) * Marital status (married people are more willing to accept disability than single or unattached) * Income (the greater someone's income, the more willing he is to accept disability) |
| Source Chart modified from Li and Moore, 1998 |

visual or speech impairment may avoid riding the subway for fear of missing his stop or of having to ask for directions. A person with mental retardation may have been victimized by new "friends" so often that she avoids pursuing friendships. Long-term use of substances may be deeply intertwined with such avoidance strategies. Treatment planning can introduce situations, such as attending a 12-Step meeting or trusting an unknown group member, to which the person's first response may be impulsive anger, or exhibiting avoidance. Early in the treatment planning process, discussions of how a person with a disability uses avoidance strategies in daily life will be beneficial to both him and the treatment provider. The person with a disability should be encouraged and supported to try other strategies.

While some people with disabilities avoid

social interactions or situations that involve risks, others take too much risk rather than too little. A client with a coexisting disability, especially if the disability is of traumatic origin such as traumatic brain or spinal cord injury, may be more likely to engage in high-risk behavior for two reasons. First, individuals who sustain injury-related disabilities are often prone to risk taking because of personality and behavioral characteristics, the same characteristics that contributed to their injury.

Second, neurological damage can impair judgment and further increase risk taking. People with learning disabilities, especially those with attention deficit/hyperactivity disorder (AD /HD), may also tend to take excessive risks because they too lack sufficient skills or judgment to recognize and avoid risky situations. Obviously, continued risk-taking behavior often places the person in situations where sobriety is challenged.

### Strengths-Based Approach

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 may, because they have so frequently been viewed in terms of what they cannot or should not attempt, have learned to define themselves in terms of their limitations and inabilities. Well­ intentioned family members and friends may encourage dependence and may even feel threatened when the person with a disability attempts to achieve a measure of independence.

However, people with disabilities must also understand their functional limitations, especially in relation to their risk for relapse.

One of the overriding goals of treatment for people with disabilities is that they gain and maintain self-awareness about their functional limitations and capacities, as well as their substance use disorders. A better understanding of one's unique learning needs is an important step toward sobriety. For example, some persons with cognitive disabilities experience a great deal of difficulty learning from written material. This can be a particularly difficult limitation to acknowledge, especially in group settings or a workplace. The client who learns that it is a sign of personal strength to make adjustments and seek accommodation for reading difficulties is not only more empowered to make important decisions relative to sobriety, but also understands the importance, for example, of expanding the repertoire of skills used to compensate for a low reading level.

It is key to the treatment planning process for

the treatment provider to learn how well a person understands her disability. Some people will have a clear knowledge of the ways in which they are functionally limited, whereas others may deny having any limitations.

Similarly, in the area of individual strengths, some people will have received extensive support from family, friends, and professional caregivers to pursue their interests and develop

unique talents, but others may have been overly sheltered or may have experienced repeated failures. A treatment provider should confer with a disability expert on this delicate topic of how to discuss a client's disability with him.

# Treatment Planning

Treatment plans for people with coexisting disabilities should be flexible enough to take into account changes that may occur in a person's condition or new knowledge that may be gained during treatment. By law, providers will need to make accommodations for people with disabilities so that they will have equal access to all components of the treatment program. Many of these accommodations are simple to make and inexpensive, but all will require planning and understanding on the part of providers.

### Making Treatment Accommodations

Many substance use disorder treatment providers have addressed the problems faced by individuals with coexisting disabilities, including those who are human immunodeficiency virus (HIV) positive or have acquired immunodeficiency syndrome (AIDS) and individuals with coexisting psychiatric disorders or disabilities from past traumas.

However, the treatment field has been slower to address the needs of individuals who have physical and cognitive disabilities. These populations, especially since the advent of the Americans With Disabilities Act (ADA), present a new challenge to the field. Providers may be uncomfortable when first confronted with a person with a physical or cognitive disability.

That unease can lead them to err in one of two directions, either by enabling the person to use his disability to avoid treatment or, conversely, by refusing to recognize that a legitimate need for accommodation exists.

##### *The need for understanding*

Some people with disabilities present in the treatment setting with issues that require a great deal of therapeutic understanding. Many of these clients begin treatment expecting that their needs will not be understood, and their previous experience has likely reinforced this view. This may lead a client to believe that no one understands her, and that she is therefore entitled to use mood-altering drugs in order to cope with her own situation (Moore, 1991c). In such cases, staff members who demonstrate an understanding of the disability, such as knowing about its onset and course, can show empathy while maintaining realistic expectations for the client's full participation in the treatment program (De Loach and Greer,

1981).

Providers should know the degree to which a disability affects a person's life. For some persons with severe physical limitations, resulting from conditions as diverse as cerebral palsy and spinal cord injury, the task of simply preparing for the day can be exhausting. Some people with disabilities must arise before dawn every day in order to begin the arduous process of dressing, conducting a hygiene program, and meeting transportation that may take hours to take them into town. Obviously in cases like this, treatment staff must consider pacing of assessments and treatment. Rest periods, breaks, and "downtime" become critical components of a successful rehabilitation program.

##### *Reasonable treatment* accommodations

If a client believes that he needs an accommodation, the treatment provider will still need to determine if the request is legitimate or an attempt to manipulate the treatment

program. Most substance use disorder treatment providers are aware of client efforts to elicit enabling behavior from them. However,

providers' vigilance in avoiding enabling may

predispose some of them to reject legitimate requests for accommodation. If there is any doubt on the part of the provider regarding the legitimacy of the person's request, he should consult a "disability expert" in order to make this determination (see Figure 3-2 on how to locate an appropriate expert). Of course, experts in disability services will themselves face uncertainty when trying to determine if an appropriate accommodation is being made or if it is enabling the client to avoid change.

Too much of the wrong type of modification, on the other hand, may unwittingly enable the person to avoid change. For example, whether she recognizes it or not, the provider may react by thinking, "He has it so hard, maybe he should be able to take it easy instead of reading all this material." Or even, perhaps in the case of a person with AIDS or spinal cord injury, "If I were in her shoes, I'd want to drink, too." Such misplaced sympathy is harmful.

Accommodation does not mean giving special preferences-it does mean reducing

barriers to equal participation in the program. People with coexisting disabilities are harmed by a provider's complicity in their avoidance of all challenges to chemical dependency.

Figure 3-3 illustrates enabling, denial, and appropriate accommodation in the treatment setting. Making the distinction among denial, enabling, and accommodation is more difficult for persons with coexisting disabilities. Adding to the challenge is the fact that people may not always be able to articulate their disability­ related needs. It is important for multidisciplinary teams of providers to discuss and resolve these issues on a case-by-case basis. Increased communication between the substance use disorder treatment and disability services fields will help providers understand the approaches and philosophies needed to treat people with coexisting disabilities. The Panel recommends cross-training between substance use disorder treatment providers and agencies that work with people with disabilities, including vocational rehabilitation (VR),

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| Figure 3-2 Locating Expert Assistance |
| "Experts" in disability services can be located several ways, depending on the nature of the client's disability and the local resources available. Clients who understand their disability may in fact be the best "experts" on their condition and specific needs; however, it is not uncommon that persons requiring treatment for substance use disorders will not understand basic aspects of their situation or condition. In such cases, immediate family members or close friends may be important sources of information and guidance. The treatment team should also consider contacting other sources: a disability specific service organization (e.g., United Cerebral Palsy, an organization for the blind or deaf, Association for Retarded Citizens), social workers, case managers, rehabilitation specialists, psychologists, nurses, or physicians associated with a social service agency providing disability services for the individual client in question (e.g., vocational rehabilitation, family services for people who are deaf and hard of hearing, the Department of Veterans' Affairs' physical rehabilitation unit, community case management services), or other organizations recognized by the disability community (e.g., CILs, governors' committees for persons with disabilities, Paralyzed Veterans Association, local or State consumer coalitions for persons with disabilities). More information on these and other pertinent organizations can be found in Appendix B; more on developing linkages with other agencies  can be found in Chapter 4. |

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| Figure 3-3  Responses in a Treatment Setting |
| 1. An agency has this rule: All clients must attend an Alcoholics Anonymous (AA) meeting every night. A young person with TBI protests that he does not want to attend AA meetings because the meetings are filled with old people who don't understand him and don't think he should be taking medication for pain.  **Denial response:** There are no exceptions to the rule. Everybody must attend AA every night.  **Enabling response:** It's OK, you don't have to go if they don't understand your problem.  **Accommodation:** We'll help you find support at the existing meeting, or a different meeting or support group that can better recognize and accept your legitimate medication needs. |
| 2. A treatment program has three discussion groups during daytime hours. A person with multiple sclerosis asks to be excused from the third discussion group because of fatigue.  **Denial response:** I'm sorry you're tired, but everyone has to attend all three meetings.  **Enabling response:** If it's a problem, you don't have to go.  **Accommodation:** Why don't you take a rest period in late afternoon, and attend a third meeting, or alternative treatment activity, in the evening? |
| 3. A person with a visual disability is being coached by the treatment program in her job search. All the positions she finds either have schedules that require her to miss her AA meetings, or are in locations inaccessible by the public transportation she requires. She argues that she should not have to attend AA.  **Denial response:** You're just making excuses. Figure out how to make it work.  **Enabling response:** You're right. This is too much of a problem. Give up the AA meetings, or the work.  **Accommodation:** We'll help you arrange to ride to work with a coworker, so that you have  transportation to and from your job. Or else, we'll help you find work with a flexible schedule. |
| 4. An unemployed person who is alcoholic with time on his hands and little social support is turned away from a State-run VR program because he has not yet maintained sobriety for 6 months. He is  outraged but decides there is nothing he can do. |

**Denial response:** You'll just have to figure it out and get a job on your own.

**Enabling response:** This is a terrible situation, but I guess you'll have to wait until January.

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| **Accommodation:** We'll work with you to plan a course of prevocational activities that you can begin doing now. Then you can file an appeal with the State concerning the denial of services; we'll help negotiate with the vocational rehabilitation program for flexibility. (The program should work to get the system to admit persons who are compliant with treatment recommendations, even if they have not yet met the requirement in terms of months of sobriety. In this way the client can begin getting involved in productive activities. Agreeing with the client that nothing can be done encourages his  sense of victimization.) |

medical, and other professional specialists on specific disabilities, disability service providers, CILs, and disability education and advocacy organizations.

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

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| Figure 3-3 (continued) |
| 5. A client with an alcohol use disorder who is deaf and lives in a remote rural area has few social contacts, and these are all at the local bowling alley, where her acquaintances tend to drink alcohol. Denial response: You're an alcoholic-you just have to stay away from bars.  Enabling response: You need to get out and socialize . Go, but try not to drink.  Accommodation: It's possible for you to see your friends at the bowling alley and not drink alcohol, even if they are. We'll teach you the skills to socialize in that setting without drinking alcohol, and teach you to recognize cues that indicate you are vulnerable to relapse. (By making such an accommodation the treatment program recognizes the unique challenges this person faces in attempting to build sources of social support, as well as the additional responsibility of the program to teach the skills she will need to function in the settings she is able to identify. If the program insists that a person avoid all settings where alcohol is served it has a responsibility to help the person find other sources of social support and companionship. Simply telling her to "stay away  from bars" denies that isolation is also a threat to her sobriety.) |

that is individualized and that takes their specific functional capacities and limitations into account.

*Extending treatment times*

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals has found that individuals who are deaf and hard of hearing have less access to prevention and intervention programs and less knowledge about addiction and recovery than nondeaf clients who enter treatment. Therefore longer term treatment may be required for them to have a level of knowledge similar to nondeaf clients when they leave treatment (Guthmann et al., 1994).

People who are blind and those with a cognitive disability have similar problems with which to contend. Sighted people gather approximately 80 percent of their information through their vision. Obviously, people who are blind or visually impaired cannot take in as much information through reading or through conversation. Many cognitive disabilities also affect the rate at which people can learn, and so people with these disabilities may also require more treatment time to understand the same amount of information.

### Motivational Aspects of Treatment

Counselors should work with all clients to decide what incentives will best motivate them. Motivational strategies in treatment involve a number of approaches, including assisting the client to better understand the intrinsic rewards of a sober lifestyle and the negative consequences of continued use. For people with coexisting disabilities, these rewards and consequences can sometimes be different from those of other individ uals.

## *Considerations for people with* physical disabilities

For a person with a spinal cord injury, there are a number of medical concerns associated with the disability that are dramatically exacerbated by substance use. Chronic bladder infections are relatively common for persons with spinal paralysis and other mobility impairments.

Alcohol consumption promotes, irritates, and inflames bladder infections, as well as nullifies the effects of antibiotics. Alcohol consumption has been identified as contributing to *autonomic hyperreflexia,* a nervous system reaction that leads to a rapid and sometimes fatal rise in blood pressure. Some persons with mobility impairments experience difficulties with

balance-even small amounts of alcohol or mood-altering drugs can impair balance to the point that falls and other problems are more likely to occur. A fall for a person with a mobility impairment can be more costly and medically debilitating than for someone without such a condition. Anecdotal evidence from physical rehabilitation programs indicates that persons with spinal cord injuries who consume substances to the point of intoxication often experience decubitous ulcers of the skin (pressure sores), a serious medical condition that can take months to heal. Persons with physical impairments are also more likely to be using prescription medication for medical management of their disability. Alcohol and drugs nullify the effects of some drugs while making others potentially lethal. Liver inflammation also occurs more rapidly when alcohol use is potentiated by some prescription drugs.

## *Considerations for people with* cognitive disabilities

People with cognitive disabilities may have difficulty recognizing the negative consequences of their substance use, which does not necessarily mean they are in denial of their

problem. Showing some people with mental retardation how substance use affects other aspects of their lives will provide them with strong motivation for continued sobriety (see Figure 3-4).

Alcoholics who have sustained TBI often perceive alcohol as improving their social interaction and comfort level, when it is actually reducing social judgment and insight to an even greater degree than it does with other, nondisabled drinkers. Clients with TBI are at a much higher risk for seizures, in general, and they should be made intensely aware of alcohol's effect in further lowering their seizure threshold. TBI patients are also at least twice as likely as other individuals to sustain additional

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| Figure 3-4  Development and Coordination of Goals |
| Fred has mental retardation and is living in a group home and working with housing program staff so that he may move with a roommate into one of the program's apartments in 2 years. Short-term goals developed with housing staff may include refining meal preparation skills, adhering to a schedule for cleaning the house, and developing interpersonal skills to solve differences with housemates.  Simultaneously, he will be working daily in a transitional employment program with the goal of graduating to competitive employment in a couple of years. Short-term goals developed with job counselors may include learning proper grooming and punctuality. Fred may seem to be advancing with little trouble toward the ultimate goals of housing and vocational independence only to experience repeated and discouraging setbacks due to monthly episodes of binge drinking. The counselor should help him understand the concrete cause-and-effect relationship between staying sober and achieving greater independence, which may not be clear to him. Treatment goals to reinforce this direct association should be developed. Treatment plans should identify specific behavioral goals and a number of different reinforcers for making progress (e.g., tokens toward the purchase of his own "Big Book"; homework of reporting his daily activities and successes to a case manager, counselor, 12-Step sponsor, or family member; a "sobriety chart" on the counselor's wall  where he can see his progress charted). |

brain injuries, a risk that rises with alcohol use (Corrigan, 1995). Educating the client about these problems can increase his motivation for abstinence (Langley et al., 1990).

**Consequences**

Developing a treatment plan often requires contracting with the individual to identify specific behaviors that indicate that the plan is not working and to determine what consequences will occur when these behaviors become evident. In case problems do arise, a graduated series of appropriate consequences will enable a better response on the part of treatment staff. A program may require outside consultation from a disability expert (see Figure 3-2) to develop an understanding of what consequences are appropriate, and should try to

have such an expert as part of the treatment team. An example of how one program, the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, works with behavioral contracts for people who are deaf is presented in Figure 3-5.

Contracts with people with disabilities may need to be more explicit than those with other people, and the consequences for relapses in particular may need to be individually tailored to what the individual is realistically capable of achieving. Discharging a patient from the treatment program for a single relapse, for example, may be counterproductive for many people with coexisting disabilities, especially considering how difficult all life transitions can be and how limited the options may be for alternative treatment or care. It is possible that dismissing a client with a coexisting disability

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| Figure 3-5  Behavioral Contracts in a Treatment Program for People Who Are Deaf |
| The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals uses a behavioral approach with clients that includes education and support designed to help individuals identify and correct self-defeating behaviors. Intervention efforts are matched to behaviors of concern. An initial intervention would typically be a private discussion with the counselor, which often helps the client recognize and change the behavior. If the behavior continues or becomes worse, a behavior contract might be an appropriate second-level intervention.  Behavior contracts may be utilized for incidents such as the violation of unit rules, arguing about staff directives, failure to complete work on time, failure to focus on treatment, or focusing on the needs or issues of other patients (rather than one's own). Behavior contracts specify the behaviors for which they are given as well as the changes that are expected.  Another behavior management technique used is the probation contract. Probation contracts may be used to help a client recognize behaviors that seriously threaten the success or quality of her treatment experience. It is used as a followup to a behavior contract if a client does not respond positively or is openly defiant to the terms of a behavior contract. Probation contracts also specify expected changes in the client's behavior and may include an assignment that helps the client identify and change her behavior. Failure to adhere to the probation contract may result in the client being  asked to leave the program. |

for a relapse will shut the door to treatment for some time.

Some nondisabled people in treatment may protest the "special treatment" of an individual with a disability, and the counselor should be prepared to address that issue with all clients in the program. The provider should emphasize that program policies, procedures, and practices aim to ensure accessibility and promote success for everyone, and therefore treatment plans need to be individualized. 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 that accommodations for persons with disabilities simply give them the help they need to meet shared goals. The exceptions and the rationale for these exceptions should be discussed openly in group meetings so that peers are aware of the exceptions and why they need to be made. The group may participate in some problem solving and have other suggestions that may be helpful. These discussions will allow the person with a disability to work in partnership with his peers as opposed to being seen as the recipient of special favors. However, some people with disabilities may, rightfully, wish to preserve their privacy and not have their disabilities discussed, and clients should be consulted about their feelings before such open discussion proceeds.

As discussed below, when a person with a

disability fails to attain a treatment goal, one consideration should be that the treatment accommodations were not sufficient and the treatment plan did not articulate the proper steps for that person to reach that goal. For example, if a nondisabled client fails to complete a written assignment of a Step 1 report for a 12- Step program, he may experience a consequence, such as withdrawal of a leisure activity. A client with a cognitive, sensory, or physical disability, however, might be unable to complete such a report. In this case, however,

the program may respond by working with her to develop an accommodation. If the individual agrees to make an audio recording of the report and fails to do so, then consequences follow.

Figure 3-6 presents three common treatment tasks with consequences and accommodations for people with disabilities.

### Provide Accessible Leisure Activities

Treatment programs often try to encourage people to participate more in leisure activities. However, many treatment programs have difficulty identifying and responding to the needs of people with disabilities. The following sections offer suggestions for making recreation programs as inclusive as possible.

##### *Leisure activities for people with* physical disabilities

Many people with disabilities resign themselves to spectatorship because their disabilities often force them to sit on the sidelines. Participating in enjoyable activities with others and having fun without consuming substances is a learned skill that many persons with disabilities don't have an opportunity to practice. 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.

A physical disability can contribute to

potential medical problems, such as poor circulation or digestion, obesity, heart disease, or other medical conditions. The often sedentary lifestyle associated with substance use only makes these conditions more pronounced . Exercise and activity can stave off these problems; therefore it is especially important for counselors to find activities that people with disabilities can participate in.

Treatment staff may need help adapting leisure activities so that all people with disabilities can participate. The local Special

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| Figure 3-6  Sample Contracts for People With Disabilities | |
| Task: | The individual must write a history of her addiction during the first 3 days of an inpatient program. |
| Consequence: | Failure to accomplish the task will result in a loss of program privileges (e.g., not  viewing the Friday night movie, placing vocational goals or plans on hold, delaying graduation from treatment). |
| Accommodations: | * Allow more time. * Allow the use of alternative formats (e.g ., someone who is blind, deaf, or cognitively impaired can dictate or draw aspects of his history). * Be specific in assigning a time period for reporting substance use history (e.g.,   last year, "since my arrest"). |
| Task: | The individual in outpatient treatment must attend all groups. |
| Consequence: | Missing a group will result in automatic discharge. |
| Accommodations: | * Work with the individual to be sure a ride is available. (Transportation problems can be substantial for some persons with disabilities.) * Pair up a person with a coexisting disability with a nondisabled group member who will help ensure he gets to the group session. * Substitute another activity if the individual cannot get to the meeting (e.g., an individual session, a 12-Step meeting, writing a report). * For persons with memory problems, call and remind them that a session is occurring or assist them in creating memory books that include necessary   information on group meetings. |
| Task: | The individual must attend 90 Alcoholics Anonymous (AA) meetings in 90 days. |
| Consequence: | Failure to attend will mean that the client is reported as noncompliant to referral sources. |
| Accommodations: | * Pair up the individual with a nondisabled group member who can accompany her to a meeting. Take extra time to assist someone in finding a temporary AA sponsor who understands disability issues or is willing to learn. * Substitute another activity if the client cannot get to a meeting, such as   requiring attendance at other groups or self-help meetings (e.g., disability­ related groups in a rehabilitation program, Schizophrenics Anonymous, church groups).   * Have the client report daily by phone to the counselor or AA sponsor. |

Olympics Committee is one resource for youth and some adults with developmental disabilities, and can be located through local school systems. The National Association of Therapeutic Recreators assists adolescents and adults in accessing a whole range of activities from which they have traditionally been

omitted; their offices can be located through university disability offices or local physical rehabilitation programs. YMCAs, YWCAs, Boys' Clubs, United Way, and CILs also can assist treatment staff in identifying specialized recreational programs that may be of assistance.

##### *Leisure activities for people with* sensory disabilities

In the case of individuals who are deaf and prefer to socialize with other people who are deaf, leisure activities with a supportive peer group are difficult to find. The size of the Deaf Community is limited. In any State, however, there will be different clubs and organizations sponsoring activities for community members. Alcoholic beverages are present at many community events, and, if not, people may go to bars after the event. It will be difficult for a person who is deaf to find alcohol-free activities that include other people who are deaf. There may be limited options to form a peer group that is deaf and substance-free. Socializing with hearing peers who do not know sign language but who are sober may not be a realistic alternative, because the person who is deaf could feel extremely isolated. The counselor and client who is deaf need to be creative in developing plans for the client to become involved in leisure and social activities.

### Adjust Treatment Goals To Fit the Person

For clients with disabilities, failure to achieve treatment goals may indicate that not enough attention has been paid in the treatment plan to outlining a series of discrete steps to meet the goals, or that the goals themselves need to be ad jus ted . In setting a goal, the client and the counselor must work closely to understand all the physical and cognitive requirements of meeting a goal. Sometimes it will be necessary to teach someone how to make a new friend before he can be expected to give up the only one he has in order to remain sober.

People with coexisting disabilities face many challenges, barriers, and apparent dead ends, and the skills training and decisionmaking practice necessary to address these issues are often not available in accessible and comprehensible ways. Consequently, treatment

goals for these consumers need to be more individualized, expansive, and reflective of the immediate environmental challenges which confront them on a daily basis. Obviously, some of these ancillary, but essential, goals need to be accomplished with the assistance of persons beyond the immediate treatment team .

##### *Adjustments for people with* physical disabilities

The treatment plan for a person with a physical disability needs to take into consideration not only the physical limitations the person might have, but also the psychological and social consequences of the disability. Issues that need to be addressed may include impulsivity, social isolation, low self-awareness relative to medical or psychological needs, anger, feelings of hopelessness, or outright panic that life without substances will be unbearable considering the disability. These issues are hardly new to the treatment provider, nor are they unique to persons with disabilities; however, a disability may exaggerate the severity of these conditions or their impact on recovery.

The counselor should work with the client to

set up incremental goals, rather than expecting major changes all at once. For example, a person who uses a wheelchair and her counselor may set a goal to attend an Alcoholics Anonymous (AA) meeting at a certain site several times a week. They may then set several interim steps for her to take with the ultimate goal of regular meeting attendance. These may include having her call the site to ensure its accessibility, working with the counselor to arrange reliable transportation, and making a trial run to the site during a less busy time of the day, perhaps with a friend or with the

counselor . In the end, the goal may or may not

be attained, and more discrete steps may be needed before it is achievable. For example, the transportation may prove to be unreliable on some days, and alternative transportation may

need to be arranged or a wheelchair-accessible AA meeting site located.

For another person with a disability, regularly preparing evening meals at home may be a treatment goal, especially if he has been accustomed to eating dinner at a bar. A number of small steps are then successfully negotiated: The person receives cooking skills training from another agency, basic cooking equipment is obtained, and a grocery delivery service is engaged. However, he may then find that he tires easily after standing for even a short period in the kitchen. An energy conservation program may be a necessary additional step before he can fully use his new skills. A disability expert on the treatment team can help the individual create strategies to conserve energy, such as obtaining a high stool to sit on during meal preparation.

***Adjustments for people with cognitive disabilities***

A similar process of planning small steps to meet a goal should be undertaken for people who have cognitive disabilities. For example, a person with brain injury and alcoholism may set as a goal avoiding drinking on Friday night after picking up her Supplemental Security Income (SSI) check in the afternoon. If she does not drink then several other leisure activities are possible during the weekend, all of which she enjoys and benefits from. She and her counselor may then develop the interim goal of cashing the SSI check at a bank on Friday instead of the liquor store, and plan a structured, sober activity for immediately after the check cashing. The individual could also meet with her case manager for the purpose of budgeting and paying bills. She and the counselor or case manager can discuss how she would like to spend what is left, and if she would like to save for something special. Alternatively, the treatment program may wish to consider forming a relationship with a nearby supermarket to ease the way for its clients to

cash checks there. The individual and counselor will then need to establish other steps toward the goal of not drinking on Saturday morning, perhaps through specific exercises in treatment that desensitize or eliminate the environmental cues that prompt her weekend bingeing.

#### *Adjustments for people with* sensory disabilities

When developing treatment goals, the counselor needs to consider what is realistic for the client who is blind or deaf. It is important for the counselor to know what resources are available in his area. For example, in all areas of the country except a few metropolitan areas, there are not enough interpreted 12-Step meetings available for a person who is deaf to attend meetings every day. Therefore, 90 meetings in 90 days is an impossible goal for the person who is deaf to achieve. Attending one meeting per week is a more realistic goal. Counselors who are not experienced in working with deaf clients should consult a professional who has that experience to provide guidance during the treatment planning process.

When working with clients who are blind or

visually impaired, the counselor must be keenly aware of their blindness adjustment skill level and the availability of the proper adaptive equipment in the environment. Before giving a reading or writing assignment, the provider must make sure the required equipment is available. Additionally, if the blind person is asked to attend 12-Step meetings, transportation must be arranged. Figure 3-7 presents other suggestions of how to interact better with clients who are blind.

### Revising and Documenting the Treatment Plan

Because the counselor's knowledge of an individual's strengths and limitations is always growing, no treatment plan should be static. In the case of a person with a coexisting disability, there may be even more reason why revision is

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| Figure 3-7  Accommodating Clients Who Are Visually Impaired |
| *Improving interactions with an individual with blindness or low vision* |
| * Develop a positive attitude about blindness. * To guide a person who is blind, let him take your arm. When encountering steps, curbs or other obstacles, identify them. * When giving directions, be as clear and specific as possible including distance and obvious   obstacles.   * Speak to the person in a normal tone and speed. * It's okay to touch a blind person on the arm or shoulder to convey communication. * Don't touch or play with a working guide dog. * Ask the person how much vision she has and what communication modality she is most comfortable using. * When leaving a room, say so. |
| *Solutions to access problems* |
| * Keep pathways clear and raise low-hanging signs or lights. * Use large letter signs and add Braille labels to all signs. * Keep doors closed or *wide* open; half open doors are hazardous. * Have adaptive equipment available so people who are blind can be full program participants (i.e., talking computer, Brailler, etc.). * Make oral announcements; don't depend on a bulletin board. * Add raised or Braille lettering to elevator control buttons, and install entrance indicators at doorways. * Utilize radio and the newsletters of organizations serving the blind for announcements and   advertising.   * Make optical magnifiers and aids available for people with visual impairments. |
| *Source:* Substance Abuse Resources and Disability Issues, 1995. |

necessary and careful documentation is called for. An individual with a disability may need to explore several methods for learning something or fulfilling a goal before an achievable approach to the situation can be identified and implemented.

Frequent revision of the treatment plan is crucial, for instance, when working with clients with TBI because they often show a dramatic recovery curve over the first year to second year following their accidents. Additionally, periods of even relatively short detoxification can dramatically clear cognitive functioning. Given these realities, treatment plans need to be frequently updated to account for these clients'

rapidly changing and improving memory, reasoning, and attention abilities. Therapeutic interventions that would not have been appropriate even a few months previous can rapidly become within the client's grasp.

However, counselors must keep in mind that these cognitive abilities may improve at different rates . For example, certain language abilities may be recovered early, while memory deficits can continue to plague the client for years after the head trauma. The treatment plan must be flexible enough to accommodate these rapidly changing cognitive abilities.

#### *Frequent consultations with clients*

In evaluating and revising a treatment plan treatment providers should get cooperation from the client. Many programs already comply with licensing regulations to review and revise the treatment plan periodically (e.g., weekly or every 30 days). Aside from such formal evaluations, frequent consultations or "reality checks" are essential. All clients should be offered the opportunity to review and revise the goals and objectives of their treatment program on a regular basis. The provider needs to know whether there are barriers in the program or problems with the treatment approach. The provider should make every effort to ensure that such discussions are serious efforts. They should ask questions about specific goals, about how the individual is feeling, and about job or personal situations troubling him. Failure to perform continual evaluations may result in the individual abruptly leaving the program.

The counselor should take every opportunity

to learn more about the client. For example, during a group outing, a counselor may take what she considers to be a short walk with a person and observe that he is rapidly tiring and lagging behind. Specific questions about his lack of stamina or level of pain may reveal a more extensive limitation than the counselor originally understood, which may lead to changes in the treatment plan. In conversation during this walk, the person with a disability may bring up other critical psychological issues related to his disability. The client may confide that he avoids the company of others when he is outdoors because many times in the past others have simply abandoned him when he lagged behind, and he has had to find his way back alone. The fear of abandonment and betrayal by friends-perhaps by thecounselor and the treatment program-may be a significant issue preventing his deeper involvement in treatment. Discussing this issue, as well as problem solving with the client about how to keep up with others

outdoors, (e.g., by use of a scooter), may be highly productive.

#### *Careful documentation*

To keep treatment on track, it is important that case notes reflect the client's progress or lack of progress toward treatment goals. Accurate, evaluative notes are one way for counselors to stay focused on a client's particular issues, and documentation of all efforts at accommodation is needed to verify ADA compliance. When people relapse, case notes often provide valuable information to explain the relapse. In addition, careful documentation is essential in negotiating with managed care firms to allow extra time for people with disabilities to meet treatment goals.

The treatment plan should document all

alterations to the usual treatment procedures that are being made. Careful documentation also allows providers to see what goals have already been met and what procedures are working for the client. For example, a person with mental retardation may not be able to write or share a report on why she is powerless over drugs and alcohol (i.e., Step 1) and may demonstrate little understanding of basic treatment concepts, yet be able to maintain abstinence. In discussions with the person, the counselor may come to understand that her abstinence is mostly attributable to the AA group, which she enjoys attending nightly. If a person who is blind does not complete a reading assignment, this should be documented and investigated. If the assignment was not completed because the facility does not have the proper material and equipment it should also be noted that (1) the patient is not held responsible and (2) he is not fully benefiting from the program.

If an approach does not work, the outcome

should still be carefully documented to prevent duplication of effort by other programs in the future. By the same token, 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. Careful documentation allows all treatment providers to see the goals of treatment and the accommodations that have been made to meet them.

# Counseling Issues

### The Counseling Environment

Making accommodations for counseling begins with a consideration of the physical environment where counseling will take place. People with different disabilities may encounter different obstacles to treatment in their environment. It is best to make accommodations on a case-by-case basis, but some disability-specific factors to consider include the following.

##### *Modifications for people with* physical disabilities

The arrangement of furniture can be

important-the room should be accessible for all clients, and those who require an assistive device, such as a wheelchair, should have room to maneuver. Counseling rooms should also be near living areas and bathrooms and should be easy to find. Some table tops and desk surfaces should be high enough in the air to be accessible to people in wheelchairs. (Some programs accommodate to these occasional needs by storing wooden blocks that can be placed under tables to elevate them to the proper height.)

Providers of chemical dependency services

need to keep in mind that the most important element to ensure physical accessibility for a facility may be the attitude of staff. If they are open and accepting-and willing to be flexible­ most physical accommodation issues can be addressed successfully.

##### *Modifications for people with* sensory disabilities

Counselors should take into account room arrangement and lighting. It is not readily apparent, but lighting can be very important when there is a person who is deaf in a mainstreamed program. Lighting needs to be sufficient for the person who is deaf to see the interpreter, especially during a movie or video when the lights might be lowered. Blinds or curtains may need to be closed in order to reduce or eliminate glare and enable the person who is deaf to effectively see the interpreter and understand what she is signing. Persons with a visual impairment may also be bothered by the glare from windows and fluorescent lights. The counselor should ask if the client is comfortable with the lighting.

##### *Modifications for people with* cognitive disabilities

The presence of visual distracters, such as photos, artwork, and desktop toys, may make it more difficult for someone with AD /HD to concentrate. The glare from windows and fluorescent lights can also be a distraction for people with AD /HD, and the amount of noise should be kept to a minimum. A treatment room away from noisy areas can help such clients gain the focus they need.

### Individual Counseling

There are many accommodations that programs can make to modify individual counseling for people with coexisting disabilities, a number of which cost little or no extra time and money.

Counselors must be willing and able to work with all people with disabilities. They should be aware of their own issues concerning disabilities and be able to discuss with other program staff potential issues that may incline them to be especially positive or negative regarding a person with a disability. See the section on staff training in Chapter 5 for more information on

how counselors can work through their own feelings about disabilities.

When working with people with coexisting disabilities, some adaptations to counseling may be necessary depending on each individual's capacities and limitations. Some modifications, however, may be helpful for all people with disabilities. For instance, session times should be flexible, so that sessions can be shortened, lengthened, or occur more frequently, depending on the individual treatment plan.

For all people with disabilities, the transmission of unconditional positive regard will help the client achieve sobriety as much as anything.

It may be useful to talk about disability issues in individual counseling, especially if the person does not want to talk about them in a group setting. Sometimes an individual's disability and societal attitudes toward it play a large role in substance use. However, there are times when the topic should be avoided.

In addition to structured individual counseling sessions, other opportunities for one­ on-one counseling may present themselves during the course of treatment. There is often an opportunity for individual counseling at the end of a group session. The counselor and person in treatment can take 10 minutes together to review what went on in group.

More frequent, less formal contacts may benefit the individual as well. Drop-in policies encourage people to stop by and say hello. The opportunity to drop in and announce that they "stayed clean today" helps motivate many people in treatment, as do telephone check-ins.

Sometimes counseling for a client with a disability will not require more time in therapy, but rather more preparation time prior to the actual counseling session. This preparation may include a trip to the library to research a disability, or involve a conversation with an expert.

##### *Modifying counseling for people* with physical disabilities

Counselors are trained to observe personal physical boundaries, but the sense of what is proper may need to be modified for some people with disabilities, as counselors may have to assist with adjusting a wheelchair, etc. When the proper course of assistance is not apparent, ask the client for guidance. The relative height of the counselor and the client, when seated and talking, may also be an important consideration when working with someone who has a physical disability. Disproportionately great differences in seated height can hinder communication, especially relative to body language.

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. Home visits can offer valuable insights into a person's life and ultimately facilitate effective delivery of treatment. The Consensus Panel recommends that providers make home visits if necessary, which may be reimbursable under case management services. Going to the residence of an individual with a disability also provides invaluable information about a client's lifestyle, interests, and immediate environmental challenges.

##### *Modifying counseling for people* with cognitive disabilities

Some individuals who have sustained a TBI or have cognitive deficits secondary to a substance use disorder have decreased abstract reasoning abilities and reduced ability to solve problems. However, these areas of deficit may not be apparent because a person can retain his language abilities. Therefore it is important to ask people with TBI to provide specific examples of a general principle; for example, a

client can be asked to identify three specific ways drinking or using drugs gets him "in trouble." His responses can be written on a note card to help remind him of the consequences of his drinking. In this way, both the abstract reasoning and memory problems that are common in TBI can be addressed. A number of other suggestions for working with people with TBI are outlined in Figure 3-8.

When working with people with cognitive disabilities, counselors need to know that insight and behavior may not be closely correlated . For example, a person with a cognitive impairment may actually reduce substance use over time even though her responses suggest that she is not yet ready to do so. Likewise, there are persons who can hear information and repeat it back in a counselor's office, but cannot maintain the behavior elsewhere. Counselors must consider both people's insight and their behavior.

Counseling materials should be organized in advance, and the goals of counseling stated clearly up front and repeated often. Memory books can help people with cognitive disabilities keep track of essential information such as names, meeting times, and maps of local areas. The main points of the treatment session can also be chronicled and dated. The counselor should make sure people use these aids. They should watch a client write down his next appointment in his pocket calendar, and, on the telephone, ask him, "Are you writing this on your calendar now?" The conversation should not be ended until the counselor is sure the client has done so.

Most people who are cognitively disabled

have trouble transferring knowledge from one situation to another. Thus the consequences of drinking must be gone over and over incident by incident. Counselors can teach clients with TBI and AD /HD, and others with poor impulse control, to hesitate and "think a drink through" before acting. People with severe cognitive

impairment may need help developing a repertoire of internal controls, rather than simply responding to external control.

Discussions should be kept concrete. People with mental retardation may not understand abstract concepts such as "powerlessness," "depression," "avoidance," "unmanageability," and "sanity." They may even have trouble with more basic terminology like "sobriety," "abstinence," "relapse," or even "drunk." Regularly review the terminology of the treatment program and any other programs (such as AA) in which the person might be participating. Do not assume people with cognitive disabilities understand the terminology used. The counselor can ask the client to repeat back her understanding of these terms. Use short sentences, and skip elaborate, abstract analogies. Goals should also be phrased in concrete terms .

When working with clients with limited

language skills, try using alternative media to communicate ideas. If, for example, the client cannot read and also has short-term memory deficits or auditory processing problems, then a tape recorder will not solve the reading problem. Some people who are nonreaders will do far better with a video (looking and hearing at the same time) than with an audiocassette.

Some people will learn better by drawing or making a collage of a concept. For example, a client who has difficulty explaining her understanding of her 12-Step group's first step may find it easier to draw five pictures showing how her life is unmanageable. Individual counseling sessions are an ideal time for the counselor to review such materials as AA's *Big Book* that a person with a cognitive disability may not be able to read.

Counselors should not assume that insight into drinking behavior will also affect other drug use-for a person with a cognitive disability these behaviors may be very different.

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| Figure 3-8  Suggestions for Providers Working **With** Persons **With** Brain Injury |
| 1. Try to determine a person's unique learning style.    * Ask how her reading is, how well she writes, or evaluate via sam ples.    * Both ask about and observe a person's attention span; be attuned to whether attention seems to change in busy versus quiet environments .    * If someone is not able to speak (or speak easily), inquire as to alternate methods of expression (e.g., writing, gestures).    * Evaluate whether someone is able to comprehend either written or spoken language (is there a   receptive language problem?). |
| 1. Help the individual compensate for a unique learning style.    * Modify written material to make it concise and to the point.    * Paraphrase concepts, use concrete examples, incorporate visual aids, or otherwise present an idea in more than one way.    * Encourage the individual to take notes or at least write down key points for later review and recall.    * If the treatment program includes a schedule, make sure a "pocket version" is kept for easy reference; homework assignments should be written down as well.    * After group sessions, meet individually to review main points.    * Provide assistance with homework or worksheets; allow the person more time and take into account reading or writing abilities.    * Enlist family, friends, or other service providers to reinforce goals.    * Do not take for granted that something learned in one situation will be generalized to another.    * Repeat, review, rehearse, repeat, review, rehearse . |
| 1. Provide direct feedback regarding inappropriate behaviors.    * Let a person know a behavior is inappropriate; do not assume he knows and is choosing to do so anyway.    * Provide straightforward feedback about when and where behaviors are ap propriate.    * Redirect tangential or excessive speech, including a predetermined method of signals for use in groups. |
| 1. Be cautious concluding that an underlying emotional state is the basis of an observed behavior.    * Do not presume that noncompliance arises from lack of motivation or resistance; check it out.    * Be aware that unawareness of deficits can arise as a result of specific damage to the brain and may not always be due to denial.    * Confrontation shuts down thinking and elicits rigidity; roll with resistance.    * Do not just discharge for noncompliance; follow up and find out why someone has not showed up or otherwise not followed through. |
| Source:The Ohio Valley Center for Brain Injury Prevention and Rehabilitation, 1998. |

For example, the person may agree not to drink anymore and may understand the consequences of drinking. The same person, however, may continue using marijuana and may not truly understand the dangers associated with that behavior.

Although counselors must not expect too much from people with cognitive disabilities, they should also not expect "too little." Many are just as capable as any other client of having the insights that are important in treatment, such as "when I drink and drug, I get in

trouble." (Exceptions include clients with severe memory deficits and some with TBI.)

Counselors will have greater success by going slowly and reiterating with each crisis the role that substance use played. Keep asking after each relapse: "What happened and what did you think would happen? How do you feel about what happened? How will you handle the situation differently next time?"

##### *Modifying counseling for people* with sensory disabilities

The counselor should ask the client who is deaf or hard of hearing what accommodations he needs. If the client is hard of hearing or deaf and does not use sign language, he may request only to have a counselor whom he can lip-read. For instance, he may not be able to lip-read a counselor with a beard and mustache, but a counselor with no facial hair blocking his mouth may be acceptable. The individual may need an interpreter, an assistive listening device for sound amplification, or Computer Assisted Realtime Transcription (CART). The accommodation requested should be provided.

Regardless of the mode of communication, the counselor should be seated so the deaf or hard of hearing client can look directly at her. When an interpreter is used, the interpreter should be seated next to the counselor in order for the client to see the counselor and the interpreter at the same time. The counselor

should speak directly to the deaf client, using

first person tense, as if the interpreter was not present. It is very common for hearing counselors (who have usually had little or no experience communicating with a person who is deaf and using an interpreter) to speak to the interpreter (saying "tell him... ") rather than to the client. There may, however, be instances where the interpreter needs to ask the counselor or the person who is deaf for clarification of something the counselor has said, in order to interpret it appropriately. This sort of interruption is part of the interpretation process. However, the counselor should not try to include the interpreter in the counseling process except to facilitate communication with the client.

Many clinicians worry about confidentiality

when using interpreters and fear that the use of interpreters will make it difficult to develop rapport with a client. Treatment programs should realize that sign language interpreters who belong to The Registry of Interpreters for the Deaf (RID), the professional association for sign language interpreters, follow a code of ethics that includes confidentiality of job-related information as one of its tenets. The staff of a treatment program can emphasize the importance of discretion in this situation by informing the interpreter of the strict laws regarding confidentiality in substance use disorder treatment.

Certain programs for the deaf have

successfully used alternative media in place of the writing assignments often given to hearing clients. The Clinical Approaches manual developed by the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing contains numerous drawing assignments concerning concepts important for recovery that clients can be given as homework. These activities are particularly useful for clients who are deaf and may not be comfortable with their written English skills or for those with minimal communication skills in sign language.

Both one-to-one and group discussions are more tiring for people who are blind or visually impaired because they lack the benefit of observing facial expression, gestures, and posture. Sighted counselors can help their blind clients by avoiding visual images in conversation that a congenitally blind person will not understand. People who are blind will also require more time for reading assignments. A good print reader may read and comprehend from 600 to 700 words per minute (wpm), while a good Braille reader reads only 100 wpm. "Reading" an audiocassette proceeds at 200 to 250 wpm. These alternative ways of reading take not only more time but more energy as well.

### Group Counseling

While accommodations may be needed to integrate people with coexisting disabilities into group counseling, it is important to first emphasize what all group members have in common. Counselors can emphasize to the group that, despite a wide variety of individual differences, all members are there for the same reason. Everyone is present because they cannot control their substance use, and they want to stay sober.

Some counseling groups with a single person who has a visible disability may meet on a regular basis, and disability issues are never discussed. For other groups, this topic may emerge quickly. Although it's not possible to state one policy that applies to all situations, there are some common considerations. Group members should be oriented to any special considerations that someone with a disability may require in order to effectively participate.

Discussions about an individual's disability can be quite therapeutic and pertinent to the process of recovery, especially if the client has recently acquired the disability or has spent so much time under the influence that he has continuing adjustment problems associated with the

disability. Consequently, treatment staff should encourage discussion of disability issues when clients bring them up.

Group members can be trained to assist in making accommodations for peers who have disabilities. It is important, however, to work with nondisabled clients to minimize their enabling of or overcompensation for people with coexisting disabilities. Describe to the group the practical aspects of helping the person with a disability, and ask that person to describe what she expects people around her to do. The concept of asking for help is congruent with many treatment approaches. However, for a person with less awareness or acceptance of her disability, it is important that peers are aware of what is appropriate help to offer.

When working with people with coexisting

disabilities in a group counseling setting, counselors may find it useful to alter group participation expectations, limit the time in group, and work with the group to extend the group learning experience outside the confines of the group session. While the actual accommodations used will likely be tailored to each individual, there are some general strategies (discussed below) that have been successful in making group counseling more accessible for individuals with particular types of disabilities.

Finally, providers must consider and prepare to justify modifications to group counseling for billing purposes, especially with regard to Medicaid and managed care organizations. In most cases, billing for these services by the half­ hour would be acceptable, although the standard unit of service is 1 hour. In some cases, counselors can conduct shorter sessions but bill for the entire session, which is appropriate because additional preparation time is needed for these modified group sessions.

##### *Group counseling for people with* sensory disabilities

People who are visually impaired need to orient themselves to the group in a different manner than those who are sighted. They will need to understand the group counseling environment, including the position of all the participants and the format or structure of learning activities such as reading assignments, so that they can prepare for them in advance. Other group members should be aware that they can not use eye contact to communicate with members of the group who are blind, and must rely on different methods . See Figure 3-7 for other

suggestions of how to work with clients who are blind or visually impaired.

If a person who is deaf is using an interpreter, group members will need to take turns during discussions. If several people are talking at the same time, which is not uncommon for hearing people, the interpreter will be unable to communicate all the information. Requiring people to raise their hands before speaking is a good method to ensure that only one person is speaking at a time, as is deciding beforehand the order in which people will speak. In a group session the person who is deaf will normally be a few seconds or minutes behind the hearing group members; it will usually take longer to interpret a sentence than it took for the person to speak it. An interpreter must understand the context before interpreting and it may happen that a message will require more signs than words.

The counselor should make a point of asking the

group members who are deaf for their responses and questions in order to ensure that they are included in the discussion. If a session lasts more than an hour, two interpreters may be necessary, because signing is very fatiguing.

Even if staff members are fluent in sign language, other types of interpreters (i.e., a CART reporter) may be needed. Not all individuals who are deaf are fluent in sign

language, and some, such as a person who is deaf and blind, may have very particular communication needs. The issues for the group process are similar in these instances, however. For example, the deaf or hard of hearing individual will get the message through CART slightly later than the hearing clients. The CART reporter will have the same difficulty as the sign language interpreter if hearing group members talk at the same time as one another. The biggest difference is that individuals who are deaf and do not use sign language generally prefer to be included in groups with hearing clients rather than being in all-deaf gro ups.

These individuals have spent most of their lives

with hearing peers and do not socialize primarily with other people who are deaf. Their identity is not tied to being deaf and using sign language.

##### *Group counseling for people with* cognitive disabilities

Accommodations for persons with cognitive impairments can include the use of visual cues, mixed media, and the repetition of major points. Expressive therapy, or the practice of using movement to express feelings, is also often effective for persons with mental retardation and other cognitive disabilities. Role-playing works well for persons with developmental disabilities-the process of playing a role themselves helps them to internalize it.

The use of verbal and nonverbal cues will help increase participation and learning for people with cognitive disabilities and make the group run more smoothly for all. People with cognitive impairments are often impulsive because they lack normal feedback mechanisms. They do not wish to be impulsive, but lack the ability to regulate this behavior for themselves . Therefore, counselors and peers should try to provide external cueing until the person can internalize it. 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"). If cues are used in a setting where other people will observe them, alert the group to the cue in a matter of fact way as you would alert them to a use of a dog or the space needed for a wheelchair. Cueing can be useful for people with other types of disabilities and for other purposes as well.

For people with AD /HD, it is helpful to establish a maximum length of time, for example, 10 minutes, for presentations. Another modification to group counseling, which is beneficial for those with mental retardation or brain injury (as well as other clients), is to set aside 10 minutes at the end of the session to reinforce what occurred during therapy. Such discussion ensures that content is retained and promotes active rather than passive learning.

Some people with cognitive disabilities may have problems with time management and will need to be reminded of group sessions with a phone call or a page.

Accommodations for disabilities can be made when developing goals and awards for successful participation in group counseling. It may be helpful to ask a person what he would like in recognition for accomplishing his goals. Something as simple as a certificate of completion may be an extremely important reward for a person with mental retardation.

Utilizing token economies, such as the "medallions" given in a 12-Step program, may be another method.

It may be necessary to make changes to group learning activities in order to accommodate people with cognitive disabilities. The use of alternative media to replace traditional homework assignments involving reading and writing may be required . An individual who has an expressive language disorder may be unfairly judged as uncooperative in expressing feelings and participating in group process. However, given the opportunity to express herself through

therapeutic artwork, she may communicate quite a bit.

Mixed media can be incorporated in other ways as well. As a group project, clients could work together to "draw the road to sobriety," depicting the pitfalls they might expect to encounter along the way, or work as a group to construct an image of a "sober city." Clients can create memory books or journals (to capture the content of sessions), or flash cards (of words or pictures) to jog memory for relapse prevention, perhaps presenting people and places to avoid. Clients can also design flash cards containing phrases that are meaningful to them to assist them when they are confronted with a situation that threatens their sobriety .

Counselors should not assume, however,

that one person's experience will be understood by another, particularly in the case of a person with a cognitive disability . There may be a great deal of shared experience, but the person with a disability may not understand it unless it is made specific and pertinent to his own life .

##### *Group counseling for people with* physical disabilities

As a general modification, it is necessary to accept different types of body positioning for people with physical disabilities-some people may need to stand up or move during a group session, and this activity should not be considered rude. Counselors may have to keep group sessions short or schedule frequent breaks to help people who lack physical stamina and make allowances for increased travel time to meetings for people who use wheelchairs or rely on public transportation. Sometimes

individuals with spasticity or other motor

problems, such as those associated with quadriplegia, have voluntary or involuntary movements that are sudden and unusual for people not familiar with them . The counselor should ensure that group members are not distracted by these movements and understand

that they are a normal manifestation of some disabilities.

# Medication Assessment And Management

The counselor should be aware that people with disabilities may be dependent on or inappropriately using prescription medications. Drugs are often perceived as providing comfort and managing the symptoms of a disability even while they are contributing to secondary complications. The routine of taking particular medications may itself provide feelings of control, stability, or safety. Additionally, some physicians prescribe medications in a palliative manner in an attempt to assist with disabilities they cannot cure (e.g., chronic pain, multiple sclerosis); unfortunately, the physician may not get proper feedback from patients regarding the efficacy of a given drug unless a patient is educated and motivated regarding the need to provide such feedback.

The Panel recommends that early in

treatment, a medical professional conduct a medical examination and prescription assessment of all clients with coexisting disabilities. The medication assessment should review the consumption of both prescribed and over-the-counter drugs, including herbs and vitamins. The necessity for this review has increased in recent years because managed care has made it increasingly less likely that one physician will be writing or be knowledgeable about all prescriptions provided to a patient.

Learning self-advocacy and assertiveness with physicians and around the issue of health care and medication is important for people with disabilities. Persons with disabilities, like other individuals, may take a passive role during interactions with physicians, consequently receiving incomplete information about medications that are prescribed for them. Clients should also have a basic understanding

of medication compliance (e.g., taking a medication regularly and on schedule, rather than just when the condition flares up). An important component of learning to live a sober life is to understand and properly use medications.

Treatment programs that care for people with disabilities have found it helpful to contract with a knowledgeable physician or a licensed pharmacist (Pharm.D.) to conduct medication assessments and review an individual's charts for possible drug interactions. The resulting information and suggestions can then be forwarded to medical authorities associated

with the care of this individual. A licensed pharmacist often has a wider knowledge of drugs of many classes than most physicians, who may specialize in treating certain conditions and may only be familiar with a limited number of drugs.

Conditions such as diabetes, leukemia, and AIDS may require the use of medications that are self-injected or administered through a pain pump. Philosophically, self-injecting people may pose a problem for some drug treatment programs, but providers should keep an open mind. Under no circumstances should nonmedical treatment staff advise clients to take or not to take particular medications, vitamins, or herbs. Medication decisions should always be left to specialists. Staff should, though, become more knowledgeable about the purposes and potential side effects of medications taken by people with disabilities.

TIP 26, *Substance Abuse Among Older Adults*

(CSAT, 1998), reviews many of the medications used by people with disabilities.

### Chronic Pain

Some people with disabilities experience recurring or chronic pain as a result of a disabling condition. The treatment provider must consider pain management as an important part of the rehabilitation plan.

Persons with chronic pain may enter treatment addicted to the medication that they are taking for the pain. In these cases, it is critical that the treatment plan involve a physician for consultation and medication management as well as knowledgeable rehabilitation specialists who understand alternative treatments for chronic pain.

Sobriety may not be attractive or desirable if it is associated with unrelieved pain. The treatment provider should explore with the client what pain management options have been tried in the past, and which alternatives seem to hold promise. The individual should be encouraged to discuss her feeling about pain and how it affects her daily life.

#### *Accommodating chronic pain*

There are a number of accommodations that a treatment provider must make for persons with chronic pain. Providers must attempt to determine if the pain is the real reason an individual has been using a substance; if it is, they will need access to a good alternative pain management program (preferably one accredited by the Commission on Accreditation of Rehabilitation Facilities) to help manage withdrawal. The substance use disorder treatment provider should not make these decisions alone, but in consultation with the rest of the treatment team and the client.

Confirmation of the medical condition can be obtained with the individual's consent from the medical provider.

In cases of chronic pain it is critical to obtain an accurate pain therapy history for each person. That history should ascertain the amount of medication being taken and determine whether it is within the prescribed limits and whether or not more than one physician has been prescribing medications for the same or similar conditions.

Since most medications for pain management are abusable drugs, programs may need to alter

their policies regarding the use of such drugs.

In these cases, the client can be given a locked place to store medications on the premises; however, although it may be convenient to ask a person with chronic pain to leave his medication with the treatment staff for dispensing, this may not be legal in a typical, residential substance use disorder treatment program.

#### *Alternative treatments for* chronic pain

There are alternatives to the use of analgesic narcotics for chronic pain management that can be considered for people with disabilities who are in treatment for substance use disorders.

Acupuncture is one technique used to manage chronic pain. It is already used in some treatment programs for detoxification and to help relieve symptoms of withdrawal. Some anesthesiology departments now have an acupuncturist on staff, and the technique is gaining broader acceptance. Other alternative treatments for chronic pain include

* Physical therapy and exercise
* Chiropractic care
* A transcutaneous electrical nerve stimulation (TENS) unit
* Biofeedback
* Hypnotism
* Magnetic therapy
* Exercise
* Therapeutic heat or cold

Many of these therapies have limited or anecdotal support of their efficacy. The treatment provider will need to seek expert advice on their use for any person with chronic pain.

**Aftercare**

For people with disabilities, providers should begin thinking of aftercare options early on in treatment, as it may be difficult to find the necessary services in the local community. It is important to understand that a person with a

disability may require more sustained contact with aftercare resources than usual in order to enhance skill development, fulfill employment goals, or develop alternative social suppor ts. Aftercare plans need to include provisions for counseling or relapse prevention groups, as well as other practical matters such as housing concerns or legal issues. Ideally, one professional within the treatment program or affiliated with some other community agency will be responsible for monitoring aftercare activities. If aftercare services are not reasonably accessible, treatment programs can direct clients to tape or book libraries, Internet sites, or other types of self-directed support activities. Again, the treatment provider should consider that clients with certain disabilities will require more structure and assistance than normal in order for the program to be effective.

Programs will need to make use of linkages in order to facilitate aftercare for people with disabilities (see Chapter 4). For example, a halfway house or other sober living arrangement can help extend support and structure over a longer period of time, which is particularly beneficial for people with disabilities. The ADA requires that halfway houses and sober houses be adaptable for people with disabilities, but in reality that is not always the case. The treatment provider should investigate whether accommodations will be made for a client with a coexisting disability before sending him to an aftercare facility. Even if a person is not going to an aftercare facility, treatment providers should make housing a priority and find out from the community network or other systems serving the person whether there is housing available and if it is app ropriate.

### Aftercare for People With Cognitive Disabilities

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 . These clients can be very context­ bound in their learning, and providers cannot assume that the lessons learned in treatment will be applied in aftercare.

The use of role-playing to rehearse what will happen at 12-Step-based meetings or in other aftercare settings can be a great help to all clients in treatment, not just those with coexisting disabilities. Someone with a cognitive impairment may find it extremely difficult to understand and complete all 12 Steps, but exposure to even a few of the steps can help her recovery. There are versions of the 12 Steps adapted for persons with brain injury, reading limitations, and mental retardation (although not all 12-Step members or groups agree on these modifications). Other modifications to 12- Step programs may also prove more beneficial to some people with disabilities. For persons with mental retardation, the presence of a facilitator may be very helpful, even though facilitators are not normally a part of 12-Step meetings.

People with disabilities face the same stigma

and the same barriers in aftercare as they do in the rest of society . Individuals with mental retardation may be shunned or ignored in 12- Step meetings. They may not understand slogans or concepts or follow what is said in meetings. On the other hand, they may also find groups or individuals who can be very accepting. It may help if counselors find someone in a local 12-Step group willing to help someone with a cognitive disability connect with others in the group.

Perhaps one of the greatest risks for clients with TBI during aftercare is the difficulty of unstructured settings. While they may thrive in highly structured day treatment or residential programs, they might be at high risk for relapse when they must self-structure their environments . After leaving formal treatment, a

client with TBI might be unable to avoid high­ risk situations, follow treatment recommendations, or find a ride to an AA meeting. The fact that the disability is often not obvious to staff, peers, or family members intensifies this susceptibility to the loss of structure that accompanies treatment discharge. Role-playing and other techniques that enable clients to prepare for upcoming high-risk situations will be very beneficial for people with TBI.

### Aftercare for People With Sensory Disabilities

People who are deaf often leave home to attend one of a few inpatient treatment programs across the country and then return to their home States to receive aftercare. There they may find few resources available. Staff members should try to set up a comprehensive aftercare program in the client's home area that would offer education and support from local service providers. Ideally, after an individual has completed primary treatment, she will have access to a variety of aftercare resources, including self-help groups, a relapse prevention group, aftercare therapists fluent in American Sign Language, an interpreter referral center, vocational assistance, halfway houses, sober houses and other sources of assistance and support. Networking with other service providers both locally and nationally is an important activity in aftercare (see Chapter 4 of this TIP for more information on linkages with other programs).

It will be difficult for people who are deaf or

hard of hearing to find 12-Step meetings where sign language interpreters are available. Even if

they have an interpreter to assist them, many 12- Step terms are foreign to American Sign Language and require very competent signing to translate. If a person who is deaf doesn't know sign language, the situation becomes even more complicated. Professionals who work with people who are deaf have different answers to this problem. Some believe that even if no interpreter is present, a 12-Step meeting is at least a sober environment where the temptation to use may be reduced for some period of time. However, others believe that sitting in a meeting and being unable to communicate with anyone or understand anything that is said is of no use to the individual and can even be harmful. The individual could feel isolated in this situation, become frustrated and angry, and be more apt

to use. Meeting attendance is an important issue

for the counselor to discuss with a person who is deaf during treatment; the person needs to leave treatment with a realistic plan for how to deal with this issue. The possibility that a client may use her deafness as an excuse for not attending meetings should also be carefully explored.

One common pitfall of aftercare for clients who are blind is low expectations. Too often therapists expect too little from people with disabilities instead of making accurate accommodations to an aftercare plan. For example, if a person is expected to keep a journal but does not have a keyboard or is not Braille literate, he should use audiocassettes. If bibliotherapy is an integral component, the provider should research the availability of the material at the State's regional library for the blind or National Recordings for the Blind.

**Appendix** A

**Bibliography**

Alemi, F.; Stephens, R.C.; and Butts, J. Case management: A telecommunications practice model. In: Ashery, R.S., ed. *Progress and Issues in Case Management.* NIDA Research Monograph Series, Number 127. HHS Pub. No. (ADM) 92-1946. Rockville, MD: National Institute on Drug Abuse, 1992. pp. 261-273.

Alterman, A., and Tarter, R. An examination of selected typologies: Hyperactivity, familial, and antisocial alcoholism. In: Galanter, M., ed . *Recent Developments in Alcoholism.* New York: Plenum Press, 1986. pp. 169-189.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed. Washington, DC: American Psychiatric Press, 1994.

American Society of Addiction Medicine.

*Patient Placement Criteria for the Treatment of Substance Related Disorders,* 2nd ed. Chevy Chase, MD: American Society of Addiction Medicine, 1996.

Anthenelli, R.M., and Schuckit, M.A. Genetics. In: Lowinson, J.H.; Ruiz, P.; and Millman, R.B., eds. *Substance Abuse: A Comprehensive Textbook .* Baltimore: Williams & Wilkins, 1992. pp. 39- 50.

Ashery, R.S. Case management community advocacy for substance abuse clients. In: Ashery, R.S., ed. *Progress and Issues in Case Management .* National Institute on Drug Abuse Research Monograph, Number 127. HHS Pub. No. ADM 92-1946. Rockville, MD: National Institute on Drug Abuse, 1992. pp. 383-394.

Ballew, J.R., and Mink, G. *Case Management in Social Work: Developing the Professional Skills Needed for Work With Multiproblem Clients.* Springfield, IL: Charles C. Thomas, 1996.

Barco, P.; Crosson, B.; Bolesta, M., Werts, D.; and Stout, R. Training awareness and compensation in postacute rehabilitation. In: Kreutzer, J.S., and Wehman, P.H., eds.

*Cognitive Rehabilitation for Persons With Traumatic Brain Injury: A Functional Approach.* Baltimore: P.H. Brookes, 1991. pp. 129-146.

Betts, H.B., and Richmond, J.B. *Disability in America Report.* Washington, DC: Institute of Medicine, Centers for Disease Control, and the National Council on Disability, 1991.

Blackwell, L.R. Going beyond the anger. In: Garretson, M.D., ed. *Deafness 1993--2013: A Deaf American Monograph.* Vol. 43. Silver Spring, MD: National Association of the Deaf, 1993. pp. 11-14.

Brown, V.B.; Ridgely, M.S.; Pepper, B.; Levine, I.S.; and Ryzlewicz, H. The dual crisis: Mental illness and substance abuse: Present and future directions. *American Psychologist* 44(3):565-569, 1989.

Bruckman, B.; Bruckner, V.T.; and Calabrese, C. *Alcohol and Drug Programs and the Americans With Disabilities Act: A Compliance Guide for Privately-Operated Programs.* Oakland, CA: Pacific Research and Training Alliance, 1997.

Burgdorf, R.L. Equal access to public accommodations. In: West, J., ed. *The Americans With Disabilities Act.* New York: Milbank Memorial Fund, 1991. pp. 183-213.

Buss, A., and Cramer, C. *Incidence of Alcohol Use by People With Disabilities: A Wisconsin Survey of People With Disability.* Madison, WI: Office of Persons with Disabilities, 1989.

Cahalan, D.; Cisin, I.H.; and Crossley, H.M. *American Drinking Practices: A National Study of Drinking Behavior and Attitudes.* New Haven, CT: College University Press, 1969.

Center for Substance Abuse Treatment.

*Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse.* Treatment Improvement Protocol (TIP) Series, Number 9. HHS Pub. No. (SMA) 94-2078. Washington, DC: U.S.

Government Printing Office, 1994.

Center for Substance Abuse Treatment. *Substance Abuse Among Older Adults.* Treatment Improvement Protocol (TIP) Series, Number 26. HHS Pub. No. (SMA) 98-3179. Washington, DC: U.S. Government Printing Office, 1998.

Center for Substance Abuse Treatment.

*Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series, Number 27. HHS Pub. No. (SMA) 98-3222. Washington, DC:

U.S. Government Printing Office, 1998.

Corrigan, J.D. Substance abuse as a mediating factor in outcome from traumatic brain injury. *Archives of Physical Medicine and Rehabilitation* 76:302-309, 1995.

Corrigan, J.D.; Rust, E.; and Lamb-Hart, G.L. The nature and extent of substance abuse problems in persons with traumatic brain injury. *Journal of Head Trauma Rehabilitation* 10(3):29-46, 1995.

Deloach, C., and Greer, B.G. *Adjustment to Severe Physical Disability: A Metamorphosis.* New York: McGraw Hill, 1981.

de Miranda, J., and Cherry, L. California responds: Changing treatment systems through advocacy for the disabled. *Alcohol, Health and Research World* 13(2):154-157, 1989.

de Miranda, J.; Kiley, D.; and Gambina, H.

###### *Inform Yourself: Alcohol, Drugs, and Spinal* Cord Injury. A Resource Guide for Persons With Spinal Cord Injury and Their Families. San Mateo, CA: Novation, 1992.

Dick, J.E. "Signing for a high: A study of alcohol and drug use by deaf and hard of hearing adolescents." Ph.D. dissertation, Rutgers University, New Brunswick, 1996.

Drake, R.E.; Mueser, K.T.; Clark, R.E.; and Wallach, M.A. The course, treatment, and outcome of substance disorder in persons with severe mental illness. *American Journal of Orthopsychiatry* 66(1): 42-51, 1996.

Drubach, D.A.; Kelly, M.P.; Winslow, M.M.; and Flynn, J.P.G. Substance abuse as a factor in the causality, severity, and recurrence of traumatic brain injury. *Maryland Medical Journal* 42(10): 989-993, 1993.

Elmquist, D.L.; Morgan, D.P.; and Bolds, P.K. Alcohol and other drug use among adolescents with disabilities. *International Journal of the Addictions* 27(12):1475-1483, 1992.

Ford, J.A., and Moore, D. *Substance Abuse Resources and Disability Issues Training Manual.* Dayton, OH: Wright State University School of Medicine, 1992.

Freeman, A.C.; Ferreyra, N.; and Calabrese, C. *Fostering Recovery for Women with Disabilities: Eliminating Barriers to Substance Abuse Programs. Meeting the Needs of Women with Disabilities: A Blueprint for Change.* Oakland, CA: Berkeley Planning Associates, 1997.

Frieden, A. L. Substance abuse and disability: The role of the independent living center. *Journal of Applied Rehabilitation Counseling* 21(3):33-36, 1990.

Galanter, M., and Kleber, H. *Textbook of Substance Abuse Treatment.* Washington, DC: American Psychiatric Press, 1994.

Glover, N.; Janikowski, T.P.; and Benshoff, J.J. The incidence of incest histories among clients receiving substance abuse treatment. *Journal of Counseling and Development* 73:475- 480, 1995.

Greenwood, W. Alcoho lism: A complicating factor in the rehabilitation of disabled individuals. *Journal of Rehabilitation* 50(4):51- 52, 72, 1984.

Greer, B.G. Substance abuse among people with disabilities: A problem of too much accessibility. *Journal of Rehabilitation*

14(1):34-37, 1986.

Guthmann, D. "An analysis of variables that impact treatment outcomes of chemically dependent deaf and hard of hearing individuals." Ph.D. dissertation, University of Minnesota, Minneapolis, 1996.

Guthmann, D.; Lybarger, R.; and Sandberg, K. Chemical dependency treatment: Specialized approaches for deaf and hard of hearing clients. In: *Proceedings from the Innovative Partnerships in Recovery: The Diverse Deaf Experience.* Washington, DC: Gallaudet University, 1994. pp . 31-50.

Hanson, V.L., and Padden, C.A. Interactive video for bilingual ASL/English instruction of deaf. *American Annals of the Deaf* July:209- 213, 1989.

Heinemann, A.; Doll, M.; Armstrong, K.; and Schnoll, S. Substance use and receipt of treatment by persons with long-term spinal cord injuries. *Archives of Physical Medicine and Rehabilitation* 72:482-487, 1991.

Heinemann, A.W.; Doll, M.; and Schnoll, S. Treatment of alcohol abuse in persons with recent spinal cord injuries. *Alcohol Health and Research World* 13(2):110-117, 1989.

Heinemann, A.W.; Keen, M.; Donohue, R.; and Schnoll, S. Alcohol use by persons with recent spinal cord injury. *Archives of Physical Medicine and Rehabilitation* 69:619-624, 1988.

Helwig, A.A., and Holicky, R.. Substance abuse in persons with disabilities: Treatment considerations. *Journal of Counseling and Development* 72(2),:227-233, 1994.

Hser, Y.; Anglin, M.D.; and Chou, C. Evaluation of drug abuse treatment: A repeated measures design assessing methadone maintenance. *Evaluation Review*

12(5):547-571, 1988

Jessor, R., and Jessor, S. *Problem Behavior and Psychological Development: A Longitudinal Study of Youth.* New York: Academic Press, 1977.

Kelley, S.D.M., and Benshoff, J.J. Dual diagnosis of mental illness and substance abuse: Contemporary challenges for rehabilitation. *Journal of Applied Rehabilitation Counseling* 28(3):43-49, 1997.

Kessler, D.T., and Klein, M.A. Drug use patterns and risk factors of adolescents with physical disabilities. *International Journal of the Addictions* 30:1243-1270, 1995.

Kirkubakaran, V.; Kumar, N.; Powell, B.; Tyler, A.; and Armatas, P. Survey of alcohol and drug misuse in spinal cord injured veterans. *Journal of Studies in Alcohol* 47(3):223-227, 1986.

Kosten, T.R.; Rounsaville, B.J.; and Kleber, H.D. Concurrent validity of the Addiction Severity Index. *Journal of Nervous and Mental Disease* 171(10):606-610, 1983.

Kressler, H., and Ward, E. Bridging cultures: Providers work with disability services. *Alcoholism and Drug Abuse Weekly* August 4:3, 1997.

Kreutzer, J.S.; Witol, A.O.; and Marwitz, J.H. Alcohol and drug use among young persons with traumatic brain injury. *Journal of Learning Disabilities* 29(6):643-651, 1996.

Kubler-Ross, E. *On Death and Dying.* New York: Macmillan, 1969.

Ladd, P. Deaf cultural studies-towards an end to internal strife. In: Garretson, M.D., ed.

*Viewpoints on Deafness: A Deaf American Monograph.* Vol. 42. Silver Spring, MD: National Association of the Deaf, 1992. pp. 83-87.

LaDue, R.A.; Streissguth, A.P.; Randals, S.P. Clinical considerations pertaining to adolescents and adults with FAS. In: Sorderegger, T.B., ed. *Perinatal Substance Abuse: Research Findings and Clinical Implications.* Baltimore: The Johns Hopkins University Press, 1992. pp. 104-131.

Langley, M.J.; Lindsay, W.P.; Lam, C.S.; and Priddy, D.A. A comprehensive alcohol abuse treatment programme for persons with traumatic brain injury. *Brain Injury* 4(1):77- 86, 1990.

LaPlante, M.P. *How Many Americans Have a Disability.* Disability Statistics Abstract, Number 5. San Francisco, CA: Disability Statistics Center, 1992.

LaPlante, M.P.; Kennedy, J.; Kaye, S.; and Wenger, B.L. *Disability and Employment.* Disability Statistics Abstract, Number 11. San Francisco, CA: Disability Statistics Center, 1997.

Li, L., and Moore, D. Acceptance of disability and its correlates. *Journal of Social Psychology* 138(10):13-25, 1998.

Livneh, H., and Male, R. Functional limitations: A review of their characteristics and vocational impact. *Journal of Rehabilitation* 59(4):44-50, 1993.

Manisses Communication Group. California pact on disabled could open floodgates. *Alcoholism and Drug Abuse Weekly* October 17:1-7, 1994.

Marshak, L., and Seligman, M. *Counseling Persons With Physical Disabilities: Theoretical And Clinical Perspectives.* Austin, TX: Pro-Ed, 1993.

Minnesota Chemical Dependency Treatment Program for Deaf and Hard of Hearing Individuals. *Clinical Approaches: A Model for Treating Chemically Dependent Deaf and Hard of Hearing Individuals.* Minneapolis, MN: Deaconess Press, 1996.

Moore, D. "Research in substance abuse and disabilities: the implications for prevention and treatment. "Plenary Session Paper Presented at the Third National Prevention and Training Conference: People with Disabilities. Phoenix, AZ, April 4-7, 1990a.

Moore, D. "Substance abuse prevention and intervention for students with physical disabilities." Paper presented at the National Conference for the Association on Handicapped Students Service Programs in Post-Secondary Education. Nashville, TN, August 1-4, 1990b.

Moore, D. "The magnitude of the problem: the scope of prevention and treatment issues for persons with mental retardation or learning disability." Paper presented at Alcohol and Other Drug Abuse: Implications for Mental Retardation and Learning Disability Conference. Hofstra University, Hempstead, NY, June 10, 1991a.

Moore, D. "Middle-aged and older adults with disabilities." Paper presented at the Fourth National Prevention Research and Training Conference. Salt Lake City, UT, March 22, 1991b.

Moore, D. "Substance Abuse and persons with disabilities: A significant public health problem." Paper presented at the American Public Health Association. Westin Peachtree Plaza Hotel, Atlanta, GA, November 13, 1991c.

Moore, D. Substance abuse assessment and diagnosis in medical rehabilitation .

*NeuroRehabilitation* 2(1):7-15, 1992.

Moore, D., and Ford, J.A. Prevention of substance abuse among persons with disabilities: A demonstration model. *Prevention Forum* 11(2):1-3, 7-10, 1991.

Moore, D.; Greer, B.; and Li, L. Alcohol and other substance use/ abuse among people with disabilities. *Journal of Social Behavior and Personality* 2(5):369-382, 1994.

Moore, D., and Li, L. Substance use among rehabilitation consumers for vocational rehabilitation services. *Journal of Rehabilitation* 38(2):124-133, 1994.

Moore, D., and Li, L. *Final Report to NIDRR: Results of an Epidemiologic Survey of Drug Use Among Persons with Disabilities.* Dayton, OH: Rehabilitation Research and Training Center on Drugs and Disability, 1996.

Moore, D., and Polsgrove, L. Disabilities, developmental handicaps, and substance misuse: A review. *International Journal of the Addictions* 26(1):65-90, 1991.

Moore, D., and Siegal, H. Double trouble: Alcohol and other drug use among orthopedically impaired college students. *Alcohol Health and Research World* 13(2):118- 123, 1989.

Motet-Grigoras, C., and Schuckit, M. Depression and substance abuse in handicapped young men. *Journal of Clinical Psychiatry* 47:234-237, 1986.

National Association on Alcohol, Drugs and Disability. *Facts Sheet on Alcohol, Drugs, and Disability.* Oregon, WI: National Association on Alcohol, Drugs and Disability, 1997.

Nelipovich, M., and Buss, E. Alcohol abuse in persons who are blind. *Alcohol Health and Research World* 13(2):128-131, 1989.

Office for Alcohol and Substance Abuse Services, New York State. "Management sytems data." Internal report. Albany, NY, 1998.

Ohio Valley Center for Brain Injury Prevention. "Suggestions for Providers Working With Persons With Brain Injury." Training sheet.

Columbus, OH, 1998.

Regier, D.A.; Farmer, M.E.; Rae, D.S.; Locke,

B.Z.; Keith, S.; Judd, L.; and Goodwin, F. Comorbidity of mental disorders with alcohol and other drugs abuse: Results from the epidemiologic catchment area (ECA) study. *Journal of the American Medical Association* 264(19):2511-2518, 1990.

Rehabilitation Research and Training Center on Drugs and Disability. *National Needs Assessment Survey Results Summary .* Dayton, OH: Rehabilitation Research and Training Center on Drugs and Disability, 1995.

Rehabilitation Research and Training Center on Drugs and Disability. *Substance Abuse, Disability and Vocational Rehabilitation.*

Dayton, OH: Rehabilitation Research and Training Center on Drugs and Disability, 1996.

Research and Training Center on Independent Living. *Guidelines for Reporting and Writing About People with Disabilities.* 5th ed.

Lawrence, KS: Research and Training Center on Independent Living, 1996.

Research Development Associates. "Comprehensive treatment for critical populations: A model substance abuse treatment program for racial and ethnic minority group members with disabilities." Evaluation summary. Dayton, OH, 1997.

Rhodes, S.S., and Jasinski, D.R. Learning disabilities in alcohol dependent adults: A preliminary study. *Journal of Learning Disabilities* 23:551-556, 1990.

Robert Wood Johnson Foundation. *The Robert Wood Johnson Foundation Annual Report 1994: Cost Containment.* Princeton, NJ: Robert Wood Johnson Foundation, 1994.

Rourke, S.B., and Loberg, T. The neurobehavioral correlates of alcoholism. In: Grant I., and Adams, K.M., eds.

*Neuropsychological Assessment Of Neuropsychiatric Disorders,* 2nd ed. New York: Oxford University Press, 1996. pp. 423- 485.

Schaschl, S., and Straw, D. Results of a model intervention program for physically impaired persons. *Alcohol and Research World* 13:150-153, 1989.

Schaschl, S., and Straw, D. Chemical dependency: The avoided issue for physically disabled persons. *Aid Bulletin* 11(2):1-8, 1990.

Schwab, A.J., and DiNitto, D.M. Factors related to the successful vocational rehabilitation of substance abusers. *Journal of Applied Rehabilitation Counseling* 24(3):11-20, 1993.

Schwab, A.J., Smith, T.W., and DiNitto, D. Client satisfaction and quality vocational rehabilitation. *Journal of Rehabilitation* 59(4):17-23, 1993.

Shrey, D.F. Disability management. In: Dell Orto, A.E., and Marinelli, R.P., eds.

*Encyclopedia of Disability and Rehabilitation.* New York: Macmillan Publishing, 1995. pp. 270-274.

Soderstrom, C.A.; Smith, G.S.; Dischinger, P.C.; McDuff, D.R.; Hebel, J.R.; Gorelick, D.A.;

Kerns, T.J.; Ho, S.M.; and Read, K.M. Psychoactive substance use disorders among seriously injured trauma center patients.

###### *Journal of the American Medical Association*

277(22):1769-1774, 1997.

Sparadeo, F.R., and Gill, D. Effects of prior alcohol use on head injury recovery. *Journal of Head Trauma Rehabilitation* 4(1):75-82, 1989.

Stedman, T.L. *Stedman's Medical Dictionary.*

25th ed., illustrated. Baltimore: Williams and Wilkins, 1990.

Storti, S. *Alcohol, Disabilities, and Rehabilitation.* San Diego, CA: Singular Publishing Group, 1997.

Substance Abuse Resources and Disability Issues. *Blindness, Visual Impairments and Substance Abuse: Facts for Substance Abuse Prevention and Treatment Professionals.*

Dayton, OH: Substance Abuse Resources and Disability Issues, 1995.

Susser, E.S.; Lin, S.P.; and Conover, S.A. Risk factors for homelessness among patients admitted to a state mental hospital. *American Journal of Psychiatry* 148:1659-1664, 1991.

Taylor, H.; Kagay, M.R.; and Leichenko, S. *The ICD Survey of Disabled Americans: Bringing Disabled Americans Into the Mainstream .* New York: Louis Harris and Associates, Inc., 1986.

Varley, C.K. Schizophreniform psychoses in mentally retarded adolescent girls following sexual assault. *American Journal of Psychiatry* 141(4):593-595, 1984.

Vash, C. *Psychology of Disability.* New York: Springer Publishing, 1981.

Wallace, B.C. Crack cocaine smokers as adult children of alcoholics: The dysfunctional family **link.** *Journal of Substance Abuse Treatment* 7:89-100, 1990.

World Health Organization. *International Classification of Impairments, Disabilities, and Handicaps: A Manual of Classification Relating to the Consequences of Disease.* Geneva: World Health Organization, 1980.

World Health Organization. *Guidelines for Counseling About HIV Infection and Disease.* WHO *AIDS Series 8.* Geneva: World Health Organization, 1990.