Quick Guide

For Clinicians

Based on TIP 29

Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities

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

Contents

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This Quick Guide is based almost entirely on information contained in TIP 29, published in 1998 and based on information updated through October 1997. No additional research has been conducted to update this topic since publication of the original TIP.

WHY A QUICK GUIDE?

This Quick Guide was developed to accompany *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities*, Number 29 in the Treatment Improvement Protocol (TIP) Series published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration. This Quick Guide is based entirely on TIP 29 and is designed to meet the needs of the busy clinician for concise, easily accessed "how-to" information.

The Guide is divided into seven sections (see ***Contents***). These sections will help readers quickly locate relevant material.

Terms related to people with disabilities are listed on page 28 in the ***Glossary*** and are included to enable clinicians to talk knowledgeably with their clients and clients' medical providers. The ***Resources*** section on page 24 provides information on developments in the field of substance use disorder treatment for people with disabilities.

For more information on the topics in this Quick Guide, readers are referred to TIP 29.

WHAT IS A TIP?

The TIP series has been in production since 1991. This series provides the substance abuse treatment and related fields with consensus-based, field-reviewed guidelines on substance abuse treatment topics of vital current interest.

TIP 29 *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities*

- Addresses concerns of a broad range of readers including clinicians, social workers, medical personnel, mental health workers, program administrators, and policymakers
- Includes extensive research
- Lists numerous resources for further information
- Is a comprehensive reference on substance abuse and people with disabilities

See the inside back cover for information on how to order TIPs and other related products.

INTRODUCTION

Studies show that people with disabilities are at much higher risk than the rest of the American population for substance abuse or dependence. Yet despite the Americans With Disabilities Act of 1990 (ADA), these people are less likely to enter or complete treatment.

Fortunately, substance use disorder treatment providers are better able to face the challenges of accommodating people with coexisting disabilities today. Rather than placing a person in an established treatment "slot," treatment providers are learning the importance of modifying and adapting services to meet a client's needs. Thus, the knowledge and skills necessary to adapt a treatment program to meet the needs of people with coexisting disabilities are improving.

This Quick Guide contains information on substance abuse treatment for people with physical, sensory, and cognitive disabilities.

For more detailed information, see TIP 29, pp. 1–15.

DISABILITY ETIQUETTE

- It is always a good idea to ask a client who has a disability if there are any accommodations he may need for successful treatment.
- Clinicians should use "people-first" language when referring to people with disabilities. For example, instead of saying "wheelchair user," say "a person who uses a wheelchair."
- Clinicians should offer "sighted guide" assistance, during which a person who is blind holds a sighted person's arm just above the elbow and they walk in tandem.
- A service animal should not be distracted from its job; the animal should not be touched or petted.
- It is important to look directly at a person who is deaf when communicating so he can see facial expressions and has the option of lip-reading.
- Touching a wheelchair user's chair may be offensive because people who use wheelchairs often regard the chair as an extension of themselves.
- Preferred terms:
  - –People with (or living with) HIV/AIDS
  - –Person who is blind, visually impaired, or has low vision

- –Person with a brain injury
- –People with mental retardation
- –People with psychiatric disabilities, psychiatric illnesses, emotional disorders, or mental disabilities
- –Person who is paralyzed
- –Stroke survivor

For more detailed information, see TIP 29, pp. 17–18, and Appendix C.

SCREENING

Screening for sensory disabilities

Consider the following when screening someone who is deaf or hard of hearing:

- Is the family of the client deaf or hearing?
- What is the extent of communication between the client and significant family members?
- What is the communication mode used by the client? If signing, what is the style used?
- Is the client's primary peer group deaf or hearing? If hearing, what is the extent of communication with these peers (how fluent)?
- How does the client feel about and cope with his hearing loss?

Counselors who are not experienced in working with deaf clients should consult a professional to provide guidance during the treatment planning process.

Screening for cognitive and affective disabilities

- Try to ask concrete questions, perhaps using time markers. Ask, "Did you get high today?" or "What about yesterday?"

- Do not assume that people with cognitive disabilities understand the terminology being used; explain or define terms and ask them to repeat back their understanding of the words.
- One way to screen self-care and problem-solving abilities is by asking the client to complete some simple activities such as writing a check or performing a practical math problem.

Substance use disorders can obscure a disability: the use of cocaine can mask clinical depression; people with mental retardation or developmental disabilities often use marijuana or alcohol to try to mask their disability.

Intake Interview

People with certain physical or cognitive disabilities may need a longer interview, and rest periods may need to be scheduled. Intake interviews of people with coexisting disabilities should be conducted by those who have been specifically trained to understand their needs.

Many intake interviewers begin an interview by asking very open and friendly questions such as "What led you here?" or "What happened to bring you here today?"

The interviewer must remember the focus is the person, not her disability.

Intake interview for people with cognitive disabilities

- Questions for people with traumatic brain injury (TBI) should be structured to provide concrete landmarks ("What were you doing 3 weeks before your automobile accident?").
- Keep questions concrete and avoid abstract concepts.
- Ask simple questions and repeat them.
- Ask the client to repeat back, in her own words, what's been said.
- Periodically check whether the client understands what is being asked—if the question is not understood it will need to be repeated in a different way.
- It is important to not talk to people with cognitive disabilities below their level of communication or as if they were children—they will be highly insulted, and will probably not come back.
- End the interview by summarizing the information learned.

Intake interview with people with sensory disabilities

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

- What travel aid is used?
- What communication method is used?
- How does the client maintain clothing organization?
- What are the client's skills in food preparation and hygiene?

Direct questions such as, "Tell me how often you've used Braille in the last 2 weeks," can be used to assess the client's level of ability.

When interviewing people who are deaf, a family member or friend of the client should not be used as an interpreter. Use only interpreters qualified by either a chapter of the Registry of Interpreters for the Deaf or a State interpreter screening organization.

If the client does not use sign language, an interpreter may not know how to communicate questions to the person who is deaf. The screener can try to use props or pictures to help make the message understood in a different way.

For more detailed information, see TIP 29, pp. 25–35.

TREATMENT PLANNING

People with physical disabilities

The treatment plan for a person with a physical disability needs to take into consideration not only the client's physical limitations, but also the psychological and social consequences of the disability. Issues that need to be addressed include

- recklessness
- social isolation
- low self-awareness of medical or psychological needs
- anger
- hopelessness
- panic that life without substances will be unbearable

People with cognitive disabilities

People with cognitive disabilities may have difficulty recognizing the negative consequences of their substance use. Showing them how substance use

Clients with traumatic brain injury are generally at a much higher risk for seizures and they should be made aware that alcohol can lower their seizure threshold.

affects other aspects of their lives will provide strong motivation for continued sobriety.

Memory books can help people with cognitive disabilities keep track of essential information such as names and meeting times.

Counselors can teach clients with TBI and Attention Deficit/Hyperactivity Disorder—as well as others with poor impulse control—to hesitate and "think a drink through" before acting.

People with sensory disabilities

Before giving a reading or writing assignment, the provider must make sure the required equipment is available. If a blind person is asked to attend 12-Step meetings, transportation must be arranged.

Meeting attendance is an important issue for the counselor to discuss with a person who is deaf. The possibility that a client may use her deafness as an excuse for not attending meetings should also be carefully explored.

Consequences

Contracts with people with disabilities may need to be more explicit than those with other people, and the consequences for relapses may need to be tailored to what the client is realistically capable of achieving.

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 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. The treatment plan should document all alterations to the usual treatment procedures.

The Counseling Environment

Some disability-specific factors to consider

- The room should be accessible for all clients, and those who use an assistive device (such as a wheelchair) should have room to maneuver.
- Counseling rooms should be near living areas and bathrooms and should be easy to find.
- Some table tops and desk surfaces should be high enough to be accessible to people who use wheelchairs (wooden blocks can be placed under tables to elevate them to the proper height).
- Lighting needs to be sufficient for a person who is deaf to see his interpreter.
- The presence of visual distractions (photos, art-work, desktop toys) may make it more difficult for someone with AD/HD to concentrate.

- The glare from windows and fluorescent lights can be a distraction for people with AD/HD.
- The amount of noise should be kept to a minimum.

Individual Counseling

- Some adaptations may be necessary. For instance, session times should be flexible, so that sessions can be shortened, lengthened, or occur more frequently, depending on the individual treatment plan.
- 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.
- There is often a chance for individual counseling at the end of a group session. The counselor and patient can take 10 minutes together to review what went on in group. More frequent, less formal contacts may benefit the individual as well.
- If the client has limited transportation options, conduct individual counseling by telephone, go to his house, or meet at a rehabilitation center or other alternative site.

Group Counseling

Discussions about an individual's disability can be therapeutic and pertinent to the process of recov-

ery, so treatment staff should encourage discussion of disability issues when clients bring them up. It is important, however, to work with nondisabled clients to minimize enabling of or overcompensation for people with coexisting disabilities.

Counselors may also find it useful to

- alter group participation expectations
- limit the time in group
- work with the group to extend the learning experience outside the confines of the session

People who are visually impaired may need help orienting themselves to the group, including the position of all the participants and the format or structure of learning activities.

If a person who is deaf is using an interpreter, group members will need to take turns during discussions. In a group session the person who is deaf will normally be a few seconds or minutes behind the hearing group members; signing is very tiring, so a session that lasts more than an hour may require two interpreters.

Expressive therapy—the practice of using movement to express feelings—is often effective for people with mental retardation and other cognitive disabilities. Role-playing works well for people

with developmental disabilities—the process of playing a role themselves helps them to internalize it.

Sometimes people with spasticity or other motor problems 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 part of some disabilities.

Chronic Pain

People 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.

Clinicians must attempt to determine if pain is the real reason a client has been using a substance; if it is, they will need access to a good alternative pain management program to help manage withdrawal.

The clinician should not make these decisions alone, but in consultation with the rest of the treatment team and the client.

It is critical to obtain an accurate pain therapy history for each person which should ascertain

- the amount of medication being taken
- whether it is within the prescribed limits
- whether or not more than one physician has been prescribing medications for the same or similar conditions

Aftercare

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 supports.

If aftercare services are not reasonably accessible, treatment programs can direct clients to tape or book libraries, Internet sites, or other self-directed support activities.

There are versions of the 12 Steps adapted for people with brain injury, reading limitations, and mental retardation. Other modifications to 12-Step programs may also prove more beneficial to some people with disabilities. For people with mental retardation, the presence of a facilitator may be very helpful, even though facilitators are not normally a part of 12-Step meetings.

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.

Linkages in Aftercare

Examples of key differences in aftercare likely to apply to many people with disabilities

- Ongoing and more frequent monitoring may be required.
- Friends, family, and advocates can be key to the recovery of a person with a coexisting disability because of a higher degree of reliance on their care and support.
- The circle of people involved with recovery may be larger; for example, the support of attendants, residential facility staff, or home health care providers may be critical.
- Modifications to "typical" aftercare plans are likely to be required; provisions for transportation and communication aides may be necessary.

- Service coordination and case management responsibilities are more prominent and time consuming than for clients without disabilities.
- The transition counselor for the referring program may need to brief outpatient program staff on the client's needs, functional limitations and capabilities, and suggest accommodations or modifications to usual procedures.

For more detailed information, see TIP 29, pp. 46–65, and p. 80.

LINKAGES

Why Linkages Are Necessary

- To improve an individual's prognosis for recovery
- To ensure compliance with legal mandates
- To increase teamwork among providers in addressing advocacy issues
- To improve coordination of services
- To access scarce financial resources
- To identify appropriate accommodations and procedural modifications

Finding Partners

Partners can be found through

- State Independent Living Councils
- Public health departments
- The United Way
- County governments
- State agencies for vocational rehabilitation

Sources of Technical Assistance

Centers for Independent Living (CILs)—These non-residential groups provide advocacy, information, independent living skills training, and peer counseling for people with disabilities.

Disability Advocacy and Service Groups—Programs that begin working with a person who has a disability they have not yet encountered should consider contacting an appropriate advocacy and service group to ask for information, to explore linkage possibilities, or to locate specialized services.

Vocational Rehabilitation Centers—Each State has an agency focused on providing vocational training and rehabilitation services to people with disabilities, with the goal of placing these individuals into competitive employment.

Rehabilitation Research and Training Centers (RRTCs)—Different RRTCs focus on topics such as spinal cord injury, traumatic brain injury, mental illness and long term employment, managed care, family issues, deafness, aging, or Native Americans with disabilities.

Disability Business Technical Assistance Centers (DBTACs)—These centers provide information, training, and technical assistance to businesses and agencies covered by the ADA and to people with disabilities who have rights under the ADA.

Linkages in Primary Treatment

During primary treatment, many people with disabilities face challenges that may be addressed more effectively through well-chosen linkages.

Many people with disabilities will have specific needs with which the treatment provider may not be familiar. Informed resources, such as disability advocacy groups, can help educate providers about these needs.

Linkages can assist the client with

- living situation
- support systems
- addressing discrimination
- resume preparation and interview coaching
- providing job training and purchasing tools
- developing job skills and finding employment

Employers with specialized hiring programs are excellent contacts. Employers who are able to hire large numbers of people with disabilities, such as Goodwill Industries, may also be able to suggest other agencies.

Local or State commissions may exist that address employment issues for people with disabilities.

Employment Linkages

People with disabilities often have more difficulty securing employment, and thoughtful management of the return to employment may be especially important.

- DBTACs, local disability law centers, the Equal Employment Opportunity Commission, and civil rights commissions or offices may provide legal counsel or information concerning employment issues.
- Encourage the client to use Employee Assistance Programs if they are available.
- Consider meeting with the employer to facilitate understanding of recovery needs.

For more detailed information, see TIP 29, pp. 68–83.

RESOURCES

American Association of People With Disabilities
1819 H Street, NW, Suite 330
Washington, DC 20006
(800) 840-8844 (voice)
(202) 457-0473 (fax)
www.aapd-dc.org

The Arc (formerly Association for Retarded Citizens)
1010 Wayne Ave., Suite 650
Silver Spring, MD 20910
(301) 565-3842 (voice)
(301) 565-5342 (fax)
www.thearc.org/

Brain Injury Association
105 North Alfred Street
Alexandria, VA 22314
(703) 236-6000 (voice)
(703) 236-6001 (fax)
www.biausa.org

Children and Adults With ADD
8181 Professional Place, Suite 201
Landover, MD 20785
(800) 233-4050
(301) 306-7070 (voice)
(301) 306-7090 (fax)
www.chadd.org/

National Association on Alcohol, Drugs and Disability
2165 Bunker Hill Drive
San Mateo, CA 94402-3801
650-578-8047 (voice/TTY)
650-286-9205 (fax)
www.naadd.org/

National Association of the Deaf
814 Thayer Avenue
Silver Spring, MD 20910-4500
(301) 587-1788 (voice)
(301) 587-1789 (TTY)
(301) 587-1791 (fax)
http://www.nad.org

National Center for Learning Disabilities, Inc.
381 Park Avenue South, Suite 1401
New York, NY 10016
(212) 545-7510
(888) 575-7373
http://www.ncld.org/

National Council on Independent Living
1916 Wilson Boulevard, Suite 209
Arlington, VA 22201
(703) 525-3406 (voice)
(703) 525-4153 (TTY)
(703) 525-3409 (fax)
www.ncil.org

National Easter Seal Society
230 West Monroe Street, Suite 1800
Chicago, IL 60606
(312) 726-6200 (voice)
(312) 726-4258 (TTY)
(312) 726-1494 (fax)
www.easter-seals.org/

National Institute on Disability and Rehabilitation Research
400 Maryland Avenue, S.W.
Washington, DC 20202-2572
Voice: (202) 205-8134
TTY: (202) 205-4475
www.ed.gov/offices/OSERS/NIDRR/

President's Committee on Employment of People With Disabilities
1331 F Street, NW, 3rd floor
Washington, DC 20004-1107
(202) 376-6200 (voice)
(202) 376-6205 (TTY)
(202) 376-6219 (fax)
http://www.pcepd.gov

For more detailed information, see TIP 29, Appendix B.

GLOSSARY

AIDS: Acquired immunodeficiency syndrome, an infectious disease resulting in the loss of the body's immune system to ward off infections. The disease is caused by the human immunodeficiency virus (HIV).

Blind: A condition in which a person has a loss of vision for ordinary life purposes. Visually impaired is a generic term for all degrees of vision loss.

Brain injury: A condition where there is long-term or temporary disruption in brain function which can include difficulties with cognitive, physical, emotional, or social functioning. It is also referred to as traumatic brain injury (TBI).

Deaf: A profound degree of hearing loss that prevents understanding speech aurally.

Developmental disability: Any mental or physical disability starting before the age of 22 and continuing indefinitely. Includes individuals with mental retardation, cerebral palsy, autism, epilepsy (and other seizure disorders), sensory impairments, congenital disabilities, traumatic injuries, and conditions caused by disease (polio, muscular dystrophy, etc.), and it may be the result of multiple disabilities. People often use this term to refer to a person with mental retardation.

Handicap: A condition or barrier imposed by society, the environment, or by one's own self. Handicap is synonymous with barrier and not a synonym for disability. Some people prefer inaccessible or not accessible to describe social and environmental barriers. Handicap can be used when citing laws and situations, but should not be used to describe a disability.

Hard of hearing: Mild and moderate hearing loss that may or may not be corrected with amplification.

Mental retardation: Substantial intellectual delay which requires environmental or personal supports to live independently. Mental retardation is exhibited by below average intellectual functioning in two or more life areas and is present before the age of 18. Mental retardation is commonly referred to as a developmental disability.

Nondisabled: Appropriate term for people without disabilities. Normal, healthy, or whole are inappropriate because they imply that people who are disabled are not these things.

Seizure: An involuntary muscular contraction, a brief impairment or loss of consciousness, etc., resulting from a neurological condition such as epilepsy or from an acquired brain injury.

Spastic: A muscle with sudden abnormal and involuntary spasm. It is not an appropriate term for describing a person: muscles are spastic, not people.

Spinal cord injury: A condition in which there has been permanent damage to the spinal cord. Quadriplegia means substantial or total loss of function in all four extremities. Paraplegia refers to substantial or total loss of function in the lower part of the body only.

Stroke: An interruption of blood to the brain. Hemiplegia (paralysis on one side) may result.

For more detailed information, see TIP 29, Appendix C.

Ordering Information

TIP 29 ***Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities***

TIP 29-Related Products

KAP Keys for Clinicians Based on TIP 29

Easy Ways to Obtain Free Copies of All TIP Products

1. Call SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at **800-729-6686**, TDD (hearing impaired) **800-487-4889**
2. Visit CSAT's Web site at **www.csat.samhsa.gov**

Other Treatment Improvement Protocols (TIPs) that are relevant to this Quick Guide:

TIP 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse (1994)* **BKD134**

TIP 15, *Treatment for HIV-Infected Alcohol and Other Drug Abusers (1995)* **BKD163**

TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians (1997)* **BKD234**

TIP 27, *Comprehensive Case Management for Substance Abuse Treatment (1998)* **BKD251**

TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse (1999)* **BKD341**

TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment (1999)* **BKD342**

TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS (2000)* **BKD359**

See the inside back cover for ordering information for all TIPs and related products.

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