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SCREENING FOR ALCOHOL AND DRUG USE AMONG PERSONS WITH DISABILITIES

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SCREENING FOR ALCOHOL AND DRUG USE AMONG PERSONS WITH
DISABILITIES

by

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B.S., Southern Illinois University at Edwardsville, 2009

A Research Paper
Submitted in Partial Fulfillment of the Requirements for the
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Master of Science

in the field of Rehabilitation Counseling

Approved by:

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Graduate School
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CHAPTER 1

INTRODUCTION

A person must be an individual that has a disability, either mental or physical, that results in a substantial barrier to employment to be eligible to receive vocational rehabilitation (VR) services from state funded Division of Rehabilitation Service (DRS) agencies. VR agencies provide comprehensive, coordinated, effective, efficient, and accountable services needed by those individuals who are deemed eligible for services to help them retain employment (Indiana Family and Social Services Association, 2011). There are many functional limitations that prevent persons with disabilities (PWD) from obtaining employment; “Functional limitations are understood to be the impairments in physical, behavioral, or emotional functioning that result directly from disability” (Janikowski, Donnely, & Lawrence, 2007, p 1); however, one limitation that PWD face are alcohol and drug abuse (AODA) barriers.

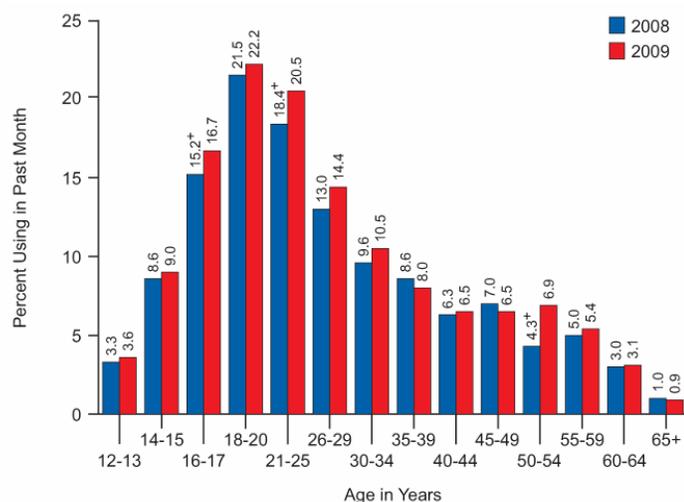
Individuals who experience physical and cognitive disabilities are likely to experience AODA disorders at rates far in excess of the general population (Koch & Dotson, 2008; Koch, 2002; CSAT, 1998). As noted by the Office on Disability-Substance Abuse and Disability (2010), “Substance use disorders occur more often in persons with disabilities than in the general population; People with disabilities experience a number of risks that increase their chances for substance abuse to adversely impact their lives. These risks include: medication and health problems, societal enabling, a lack of identification of potential problems, and a lack of accessible and appropriate prevention and treatment service”. Additionally, referenced by the Office on Disability, as many as 1.5 million persons with disabilities may need treatment for their substance use disorders

(Moore, 2002) and substance abuse prevalence rates increase with specific types of disabilities.

Past research on the existence of alcohol and other drug abuse (AODA) is mixed; however, it affects different cultures, genders, people of all ages, and persons with disabilities (Koch, Nellipovich, & Sneed, 2002; Benschhoff & Janikowski, 2000; Doweiko, 1999). As cited by Yu, Huang, and Newman (2008):

Empirical evidence regarding the prevalence of substance use among people with disabilities has been mixed, with some findings suggesting that substance use is similar or lower among individuals with disabilities than among the general population (Katims, Zapata, and Yin 1996; McCrystal, Percy, and Higgins, 2007; McGillicuddy, 2006; Moore and Siegal 1989; Rurangirwa et al., 2006), while other studies indicate a higher prevalence of alcohol, tobacco, or illegal drug use among individuals with disabilities (Blum, Kelly, and Ireland, 2001; Gilson, Chilcoat, and Stapleton, 1996; Hogan, McLellan, and Bauman, 2000; Milberger, Biedermann, Faraone, Chen, & Jones, 1997). Contributed to the mixed findings are the limited studies that consist of few disability types and having a low amount of studies decrease the opportunity to generalize (Yu, Huang, & Neman, 2008; Barret & Paschos, 2006). Although the exact amount of persons with disabilities (PWD) that use substances are uncertain, in 2002 the Substance Abuse and Mental Health Services Administration (SAMHSA) suggests that approximately 4.7 million Americans with disabilities experience co-existing substance abuse challenges (Office on Disability-Substance Abuse and Disability, 2010).

Figure 1. Past Illicit Drug Use Categorized by Age (2009).



The figure above represents the past month illicit drug use and places the trends into age categories in the general population (SAMHSA, 2009). In addition to describing the trends into age categories, the figure also compares prevalence rates of 2009 and 2008. The 18-20 age group experiences the highest usage rates compare to the other groups. This rate increases from 2008 (21.5%) to 2009 (22.5%). The age group of 21-25 experienced rate increases from 18.4% to 20.5%. The SAMHSA statistics report indicates that there are approximately 22.3 million individuals in the U.S. aged 12 or older (9% of the general population) who met the DSM-IV TR diagnostic criteria for substance abuse or dependence in 2007 (Walls, Moore, Batiste, & Loy, 2009; SAMHSA, 2008). According to the National Survey on Drug Use and Health (NSDUH), in 2008 the current illicit drug use rate was 8.7 percent of the general population (SAMHSA, 2008).

As of recent, new data has been collected and it has been suggested that 50% of persons with traumatic brain injury, spinal cord injuries, or mental illness use substances and 40-50% of persons with spinal cord injury, orthopedic disabilities, vision impairment, and amputations can be classified as heavy drinkers (SAMHSA, 2011). The Washington

State Department of Health (2008) estimates that in 2004, 18% of 8th graders, 23% of 10th graders, and 23% of 12th graders were classified as having a disability in study they conducted. They found that when compared to the non-disability group, those with disabilities used more illicit drugs. As mentioned earlier, the exact prevalence of substance use disorders among PWD is mixed; however, the Office on Disability (2010) claims that substance use disorders (SUDS) occur 2-4 times more often with PWD than the general population. Using data to describe occurrence of SUDS in the general population may be a starting point when understanding the amount of PWD affected by AODA. With substance use disorders around 8.7 percent (Walls, Moore, Batiste, & Loy, 2009; SAMHSA, 2008) and illicit drug use around 9 percent (SAMHSA, 2010), and since it is suggested that PWD experience SUDS 2-4 times more than the general population, substance abuse continues to be a barrier that must be addressed for PWD.

Today, SUDS continue to be a barrier for PWD. As literature continues to demonstrate that PWD are affected directly by alcohol or drug use, identifying those who need treatment and motivating these individuals to get treatment is difficult. The goal of this paper is to identify the lack of screening of drug and alcohol problems of PWD and provide suggestions to help in the screening process. This paper will accomplish this by providing literature on the lack of screening in public funded State VR programs, present a new initiative to help identify those with AODA barriers, and to suggest an appropriate instrument to assist in the new initiative being provided. Lastly, a synthesis of the literature will be completed, implications provided, and the author's position with defensible evidence while suggesting a potential pilot study.

Definition of Terms:

SBIRT – Screening, Brief Intervention, and Referral to Treatment: Initiative to provide agencies with ways of identifying individuals who are experiencing alcohol and drug challenges and to provide brief intervention or referral to treatment depending on the severity of use.

SAMHSA – Substance Abuse Mental Health Services Administration: A United States federal agency that attempts to improve prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

SUDS – Substance Use Disorders: A term that is dichotomized into Abuse or Dependence. It relates to the severity of drug and alcohol problems that a person faces.

Functional limitations: Impairments in physical, behavioral, or emotional functioning that result directly from disability.

Change Talk: Change Talk refers to the client's mention and discussion of his or her Desire, Ability, Reason, and Need to change behavior and Commitment to changing.

Motivational Interviewing: A client-centered approach developed to help a client develop intrinsic motivation to change behaviors

Solution Focused Therapy: Focuses on supporting people to explore their preferred future and how some of the pieces are already happening in their current life that are leading to their preferred future.

Stages of Change: Model that suggests change happens in different stages rather than in one step and that people progress through changes at their own pace.

Pre-contemplation: Not yet acknowledging that there is a problem behavior that needs to be changed

Contemplation: Acknowledging that there is a problem but not yet ready or sure of wanting to make a change

Preparation/Determination: Getting ready to change

Action/Willpower: Changing behavior

Maintenance: Maintaining the behavior change

Relapse: Returning to older behaviors and abandoning the new changes

Comprehensive Vocational Evaluation: services which provide an individualized, timely, and systematic process by which a person seeking employment, in partnership with an evaluator, learns to identify viable vocational options and develop vocational goals and

objectives. A vocational evaluator or vocational specialist approves or supervises the services

Summary of Chapter 1

Research has shown that PWD have higher rates of SUDS than the general population. This indicates that there is still a challenge that needs to be addressed with respect to getting these individuals into treatment. The Office on Disability-Substance Abuse and Disability (2010), “Substance use disorders occur more often in persons with disabilities than in the general population; People with disabilities experience a number of risks that increase their chances for substance abuse to adversely impact their lives. These risks include: medication and health problems, societal enabling, a lack of identification of potential problems, and a lack of accessible and appropriate prevention and treatment service”. If SAMHSA is correct when stating that SUDS are 2-4 times that of the population and that the general population experiences SUDS around 8.7 percent, then having protocols that identify those affected by these is crucial. The challenges faced by PWD and co-existing substance use disorders are substantial and this paper may be of importance in creating ways to help these individuals.

CHAPTER 2

OVERVIEW OF LITERATURE

Employment is the primary concern of vocational rehabilitation professionals. One goal is to identify functional limitations or barriers that may prevent PWD from finding employment. West (2008) suggests that VR services may aid substance abusers by helping them obtain competitive employment and maintaining a substance free lifestyle. Competitive employment may increase a person's self-worth or esteem. The challenge of helping the client to recognize if their substance use is a barrier is difficult. Policies and procedures that dictate each client must be screened haven't been implemented in all State-funded VR programs (Moore, McAweeney, Keferl, Glenn, & Ford, 2008). For example, a study conducted to evaluate screening for substance use disorders of customers in different states (Illinois, Kentucky, Ohio, Utah, West Virginia) indicate that 30.1 percent of consumers were identified as having potential SUDS (Heinemann, McAweeney, Lazowski, & Moore, 2008). Researchers specify of the intakes performed, the states' only asked a certain percentage of customers if they would like to volunteer, including: Illinois (14%); Kentucky (57%); Ohio (18%); Utah (53%); West Virginia (23%). Furthermore, of the individuals asked to volunteer, researchers detected a refusal rate of 9.1 percent in Illinois, 16.6 percent in Kentucky, 18.0 percent in Ohio, 4.7 percent in Utah, and 22.8 percent in West Virginia.

Atherton, Toriello, Sligar, and Campbell (2010) suggest that persons with SUDS continue to experience a higher rate of unsuccessful case closures after receiving VR services. Additionally, the authors cite that these unsuccessful case closures are due to a magnitude of challenges (Shepard & Reif, 2004, p 23):

Persons with SUD face a multitude of barriers to successful employment. Problem areas can include a consumer's inability to control substance use, concern about keeping secrets, family problems, lack of social skills, lack of work experience, unrealistic goals for employment, problems with reliable transportation, and the reluctance of employers to hire or maintain the employment of people with SUD.

Carise, McLellan, Festinger, & Kleber (2004) reported that retention in rehabilitation services increases when a consumer's needs are identified early and services match the specified problem areas. The issue that is present is that AODA problems are not being identified early and these problems continue to manifest and burden the individuals needing services.

Preliminary literature on vocational rehabilitation and substance abuse has shown that implementing the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model is a vital component to identifying individuals who have AODA challenges that may require behavioral interventions; however, not all individuals receiving vocational services are being screened for SUDS. Heinemann and colleagues (2008) state that counselors' limited educational and field experience with this disorder, limited resources and a mandate to serve as many customers as possible, consumers attempt to conceal their problems, and the lack of procedures and policies for detecting substance abuse are all factors that may contribute to why these individuals are not being screened.

Christensen, Boisse, Sanchez, and Friedman (2004) wanted to determine if vocational rehabilitation (VR) counselors' knowledge on screening and brief intervention would improve after receiving the one-day training. They found that VR counselors' knowledge improved immediately after the training and retained a high level of

competency; however, they reported that they were unable to devote time to issues of substance abuse with clients. The authors suggest that VR counselors may benefit from early recognition of at risk clients and refer these individuals for treatment prior to the substance use becoming a greater barrier. Identifying substance abuse as barriers may be difficult without additional SBIRT training that emphasizes on screening clients.

Training VR professionals is crucial because studies indicate that substance use disorders affect approximately 25-50% of all VR consumers (Donnell, Mizelle, & Zheng, 2009; Hinemann, Lazowski, Moore, Miller, & McAweeney, 2008; Janikowski, Lawrence, & Donnelly, 2007). McAweeney, Keferl, Moore, and Wagner (2008) reviewed the RSA-911 data and found a success rate of 55% for persons diagnosed with SUDS who received VR services. These rates are primarily due to a portion of consumers receiving other services with VR services, including counseling and appropriate job placement. A large portion do not receive collaborative services, which may be cause by different factors, with one being lack of knowledge by rehabilitation professionals (Hollar, McAweeney, & Moore, 2008). This may be evident as consumers who have a substance use disorders have higher unsuccessful case closures and have higher unemployment rates despite receiving VR services (Hollar, 2008). Furthermore, Hollar suggests that additional and specific training is necessary to identify underlying problems that are caused by the SUDS during intake.

As data and research indicate, there is a large portion of consumers who are not being screened for alcohol or drug problems and are not receiving the appropriate services. More clients may be reached by expanding screening practices in other agencies that have direct contact with PWD. An example of another agency that has direct contact

with PWD and SUDS are those that provide comprehensive vocational evaluation services. The 2008 Commission on Accreditation of Rehabilitation Facilities (CARF) manual explains that a comprehensive vocational evaluation is a service that provides an individualized, timely, and systematic process in which a person seeking employment, in partnership with an evaluator, learns to identify viable vocational options and develop employment goals and objectives (CARF Manual, 2008).

According to Sligar and Toriello (2007), as cited by Atherton and Toriello, there are three particular barriers for addressing SUD during the VE process, including: (a) time constraints of assessing for substance abuse due to large caseloads, (b) perceived or actual lack of expertise in appropriately serving persons with SUD, and (c) inconsistent guidelines on the evaluation and/or referral for persons with SUD. With the challenges faced by VR counselors, another screening mechanism needs to be identified so that PWD will be given appropriate services for all limitations they experience.

State-funded rehabilitation agencies that provide comprehensive vocational evaluations may be an appropriate agency to help in the screening process. Clients receive evaluations to identify other barriers that they face and SUDS should be considered. Clients of these agencies are usually referred from state-funded VR programs for further evaluation on challenges and barriers to employment. Some evaluations clients may be referred for are psychological assessments, success in educational settings, and transferable skills analysis to help place a client in a different work setting. These evaluations are used to see what accommodations are needed to help the client succeed in whatever goals they have. The challenge that rehabilitation facilities may face is being uneducated on how to appropriately screen for AODA challenges. Since alcohol and

drugs can decrease the ability to provide such services in an effective manner, finding models to provide help to clients with these problems is important.

SBIRT

The Substance Abuse and Mental Health Services Administration (SAMHSA) created the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Initiative to provide agencies with ways of identifying individuals who are experiencing alcohol and drug challenges and to provide brief intervention or referral to treatment depending on the severity of use. Madras, Compton, Avula, Stegbauer, Stein, and Clark (2009) state that in 2003, SBIRT has screened over 690,000 to date and this module is being implemented in various healthcare sites (inpatient, emergency departments, ambulatory, primary and specialty healthcare settings, and community health clinics).

Additionally suggested, is that 95.5% do not recognize they have a problem and do not seek treatment. SAMHSA provided two grants worth 2.8 million dollars each (5.6 million total) to expand and enhance state substance abuse treatment systems, including SBIRT (Alcoholism & Drug Abuse Weekly: March 13, 2006). Identifying individuals who may need substance abuse treatment compared to those who do not may be challenging. Rehabilitation professionals may be unaware of what questions to ask, how to differentiate substance abuse problems to non-problems, and what they should do when determining their client has a problem that may require further evaluation and/or behavioral intervention. Screening instruments usually consists of a questionnaire with few questions that professionals can administer in 5 minutes and determine how severe a problem is, with respect to levels of risk.

Screening

Screening is performed by using a variety of suggested screening tools to identify problematic substance use. Tools such as the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol, Smoking, and Substance Involvement Test (ASSIST), the Drug Abuse Screening Test (DAST) are the most common screening instruments used by many professionals and can help a professional quickly identify individuals who may be in need of brief intervention or referral to treatment.

The AUDIT was created by the World Health Organization (WHO) to identify persons with hazardous and harmful patterns of alcohol consumption (Babor, Higgins-Biddle, Saunders, and Monteiro, 2001). Moreover, it was developed as a screening for excessive drinking and to assist in providing framework for an intervention to prevent further harmful consequences from continued use. The screener consists of 10 questions, including: (1) How often do you have a drink containing alcohol; (2) How many standard drinks containing alcohol do you have on a typical day when drinking; (3) How often do you have six or more drinks on one occasion; (4) During the past year, how often have you found that you were not able to stop drinking once you had started; (5) During the past year, how often have you failed to do what was normally expected of you because of drinking.

The ASSIST is a brief questionnaire to identify a person's use of psychoactive substances and was developed by the World Health Organization and team of international substance use researchers (Henry-Edwards, Humeniuk, Ali, Poznyak, & Monteiro, 2003). It is to be used as a simple method of screening for tobacco, alcohol, cannabis, cocaine, amphetamine type stimulants, sedatives, hallucinogens, inhalants,

opioids, and other drugs. It consists of 7 questions including: (1) in your lives, which of the following substances have you ever used, it then lists each drug; (2) In the past three months, how often have you used the substances you mentioned; (3) During the past three months, how often have you had a strong desire or urge to use; (4) During the past three months, how often has your use of (*1st drug, 2nd drug, etc.*) led to health, social, legal or financial problems.

The DAST-20 is a 20-item self-report scale of the original 28 item DAST that is consistent with the Michigan Alcoholism Screening Test (MAST). Participants answer yes or no to questions resembling (Cassidy, Schmitz, & Malla, 2008): Have you used drugs other than those required for medical reasons; have you abused prescription drugs; do you abuse more than one drug at a time. It is used to cover screening for the previous 3 months is internally consistent ($\alpha = .998$) as recognized by Cassidy and colleagues.

Brief Intervention

These screening tools are not meant to diagnose a substance use disorder as classified in the Diagnostic and Statistical Manual (DSM IV-TR). The tool is only for identification purposes and then the next step may be brief intervention. Furthermore, if rehabilitation professionals were able to recognize substance abuse challenges, telling clients to seek treatment or making referrals may not be feasible. An estimated 95.5% of the 22.6 million individuals with diagnosable substance use disorders do not seek treatment or feel they have a problem (Madras, Compton, Avula, Stegbauer, Stein, & Clark, 2009). Due to the high percentage of individuals who feel they do not have a problem, an intervention can be performed to help individuals recognize that they may have problems that require further evaluation and counseling. Brief Interventions have

been found to be effective as referenced by the Center for Substance Abuse Treatment (1993) to perform the following: Reduce no-show rates for the start of treatment; Reduce dropout rates after the first session of treatment; Increase treatment engagement after intake assessment; Increase compliance for doing homework; Increase group participation; Address noncompliance with treatment rules (e.g., smoking in undesignated places, unauthorized visits, or phone calls); Reduce aggression and violence (e.g., verbal hostility toward staff and other clients); Reduce isolation from other clients; Reduce no-show rates for continuing care; Increase mutual-help group attendance; Obtain a sponsor, if involved with a 12-Step program; Increase compliance with psychotropic medication therapies; Increase compliance with outpatient mental health referrals; Serve as interim intervention for clients on treatment program waiting lists. Brief Intervention is accomplished by using motivational interviewing (MI) or solution focused therapy (SFT) techniques to help the client become aware of the problems that their substance use is creating.

Motivational Interviewing. Motivational Interviewing (MI) is a client-centered approach developed to help a client develop intrinsic motivation to change behaviors (Miller & Rollnick, 2002). MI focuses on clients' experiences, values, goals, and plans while also promoting client choice and responsibility in implementing change (Wagner & McMahon, 2004). The MI Counselor believes all individual have an internal drive toward change and growth and have the capacity to successfully complete rehabilitation and live a high quality of life, regardless of disability, demographics, circumstances, and motivational state (Toriello, Atherton, Campbell, & Sligar, 2010). Moreover, Wagner and McMahon suggest placing the focus on the client, assuring the client they have real

choices and are in control, providing accurate information in a format clients can use, defining roles/responsibilities and expectations explicitly and truthfully, eliminating or reducing disempowering vocabulary and language, encouraging and facilitating ongoing evaluation of the counseling relationship, and identifying natural supports are recommendations that should be considered.

Miller and Rollnick discussed common roadblocks to communication that can be ineffective. These roadblocks include: ordering, directing, or commanding; warning, cautioning, or threatening; giving advice, making suggestions, or providing solutions; persuading with logic, arguing, or lecturing; telling people what they should do (moralizing); disagreeing, judging, criticizing, blaming; agreeing, approving, praising; shaming, ridiculing, labeling; interpreting or analyzing; reassuring, sympathizing or consoling; questioning or probing; withdrawing, distracting, humoring, or changing the subject. There are ways to avoid the common roadblocks to communication.

As Miller and Rollnick suggest, using the summarization counseling skill, setting clear goals, eliciting commitment, and asking permission to continue will help avoid the common roadblocks to communication. In addition to these recommendations, using open questions may increase the strength of the therapeutic relationship. Some of the suggested open questions include: how can I assist you in your employment goals or what do you want to do about your drinking, quit, cut down, or stay the same? This helps the client develop change talk. Change talk refers to the client's ability, desire, reasons, need, and commitment to change their behaviors. If a client becomes defensive when discussing a certain issue or problem, this may indicate their desire to change or suggest that the counselor's is not performing the techniques correctly.

Overall, MI can be an effective model in the brief intervention portion of the SBIRT model. It is crucial to remember that the approach is client-centered, meaning that they are the experts and they are an active contributor to the counseling process. Learning the roadblocks to communication will be effective in fully understanding how to administer MI and will allow for the most effective use of MI. MI is only one of the identified types of brief intervention used in the SBIRT model.

Solution Focused Therapy. Solution Focused Therapy (SFT) is the other intervention used in the SBIRT model. It focuses on what goals clients are attempting to accomplish and the barriers that are inhibiting them from accomplishing their goals (Cotton, 2010). This theory focuses on the present or future and tries to avoid focusing on the past, unless they are stories that are empowering. The counselor uses curiosity and foreshadowing to allow the client to express their preferred future and helps the client construct a concrete vision. SFT focuses on supporting people to explore their preferred future and how some of the pieces are already happening in their current life that are leading to their preferred future (Burwell & Chen, 2006). The miracle question, scaling questions, coping questions, and emphasis on problem-free talk are some techniques that give SFT foundation.

The miracle question helps the client envision what their lives would be like if the problem were no longer present and helps them create a concrete vision of their future.

An example of a miracle question is cited (Burwell & Chen, 2006, p. 202):

Suppose that when you leave here you go out and do what you have to do, you get home, have something to eat and later on you go to bed. While you are asleep something miraculous happens and the problems that brought you here vanish, in the click of a

finger. But because you were asleep you don't know this has happened. When you wake up in the morning, what do you suppose will be the first thing you will notice that will tell you that this has happened?

The goal of the counselor is to stimulate as much information as possible from the client, which will allow them to articulate a clear vision of their future.

Scaling questions are useful in measuring progress that the client has made or to assess motivation to take action. For instance, an example of a question may be on a scale from one to ten, where one is not at all and ten is definitely, how likely are you to quit using alcohol or drugs. If a client were to provide a response of a three, the counselor may ask what it will take to reach a four or five. These types of questions also allow clients to visualize their future.

Coping questions intend to elicit information about resources available to the client using genuine curiosity. Clients may discuss a hopeless stories and instances of depression on how hard things are. Counselors can use genuine curiosity or coping questions to allow the client to explore ways that they have coped with their difficult times. For example, a counselor may say: "I am able to see that you have been struggling with this for some while, and you have expressed that you are feeling hopeless and yet you still manage to get up every day and fulfill your responsibilities. How are you able to continue to function"? Counselors can elicit thought in their clients, which can allow them to discover how they have been coping with situations and induce empowerment.

The last technique is emphasizing problem-free talk. This helps the client relax and teaches the client to be more assertive. When clients discuss problems they are experiencing, many times they will feel hopeless. If the counselor uses problem free talk,

or in other words, starts discussing experiences that the clients have had that aren't problematic, then clients may be able to gain assertiveness and relax. Leisure activities or discussing strengths of the client are examples of some problem-free talk.

Overall, solution focused therapy can be an effective tool to use when conducting brief counseling. For instance, the brief intervention portion of the SBIRT model would be an appropriate place for SFT. It is important to remember to avoid allowing the client to talk about past events because emphasis is placed on the present and future. The past can give some positive information; however, if the client is stuck in the past it will be difficult to move forward.

Referral to Treatment

Krupski and researchers (2010) found that individuals who were screened and received a brief intervention were significantly more likely to enter specialized treatment within a year compared to those who did not receive a brief intervention. Conducting a brief intervention has been shown to be effective; however, the last step of the initiative and having a referral source for those receiving the brief intervention is vital or those with SUDS may not get the treatment needed.

As mentioned, referral is the last component to the SBIRT model and this process is for individuals who are experiencing more severe problems. At this point the individual will be referred for further evaluation and given comprehensive assessment from a qualified substance abuse professional that will diagnose presence or lack thereof a DSM IV-TR substance use disorder. The assessment is also used to determine appropriate level of care as outlined in the American Society of Addiction Medicine (ASAM).

Levels of care. There are four main levels of care identified by the Center for Substance Abuse Treatment (1993). First is Level I-Outpatient treatment, which is an organized nonresidential treatment service with substance abuse professionals and clinicians that provides treatment that occurs on a regular schedule usually fewer than 9 contact hours a week. Next is Level II-Intensive Outpatient treatment, which is similar to Level I; however, clients receive a minimum of 9 treatment hours per week. Third is Level III-Medically monitored intensive inpatient treatment, which includes 24-hour observation, monitoring, and treatment. The final level of care is Level IV-Medically managed intensive inpatient treatment. This level is an organized service in which substance abuse professionals provide planned, 24-hour medically directed evaluation, care, and treatment. Clients typically have severe withdrawal or medical symptoms combined emotional and behavioral problems that require medical and nursing services.

Stages of Change. A challenge for rehabilitation professionals is understanding what stage of change the client is in. If they are in an earlier stage, the client may resist the idea of treatment. The stages of change refer to the progression or state of mind the client is in with regards to their substance use (Stevens, McGeehan, Kelleher, 2010). The first stage, pre-contemplation, suggests clients do not realize they have a drug or alcohol problem. Additionally, they may not yet acknowledge there is a behavioral problem that needs to be changed. The goal of SFT is to help the client realize that there are behavioral consequences to their drinking or drug use and to progress to the second stage, called contemplation. This stage refers to clients acknowledging a there is a problem but may not be ready or sure of want to make the change. After the client realizes that their substance use has been a barrier to treatment and they realize they may have a problem,

using MI to motivate them to make a behavioral change is essential. MI can help motivate the client to enter treatment or lead into the third stage, which is preparation or determination. This refers to the client getting ready to change. The next stage is the action/willpower stage, or the actual change of behavior. After the client makes the change the maintenance stage is present, or maintaining what the client has learned and remaining abstinent from substance use. Maintaining healthy behaviors is difficult. When clients are used to certain patterns of behavior and those behaviors are reinforced for long periods of time, it is easy to fall back into their old ways, which is the next and final stage called relapse. Relapse is simply returning to older behaviors and abandoning the new changes.

The stage of change model is based on a continuum, meaning it is not in any particular order. Clients who are in the action stage of the model may fall back into the pre-contemplation stage. It is important to continue to give support and there is a concept in the substance abuse community, which is if you take something away (substance use) you need to give something back (something that replaces substance use). The hope is that employment will be that replacement of the substances.

Success of SBIRT. SBIRT has shown to be successful in many settings. Madras et al., (2009) conducted a secondary analysis to address the effectiveness of SBIRT in multiple healthcare settings. Their results indicated rates of drug use were reduced by 67.7% and 38.6% for heavy alcohol use at six month follow-up which shows significant improvement as a result of SBIRT implementation. Vocational Rehabilitation agencies would benefit substantially from implementing the SBIRT. SAMHSA conducted a study to observe the effectiveness of SBIRT and found a 67.7 percent reduction in illicit drug

use over six months of those who received SBIRT (Alcoholism & Drug Abuse Weekly: November, 2008). Additionally, 29.3 percent reported feeling generally healthier, 31.2 percent reported experiencing fewer emotional problems, 15.4 percent reported improved employment status, 64.3 percent reported fewer arrests, and 45.8 percent who were homeless reported no longer being homeless. SBIRT protocols have also been proven to be successful for persons of different culture within an Emergency Room setting (Cherpitel, Bernstein, Bernstein, Moskalewicz, & Swiatkiewicz, 2009) and have been shown to be an effective model to screen for substance use disorders. Madras and colleagues add that SBIRT has demonstrated that a rapid and simple set of procedures has potential for impacting the public health burden and reference that the cost-savings is approximately \$4 for each \$1 expended for alcohol screening and brief intervention.

GAIN-SS

As mentioned earlier, the common screening instruments used in agencies that use the SBIRT model typically include the AUDIT, DAST, and ASSIST. The Global Appraisal of Individual Needs-Short Screener is a newer screening instrument that usually takes 5 minutes to administer and is designed as a screener for the “general populations to quickly and accurately identify clients whom the full 1.5 to 2 hour GAIN-Initial would identify as having one or more behavioral health disorders, which suggests the need for referral to some part of the behavioral health treatment system” (Dennis, Feeney, Stevens, & Bedova, 2007, p. 1).

Factor Analysis were conducted from the 123-item GAIN Individual Severity Scale (GISS) and from the four subsections (Internal Mental Distress Scale, Behavior Complexity Scale, Substance Problem Scale, Crime and Violence Scale), which resulted

in the GAIN-SS (Dennis, Feeney, Stevens, & Bedova, 2007, p. 1; Dennis, Chan, and Funk, 2006). The GISS and GAIN-SS are highly correlated ($r = .84$ to $.94$), along with the subsections of the screener with the entire GISS, and the 20-item screener has high internal consistency ($\alpha = .96$) for the total screener.

The GAIN-SS has 4 subsections and when scoring each section, participants are placed in to 3 categories, 0 = Low (Unlikely to have a diagnosis or need services), 1-2 = Moderate (A possible diagnosis; the client is likely to benefit from a brief assessment and outpatient intervention, 3-5 = High (High probabilities of a diagnosis; the client is likely to need more formal assessment and intervention, either directly or through referral. Consider residential treatment, particularly for higher scores).

Summary

VR professionals attempt to identify challenges clients are facing that will continue to be a barrier when attempting to find employment. Once these challenges have been identified, VR counselors then find resources available to help the client eliminate these challenges, which in turn, may reduce the barrier to employment. Substance use disorders are one challenge that many PWD face and is identified as a barrier to treatment. VR counselors can play a significant role in providing resources for these clients but are unfamiliar with how to properly detect the clients most appropriate for services. Additionally, policies and procedures that dictate each client must be screened haven't been implemented in all state-funded VR programs (Moore, McAweeney, Keferl, Glenn, & Ford, 2008). Moreover, Heinemann, McAweeney, Lazowski, and Moore (2008) found that of certain state funded VR agencies, a high percentage that have screening programs in place are continuing not to screen each persons that receive services. One

reason to explain the lack of screening is the limited amount of education. For instance, Christensen, Boisse, Sanchez, and Friedman (2004) found that VR counselors had improved knowledge and an increased level of competency following 1-day training on screening and brief intervention. With substance use disorders affecting approximately 25-50% of all VR consumers (Donnell, Mizelle, & Zheng, 2009; Hinemann, Lazowski, Moore, Miller, & McAweeney, 2008; Janikowski, Lawrence, & Donnelly, 2007) and such a high percentage not being screened in VR-state funded agencies, it is important to identify other ways to screen for SUDS. One recommendation is screening at state funded rehabilitation agencies.

Screening at state funded rehabilitation agencies can play an important role in identifying clients with potential SUDS; however, these agencies need specialized training to be able to properly help those with SUDS. SBIRT is a model that can be implemented and focuses on screening, brief intervention, and referral to treatment. The AUDIT, CAGE, and ASSIST are commonly used in SBIRT but the GAIN-SS is an appropriate instrument to use as well. MI and SFT are two brief interventions used to motivate clients to seek help. Once clients agree to seek help, counselors are able to refer them for appropriate services depending on the level of care they may require.

CHAPTER 3

DISCUSSION AND IMPLICATIONS

The goal of the paper was to identify the lack of screening of drugs and alcohol among PWD in the State VR program and provide some possible recommendations to deal with these challenges. SUDS have been shown to be a barrier to employment for PWD, and PWD with SUDS continue to experience a higher rate of unsuccessful case closures after receiving VR services (Atherton, Toriello, Sligar, & Campbell, 2010). Heinemann and colleagues (2008) conducted a study and indicated that 30.1 percent of consumers have potential SUDS. The challenge they found is the lack of screening in the State VR program. They suggest that there is a large percentage of consumers receiving VR services that are not being screened for SUDS. Although VR counselors are extremely busy and perhaps do not have adequate amounts of time to screen each consumer they serve, it is important to provide knowledge of how extreme the problem of SUDS can be to finding gainful employment.

PWD are at risk due to medication and health problems, societal enabling, a lack of identification of potential problems, and a lack of accessible and appropriate prevention and treatment services. A large portion of individuals who are identified as having potential SUDS do not receive collaborative services (Hollar, McAweeney, & Moore, 2008). As problems arise these individuals may not have the resources or coping mechanisms to deal with such problems. The problem that AODA creates for PWD is provided and shown in the VR program as there is an increase in unsuccessful case closures when AODA is present among these consumers.

One explanation to why all PWD are not being screened for SUDS is that policies and procedures that dictate each client must be screened haven't been implemented in all State-funded VR programs (Moore, McAweeney, Keferl, Glenn, & Ford, 2008). It is difficult for administrators to continue to give additional work for their staff and counselors. There is an enormous time barrier of each VR counselor. An additional factor that may contribute to the absence of policies and procedures is the lack of knowledge of appropriate screening instruments and/or the SBIRT process.

SUDS affect approximately 25-50% of all VR consumers (Donnell, Mizelle, & Zheng, 2009) and yet only a certain portion of consumers are screened for alcohol and drug problems (Heinemann, McAweeney, Lazowski, & Moore, 2008). Another explanation of why these individuals are not being screened is because of counselors' limited educational and field experience with this disorder, limited resources and a mandate to serve as many customers as possible, consumers attempt to conceal their problems, and the lack of procedures and policies for detecting substance abuse may be factors contributing to the lack of screening.

Even though there is a challenge among VR counselors to perform screening among their consumers, having other agencies, or subcontractors that state VR programs use may be another method to screen for SUDS. Many states have agencies that provide comprehensive vocational evaluations to consumers referred for vocational services. A comprehensive vocational evaluation may be defined as "...services which provide an individualized, timely, and systematic process by which a person seeking employment, in partnership with an evaluator, learns to identify viable vocational options and develop vocational goals and objectives. A vocational evaluator or vocational specialist approves

or supervises the services...” (CARF Manual, 2010, p. 190). Alcohol and drugs are barriers that may diminish the capacity to identify and develop vocational goals and objectives. When these barriers are present, comprehensive vocational evaluations may not be as beneficial for the consumers.

To help alleviate these barriers is by providing an SBIRT model and having training seminars to help vocational specialists learn how to screen, provide brief interventions like motivational interviewing and solution focused therapy, and refer for appropriate treatment. This will take a portion of the burden off of VR counselors and help the consumer make an appropriate behavioral change. One screening instrument that may be appropriate to use among PWD served at subcontracted state vocational programs would be the GAIN-SS.

The GAIN-SS can be used to measure not only SUDS, but other problems PWD may have, including: Internal Mental Disorders (i.e., mood disorders); External Mental Disorders (i.e., ADHD, Adjustment Disorders); Substance Abuse Problem; Crime and Violence. VR counselors have limited amount of time to provide the adequate services that each consumer needs. They attempt to be efficient in their delivery or trying to be as effective as they can with the limited time they have. This screening instrument may identify barriers that will decrease the likely hood of having a successful closure. It will be a 5-minute survey that will provide data that helps the VR counselor provide appropriate services using evidence-based and research supported instruments, while also adding more time for other needs the consumer has. A needs assessment that observes if the screening component of the SBIRT model will be effective in this setting must be conducted.

Pilot Study

As literature suggests rates of AODA disorders are far in excess of the general population (Koch & Dotson, 2008; Koch, 2002; CSAT, 1999) and substance use disorders are around 8.7 percent (Walls, Moore, Batiste, & Loy, 2009). The Office on Disability (2010) suggests that rates are usually 2-4 times that of the general population. If the study indicates substance use rates higher than the general population then it may be appropriate to implement a screening device; however, when deciding on a certain screening device it is important to get feedback from vocational evaluation specialists to determine if the instrument is being effective. Thus, when using the GAIN-SS it is important to get feedback of whether the instrument is appropriate. This study will require a mixed-methods design of qualitative and quantitative measures. A frequency distribution that determines if the sample size is equivalent or exceeds the general population rates will be a great detector of whether screening should occur in this setting and having the vocational evaluation specialists determine if the screening instrument is appropriate. The sample size should also consider disability types, including but not limited to: Mental Illness or Cognitive Impairment and Orthopedic Disabilities.

The follow-up-evaluation that measures the appropriate of the instrument would have an increase in validity if multiple rehabilitation professionals evaluate the survey and provide feedback. The appropriateness follow-up-evaluation questionnaire for vocational evaluation specialists should at least include: How well did the consumer comprehension the questions asked by the screening instrument; How many times did the evaluation specialist have to provide clarification on what was being asked, which is similar to the comprehension component; How to improve the screening instrument; Did

the consumer need rest periods; How frustrated did the consumer become while answering questions.

When using the GAIN-SS it is recommended to use the GAIN-SS version: 2.0.3 rather than the 2.0.2 version. The newer version offers problems experience in the past month, as well as, the over the past 12 months. The older version only views problems over the past 12 months. This is important because vocational evaluation specialists can indicate how recent the problem is. This will help when making referrals for substance abuse treatment or further follow-up.

Conclusion/Implications/Recommendations

After a pilot study is conducted to determine if consumers are at or exceed the general population with regards to SUDS, the SBIRT model may be implemented. Directors and administrators of subcontracted state VR programs should identify training seminars to allow their vocational evaluation specialists to gain an up-to-date training and gain knowledge on the SBIRT process. Prior research (Heinemann, McAweeney, Lazowski, & Moore, 2008; Christensen, Boisse, Sanchez, and Friedman, 2004) has evaluated the SBIRT model in vocational rehabilitation agencies and found that after training, VR professionals were competent and felt comfortable using the model. This training may have similar results in the subcontracted agency as well. It also allows evaluation specialists to reduce nervousness and anxiety.

SBIRT Training

The National Institute on Drug Abuse (NIDA) is funding a website primarily devoted to SBIRT. The website created provides online training course modules in the following areas (SBIRT Training, 2011):

1. *SBIRT: Brief and Effective Substance Abuse Screening:*

This course will address the lack of education and skills in patient assessment for substance abuse that negatively impacts patient outcomes when they are not properly screened for alcohol, tobacco, or illicit drug use.

2. *SBIRT: Brief Intervention and Other Treatments:*

Due to the lack of primary care provider awareness of the value of benefits of substance abuse prevention, detection, treatment, and referral, this course will provide the necessary skills and education to increase the use of brief interventions in primary care settings.

3. *SBIRT: Referral to Treatment and Follow-up Care:*

This course will inform primary care providers of the different types of specialty treatment so they can make appropriate referrals for their substance abuse patients. This course will address planning for and arranging substance abuse treatment referral.

4. *SBIRT: In Practice:*

This interactive case-based course gives primary care providers a chance to take what they learn in the core courses and "practice" SBIRT clinical skills on three different patient cases.

The SBIRT Core Training program teaches professionals how to select and utilize screening tools, perform brief interventions for substance use problems, refer consumers to appropriate substance abuse treatment centers and/or specialists, and how to follow-up and reassess consumers who receive substance abuse treatment. These training modules have minimal costs (approximately \$20 - \$40 per SBIRT course or \$75 for an organization) and may be beneficial for all vocational evaluation specialists who have direct service contact with consumers.

Training Vocational Evaluation Specialist

As suggested earlier, VR professionals working for state VR programs have many constraints that make it difficult to screen for SUDS of each consumer that they serve.

Vocational evaluation specialists may be able to help in the SBIRT process if a pilot study indicates a need among the populations referred for comprehensive vocational evaluation services. An organization can register for SBIRT training at the NIDA-funded

website (<http://www.sbirtraining.com>) and complete the training module. After completion of the courses, a certificate of completion may be printed out. This certification can be useful for other reasons as well.

Many state-funded, sub-contracted comprehensive vocational evaluation programs are accredited through the Commission on Accreditation for Rehabilitation Facilities (CARF). CARF establishes standards that facilities must meet if they want to obtain or maintain certification. Additional training is strongly recommended by CARF in areas that are appropriate and will benefit consumers. SBIRT training will benefit consumers because it will help eliminate barriers to employment. Evaluation specialists' goals are to identify barriers and training will help them learn what to do when they detect potential SUDS. The SBIRT model is an easy model to grasp, especially for vocational evaluation specialists. These individuals are trained in many vocational evaluations (i.e., WRAT IV, O*NET Ability Profiler) and being trained to administer screening instruments should not be difficult to learn as well. Additionally, training in MI will be beneficial for the SBIRT model, as well as, other services provided. For instance, increase consumer's motivation to be more proactive to finding employment is one goal of evaluation specialists. In other words, motivational interviewing training will be beneficial for many services offered at state-funded, sub-contracted vocational rehabilitation facilities and the brief intervention phase of the SBIRT model.

Motivational Interviewing Training

As mentioned in the previous chapter, MI is a client-centered approach developed to help a client develop intrinsic motivation to change behaviors (Miller & Rollnick, 2002). MI focuses on clients' experiences, values, goals, and plans while also promoting

client choice and responsibility in implementing change (Wagner & McMahon, 2004). The MI Counselor believes all individual have an internal drive toward change and growth and have the capacity to successfully complete rehabilitation and live a high quality of life, regardless of disability, demographics, circumstances, and motivational state (Toriello, Atherton, Campbell, & Sligar, 2010).

The Mid-Atlantic Addiction Technology Transfer Center (2011) developed a website (<http://www.motivationalinterview.org/>) in 1999 (sponsored by SAMHSA) that is information on MI. The website states that “the materials included here are designed to facilitate the dissemination, adoption and implementation of MI among clinicians, supervisors, program managers and trainers, and improve treatment outcomes for clients with substance use disorders” (Mid-Atlantic Addictions Technology Transfer Center, 2011). Training is provided in online seminars covering theoretical background and the eight stages of learning MI. In addition to online seminars, the website provides a list of trainers across the country that agencies can request for a fee. The fees vary depending which trainer is hired. Other resources are available to increase knowledge of MI.

GAIN-SS

The Global Appraisal of Individual Needs-Short Screener is a newer screening instrument that usually takes 5 minutes to administer and is designed as a screener for the “general populations to quickly and accurately identify clients whom the full 1.5 to 2 hour GAIN-Initial would identify as having one or more behavioral health disorders, which suggests the need for referral to some part of the behavioral health treatment system” (Dennis, Feeney, Stevens, & Bedova, 2007, p. 1). This instrument is used through Chestnut Health Systems (CHS), a mental health facility that provides behavioral health

care in Illinois, to help identify barriers that individuals experience to a degree that may require counseling and behavioral intervention.

CHS has GAIN certified instructors throughout the country that are capable of providing training on how to administer the screening instrument. The costs are minimal and an agency should contact CHS to identify a local trainer. In addition to identifying a local trainer, CHS offers a week long seminar on administering the full GAIN, as well as, the GAIN-SS. This route has high costs (usually above \$1000.00); however, if one does receive this specialized training they are able to train others to use components of the GAIN.

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