Chapter 1—Overview of Treatment Issues

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

Though the ADA is correcting the situation, many people with disabilities remain stigmatized and shut out. They are also at much higher risk than the rest of the population for substance abuse or dependence. A study of adult males receiving treatment for alcoholism, for instance, revealed that 40 percent had a history indicative of learning disabilities (Rhodes and Jasinski, 1990). Another study indicated that at least one half of persons with a substance use disorder and a coexisting disability are not being identified as such by the systems providing them services (Rehabilitation Research and Training Center on Drugs and Disability [RRTC], 1996).

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

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

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

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

Definitions and Terminology

Physical and cognitive disabilities are very sensitive topics for discussion and providers need to pay attention to the language they use to discuss this issue. Appendix C presents specific guidelines on how to refer to persons with disabilities in a respectful, sensitive manner. As a general rule, one should always put people first, before their disabilities, referring to "persons with disabilities" rather than "disabled people." One should never refer to the disability in place of the person (not "the retarded" but rather "people who are retarded"). Nor should one call a person with a disability a "patient" or "case," unless it is to refer to his relationship with his doctor.

Disabilities

Diseases, disorders, and injuries, whether congenital or acquired, can have various effects on organs and body systems. Conditions (and diseases) such as multiple sclerosis, TBI, spinal cord injury, diabetes, and cerebral palsy can lead to impairments, such as impaired cognitive ability, paralysis, blindness, or muscular dysfunction. These impairments in turn cause disabilities, which limit an individual's ability to function in various areas of life, such as learning, reading, and mobility. While diseases, impairments, and disabilities are distinct categories, they are often used interchangeably; to ensure clarity, they are defined in Figure 1-2.

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

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

1. Physical impairments are caused by congenital or acquired diseases and disorders or by injury or trauma. For example, spinal cord injury is a disorder that can cause paralysis, an impairment.

2. Sensory impairments include blindness and deafness, which may be caused by congenital disorders, diseases such as encephalopathy or meningitis, or trauma to the sensory organs or the brain.

3. Cognitive impairments are disruptions of thinking skills, such as inattention, memory problems, perceptual problems, disruptions in communication, spatial disorientation, problems with sequencing (the ability to follow a set of steps in order to accomplish a task), misperception of time, and perseveration (constant repetition of meaningless or inappropriate words or phrases).

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

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

Functional Capacities and Limitations

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

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

1. Self-care
   - Eating
• Grooming
• Bathing
• Dressing
• Bowel and bladder management
• Medication usage

2. Mobility
• Positioning
• Walking, with or without assistive devices
• Use of wheelchair or other mobility aid
• Use of stairs
• Ability to operate motor vehicle
• Use of public transportation (or other access to transportation)

3. Communication
• Reading
• Writing
• Speaking
• Listening

4. Learning
• Attention
• Comprehension
• Retention
• Application

5. Problem-solving
• Awareness and recognition of problems
• Identification of alternatives
• Anticipation of possible consequences of various alternatives
• Deciding on optimal alternative

6. Social skills
• Understanding of social mores and values
• Impulse control
• Intimacy
• Conversational skills
• Empathy

7. Executive functions
• Planning and organization
• Motivation and initiation
• Monitoring and reviewing
• Decisionmaking

Disabilities and Chemical Dependency
Data from the Robert Wood Johnson Foundation indicate that about 10 percent of the population have a substance use disorder (Robert Wood Johnson Foundation, 1994). Yet studies have consistently found that 20 percent or more of all persons qualifying for State vocational rehabilitation services exhibit symptoms qualifying them for a diagnosis of substance abuse or substance dependence (Moore and Li, 1994; Schwab and DiNitto, 1993; RRTC, 1996). In the 1996 RRTC study, the disabilities represented included those most prevalent within State vocational rehabilitation (VR) systems: mental illness, various orthopedic impairments, deafness/hearing impairments, blindness/visual impairments, learning disability, mental retardation, TBI, and chemical dependency. In a subsequent analysis, persons with the primary disability of chemical dependency were omitted from the sample. Yet the remaining VR consumers with other disabilities reported patterns of illicit drug use that were more frequent and heavier for every drug compared with a general population sample matched for age and geographic distribution (RRTC, 1996).

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

Not all people with disabilities are equally likely to have substance use disorders. Certain types of disabilities seem to have more impact than others on substance use behavior. For instance, research suggests that the rate of substance abuse among people with mental illness may be twice as high as that of the general population, and over 50 percent of young people with mental illness report some kind of substance use (Kelley and Benshoff, 1997; Kessler and Klein, 1995; Regier et al., 1990; Brown et al., 1989). Substance use is often the major contributing factor to both spinal cord and traumatic brain injuries, and people living with the aftereffects of such trauma often continue to have substance use disorders (Heinemann et al., 1988; Sparadeo and Gill, 1989; Corrigan et al., 1995).

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

Life Problems Contribute to Substance Use Disorders

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

Many adults with disabilities are underemployed or unemployed. Some 30 percent live below the poverty line, a rate approximately 20 percent higher than that for people without disabilities (LaPlante et al., 1997). People with disabilities at all income levels generally spend a large proportion of their income to meet their disability-related needs. Like others who have been isolated or unemployed over a long period of time, some people with disabilities lack the social skills and familiarity with workplaces needed to succeed in a job.

For many reasons, people with disabilities may rely on a smaller social network. They may be isolated because of their families' efforts to protect them, the physical difficulty of getting out to social settings, lack of opportunities to practice social skills, lack of physical stamina, trouble finding activities and negotiating transportation, poverty, and nondisabled people's discomfort with people with disabilities. An altered body image can make those with a recent disability onset (e.g., people using a wheelchair for the first time) reluctant to socialize. Additionally, physical limitations make some people fear violence or exploitation. People with disabilities are at greater risk of being victims of sexual abuse and domestic or other violence (Glover et al., 1995; Varley, 1984). They are more likely to be victimized because they are perceived as unable to protect themselves. Depression and low self-esteem associated with their disabilities can also play a role in some individuals' victimization, and in turn their substance use.
Isolation and functional limitations leave many people with disabilities with few recreational options, yet they often have much unstructured time on their hands. For example, people who are blind or have a visual impairment may face increased isolation, excess free time, and underemployment (Motet-Grigoras and Schuckit, 1989; Nelipovich and Buss, 1989). Some people may perceive bars or other places where alcohol is consumed as the only social gathering places open to them and drinking or drug use the only possible means of recreating or gaining social support (Greer, 1986).

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

**Treatment implications**

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

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

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

**Obvious Versus Hidden Disabilities**

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

Disabilities can also be hidden from clients themselves. A substance use disorder treatment program may be where a person first discovers she has diabetes, a learning disability, or a hearing loss. Even if a client knows he has a disability, he may not be aware of accommodations that could help him function better.

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

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

Hidden cognitive disabilities

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

The majority of individuals with mental retardation is in the mild to borderline range (IQ up to 83) and can function well in many treatment situations with minimal adaptations. However, people with mental retardation and other cognitive disabilities may have very good social and communication skills and yet still have serious problems with memory, decisionmaking, planning, or learning comprehension. Some highly functioning individuals go to great lengths to keep their disabilities a secret, even presenting with noncompliant or negative behavior to deflect attention from their areas of functional limitation.

Hidden physical disabilities

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

Recognizing Barriers to Treatment

In spite of two recent Federal laws (the 1992 Amendments to the Rehabilitation Act of 1973 and the Americans With Disabilities Act of 1990), substance use disorder treatment programs continue to provide inadequate services for people with disabilities. Although this difficulty is most visible in inpatient or residential programs, statewide legal proceedings on behalf of people with disabilities have been initiated regarding access to outpatient settings as well. According to the ADA, programs must remove or compensate for physical or architectural barriers to existing facilities when accommodation is readily achievable, meaning "easily accomplishable and able to be carried out without much difficulty or expense" (P.L. 101-336 -301). Providers should examine their programs and modify them to eliminate four fundamental groups of barriers to treatment for people with disabilities: (1) attitudinal barriers; (2) discriminatory policies, practices, and procedures; (3) communications barriers; and (4) architectural barriers. (For a more detailed explanation of what accommodations must be made, and answers to other, more specific, questions concerning ADA compliance and the best ways to overcome these barriers, see Appendix D).

Attitudinal Barriers

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

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

- People with disabilities do not abuse substances.
- People with disabilities should receive exactly the same treatment protocol as everyone else, so that they aren't singled out as different. Being mainstreamed into society means that you should do exactly the same things as everyone else.
A person is noncompliant when her disability prevents her from responding to treatment.

A person with a disability will make other clients uncomfortable.

People with disabilities will sue the program regardless of the services offered.

Serving people with disabilities requires going to extremes.

Every person with a disability requires hospitalization rather than a residential or outpatient program.

People with cognitive disabilities are not capable of learning how to stay sober.

People with disabilities make too many demands and use their disability as an excuse for not fully participating in treatment.

People with disabilities deserve pity, so they should be allowed more latitude to indulge in substance use.

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

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

Discriminatory Policies, Practices, and Procedures

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

- We do not serve clients who are taking medication (even if the medication is for a medical condition, such as epilepsy). (Such discrimination is also often seen against clients in opioid maintenance therapy or those who require psychoactive medications for a psychiatric condition.)

- People who miss appointments must pay fines (even though disability-related problems may make it impossible for a person to make a scheduled appointment)

- Fire and safety regulations require that all clients be able to walk out of the building independently (which precludes the participation of a person who uses a wheelchair).

- All clients must participate in house chores such as washing dishes and mowing the lawn (which precludes the participation of people with particular physical disabilities).

- Every person must read two chapters of a book per day (even if some people do not have the necessary reading skills).

Examples of discriminatory practices include the following:

- A client is excluded from the residential setting because he needs assistance in transferring from the wheelchair to the bed (even though this task is readily learned by program staff and is required only twice per day for 2 minutes at a time).

- A client is discharged from outpatient treatment for missing three sessions, when the client was actually delayed by waiting for a "handicapped-accessible" bus that does not run on a set schedule.

The ADA sets forth many requirements to protect people with disabilities from administrative barriers. Programs should periodically review their existing policies, practices, and procedures and adopt new ones as needed in order to avoid discrimination. Rules and treatment plans can be specifically tailored to meet the needs of each person, and consequently the specific treatment requirements will vary for some people. An individualized treatment approach permits more latitude in assigning different types of chores or homework to individuals and in using different techniques or learning modalities (e.g., allowing a client who has great difficulty speaking in a group setting to turn in an oral report on audiocassette). Also, when all clients receive individualized treatment there will be less friction when one client is permitted to do an assignment differently.

Barriers to Communication

These barriers exist when a program's communications with people with coexisting disabilities are less accessible
Communications with people with physical disabilities

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

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

Communications with people with sensory disabilities

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

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

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

Once the individual who is deaf has been admitted to the program, someone will have to translate the spoken communication that comprises most of the program. Clients who are deaf and use sign language will need sign language interpreters in order to have access to communication. Individuals whose first language is American Sign Language (ASL) know written English as a second language, and may have the same difficulties with it that other nonnative speakers have. Interpreters should be available at all times so that clients who are deaf can fully participate in the program; if there are no staff who use sign language then one or more outside interpreters will need to be hired.

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

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

Treatment programs may have deaf clients who do not use sign language. In this case, a program may need to get an oral interpreter (who mouths the words that people are saying) or Computer Assisted Realtime Transcription (CART) services. A CART reporter types everything that is said into a computer system, which a deaf person then reads on a monitor or laptop screen. Some individuals who are deaf or hard of hearing may request an assistive listening device to amplify sound. The client who is deaf can provide advice to the program and should be provided the type of device he asks for. The State agency for people who are deaf or the State VR...
agency should know where to obtain these devices.

**Communications with people with cognitive disabilities**

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

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

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

Cognitive disabilities may limit people’s understanding of basic concepts of treatment. Individuals with developmental disabilities may not have acquired abstract thought skills, and dealing with abstract concepts such as admitting their powerlessness over alcohol can be daunting. Those with learning disabilities may have trouble processing and using abstract information. Many will have limited vocabularies. And many individuals with a variety of disabilities—not necessarily cognitive ones—have poor educational achievement due to negative school experiences. Bad experiences in school are also predictors of later substance use disorders (Jessor and Jessor, 1977).

**Architectural Barriers**

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

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

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

**Mainstreaming Versus Specialized Services**

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

People who are deaf and identify with Deaf Culture will usually prefer specialized treatment programs (see below). In addition, clients who have severe psychiatric disorders will benefit from specialized services that understand their medication and behavioral issues. People with mental retardation may find it easier to understand and participate in discussions that involve others with similar disabilities. They do not have to channel all their energy into “passing as normal” and are less ashamed to ask questions. Some clinicians find that even people with mild and borderline mental retardation, and with limited or no reading abilities, prefer to be placed with other nonreaders. Other disability conditions that may warrant some stand-alone services include TBI, spinal cord injury, or severe or multiple disabilities.
In some situations, however, grouping people with similar disabilities may be counterproductive. For example, persons who are grouped by disability may try to ignore the larger treatment population, or they may be at widely dissimilar stages of acceptance or adaptation to their disabilities. Depending on the personalities of the individuals involved, one person may keep another from going forward in treatment. While grouping generally can produce positive outcomes, it is an adaptation that should be monitored once established.

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

**Deaf and Hard of Hearing**

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

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

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

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

**Working With People With Disabilities**

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

The TIP also aims to educate providers about the needs common to most (if not all) people with disabilities and the legal, ethical, and practical reasons to accommodate this significant client population. Information is provided concerning screening for the physical and cognitive disabilities of those seeking treatment (in Chapter 2), how
treatment can be modified to work better for people with disabilities (in Chapter 3), establishing linkages with other types of agencies and programs (in Chapter 4), modifications to the program that might need to take place at the administrative level (in Chapter 5), and ADA compliance (see Appendix D).

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

The process of education will help treatment providers discover that people with disabilities are more like than unlike other clients, and that they have already been treating people with disabilities without knowing it. The presence of people with disabilities in a treatment group can benefit all clients. Appropriate accommodation of a person with a disability fosters cooperation at the same time it enriches group diversity. By better serving people with identified disabilities, the treatment provider will improve care for a great many other clients as well, as providers learn to tailor treatment to each client's individual needs.
Figure 1-2: Some Definitions

<table>
<thead>
<tr>
<th>The definitions that follow explain the terms used in this TIP:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disease</strong>: An interruption, cessation, or disorder of body functions, systems, or organs. *</td>
</tr>
<tr>
<td><strong>Impairment</strong>: Any loss or abnormality of psychological, physiological, or anatomical structure or functions. **</td>
</tr>
<tr>
<td><strong>Disability</strong>: Any restriction or lack (resulting from an impairment) of the ability to perform an activity in the manner or within the range considered normal for a human being. A disability is always perceived in the context of certain societal expectations, and it is only within that context that the disadvantages accruing from a disability (often called &quot;handicaps&quot;) can be properly evaluated. **</td>
</tr>
<tr>
<td><strong>Functional capacities</strong>: The ability or degree of ability possessed by the individual to meet or perform the behaviors, tasks, and roles expected in a social environment. ***</td>
</tr>
<tr>
<td><strong>Functional limitations</strong>: The inability to perform certain behaviors, fulfill certain tasks, or meet certain social roles as a consequence of a disability. Those limitations can be anatomical (e.g., amputation), physiological (e.g., diabetes), cognitive (e.g., traumatic brain injury), or affective (e.g., depression) in origin and nature. They represent substandard performance on the part of the individual in meeting life activities and reflect the interaction between the person and the environment. (A list of the seven areas of functional capacities and limitations most often assessed follows on page 5.) ***</td>
</tr>
</tbody>
</table>

### Figure 1-3: Disability Chart

<table>
<thead>
<tr>
<th>Category</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Spina bifida, Spinal cord injury, Amputation, Diabetes, Chronic fatigue syndrome, Carpal tunnel, Arthritis</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Learning disability, Traumatic brain injury, AD/HD</td>
</tr>
<tr>
<td>Affective</td>
<td>Depression, Bipolar disorder, Schizophrenia, Eating disorder, Anxiety, Posttraumatic stress disorder</td>
</tr>
<tr>
<td>Sensory</td>
<td>Blindness, Deafness, Visual impairment, Hard of hearing</td>
</tr>
</tbody>
</table>
Boxes

Figure 1-1: Substance Use Disorders as a Coexisting Disability
Chemical dependency is called a disability and covered as such under the provisions of the Americans With Disabilities Act (ADA). Substance abuse is an illness that frequently results in serious functional limitations or death when not properly treated. If an individual has both a substance use disorder and a physical or cognitive disability, then he is really coping with coexisting disabilities. However, for the purposes of this Treatment Improvement Protocol (TIP), the term "disabilities" will refer to physical and cognitive disabilities and not substance use disorders. When the TIP refers to a person with a "disability," therefore, it should be understood that it is a coexisting disability.

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 capacity. The following are some of the factors that affect a person's willingness to accept the realities of her disability:

- 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 lifestyle 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

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Chapter 2—Screening Issues

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

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

"Disability Etiquette"

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

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

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

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

People With Sensory Disabilities

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

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

Word use is important. The counselor must use more descriptive and detailed language and strive to avoid phases like "over there" or "like this." There is no need to avoid words like "see" and "look"—they are part of everyone's daily language.
Finally, more than 80 percent of people considered "blind" have some residual vision. This remaining vision is typically light- or glare-sensitive. It is helpful to ask if the lighting in the current environment is uncomfortable. Figure 3-6 in the next chapter presents these and other suggestions for working with people who are blind in the form of an easy-to-follow list of suggestions.

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

People With Physical Disabilities

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

People who use wheelchairs often come to regard the chair as an extension of themselves, and touching the chair may be offensive to them. Never take control of the wheelchair or touch any other adaptive equipment without permission.

Screening for Disabilities

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

It is the level of abilities and of the functioning of the individual—not the simple determination of whether a disability exists—that must be assessed if screening is to lead to an effective treatment plan. In situations where a diagnosis of disability is needed (e.g., to qualify for special services), treatment providers should refer the client to a disabilities services professional. State vocational rehabilitation (VR) programs may be a good source for referral.

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

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

Initial Screening

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

Questions relating to disabilities can and should be incorporated as seamlessly as possible into a comprehensive screen, rather than treated as an altogether separate subject. After discussion of the substance use disorder, the interviewer can bring up visibly obvious impairments, such as those requiring the use of a wheelchair or cane. The questions can be framed by the program's desire to respond to individual needs: "Do you need any accommodations to participate in this program?" This question should be posed to everyone, not only to those the interviewer thinks have a disability.

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

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

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

Figure 2-2 presents the questions from Figure 2-1 in the manner they might be asked during a spoken (or signed) interview, with the numbers of the relevant questions provided in parentheses. This figure also provides further questions that might be asked and ideas for how the information gained in the interview could be used in followup treatment planning. Throughout the screening interview, it is important for the screener to pay attention to the individual's affect and behavior in order to pick up on possible cognitive or affective impairments. Screening for psychiatric disorders is discussed in TIP 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (CSAT, 1994).

**Screening for sensory disabilities**

A treatment provider need not conduct an assessment of hearing loss when working with people who are deaf or hard of hearing. The provider should, however, note the individual's apparent adjustment to the hearing loss and psychosocial factors related to it. This information could be used in determining the type of program to which to refer the client (a mainstreamed program or an all-deaf program) and could be useful to the treatment provider in developing a treatment plan. Clinicians who conduct screenings should consult with a professional who is experienced in working with people who are deaf and can assist the clinician in developing an appropriate referral to treatment.

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

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

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

**Screening for cognitive and affective disabilities**

Some cognitive impairments, while not readily apparent, may be revealed by subtle behavioral cues. For instance, difficulty in attending to the questions being asked or fidgeting and restlessness during the interview may indicate an attention disorder.

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

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

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

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

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

From Screening to Treatment

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

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

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

Case Study

"John," a 26-year-old white male, was referred from a local criminal justice agency after an arrest for driving under the influence (DUI). A high-school graduate, he lived with his mother and had held a series of entry-level jobs, none for more than 8 months. He had no obvious disabilities and stated that he is at the program because he "got
into trouble." The screening questions presented below reflect a portion of a lengthier interview; John's answers to
the questions will assist providers in planning his treatment program.

Q: Do you feel you have a disability, or has anyone ever told you that you have one?
A: No, nothing like that.

Q: Have you ever had to stay in a hospital overnight, or gone to an emergency room for any reason?
A: I've had some falls, and once I broke my arm. I went to the emergency room. But I never had to stay overnight.

Q: Have you ever seen a doctor for a long period of time, more frequently than just one visit or for routine check-ups?
A: Yes when I was in grade school.

Q: What was going on for you that you needed to see the doctor so often?
A: I'm not sure. I think I was overactive. I was on some kind of medicine.

Q: Do you know what kind of medication it was?
A: It was "rid-lin" [Ritalin] or something like that.

Q: Were you ever diagnosed with a learning disorder?
A: I don't think so.

Q: Were you ever in special education classes in school or did you receive any kind of tutoring?
A: I had some tutoring for math.

Q: Have you ever been given a hearing test?
A: Yeah. When I was in school they did hearing tests. I always passed them with flying colors. I don't have any hearing problems.

Q: Do you ever have to ask people to repeat what they're saying? Or has anyone ever complained to you that you don't listen?
A: Yeah, well my boss at work always says that I don't listen. And my teachers at school used to tell my mother that I don't hear what people are saying to me.

Q: Did you ever need to wear glasses?
A: No.

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

Q: Have you ever been hit on the head or had any blows to the head?
A: Now that you mention it, there was this one time in high school after football practice. Some of us were fooling around and I got into a fight. I don't know what happened. But I had to get some stitches and I had a headache for a few days.

Q: Did you lose consciousness?
A: I don't know. I guess there were some things I don't remember that people told me about later.

Q: What's the first thing you remember after the fight?
A: Riding in the ambulance.

Q: What did they do at the hospital?
A: I got some stitches in my forehead and they kept me around for a while to keep an eye on me.

Q: Did you notice any changes in your abilities since then?
A: No, not really.

Q: Have you had problems with bad or frequent headaches since the fight?
A: I guess sometimes I have headaches.
Q: Have you ever talked to a doctor about them?
A: No, not really.

[This is a problem that may need to be followed up with a physician visit. If neuropsychological testing was never done after the accident, it should be performed now if funds are available.]

Q: Have you ever received benefits of any kind? Like from a government agency?
A: No.

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

Q: What was the longest job that you held?
A: Last year I worked for 8 months as a grocer's assistant. I quit because the boss was getting on my case. I don't think he liked me very much.
Q: Why do you think that?
A: Well, he would yell at me or tell me that I didn't do my job right. I should have been given a better job there, but he would say that I couldn't figure out how to do the job I had. He said I was forgetful.
Q: Do you think that you are forgetful?
A: Yeah, I guess so. I just sometimes forget things at work. There's too much to remember all at once.
Q: How were you taught your job?
A: Well, I followed this guy around and did what he told me to.
Q: Did that work? Do you feel that you learned the job?
A: It was OK when we worked together. Then they gave me a big list of stuff and I was supposed to just follow the list, but it didn't make sense.
Q: Were you able to read the list OK?
A: I guess some of it I didn't understand.
Q: Were you able to ask someone to explain the tasks required?
A: No, I just kind of figured it out. I don't like to ask a lot of questions. People don't always understand what I'm asking about anyway.
Q: Do you ever have trouble controlling your anger?
A: Maybe when I'm drinking.
Q: Do you ever feel anxious or on edge?
A: Sometimes. When I'm bored.
Q: How about feeling depressed? Or really happy for no reason?
A: No.
Q: Is English your first language? Did you speak any other language when you were growing up?
A: No, I only speak English.
Q: Tell me about your reading habits. What kind of stuff do you like to read? How often do you read?
A: I don't really like to read. I mostly read the comics. Stuff like that. [The screener suspects a reading problem from this answer. Later on in the interview the client is asked to read a simple sentence from a Release of Information form, and he labors over it in a halting manner.]
Q: Do you ever have trouble paying attention or concentrating on things?
A: With things I like, I don't have a problem, no.
Q: What kinds of things interest you and hold your attention?
A: Sports and TV shows I like--mostly comedies.

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

The results of this screening interview and how they pertain to the identification of areas in which John may have impairments and disabilities are presented in Figure 2-3. The interview with John and the accompanying profile may raise as many questions as they answer. However, after the interview the major issues become clearer, and the next steps are more evident. John may have had one or more sources of compromise to his mental abilities. Regardless of the source, at this point the screening has raised questions about his reading, learning ability, problem-solving ability, and social skills. Additionally, executive functions as they relate to vocational capability need to be further evaluated. There are two questions the treatment provider should consider at this point:

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

The extent to which John's needs will affect participation depends on the program. His reading problems will only limit participation if written materials are a pivotal part of the program. Attention problems will be more of a difficulty in group treatment, extended sessions, or treatment that occurs at the end of the day. His possible difficulties with awareness and problem solving will be more limiting if the treatment program requires higher levels of insight and abstraction, particularly if there are not opportunities for individualized attention to assist with understanding and recognition. Finally, limitations in social skills may limit participation in a residential program or other treatment that involves significant peer interaction.

If the nature of the treatment program is such that John's needs will limit his participation, then more aggressive steps to seek additional information and assistance may be necessary. For instance, consultation with a rehabilitation psychologist might be called for to help ascertain John's optimal learning style and ways in which problem-solving abilities and social skills can be mediated. On the other hand, if there appear to be few ways in which John's participation in the program will be hindered by his functional limitations, then treatment might be initiated with the intention that if problems emerge additional information or consultation will be sought.

Intake

Admissions Procedures

The Consensus Panel recommends an "open door" policy that states that all clients are entitled to an assessment if they are presenting with a chemical dependency problem, regardless of what other problems they may appear to have. If the proper course of treatment is not available at the facility, it is still possible to perform an assessment for substance use disorders and refer the client for treatment elsewhere.

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

Admissions procedures for people with sensory disabilities

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

Due to the wide range of reading abilities among people who are deaf, paper and pencil should never be utilized to gather detailed screening information. Written English forms and questionnaires should be interpreted into sign language for these clients. Some programs use a videotape in ASL, or with captioning to ensure understanding. The client who is deaf may have questions after watching the video, so an interpreter should be available to interpret any questions and the answers from the counselor.
If there are forms to be completed, people who are blind must have the option to complete them in the medium of their choice (Braille, large print, audiocassette, or sighted assistance). Admission to substance use disorder treatment can be a stressful process that will be made more uncomfortable by forced adherence to an uncomfortable modality. Individuals who are both deaf and blind will need to have a tactile interpreter to translate for them during the admissions process and afterward.

**Admissions procedures for people with cognitive disabilities**

A program should examine its written forms, from intake and screening forms to treatment plans, to determine whether they adequately address the needs of people who are cognitively impaired. Intake forms should either be simple enough for a cognitively impaired person to understand or else someone should be available to assist the client in completing them.

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

**Admissions procedures for people with physical disabilities**

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

**Intake Interview**

A supportive, nonconfrontational intake interview is critical to engaging the client. Often, it is the pivotal meeting during which a client makes a short-term commitment to "check out" treatment. Depending on the treatment program, various approaches are used to help a client admit that he needs help in overcoming addiction. The Consensus Panel recommends that intake interviews of persons with coexisting disabilities be conducted by the most qualified staff members--those who have been specifically trained to understand their needs. The interviewer must have the skills to ask difficult questions in ways that are not offensive and maintain a good rapport with the client. Most important, such an interviewer will be more likely to detect subtle or hidden disabilities not previously identified that may make a significant difference in treatment outcome. If the intake interviewer does not have expertise or knowledge about disabilities and she knows that the individual being interviewed for admission has a particular disability, a professional who is knowledgeable about that disability should be included in the intake interview.

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

**Intake interviews for people with cognitive disabilities**

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

Questions for people with TBI should be structured to provide concrete landmarks (e.g., "What were you doing 3 weeks before your automobile accident?"). Working backward in time while using specific events will assist the client to structure his responses. For any person who is cognitively impaired, keep questions concrete and avoid abstract concepts.

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

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

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

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

**Intake interview with people with sensory disabilities**

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

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

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

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

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

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

Some of the questions during the intake process may be difficult to interpret into sign language. For example, some assessments include questions to test orientation to reality and cognitive functioning. In order for the interpreter to interpret these questions correctly, she could give away the answers. In these instances, the interpreter will need to discuss the question with the counselor to determine how the question can best be asked.
to obtain the information needed. Much of the language used in substance use disorder treatment will not be familiar to clients who are deaf and will need to be explained.

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

Intake interview with people with physical disabilities

When conducting an interview with an individual with a physical disability, make certain that table surfaces are the correct height, and in particular that wheelchairs can fit beneath them. Interviewers should try to place themselves so that they are no higher than the person being interviewed. They should be aware of the pace of the interview, and attempt to gauge when clients are becoming fatigued. In addition, some forms of chronic pain make lengthy interviews excruciating. Periodically inquire how the individual is doing and offer to take breaks in order to make the experience more tolerable.

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

Adapting Substance Use Disorder Screening for Persons With Coexisting Disabilities

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

Drug and Alcohol History

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

Screening people with cognitive disabilities

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

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

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

Psychosocial History

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

Use of Screening Information

Treatment providers should not feel the need to be experts on all disabilities or disability issues. Instead, providers should view the task of screening for disability symptoms as a benefit for individualizing and developing appropriate treatment goals. Treatment should be more beneficial to clients if their limitations are considered in the development of their treatment goals. This in turn should make the counselor’s job less frustrating and difficult. Chapter 3 of this TIP discusses how screening information can be applied in treatment planning and counseling and the alterations that will need to be made for clients with coexisting disabilities.
### Figure 3-6: Sample Contracts for People With Disabilities

<table>
<thead>
<tr>
<th>Task</th>
<th>The individual must write a history of her addiction during the first 3 days of an inpatient program.</th>
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<tbody>
<tr>
<td><strong>Consequence:</strong></td>
<td>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).</td>
</tr>
</tbody>
</table>
| **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"). |

<table>
<thead>
<tr>
<th>Task</th>
<th>The individual in outpatient treatment must attend all groups.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consequence:</strong></td>
<td>Missing a group will result in automatic discharge.</td>
</tr>
</tbody>
</table>
| **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. |

<table>
<thead>
<tr>
<th>Task</th>
<th>The individual must attend 90 Alcoholics Anonymous (AA) meetings in 90 days.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consequence:</strong></td>
<td>Failure to attend will mean that the client is reported as noncompliant to referral sources.</td>
</tr>
</tbody>
</table>
| **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. |
### Figure 2-1: Educational and Health Survey

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

1. Do you have a disability or have you ever been told that you have a disability?  
   ___ Yes ___ No

2. Are you currently under the care of a doctor or other medical care professional?  
   ___ Yes ___ No

3. Do you take medications?  
   ___ Yes ___ No

4. Do you have difficulty hearing in group settings (e.g., theaters, classrooms, family dinners)?  
   ___ Yes ___ No

5. Do you frequently need people to repeat what they have said to you?  
   ___ Yes ___ No

6. Have people complained that you don’t hear or don’t listen to them?  
   ___ Yes ___ No

7. Do you wear glasses or contact lenses?  
   ___ Yes ___ No

8. Do you have difficulty seeing things that are far away or very close?  
   ___ Yes ___ No

9. Do you have frequent eye pain or headaches?  
   ___ Yes ___ No

10. Have you ever hit your head and lost consciousness?  
    ___ Yes ___ No

11. Have you ever received health or disability benefits?  
    ___ Yes ___ No

12. Have you ever been unemployed for a long period of time?  
    ___ Yes ___ No

13. Have you ever been fired from a job, asked to leave a job, or passed over for a promotion?  
    ___ Yes ___ No

14. Did you ever have special classes or tutoring in school?  
    ___ Yes ___ No

15. In a school or work setting, do you like to learn or learn best by  
   ___ Listening to someone talk  
   ___ Watching someone perform a task  
   ___ Reading on your own  
   ___ Performing tasks yourself  
   ___ Discussing things with another person  
   ___ Discussing things with a group of people

16. Have you had problems or difficulty with any of the following?  
   ___ Getting your point across to others  
   ___ Sitting still  
   ___ Focusing on the task at hand for more than several minutes at a time  
   ___ Understanding the point that others are making to you or what others are saying to you  
   ___ Communicating your feelings or thoughts to others

17. Have you ever had problems with or been bothered by any of the following?

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Chapter 2—Screening Issues - SAMHSA/CSAT Treatment Improvement...  
### Figure 2-1
Educational and Health Survey

<p>| | |</p>
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18. Have you ever had problems or been bothered by any of the following?

- ___ Depression
- ___ Anxiety
- ___ Forgetfulness
- ___ Sleep problems
- ___ Nervousness
- ___ Muscle tension or soreness
- ___ Uncontrolled worry
- ___ Excessive worry
- ___ Irritability
- ___ Restlessness (feeling on edge)
- ___ Mind "going blank"
- ___ Rapid heart rate
- ___ Pounding in chest
- ___ Heart burn or stomach pain
- ___ Uncontrolled feelings of happiness or euphoria
### Figure 2-2: Impairment and Functional Limitation Screen

<table>
<thead>
<tr>
<th>Questions</th>
<th>Further Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a disability, or have you ever been told that you have one?</td>
<td>It may be useful to ask what a typical day is like to gain a better understanding of how these accommodations affect the person's daily life. Ask client to specifically describe the activities and events of the day. Her answer may indicate problems in functional areas such as self-care, learning style, mobility requirements, or reveal her participation in a work program. If the person uses an assistive device, inquire how long it has been used.</td>
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<tr>
<td>Are you currently under the care of a doctor or other medical care professional?</td>
<td>Inquire as to how a condition affects the person's daily life (e.g., what accommodations and precautions he takes).</td>
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<tr>
<td>Are you taking any medications (prescribed or over-the-counter)?</td>
<td>If the client takes medications, does she understand what they are being taken for? What side effects from medications has she experienced? A recent medication history should be taken.</td>
</tr>
<tr>
<td>Do you have difficulty hearing in group settings (e.g., theaters, classrooms, family dinners)? Do you frequently need people to repeat what they've said to you? Have people complained that you don't hear or don't listen to them?</td>
<td>Ask if client has had his hearing tested recently (or ever). Look for nonverbal signals that he is having difficulty hearing (e.g., looking at lips instead of eyes, thinking a long time before answering questions, ignoring questions, not directly answering questions). Some attempt should be made to determine if problems are attentional in nature rather than due to a hearing impairment.</td>
</tr>
<tr>
<td>Have you ever hit your head and lost consciousness?</td>
<td>Further investigate any occurrences even if the client was not sure whether he sustained an injury (sometimes issues of inebriation and the loss of consciousness due to</td>
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<tr>
<th>Followup Treatment</th>
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<tr>
<td>Refer to vocational rehabilitation. Consult with disability professionals.</td>
</tr>
<tr>
<td>Consult and communicate with physician. Obtain medical records.</td>
</tr>
<tr>
<td>Provide medication education. Use charting or a pill case to organize medications and ensure proper use. Remind client when she should take medication. Use timers or pagers to remind client of when to take medication. Set up appointment for medication check with physician.</td>
</tr>
<tr>
<td>Administer hearing test and language or communication test. Have client sit in front during classroom type sessions. Place client nearer to the speakers when movies or tapes are being used. Have sessions with client in the room with the best acoustics. Meet with client after group sessions to discuss what occurred as a way to determine whether he heard everything that was said. Arrange the room so that outside noise is minimal and so that clients can all see each other. Develop a cueing system to let client know when he is being spoken to and so client can signal when he cannot hear. Repeat the points or questions of group members often. Use an interpreter when appropriate. Use a microphone in a large group setting. Use other assistive devices like a radio amplification system. Frequently check in with client to make certain that he is following what is being said.</td>
</tr>
<tr>
<td>Obtain results of any previous neuropsychological exam. If none has been done, arrange to have one administered (if funds are available). Consult with a psychologist about the neuropsychological</td>
</tr>
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</table>
### Figure 2-2
**Impairment and Functional Limitation Screen**

<table>
<thead>
<tr>
<th>Question</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Have you ever received health or disability benefits?&quot; (11)</td>
<td>Ask client why she received these benefits and if that influenced her work or search for a job. Request records. Consult with client's case manager or benefits coordinator. Help client to get assistance that she is entitled to.</td>
</tr>
<tr>
<td>&quot;Have you ever been unemployed for a long period of time? Have you ever been fired from a job, asked to leave a job, or been passed over for promotion?&quot; (12-13)</td>
<td>Ask if the client feels unsatisfied with the work he's been able to find. Ask if he's ever had a job where he didn't understand the tasks he was asked to perform or felt unable to perform them. Ask how he obtained his most recent work, and whether he has ever been involved in a vocational rehabilitation program. Obtain vocational rehabilitation records if applicable. Refer to vocational rehabilitation. Use self-administered interest inventories. Design assignments and treatment goals relating to employment and/or vocational rehabilitation.</td>
</tr>
<tr>
<td>&quot;Did you ever have special classes or tutoring in school?&quot; (14)</td>
<td>Ask whether the person has ever had a past diagnosis of a learning disability. Ask questions such as, &quot;Is English your first language? Can you read English? Do you like to read? What do you like to read? How often do you read and for how long generally?&quot; For a client who is blind, ask, &quot;How do you read? Audiotapes? Braille? Any other method?&quot; Unless the person states that she cannot read, find an opportunity--later in the interview, so that it is not connected with the question--to have her read something aloud. This should be something brief, such as a sentence in a release statement or a standardized screening questionnaire for substance use. Use audio- and/or videotapes. Use murals, art activities, role-playing, etc., instead of written assignments. Use feelings chart or other picture tools during session. Take frequent breaks. Confer with client periodically to find out if she is understanding material. Arrange for extra help/tutoring from peers or counselor.</td>
</tr>
<tr>
<td>In a school or work setting, do you like to learn or learn best by listening to someone talk, watching someone perform a task, reading on your own, performing tasks yourself, discussing things with another person, discussing things with a group of people? (15)</td>
<td>While many clients will not be able to answer this question very easily, those that can will be able to provide information that can prove to be very valuable in developing a treatment plan. Ask for details concerning positive and negative learning experiences. Find out if any accommodations have been made in the past in order to help the client learn most effectively. Attempt to utilize client's preferred means of learning as much as possible.</td>
</tr>
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</table>
## Figure 2-2
### Impairment and Functional Limitation Screen

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Action</th>
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<tbody>
<tr>
<td>Do you ever have difficulty sitting still, focusing on a task for more</td>
<td>Anything but an unqualified &quot;no&quot; should be followed up since it could</td>
<td>Take frequent breaks. Allow client to stand or alternate standing and</td>
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<tr>
<td>than several minutes, understanding what people are saying to you, or</td>
<td>point to a possible attention deficit. Ask under what circumstances the</td>
<td>sitting. Use shorter sessions. Have an agenda for each session which</td>
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<td>communicating your thoughts and feelings to others? (16)</td>
<td>person has had these problems and what kinds of distractions he has had</td>
<td>clients can follow. Stagger client participation during a session to</td>
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<td>such as environmental (noise) or physical (pain). Observe whether he is</td>
<td>keep him involved (for example, every ten minutes after each key point</td>
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<td>able to sit still during the interview. The sensory aspects of</td>
<td>or after each group member shares). Use cues to let client know when he</td>
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<td>understanding speech need to be addressed separately (see above).</td>
<td>is getting off track. Use other refocusing techniques like summarizing</td>
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<td>what has happened or using quick response activities (&quot;everyone tell</td>
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<td></td>
<td>me how you are feeling right now&quot;). Limit the number of key points per</td>
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<td>session. Alternate types of activities throughout the session.</td>
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<tr>
<td>Do you ever have problems controlling your anger, remembering things,</td>
<td>Ask about friendships and relationships with others; find out if the</td>
<td>Use relaxation techniques. Use memory books. Provide client with a</td>
</tr>
<tr>
<td>following instructions (either verbal, written, or demonstrated),</td>
<td>client has problems with friends, family, or being a &quot;loner.&quot; Ask if she</td>
<td>schedule that is in short increments. Adhere to regular scheduling.</td>
</tr>
<tr>
<td>concentrating, becoming tired easily, or getting along with others? (17)</td>
<td>is getting tired or having trouble concentrating during the interview.</td>
<td>Give client as much notice (and reminders) as possible if schedule will</td>
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<td>change. Use written and/or pictorial instructions. Use audio and/or</td>
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<td>video instructions. Involve the client in role-playing. Use mock</td>
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<td>sessions to prepare client for what will happen. Arrange field trips.</td>
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<td></td>
<td></td>
<td>Use cues to keep client on track. Take frequent breaks. Determine</td>
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<td></td>
<td>client's most alert times and attempt to schedule key activities</td>
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<td></td>
<td>during those times. Begin treatment plan utilizing individual</td>
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<td>counseling only and work towards group involvement. Allow client to</td>
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<td></td>
<td></td>
<td>observe group before engaging. Include anger management activities in</td>
</tr>
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<td></td>
<td></td>
<td>treatment plan. Expect to repeat key points often.</td>
</tr>
<tr>
<td>Have you ever been bothered by any of the following: depression,</td>
<td>Ask the client if he is in or has ever been in counseling. If he has, ask</td>
<td>Obtain medical records or mental health records if possible. Refer for</td>
</tr>
<tr>
<td>anxiety, forgetfulness, sleep problems, nervousness, muscle tension or</td>
<td>how often he visited a mental health professional and what problems were</td>
<td>mental health assessment. Use relaxation techniques. Use recreation</td>
</tr>
<tr>
<td>soreness, uncontrolled worry, excessive worry, irritability, restless-</td>
<td>most often discussed. Find out if the client currently has or has ever</td>
<td>therapy. Refer for a physical therapy or occupational therapy assessment.</td>
</tr>
<tr>
<td>less (feeling on edge), mind &quot;going blank,&quot; rapid heart beat, pounding</td>
<td>had any suicidal ideation. Ask what his normal sleeping and eating</td>
<td>Refer for a medication check. Have client keep a journal or log about</td>
</tr>
<tr>
<td>in chest, heartburn or stomach pain, uncontrolled feelings of happiness,</td>
<td>patterns are, and what a typical day is like. Look to see if he appears</td>
<td>his symptoms to see if there is a pattern to them. Use memory book or</td>
</tr>
<tr>
<td>or euphoria? (18)</td>
<td>sad or depressed, and if his grooming is adequate.</td>
<td>other memory techniques. Have client practice memorizing short slogans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or phrases.</td>
</tr>
</tbody>
</table>
Figure 2-3: Profile of "John"

<table>
<thead>
<tr>
<th>Functional Area</th>
<th>Strengths</th>
<th>Needs</th>
<th>Recommended Followup</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td>OK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grooming</td>
<td>Well groomed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td>OK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td>OK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel and bladder management</td>
<td>OK</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mobility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positioning</td>
<td>OK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking, with or without</td>
<td>OK</td>
<td></td>
<td>License suspended due to DUI</td>
</tr>
<tr>
<td>assistive devices (e.g., walker,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cane)</td>
<td></td>
<td></td>
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<tr>
<td>Use of wheelchair</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of stairs</td>
<td>OK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to operate motor</td>
<td></td>
<td>License suspended due to DUI</td>
<td>Check on the availability of transportation and the need for explicit directions to</td>
</tr>
<tr>
<td>vehicles</td>
<td></td>
<td></td>
<td>treatment site</td>
</tr>
<tr>
<td>Use of public transportation (or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>other access to transportation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading</td>
<td></td>
<td>Apparent reading problem</td>
<td>Request school records; records should also indicate whether or not he took special</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>education classes, received a regular high school diploma, or was diagnosed with a</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>learning disability</td>
</tr>
<tr>
<td>Writing</td>
<td></td>
<td></td>
<td>Writing skills need to be determined, but requirements are minimal in program</td>
</tr>
<tr>
<td>Speaking</td>
<td>Well-spoken</td>
<td></td>
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</tr>
<tr>
<td>Listening</td>
<td></td>
<td></td>
<td>Listening ability may be limited by attention problems</td>
</tr>
<tr>
<td><strong>Learning</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Attention</td>
<td></td>
<td>Attention problems</td>
<td>Ritalin use in childhood may indicate the need for a referral to a psychiatrist for</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>further evaluation</td>
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<tr>
<td>Comprehension</td>
<td></td>
<td>Comprehension appears to be</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>good</td>
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<tr>
<td>Retention and Application</td>
<td></td>
<td></td>
<td>May need formal assessment of retention and application abilities</td>
</tr>
<tr>
<td><strong>Problem-Solving</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness and recognition of</td>
<td></td>
<td>Statement that reason for</td>
<td></td>
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<tr>
<td>problem</td>
<td></td>
<td>being in treatment is the</td>
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<td></td>
<td></td>
<td>&quot;got into trouble&quot; may</td>
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<td></td>
<td></td>
<td>indicate lack of awareness of</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>problem</td>
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<tr>
<td>Identification of alternatives</td>
<td>Screen problem-solving skills and anticipate possible consequences of various alternatives; then decide on optimal alternative</td>
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<td>-------------------------------</td>
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<tr>
<td>Social Skills</td>
<td></td>
<td></td>
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<tr>
<td>Understanding of social mores and values</td>
<td>Statement that he &quot;got into trouble&quot; indicates awareness of social values</td>
<td></td>
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<tr>
<td>Impulse control</td>
<td>DUI and story of fight indicate impulse control problem; although they may be drinking-related</td>
<td></td>
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<tr>
<td>Intimacy</td>
<td>Further evaluation called for since substance use can cause a lack of impulse control</td>
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<tr>
<td>Conversational skills</td>
<td>Conversational skills consistent with age, etc.</td>
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<tr>
<td>Empathy; ability to identify with others</td>
<td>Explore relationships</td>
<td></td>
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<tr>
<td>Executive Functions</td>
<td></td>
<td></td>
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<tr>
<td>Planning and organization</td>
<td>Explore basis of sporadic work history</td>
<td></td>
<td></td>
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<tr>
<td>Motivation and initiation</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Monitoring and reviewing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motivation, decision-making, disinhibition</td>
<td></td>
<td></td>
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</tbody>
</table>