Quick Guide

For Administrators

Based on TIP 29

Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities

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

Contents

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

WHY A QUICK GUIDE?

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

The Guide is divided into nine sections (see ***Contents***). These sections will help readers quickly locate relevant material. The ***Resources*** section on page 39 provides information on organizations that can assist programs that offer services to persons with disabilities.

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

WHAT IS A TIP?

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

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

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

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

INTRODUCTION

Nearly one-sixth of all Americans have a disability that limits their activity. Countless others have disabilities (mostly cognitive in nature) that go unrecognized and undiagnosed. The Americans With Disabilities Act (ADA) was signed into law in 1990 to ensure equal access to all community services and facilities—including public and private substance use treatment facilities—for all people, regardless of any physical or mental impairment they might have.

The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities or a record of such impairment. Major life activities are defined as essential functions such as personal care tasks, manual tasks, walking, seeing, hearing, speaking, breathing, thinking, learning, and working.

This Quick Guide provides a brief overview of the steps that substance abuse treatment program administrators can take to ensure compliance with the ADA, accrediting agencies, and regulations regarding the care of persons with disabilities.

Readers are encouraged to familiarize themselves with TIP 29 for a more extensive discussion of these issues, and to reference the Resources section on page 39 to learn more about organizations that can assist substance abuse treatment programs that seek to comply with ADA regulations.

Note: This Quick Guide discusses the ADA and issues of funding as they relate to *substance abuse treatment programs*. Thus, for the sake of brevity, any use in this text of the terms *program* or *programs* by themselves should be taken to mean a public or private facility that offers *substance abuse treatment* services.

AN OVERVIEW OF THE AMERICANS WITH DISABILITIES ACT (ADA)

The ADA is a Federal law initiated and championed by persons with disabilities. The ADA states that accommodations must be made by society, not by individuals with disabilities, to guarantee equal opportunity in public and private sector services and in employment.

The ADA is organized into five titles:

Title I: Employment

Employers with 15 or more employees must ensure that their employment practices do not discriminate against qualified people with disabilities. (In California and other States, State and local laws may expand disability rights, including extending ADA protections to employees of companies with fewer than 15 employees.) Title I provides protection for job applicants and employees during all phases of employment. Employers must also reasonably accommodate the disabilities of qualified applicants and employees, unless an undue hardship would result.

Title II: State and Local Government Services

Requires that public programs and services be made accessible to persons with disabilities.

Mandates nondiscrimination on the basis of disability in policy, practice, and procedures.

Title III: Public Accommodations

Title III requires places of public accommodation to be accessible to, and usable by, people with disabilities. Places of public accommodation are all private businesses and privately owned and operated programs that offer goods and services to the general public.

Substance abuse treatment programs operated by private agencies (whether or not they receive Federal, State, or local funding) are considered places of public accommodation under the ADA and are therefore subject to Title III requirements.

Title IV: Telecommunication

Title IV has mandated the establishment of a national network of telecommunication relay services that is accessible to people with hearing or speech disabilities. It also requires captioning of all federally funded television public service announcements.

Title V: Nonretaliation, and Other Provisions

Title V explicitly prohibits retaliation against people exercising their rights under the ADA. It sets forth specific responsibilities for the adoption of enforcement regulations by Federal agencies. It also includes a number of miscellaneous provisions.

The Civil Rights Division of the U.S. Department of Justice has provided the following overview of the responsibilities of Title III entities. Under the ADA, a privately operated substance abuse treatment program must

- Provide services to people with disabilities in an integrated setting, unless separate or different measures are necessary to ensure equal opportunity.
- Eliminate eligibility standards or rules that deny individuals with disabilities an equal opportunity to enjoy the activities, benefits, and services of alcohol and drug programs.
- Make reasonable modifications in policies, practices, and procedures that deny equal access to individuals with disabilities, unless a fundamental alteration in the nature of the program would result.
- Furnish auxiliary aids when necessary to ensure effective communication, unless an undue burden or fundamental alteration would result.
- Remove architectural and structural communication barriers in existing facilities where readily achievable.
- Provide alternative means of delivering services when removal of barriers is not readily achievable.
- Provide equivalent transportation services and purchase accessible vehicles in certain circumstances. (If the program provides

transportation to its clients, equivalent accessible transportation for clients with disabilities must be provided.)

- Maintain accessible features of facilities and equipment.
- Design and construct new facilities and, when undertaking alterations, alter existing facilities in accordance with the *Americans With Disabilities Act Accessibility Guidelines* issued by the Architectural and Transportation Barriers Compliance Board and incorporated in the final Department of Justice Title III regulation.
- These requirements have been categorized into four fundamental groups of obstacles:
  - Attitudinal barriers
  - Discriminatory policies, practices, and procedures
  - Communication barriers
  - Architectural barriers

The following four sections will discuss how privately operated substance abuse treatment programs can take action to overcome these potential obstacles to treating people with disabilities.

For more detailed information, see TIP 29, pp. 123–125.

ATTITUDINAL BARRIERS

An attitudinal barrier can be defined as a way of thinking or feeling that results in limiting the potential of people with disabilities to function independently within society and to be "treatable" and recognized as wanting help with their substance abuse problems.

Disability-Awareness Training

Staff training is key to overcoming attitudinal barriers. Disability-awareness training should include efforts to ensure that staff members

- Overcome their fears and stereotyping of people with disabilities
- Learn the rights of people with disabilities and the responsibilities of substance abuse treatment programs under the ADA
- Develop skills and resources to provide equally effective services to people with disabilities

People with disabilities who are familiar with the ADA and substance abuse treatment can provide the best initial training for program staff. A local independent living center should be an excellent resource for meeting persons with disabilities who can provide assistance.

It is crucial that providers who attend disability awareness training have the opportunity to meet and ask questions of people with a wide variety of disabilities, especially people with disabilities who are in recovery. Panel discussions often provide the best opportunity for these dialogs and serve as a possible springboard for further contact and cooperation. Also, written materials are an invaluable addition to any disability awareness training.

Seeking Out Clients With Disabilities

Not only is it the responsibility of substance abuse treatment programs to seek out clients with disabilities, but such actions are also a clear indication of a program's commitment to removing attitudinal barriers.

The following actions have proven effective in creating a client base of people with disabilities:

- Institute an ongoing campaign to publicize your program to people with disabilities.
- Also include advocacy groups for parents of children with disabilities, and advocacy organizations for people with specific disabilities, such as arthritis, cerebral palsy, multiple sclerosis, muscular dystrophy, and vision and hearing disabilities. Don't forget your local mental health association, or local veterans and seniors groups.

- Establish links with organizations in your community that provide advocacy and services to people with disabilities, such as independent living centers. Invite their representatives to speak at staff meetings and send your staff to speak at their events.
- Actively seek qualified persons with disabilities when searching for advisory board members.
- Actively seek qualified persons with disabilities when hiring new staff members.
- Develop prevention and treatment services that target specific populations of persons with disabilities. Consider providing initial information or counseling services in disability-specific settings.

For more detailed information, see TIP 29, pp. 125–128.

DISCRIMINATORY POLICIES, PRACTICES, AND PROCEDURES

The ADA requires that privately operated substance abuse treatment programs make reasonable modifications to policies, practices, or procedures to ensure equal opportunity and avoid discrimination against people with disabilities.

Reasonable modification means any modification that does not fundamentally alter the nature of the services provided. Clients should be consulted as to the modifications they need to successfully participate in the program. An administrative review should be performed by the program director or another individual who is thoroughly familiar with the program and has the authority to effect policy changes.

Programs may require that people with disabilities meet essential eligibility criteria in order to participate in programs and services, and they may refuse services to individuals with disabilities who cannot meet these admission requirements. Programs must, however, demonstrate that these requirements are essential and that no person with a disability is unnecessarily excluded or limited from participation in programs and services.

Essential requirements are those that are fundamental to the nature of a program or activity. For example: A program cannot require that clients present a valid driver's license in order to receive services because the ability to drive is not essential to recovery. Other forms of identification, such as a social security card or birth certificate, should be accepted in lieu of a driver's license.

Admissions

Discriminating against people with disabilities often occurs during first contact. An important first step is to review your admissions procedures. These include recruitment, referral, screening, and intake of clients with disabilities; everything that occurs prior to receipt of services or participation in the program.

- Programs may not refuse to admit people solely based upon disability. Blanket policies, practices, and procedures that prohibit the participation of people with disabilities or place quotas upon the number of such individuals who can be admitted are discriminatory.
- Programs should not presume that an individual or class of individuals with a disability can or cannot participate in any aspect of a program.
- An important step in ensuring nondiscrimination is to establish procedures by which each individual

is evaluated based upon his or her unique needs and abilities.

- Even if architectural or communications barriers seemingly prevent program access for people with certain disabilities, a program must give each individual with a disability an opportunity to determine for him- or herself whether he or she can function within the program's constraints.
- If architectural, financial, or other constraints limit the number of people with disabilities that a program can serve at any given time, the program must make every effort to ensure that individuals with disabilities are provided with other options for services such as a referral to a comparable program. The individual with a disability should be apprised of all options and his or her preference for placement must be given primary consideration.
- The Department of Justice does not consider it discriminatory for a program with a specialty in a particular area to refer an individual with a disability to a different program if 1) the individual is seeking a service or treatment outside the referring program's area of expertise; and 2) the program would make a similar referral for an individual who does not have a disability.
- The ADA does not prohibit the establishment of target programs to serve communities of persons with disabilities, such as a residential treatment

facility for persons who are deaf. Nevertheless, the existence of special programs does not relieve substance abuse treatment programs of their obligation to provide reasonable modifications and auxiliary aids and services to individuals choosing to participate in the regular program.

Disabilities That Pose a Direct Threat to the Health and Safety of Others

A program may deny participation in activities to a person based upon disability when the individual's disability legitimately presents a direct threat to the health or safety of others, and cannot be eliminated or reduced to an acceptable level by reasonable changes. The program must establish that the perceived threat is real and not based upon preconceptions or unwarranted fears about the individual's disability. Assessments must consider both the particular activity and the actual abilities and disabilities of the individual.

The Department of Justice indicates that a direct threat assessment must be based on reasonable judgment that relies on current medical evidence, or on the best available objective evidence, to determine

- The nature, duration, and severity of the risk
- The probability that a potential injury will actually occur

- Whether reasonable modifications of policies, practices, or procedures will mitigate or eliminate the risk

Inquiries Regarding Disability

Inquiries regarding disability made prior to acceptance into a program are generally unnecessary and should not be made. Once a person has been accepted into the program, necessary inquiries can be made regarding special accommodations that an individual may need. Application forms, consent forms, and other documents where such inquiries are made should be reviewed and revised accordingly.

Necessary inquiries include questions asked to provide program modifications, auxiliary aids and services, health care, or emergency services to the client, questions asked to assess the client's conformance with legitimate health and safety requirements, and questions asked for some other essential purpose.

Unnecessary inquiries include those asked to screen out the participation of people with disabilities, to satisfy one's curiosity, or to discriminate in the provision of treatment, health care, emergency services, etc.

While programs cannot require that clients disclose information about disability, they may give clients an opportunity to voluntarily provide such information. This is especially true if the intention is to use such information in order to accommodate the client. Moreover, programs should have a written policy and procedure in place to ensure that records pertaining to a client's disability are kept confidential and not used in a discriminatory fashion.

Costs of Personal Equipment and Attendant Services

ADA compliance measures may result in an additional cost for serving clients with disabilities. Programs may raise the fee for all clients, but they may not place a surcharge on particular individuals with disabilities or groups of individuals with disabilities to cover these expenses.

A public accommodation is not required to provide equipment or services of a personal nature. These would include wheelchairs, prescription eyeglasses, hearing aids, or assistance in eating, toileting, and dressing.

Service Animals for the Disabled

Programs must allow a service animal (such as a guide, hearing, or companion dog) to accompany a person with a disability for all services except when doing so would fundamentally alter the

particular activity or jeopardize the safe operation of the program. It is the responsibility of the animal's owner to feed, walk, and care for the service animal in any other way.

Protection From Retaliation or Coercion

Programs may not take any retaliatory action against persons who exercise their rights under the ADA or individuals who assist others in exercising their rights. This prohibits the suspension or termination of employees for advising persons with disabilities of their right to reasonable modifications and auxiliary aids and services in the program.

For more detailed information, see TIP 29, pp. 128–134. For samples of non-discriminatory language that can be used in written policies, see TIP 29, pp. 146–149.

COMMUNICATION BARRIERS

The ADA requires programs to ensure that communication with people with disabilities is as effective as communications with others. This includes outreach, education, prevention efforts, intake interviews, group meetings, counseling sessions, telephone and mail communications, and provision of medical services. Communication barrier removal is especially important for people with sensory and/or learning disabilities.

Auxiliary Aids and Services

In many cases, ensuring effective communication entails the provision of auxiliary aids and services, a wide range of practices and equipment that allow people with disabilities to communicate and access information.

The type of auxiliary aid or service necessary will vary in accordance with the nature and duration of the communication and the individual person's preference and ability to use a particular aid or service.

- Examples for individuals who are deaf or hard of hearing include qualified interpreters, computer-aided transcription services, written materials, assistive listening systems, telephones compatible with hearing aids, closed caption

decoders, telecommunications devices for deaf persons (TDDs), and videotext displays.

- Examples for individuals with vision impairments include qualified readers, taped texts, audio recordings, Braille materials, large print materials, and assistance in locating items.
- Examples for individuals with speech impairments include TDDs, computer terminals, speech synthesizers, and communication boards.

Programs should be prepared to provide the widest variety of auxiliary aids and services possible to people with disabilities, at all phases of a client's participation. The ADA suggests that individuals with disabilities be given the opportunity to request the auxiliary aids and services of their choice, and that primary consideration be given to the choice expressed by the individual.

Fundamental Alteration

The ADA does not require privately operated programs to provide any auxiliary aids and services that would fundamentally alter the nature of the program and the services they offer or result in an undue financial burden. A fundamental alteration is defined by the Department of Justice as a modification that is so significant that it alters the essential nature of the goods, services, facilities, privileges, advantages, or accommodations offered.

For example: A program determines that it would be an undue financial burden to provide professional interpreting services for all aspects of services but resolves to provide an interpreter for weekly counseling sessions and all group meetings. Furthermore, the program welcomes clients who are deaf to bring friends or relatives to interpret for them and makes a computer terminal available for typed communications between the deaf client and program staff.

Sign-Language Interpreting Services

A program must ensure that any interpreter it hires or otherwise provides is qualified. There are a number of sign languages used. The most common methods of communication are American Sign Language and signed English.

A qualified interpreter is able to sign to the individual who is deaf what is said by the hearing person, and can voice to the hearing person what is signed by the individual who is deaf. This communication must be conveyed effectively, accurately, and impartially through the use of any necessary specialized vocabulary, and in the type of sign language the deaf person uses.

Telephone Communications

If your program has frequent or extensive telephone communications with clients and members

of the general public, a TDD makes telephone communications accessible to individuals who are deaf, hard-of-hearing, or speech impaired. A TDD allows individuals to communicate over regular telephone lines through text rather than voice.

If you provide a separate TDD phone line, that number should be listed wherever you advertise the number for regular telephone service. The Department of Justice advises that TDDs must be provided when customers, clients, patients, or participants are permitted to make outgoing calls on more than an incidental convenience basis.

Media Materials

Communication barriers also appear when programs attempt to send outreach materials to people with disabilities. Alternative formats include but are not limited to the following:

- Print materials may be made available to blind or visually impaired individuals in audiotape, large print, computer disk, Braille, or raised text format.
- Print materials may be made available to people with limited upper body use in computer disk format.

- Videotapes may be made available to deaf or hard-of-hearing individuals in captioned format (with subtitles).
- Audiotapes may be made available to deaf or hard-of-hearing individuals in print format.

Programs should include the following in all outreach, prevention, and other materials that they produce:

- A statement of the program's responsibilities under the ADA and its commitment to provide effective communication to people with disabilities
- A description of the accommodations and resources that the program has available for people with disabilities

Additional considerations

- No new or existing outreach, prevention, or other materials—whether produced or distributed by the program—should contain any discriminatory language or representation of people with disabilities.
- When selecting or designing new materials, it is recommended that programs make an effort to incorporate positive representations of people with disabilities.
- An appropriate number of materials should address issues specific to disability. For instance, since over 15 percent of California's population

are people with disabilities, it is recommended that at least 15 percent of a California-based substance abuse treatment program's materials address the needs of this population.

- It may be an unwieldy task for a program to review each of the materials that it currently distributes. As an alternative, programs may choose to establish a procedure by which persons can file a complaint if they find any material to be discriminatory against people with disabilities.

Open Meetings and Other Public Events

The following are minimum guidelines for holding an accessible meeting or other public event:

- Make invitations, flyers, and other announcements available in alternative formats upon request.
- Include clip-and-return form and phone numbers on announcements that allow persons with disabilities to contact your program in advance and request accommodations such as large-print handouts or sign-language interpreter services.
- Hold public events at a wheelchair-accessible location. At a minimum, these sites should have wheelchair-accessible parking, entrances, travel paths, seating, toilet facilities, and public phones.
- If possible, secure a sign language interpreter for the event. Otherwise, provide notice in your

ads that a sign language interpreter will be available if requested 72 hours in advance.

- If possible, make written handout materials readily available in the following common alternative formats: large print, computer disk, and audiocassette.
- Place refreshments and handout materials in an accessible location.

For more detailed information, see TIP 29, pp. 134–138.

ARCHITECTURAL BARRIERS

Under the ADA, privately operated programs should remove architectural (or physical) barriers to program areas in existing facilities where it is readily achievable to do so. Readily achievable is defined by the Department of Justice as easily accomplishable and able to be carried out without much difficulty or expense.

Both the landlord and the tenant have the full responsibility for complying with all applicable ADA Title III requirements. Title III allows that barriers be removed slowly, over time, as it becomes readily achievable to do so.

Programs are obligated to evaluate their existing resources and determine which barriers can be removed. Such a survey should be performed by a person who is thoroughly familiar with physical access standards and the operation of substance abuse treatment programs. The Department of Justice also advises that the process include consultation with individuals with disabilities or organizations representing them.

Because the California Department of Alcohol and Drug Programs (DADP) has its own obligations under the ADA and the Rehabilitation Act of 1973, readers whose programs are based in California

are encouraged to familiarize themselves with their State's specific guidelines. The Pacific Research and Training Alliance (PRTA) in Oakland, California can offer assistance in this area.

Defining Architectural Barriers

Architectural barriers are physical elements of a facility that impede access by people with disabilities. Certain architectural features, such as bathrooms and meeting rooms, must be made accessible. The following are additional examples of architectural barriers that may require action:

- Impediments such as steps and curbs that prevent access by people who use wheelchairs
- Telephones, drinking fountains, mirrors, and paper towel dispensers mounted at a height that makes them inaccessible to people using wheelchairs
- Conventional doorknobs and operating controls that impede access by people who have limited manual dexterity
- Deep-pile carpeting on floors and unpaved exterior ground surfaces that are a barrier to access by people who use wheelchairs and other mobility aids
- The location of temporary or movable structures, such as furniture, equipment, and display racks

New Construction Versus Alteration

The ADA establishes different standards for architectural barrier removal from existing facilities than for facilities undergoing a new construction or alteration project. In existing facilities where retrofitting may be expensive, the requirement to provide access is less stringent than it is in new construction and alterations, where accessibility can be incorporated in the initial stages of design and construction, often without a significant increase in cost.

Removal That Is "Readily Achievable"

Determinations as to which barriers can be removed without much difficulty or expense must be made on a case-by-case basis. The Department of Justice's regulation contains a list of examples of modifications that may be readily achievable, such as the installation of ramps, repositioning shelves and telephones, widening doors and creating designated accessible parking spaces.

Factors to consider

- The nature and cost of removal
- The overall financial resources of the site or sites involved
- The number of persons employed at the site

- Legitimate safety requirements necessary for safe operation, including crime prevention measures
- Any other impact of the action on the operation of the site

Priorities for Barrier Removal

Because available resources may not be adequate to remove all existing barriers, the regulation suggests a way to determine which barriers should be mitigated or eliminated first. These priorities are not mandatory: Programs are free to exercise discretion in determining the most effective "mix" of barrier removal measures to undertake in their facilities.

First Priority: Enable individuals with disabilities to physically enter the facility. This priority recognizes that providing physical access to a facility from public sidewalks, public transportation, or parking is generally preferable to any alternative arrangements in terms of both business efficiency and the dignity of individuals with disabilities.

Second Priority: Ensure access to those areas of the facility where services are made available to the clients.

Third Priority: Provide access to restrooms (if restrooms are provided for clients).

Fourth Priority: Remove any remaining barriers to using the program's facility (for instance, by installing visual alarms, adding Braille floor indicators to elevator panels, or lowering telephones).

Alternatives to Barrier Removal

When a program can demonstrate that the removal of barriers is not readily achievable, the program must make its services available through alternative methods, if such methods are readily achievable.

Factors to consider

- When services are provided to an individual with a disability through alternative methods because a program's facility is inaccessible, the program may not place a surcharge on the individual with a disability for the costs associated with the alternative methods.
- Security is a factor that may be considered when a program determines if an alternative method of delivering its services is readily achievable.
- The "readily achievable" obligation does not extend to areas of a facility that are used exclusively by employees as work areas. However, if one or more employees have disabilities that need to be accommodated through barrier removal, then barrier removal must be carried out unless it

poses an "undue hardship" to the employer (as established by Title I of the ADA).

- Portable ramps are permitted only when the installation of a permanent ramp is not readily achievable. A portable ramp should have railings and a firm, stable, non-slip surface, and should also be properly secured.
- The readily achievable standard does not require barrier removal that would necessitate extensive restructuring or burdensome expense. However, the programmatic access standard would require that program services be moved to an accessible site when needed. Therefore, small privately operated programs with limited budgets generally would not be required to remove a barrier to physical access posed by a flight of steps, if removal would require extensive ramping or an elevator.
- Privately operated programs are not required to lease space that is accessible. However, upon leasing, the barrier removal requirements for existing facilities apply. In addition, any alterations to the space must meet the accessibility requirements for alterations.

ADA Requirements and Historic Buildings

Barrier removal would not be considered readily achievable if it would threaten or destroy the historic significance of a building or facility that is eligible for

listing in the National Register of Historic Places under the National Historic Preservation Act (16 U.S.C. 470, et seq.), or is designated as historic under State or local law.

Maintaining Accessibility

Privately operated programs must maintain in working order equipment and features of facilities that are required to provide ready access to individuals with disabilities.

Access routes must not be blocked by obstacles such as furniture, filing cabinets, or potted plants. Similarly, accessible doors must be unlocked when the facility is open for business.

Other instances to consider

- Placing a vending machine on the accessible route to an accessible restroom would be violation if it obstructed the route.
- Placing ornamental plants in an elevator lobby may be a violation if they block the approach to the elevator call buttons or obstruct access to the elevator cars.
- Using an accessible route for storage of supplies would also be a violation, if it made the route too narrow or crowded to be accessible.

- An isolated instance of placement of an object on an accessible route would not be a violation, if the object is promptly removed.

Equipment Failure

Mechanical failures in equipment such as elevators or automatic doors occur from time to time, but the obligation to ensure that facilities are readily accessible to and usable by individuals with disabilities would be violated if repairs were not made promptly or if improper or inadequate maintenance causes repeated and persistent failures. Inoperable or "out of service" equipment does not meet the requirements for providing access.

For more detailed information, see TIP 29, pp. 139–145.

FUNDING CONSIDERATIONS

Treatment for people with coexisting disabilities can add new complexities, as well as opportunities, to the process of securing funding. While this is not an area directly addressed by the ADA, it is still an issue of vital importance to program administrators.

Sources of Funding

Services may acquire funding from a variety of sources, including

- Federal block grants such as the Substance Abuse Prevention and Treatment (SAPT) and the Community Mental Health Services (CMHS) Block Grants
- Medicaid, which includes options that allow for non-medical services (e.g., the Medicaid rehabilitation option)
- Medicare and Supplemental Security Income for people with disabilities
- Health Resources and Services Administration (HRSA) funds for migrant health, people with HIV/AIDS, and Maternal and Child Care
- Private organizations
- Veterans services
- Developmental services

- Local tax dollars
- Private foundations, such as United Way

Blended Funding

To provide sufficient funding for the longer and more complex supports that may be required for a person with a coexisting disability, blended funding is highly recommended. When several agencies have a mandate to provide care, as is the case for many people with coexisting disabilities, each may have access to funds for case management. Blending funding can enable the coordinating team to create a pool of funds sufficient to fund a single case manager at an acceptable level.

Shared Costs

Programs might consider collaborating with rehabilitation and other providers to share resources. For example, a program might carry educational and treatment services into a vocational rehabilitation site. Carry-in services reduce the overall cost of separate programs and may, in certain cases, allow for third-party payment for both providers. In these cases, there is not a blending of funding, but rather a sharing of costs and a potential for mutual billing.

Funding Under Managed Care

For people with coexisting disabilities, managed care policies can pose a serious barrier to getting the level of treatment they require. Examples of managed care

policies or limitations that could adversely affect clients include

- Lack of access to Health Maintenance Organizations (HMOs)
- Being placed on a waiting list by public HMOs
- Loss of funding due to capitation policies when treatment is required over a long time
- Restrictions on needed ancillary medical or physical care
- Not being allowed to use accessible treatment options

Poor self-advocacy skills, often coupled with low self-esteem, may impair a person's ability to "push" the system in order to get needed care. A case manager may have to either find strategies to overcome the adverse effect the managed care provider's policies have on the client or seek to change those policies through direct communication with the managed care agency.

For more detailed information, see TIP 29, pp. 92–94.

INFORMATION RESOURCES

Federal ADA Enforcement Agencies

Architectural and Transportation Barriers
Compliance Board: The Access Board
Suite 1000
1331 F Street, NW
Washington, DC 20004-1111
(800) USA-ABLE (voice)
(800) 993-2822 (TDD)
(202) 272-5434 (voice/TDD)
(202) 272-5447 (fax)
http://www.access-board.gov

Equal Employment Opportunity
Commission (EEOC)
1801 L Street, NW
Washington, DC 20507
Complaints and Information
(800) 669-4000 (voice)
(800) 699-6820 (TDD)
Documents/Public Information Center
(800) 669-3362 (voice)
(800) 800-3302 (TDD)
(513) 791-2954 (fax)
(800) 669-4000 (referral to regional offices)
http://www.eeoc.gov

Department of Justice (DOJ)
Civil Rights Division
Disability Rights Section
P.O. Box 66738
Washington, DC 20035-6738
(800) 514-0301 (voice)
(202) 514-0301 (voice)
(800) 514-0383 (TDD)
(202) 307-1198 (fax)
http://www.usdoj.gov/crt/ada/adahom1.htm

Federal and Federally Funded ADA Technical Assistance Agencies

Administration of Developmental Disabilities
370 L'Enfant Promenade, SW
Washington, DC 20447
(202) 690-6590

Clearinghouse on Disability Information
OSERS/U.S. Department of Education
Room 3132, Switzer Building
400 Maryland Avenue, SW
Washington, DC 20202-2524
(202) 205-8412 (voice)
(202) 732-1252 (fax)

Library of Congress National Library Service for the Blind and Physically Handicapped
1291 Taylor Street, NW
Washington, DC 20542
(800) 424-9100
http://www.loc.gov/nls

MRI/Penn Research and Training Center on Vocational Rehabilitation for Persons with Mental Illness
Matrix Research Institute
University of Pennsylvania Department of Psychiatry
6008 Wayne Avenue
Philadelphia, PA 19144
(215) 438-8200
http://www.matrixresearch.org/index2.html

National Institute on Disability and Rehabilitation Research
U.S. Department of Education
Room 3060
400 Maryland Avenue, SW
Washington, D.C. 20202
http://www.ed.gov/offices/OSERS/NIDRR

National Institute on Neurological Disorders
and Stroke
Building 31, Room 8A06
31 Center Drive, MSC 2540
Bethesda, MD 20892-2540
(301) 496-5751 (voice)
(800) 325-9424 (voice)
(301) 402-2186 (fax)
http://www.ninds.nih.gov

National Research and Training Center on
Psychiatric Disability
University of Illinois–Chicago
Suite 900
104 South Michigan Avenue
Chicago, IL 60603-5901
(312) 422-8180
http://www.psych.uic.edu/uicnrt

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

Rehabilitation Research and Training Center for Persons Who Are Deaf or Hard of Hearing
University of Arkansas
4601 West Markham Street
Little Rock, AR 72205
(501) 686-9691
http://www.uark.edu/depts/rehabres/

Rehabilitation Research and Training Center on Blindness and Low Vision
Mississippi State University
P.O. Drawer 6189
Mississippi State, MS 39762
(601) 325-2001
http://www.msstate.edu/dept/rrtc/blind.html

Rehabilitation Services Administration
U.S. Department of Education
Switzer Building
330 C Street, SW
Washington, D.C. 20202-2500
(202) 205-54654
http://www.ed.gov/offices/OSERS/RSA/

Research and Training Center in Rehabilitation for Persons With Long-Term Mental Illness
Boston University/Sargent College
Center for Psychiatric Rehabilitation

930 Commonwealth Avenue
Boston, MA 02215
(617) 353-3549
http://www.bu.edu/cpr

Research and Training Center on Community Integration of Individuals With Traumatic Brain Injury
Mount Sinai School of Medicine
One Gustave L. Levy Place, Box 1240
New York, NY 10029-6574
(212) 241-7917
http://www.mssm.edu/tbinet

Research and Training Center
on Community Living
University of Minnesota
College of Education and Human Development
Institute on Community Integration
RTC on Residential Services and
Community Living
150 Pillsbury Drive, SE
Minneapolis, MN 55455
(612) 624-5005
http://rtc.umn.edu

Research and Training Center on Improving Community-Based Rehabilitation Programs
University of Wisconsin–Stout
College of Human Development
Stout Vocational Rehabilitation Institute
Menomonie, WI 54751
(715) 232-1219
http://www.rtc.uwstout.edu

Research and Training Center on Rural Rehabilitation Services
University of Montana
Rural Institute on Disabilities
52 Corbin Hall
Missoula, MT 59812
(406) 243-5467
http://ruralinstitute.umt.edu/

Substance Abuse Resources for Persons With Disabilities

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

Ordering Information

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

TIP 29-Related Products

KAP Keys for Clinicians based on TIP 29

Quick Guide for Clinicians based on TIP 29

Easy Ways to Obtain Free Copies of All TIP Products

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

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

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

TIP 14, *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment (1995)* **BKD162**

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

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

TIP 38, *Integrating Substance Abuse Treatment and Vocational Services (2000)* **BKD381**

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

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