SAMHSA ADVISORY
Substance Abuse and Mental Health Services Administration

MENTAL AND SUBSTANCE USE DISORDER TREATMENT FOR PEOPLE WITH PHYSICAL AND COGNITIVE DISABILITIES

This Advisory highlights how mental and substance use disorder treatment programs can better serve people with physical and cognitive disabilities and substance use disorders (SUDs) and/or serious mental illness (SMI). The most current prevalence data (2016), an estimated 61.4 million noninstitutionalized U.S. adults had one or more disabilities.[1] SMI and co-occurring substance use disorder SUDs are generally considered disabilities under federal disability rights laws. This publication is not intended to provide guidance on complying with federal, state, or local disability rights laws. This advisory includes some recommendations that are required, may be required or may exceed the requirements of the federal, state, or local disability rights laws.

Key Messages

- People with physical and cognitive disabilities have a higher prevalence of SMI and SUD, as well as lower Treatment rates for both conditions than do people without these disabilities.
- Mental and substance use disorder treatment providers may underestimate the barriers of accessibility to their programs for people with physical or cognitive disabilities, or they may have specific exclusion criteria for some people with disabilities.
- Physical and cognitive disabilities are not always obvious. Clients with such "invisible" disabilities may receive services that do not meet their mental and substance use disorder treatment needs.
- Behaviors associated with some cognitive disabilities may falsely be mistaken for willful nonadherence or lack of motivation.
- Providers should inform each client of the program's ability to meet a range of access needs—and should act on access requests—to help ensure that clients with disabilities get the most out of their mental and substance use disorder treatment.

Some people with physical and cognitive disabilities may have different mental illness and/or substance misuse presentations compared to those without disabilities; providers should develop expertise in understanding best practices for this population

Summary of Advisory Action Steps

Have you or your program:

- Conducted and begun acting on a client pathway analysis?
- Reviewed the recommended resources for improving accessibility?
- Trained staff to inform all clients at first contact and at the intake/assessment interview about your program's ability to meet a range of access needs, and then to provide information on how to make access requests?
- Trained staff on how to act on access requests?
- Begun offering clients voluntary cognitive screening during the intake/assessment interview?
- Followed suggested tips on group and individual SUD and SMI counseling for clients with physical or cognitive disabilities?
- Learned about the accessibility efforts of local peer recovery support groups?

Some people with physical or cognitive disabilities may begin misusing substances to cope with chronic

pain, social isolation, stigma related to their disabilities, or physical or sexual abuse or other trauma. [2, 3, 4] Other SUD risk factors in this population include impulsivity and unemployment. [5, 6, 7, 8, 9] In other cases, preexisting substance misuse has contributed to an accident that caused the individual's disability. [10, 11]

> Definitions of "disability" and types of disabilities vary widely. For purposes of this Advisory, the term "physical disabilities" includes motor, medical, and sensory disabilities, and the term "cognitive disabilities" includes intellectual and developmental disabilities, although developmental disabilities may be cognitive, physical, or both.[12] For brief descriptions of motor, sensory, cognitive, intellectual, and developmental disabilities, see *www.nln.org/docs/default-source/professional-development-programs/ace-series/definitions-related-to-disability-7-20-17.pdf?sfvrsn=6. For examples of medical disabilities, see https://supportservices.jobcorps.gov/disability/Pages/Common-Disabilities-and-Related%20Accommodation-Resources.aspx*. For the Americans with Disabilities Act (ADA) definition of disability, see *www.ada.gov/ada_intro.htm*.

Although barriers to mental disorders and SUD treatment engagement for people with physical or cognitive disabilities may be social, environmental, economic, or psychological,[13] some barriers relate to treatment facilities. Examples include: [14, 15, 16]

- Inaccessible parking, entrances, and interior spaces.
- Policies that exclude people with disabilities, such as a requirement that clients be able to evacuate a facility unassisted in an emergency.
- SUD counseling that isn't adapted for people with cognitive disabilities.
- No materials in Braille or other alternative formats (e.g., large print, electronic format) for people who are blind or visually impaired.
- Lack of staff training on technologies for communicating with people who are deaf.

Disability departments stating that individuals with SMI do not fall within their jurisdiction, and mental health departments stating that individuals with disabilities do not fall within theirs

Note that some treatment providers may overestimate the accessibility of their facilities and services, [17, 18] or be unaware of the wide range of disabilities that exist and ways to accommodate them.

Client Pathway Analysis for Mental and SUD Treatment Settings

Conducting and acting on client pathway analysis can make your program more accessible to people with physical and cognitive disabilities (and other clients too).[19] It can also help your program more fully comply with disability rights laws requiring, except in certain circumstances, that people with disabilities have an equal opportunity to participate in and benefit from your services.

The analysis should include ensuring people with disabilities have physical, communication, and programmatic accessibility.[20] First, evaluate the physical access of the facility, while doing so assess the physical accessibility, furnishings, and signage from the perspective of clients with disabilities, especially physical disabilities. Second, analysis the operations and policies of the program. Consider how clients with disabilities, especially sensory or cognitive disabilities, would maneuver through the different stages, processes, and content of the program. A review of the policies on eligibility criteria and the application process should also be included in the analysis.

You should involve people with disabilities and disability organizations in the analysis. A local Center for Independent Living (CIL) is a good starting point for making these connections. See *www.ilru.org/projects/cil-net/cil-center-and-association-directory* for links to CILs. For more on the analysis process, see pages 84–85 in *Renewing the Commitment: An ADA Compliance Guide for Nonprofits* at *https://cct.org/wp-content/uploads/2015/08/2015ADAComplianceGuide.pdf.* (The basic process can be used by any type of SUD treatment

facility, not just nonprofit ones.) The NIATx walk-through guide (*https://niatx.net/Content/ContentPage.aspx?NID=146*), although not disability specific, also offers some useful ideas. See also the resources listed in the next section.

In addition, programs should review any exclusionary policies that exist. For example, a number of mental and substance use disorder providers do not provide services for those with individuals with autistic disorder. With training, staff may be able to meet the needs of such individuals.

Resources for Improving Accessibility

ADA.gov is the go-to federal website for information on ADA accessibility requirements, including materials explaining the 2010 changes to ADA regulations. See in particular the guidance on:

- Effective communication requirements (for providing alternative methods of communicating, like Braille materials and qualified sign language interpretation) and the limitations on these requirements (*www.ada.gov/effective-comm.htm*).
- Service animals (*www.ada.gov/service_animals_2010.htm*).

The 10 regional centers of the Department of Health and Human Services-funded ADA National Network provide free, confidential answers to questions on accessibility requirements of the ADA and associated laws (*https://adata.org*). They can also provide specific trainings by request. You can reach your region's ADA Center at 1-800-949-4232 or *www.adata.org/email*. Two helpful network resources are:

- The ADA Title II Action Guide for State and Local Governments website (*www.adaactionguide.org*).
- The ADA Checklist for Existing Facilities (*https://adachecklist.org/checklist.html*).

Creating a treatment environment that is welcoming and understanding of people with disabilities is one of the most important accessibility measures you can take. [21, 22] Start by:

- Taking the free Disability Implicit Attitudes Test (available online through *https://implicit.harvard.edu/implicit/takeatest.html*) or a similar measure to assess your attitudes toward people with disabilities. Encourage other staff to assess their attitudes too.
- Reviewing online resources listed at *https://disabilityinpublichealth.org/communication-with-people-with-disabilities-resources* for tips on interacting with people with disabilities.
- Improving your knowledge of specific disabilities with information at *https://askjan.org/a-to-z.cfm.*

Admissions and Intake

Clients with physical and cognitive disabilities may not know about mental disorder and SUD treatment provider's ability—and often, legal responsibility—to meet their physical, communication, or programmatic access needs. In these instances, clients with a disability may not request accommodations for their disability. Starting at intake, programs should identify and provide the appropriate adaptive services to support clients' with disabilities and other unique needs, make sure that: [23, 24, 25]

- Staff who interact with clients know that some disabilities aren't obvious. (See *https://naric.com/?q=en/node/88* for examples.)

▪ Frontline staff inform all potential clients at first contact that the program can meet a range of access needs throughout the admission, intake, and treatment process.
▪ Frontline staff give potential clients examples of how access needs are met, explain how to make access requests, and act on these requests according to program procedures.
▪ Staff conducting intake/assessment interviews remind new clients that the program can meet a range of access needs, then give examples, explain how to make access requests, and act on these requests according to program procedures.
▪ Intake/assessment interviews include voluntary brief cognitive screening, unless cognitive impairment is already documented (see "Why Offer Cognitive Screening During Intake/Assessment?").
If a client requires accessibility supports to participate in your treatment program, ensure all staff are aware of the clients' physical or cognitive disability. Ensure the accessibility support (s) are provided at each treatment encounter.

A person with a history of a opioid use disorder (OUD) is generally considered a disability under federal disability rights laws. A person, current OUD and is seeking treatment, is exempt from the ADA disability right laws in some instances. OUD treatment programs should contact the ADA for additional guidance case-by-case. ADA protections do apply for Individuals with SMI. Treatment programs may be in violation of applicable laws if their admissions policies exclude people taking Food and Drug Administration-approved medications for OUD as prescribed.[26] (Some medications should not be administered simultaneously with OUD medications. See the Substance Abuse and Mental Health Services Administration's [SAMHSA] Treatment Improvement Protocol [TIP] 63, Medications for Opioid Use Disorder, at *https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC*.)

Why Offer Cognitive Screening During Intake/Assessment?

People with traumatic brain injury (TBI), fetal alcohol spectrum disorder, intellectual disability, autism and other conditions that affect cognition make up a significant share of the SUD population, as well as populations receiving mental health services.[27, 28, 29, 30, 31] New clients won't always know or say whether they have cognitive problems, and such impairment isn't always obvious or documented. Yet treatment can be more effective if providers are aware of these problems, because clients with cognitive impairment may:[32, 33, 34, 35, 36]

- Need adaptations to group and individual mental or SUD counseling, and other services (see "Treatment Approaches" below).
- Need appointment and activity reminders (e.g., calls; alarms, apps, or tasks set up on smartphones).
- Behave in ways that could be mistaken for willful non-adherence or poor motivation. For example, reduced stamina may come across as laziness; impaired judgement as rebelliousness; memory problems as lack of motivation.
- Need simplified handouts and forms.
- Say they understand more than they really do.

Before administering a cognitive screen, make clear to the client that taking it is voluntary. Also, explain to the client that the purpose of the screening is to help make sure that treatment meets his or her needs.

One brief cognitive screen validated for people with SUDs is the Montreal Cognitive Assessment (MoCA), available for free for clinical use at *www.mocatest.org*. The MoCA requires provider training and certification. The MoCA can be administer by a diverse discipline of trained and certified clinicians.[37, 38] The MoCA and other brief cognitive screening instruments don't diagnose cognitive impairment. If indicated, follow your facility's procedures for referring a client with suspected cognitive impairment to a qualified practitioner who can do a clinical assessment for this condition.

Drug–Drug Interactions

Keep in mind the potential for dangerous interactions between medications used to treat mental disorders and

SUDs, and other medications that people with physical and cognitive disabilities may be prescribed. For example, anticonvulsant medications—which people with TBI or developmental disabilities may take[40,41] —can interact with methadone.[42]

Treatment Approaches

Special Considerations: People living with an Intellectual Disability

People living with an intellectual disability have deficits in over-all mental capacities, such as reasoning, problem solving, planning, abstract thinking, judgement, academic learning, and learning from experience (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013, p. 31.) When developing a plan of care and selecting a treatment approach, practitioners should take into consideration the special needs of people with intellectual disabilities.

Some General Principles

Individualized planning and care. Keep in mind that each client with a physical or cognitive disability is unique, with different treatment and access needs.

Trauma-informed care. Providing trauma-informed care is especially important when working with clients with disabilities. Many people with disabilities have experienced physical or sexual abuse or other trauma.[43, 44] See SAMHSA's TIP 57, Trauma-Informed Care in Behavioral Health Services, at *https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816*.

Integrated or specialized services. The ADA provides for individuals with disabilities to receive services in the most integrated setting appropriate to their needs. Separate programs are permitted if necessary to ensure equal opportunity, but individuals with disabilities may, with some exceptions, still choose the "regular" program. You should understand the ADA regulations on integrated and separate settings (see *www.ada.gov/2010_regs.htm*).

Pain. Providers should consider providing pain-coping strategies as part of mental and SUD treatment for clients with disabilities and pain issues (see SAMHSA's TIP 54, Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, at *https://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671*). Many adults with disabilities experience persistent pain, which contributes to the relatively high risk of prescription opioid misuse and heroin use among this population.[45, 46]

Promising Approach to Serving Clients With Developmental Disabilities

In 2012, Alta California Regional Center (ACRC), a Sacramento-based nonprofit that serves individuals with developmental, including intellectual, disabilities, began helping area SUD treatment professionals better identify and work with such individuals. This collaboration, launched with state grant funds, in part involved:

- Developing a brief questionnaire that SUD treatment staff could use to screen clients for developmental disabilities.
- Convening a joint task force of SUD treatment and developmental disabilities professionals to develop training materials.
- Cross-training SUD treatment personnel on working with individuals with developmental disabilities.
- Making SUD treatment staff aware of the support services available through ACRC to clients with developmental disabilities.
- Cross-training ACRC staff on working with clients with developmental disabilities and SUDs.

For information on this project, see *www.altaregional.org/post/mhsa-substance-abuse-reduction-training-project*. To connect with the developmental disabilities agencies for your clients' communities, find your state agency website at *www.nasddds.org/state-agencies* and check it for contact information. State developmental disabilities services vary significantly across the country but can include adult day programs, employment or housing support, and transportation assistance.

Selected Tips on SUD Counseling for People With Cognitive Disabilities

Limited evidence-based guidance exists on working with people with cognitive disabilities in SUD counseling settings.[48, 49] The suggestions below draw mainly on clinical experience.

For groups composed of one or more individuals with cognitive disabilities:[50, 51, 52, 53, 54, 55, 56, 57, 58]

- Minimize noise and visual distractions.
- When permissible and appropriate, supplement the client's report with input from family members or caregivers (with the client's consent) on the client's strengths and preferred learning style.
- Go over group rules, including confidentiality, at each session.
- Sum up the previous session.
- Repeat important questions and points.
- If needed, give the individual(s) with a cognitive disability a short break.
- Convey key ideas visually.
- Incorporate role-playing and skills practice (e.g., refusal skills, deep diaphragmatic breathing).
- After sessions, see whether clients with cognitive disabilities understood key points by asking them, one on one, questions that cannot be answered simply "yes" or "no."

In individual SUD counseling:[59, 60, 61]

- Emphasize concrete action steps and healthy routines instead of abstract concepts.
- Consider having more frequent but shorter sessions.
- Minimize distractions, repeat important information, take a short break when needed, convey key ideas visually, use role-playing, get family and caregiver input when permissible and appropriate (with client consent), incorporate skills practice, and check for understanding.

For more on these and other strategies, see the cited sources for this section.

Home visits or online SUD counseling may be good options for individuals with disabilities who cannot participate in your program in person for reasons related to their disabilities.

Selected Tips on SUD Counseling for People With Physical Disabilities

Suggestions are:[62, 63, 64, 65, 66]

- Incorporating role-playing and storytelling when working with clients who are deaf.
- For a group member who uses a sign language interpreter, reminding other group members to take turns speaking and to address the member who is deaf, not the interpreter.
- If a group member is blind, reminding other group members to let him or her know when they join or leave the meeting.
- If a group member with a physical disability cannot sit for long periods of time, arranging for brief breaks in the meeting.

- Keeping in mind when scheduling appointments that some individuals with physical disabilities have limited transportation options or require a significant amount of time in the morning for hygiene and dressing routines.

Selected Tips on Adapting Mental Disorder treatments for people with cognitive disabilities:

A number of professional organizations have developed best practices for the population of individuals with mental illness and cognitive disabilities.

The Mental Health and Developmental Disabilities National Training Center (MHDD-NTC)., supported by the Administration for Community Living, has been funded and provides technical assistance in the form of webinars, fact sheets, and other curricula to support care for this population.

The Mental Health Technology Transfer Center (MHTTC), supported by the Substance Abuse Mental Health Services Administration, has resources specific to individuals with mental health and co-occurring cognitive disabilities.

Innovative Approaches to Serving Clients With Cognitive Disabilities

The nonprofit Vinland National Center in Minnesota provides specialized residential and outpatient SUD treatment services for adults with cognitive impairments. Two promising practices used at Vinland that other providers can potentially replicate are:[67, 68]

- An adaptation—by Vinland and the Center for Spirituality and Healing at the University of Minnesota—of the evidenced-based Mindfulness-Based Stress Reduction program.
  - Vinland's adapted program for clients with SUD and cognitive impairment addresses such challenges as low frustration tolerance, depression, and impulsivity.
- Group work that follows the evidence-based Illness Management and Recovery (IMR) model, originally developed for people with severe mental illness (see *https://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/sma09-4463*).
  - Vinland's adapted group work approach includes problem solving, coping with stress, and goal setting.

Peer Recovery Support Groups and People With Disabilities

Your clients with physical and cognitive disabilities can face physical, attitudinal, communication, and cognitive barriers to participating in peer recovery support, or mutual-help, groups. These suggestions and resources will help you assist these clients in participating in such groups:

- Some Alcoholics Anonymous (AA) areas and districts now have accessibility committees (also called special needs committees) that work to meet participants' access needs by, for example, providing Braille materials, wheelchair ramps, sign language interpretation, or easy-to-read literature. Call or check the websites of your local AA area and districts to learn about their accessibility efforts. (See *www.aa.org* for a locator.)
- You can find a list of online AA meetings for people who are deaf or hard of hearing at *www.aa-intergroup.org/directory_dhoh.php*.
- Clients with or without disabilities who take OUD medications or other medications with abuse potential may feel uncomfortable in 12-Step meetings where some members believe in total abstinence.
- You can help prepare a client with a cognitive disability to attend 12-Step meetings by explaining what happens at them in simple terms beforehand.

* You can download a free manual on Enhanced IMR (E-IMR) for people with mental and substance use disorders from *http://mncamh.umn.edu/e-imr.* E-IMR incorporates IMR and Integrated Dual Disorder Treatment.

- While there is little specific research identifying the effectiveness of peers to improve outcomes in individuals with cognitive disabilities and mental health concerns, peers are likely to be helpful in supporting individuals in engagement and service navigation.
- The organization SMART Recovery supports appropriate use of prescribed medications. Find local and online meetings at *www.smartrecoverytest.org/local.*

Notes

1. Okoro, C. A., Hollis, N. D., Cyrus, A. C., & Griffin-Blake, S. (2018). Prevalence of disabilities and health care access by disability status and type among adults—United States, 2016. Morbidity and Mortality Weekly Report, 67(32), 882–887.
2. Brooks, G. I., DiNitto, D. M., Schaller, J., & Choi, N. G. (2014). Correlates of substance dependence among people with visual impairments. Journal of Visual Impairment and Blindness, 108(5), 428–433.
3. Substance Abuse and Mental Health Services Administration. (2011). Substance use disorders in people with physical and sensory disabilities. In Brief, Vol. 6, Issue 1.
4. Taggart, L., & Chaplin, E. (2014). Substance misuse. In J. L. Matson (Series Ed.), E. Tsakanikos & J. McCarthy (Vol. Eds.), Autism and Child Psychopathology Series: Handbook of psychopathology in intellectual disability: Research, practice, and policy (pp. 205–223). New York, NY: Springer.
5. Brooks et al. (2014).
6. Substance Abuse and Mental Health Services Administration. (2011).
7. Hammink, A. B., VanDerNagel, J., & van de Mheen, D. (2015). Dual disorders: Mild intellectual disability and substance abuse. In G. Dom & F. Moggi (Eds.), Co-occurring addictive and psychiatric disorders: A practice-based handbook from a European perspective (pp. 205–220). Berlin, Germany: Springer.
8. Taggart & Chaplin. (2014).
9. DiNitto, D. M., & Webb, D. K. (2012). Substance use disorders and co-occurring disabilities. In C. A. McNeece & D. M. DiNitto (Eds.), Chemical dependency: A systems approach (4th ed., pp. 354–406). Boston, MA: Pearson.
10. Glazier, R. E., & Kling, R. N. (2013). Recent trends in substance abuse among persons with disabilities compared to that of persons without disabilities. Disability and Health Journal, 6, 107–115.
11. Ebener, D. J., & Smedema, S. M. (2011). Physical disability and substance use disorders: A convergence of adaptation and recovery. Rehabilitation Counseling Bulletin, 54(3), 131–141.
12. American Association on Intellectual and Developmental Disabilities. (n.d.). Frequently asked questions on intellectual disability. Retrieved June 3, 2019, from https://aaidd.org/intellectual-disability/definition/faqs-on-intellectual-disability
13. Novotna et al. (2017).
14. Novotna et al. (2017).
15. National Institute on Disability, Independent Living, and Rehabilitation Research. (2018). Summary of responses from a Request for Information: People with disabilities and opioid use disorder. Retrieved June 3, 2019, through https://acl.gov/news-and-events/announcements/summary-responses-request-information-people-disabilities-and-opioid
16. Decker, J. W. (2016). Substance abuse in people with intellectual disabilities [PowerPoint slides]. Retrieved June 3, 2019, from www.uscucedd.org/component/jdownloads/send/18-dual-diagnosis-conference/156-slides-substance-abuse-in-people-with-intellectual-disabilities
17. Novotna et al. (2017).
18. West, S. L. (2007). The accessibility of substance abuse treatment facilities in the United States for persons with disabilities. Journal of Substance Abuse Treatment, 33(1), 1–5.
19. Bowen, I. (2015). Renewing the commitment: An ADA compliance guide for nonprofits. Chicago, IL: Chicago Community Trust.
20. Bowen. (2015).
21. Novotna et al. (2017).
22. Moore, D., & Lorber, C. (2005). Clinical characteristics and staff training needs of two substance use disorder treatment programs

specialized for persons with disabilities. Journal of Teaching in the Addictions, 3(1), 3–20.
23. Grant, T., Novick Brown, N., Graham, J., & Ernst, C. (2014). Substance abuse treatment outcomes in women with fetal alcohol spectrum disorder. International Journal of Alcohol and Drug Research, 3(1), 43–49.
24. Sacks, A. L., Fenske, C. L., Gordon, W. A., Hibbard, M. R., Perez, K., Brandau, S., … Spielman, L. A. (2009). Co-morbidity of substance abuse and traumatic brain injury. Journal of Dual Diagnosis, 5(3–4), 404–417.
25. Marceau, E. M., Lunn, J., Berry, J., Kelly, P. J., & Solowij, N. (2016). The Montreal Cognitive Assessment (MoCA) is sensitive to head injury and cognitive impairment in a residential alcohol and other drug therapeutic community. Journal of Substance Abuse Treatment, 66, 30–36.
26. Substance Abuse and Mental Health Services Administration. (2009). Know your rights: Rights for individuals on medication-assisted treatment. HHS Publication No. (SMA) 09-4449. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.
27. Grant, T. M., Brown, N. N., Graham, J. C., Whitney, N., Dubovsky, D., & Nelson, L. (2013). Screening in treatment programs for fetal alcohol spectrum disorders that could affect therapeutic progress. International Journal of Alcohol and Drug Research, 2(3), 37–49.
28. Sacks et al. (2009).
29. Grant et al. (2014).
30. Aharonovich, E., Hasin, D. S., Nunes, E. V., Stohl, M., Cannizzaro, D., Sarvet, A., … Genece, K. G. (2018). Modified cognitive behavioral therapy (M-CBT) for cocaine dependence: Development of treatment for cognitively impaired users and results from a Stage 1 trial. Psychology of Addictive Behaviors, 32(7), 800–811.
31. Allan, J., Collings, S., & Munro, A. (2019). The process of change for people with cognitive impairment in a residential rehabilitation program for substance problems: a phenomenographical analysis. Substance Abuse Treatment, Prevention, and Policy, 14(1), 1–11. doi:10.1186/s13011-019-0200-y
32. Novotna et al. (2017).
33. Taggart & Chaplin. (2014).
34. Bauman, S., & Shaw, L. R. (2016). Group work with persons with disabilities. Alexandria, VA: American Counseling Association.
35. Pearson, A. (2016). Addressing the challenges: Brain injury and substance use disorders [PowerPoint slides]. Retrieved June 3, 2019, from www.naadac.org/assets/2416/annette_pearson_addressing_the_challenges_ac16.pdf
36. Network of Alcohol and Drug Agencies. (2013). Complex needs capable: A practice resource for drug and alcohol services. Sydney, Australia: Author.
37. Marceau et al. (2016).
38. Hagen, E., Sømhovd, M., Hesse, M., Arnevik, E. A., & Erga, A. H. (2019). Measuring cognitive impairment in young adults with polysubstance use disorder with MoCA or BRIEF-A: The significance of psychiatric symptoms. Journal of Substance Abuse Treatment, 97, 21–27.
39. Substance Abuse and Mental Health Services Administration. (2011).
40. Hart, T., Fann, J. R., Brockway, J. A., & Maiuro, R. D. (2017). Treatment of anger and aggression following acquired brain injury. In P. Sturmey (Ed.), The Wiley handbook of violence and aggression (pp. 1–13). doi:10.1002/9781119057574.whbva080
41. Erickson, S. R., Nicaj, D., & Barron, S. (2018) Complexity of medication regimens of people with intellectual and developmental disabilities. Journal of Intellectual and Developmental Disability, 43(3), 351–361.
42. Substance Abuse and Mental Health Services Administration. (2018). Medications for opioid use disorder. Treatment Improvement Protocol (TIP) Series 63, Full Document. HHS Publication No. (SMA) 18-5063FULLDOC. Rockville, MD: Substance Abuse and Mental Health Services Administration.
43. Carroll Chapman, S. L., & Wu, L. T. (2012). Substance abuse among individuals with intellectual disabilities. Research in Developmental Disabilities, 33(4), 1147–1156.
44. Krahn, G. L., Walker, D. K., & Correa-De-Araujo, R. (2015). Persons with disabilities as an unrecognized health disparity population. American Journal of Public Health, 105(Suppl. 2), S198–S206.
45. National Institute on Disability, Independent Living, and Rehabilitation Research. (2018).
46. Lauer, E. A., Henly, M., & Brucker, D. L. (2018). Prescription opioid behaviors among adults with and without disabilities—United States, 2015–2016. Disability and Health Journal. Advance online publication. doi:10.1016/j.dhjo.2018.12.001
47. Larson, S. A., Eschenbacher, H. J., Anderson, L. L., Taylor, B., Pettingell, S., Hewitt, A., … Bourne, M. L. (2018). In-home and residential long-term supports and services for persons with intellectual or developmental disabilities: Status and trends through 2016. Minneapolis, MN: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.
48. Didden, R. (2017). Substance use and abuse in individuals with mild intellectual disability or borderline intellectual functioning: An

introduction to the special section. Research in Developmental Disabilities, 63, 95–98.
49. Aharonovich et al. (2018).
50. Taggart & Chaplin. (2014).
51. Bauman & Shaw. (2016).
52. Pearson. (2016).
53. Gavriel, M. (2018). ASAM 3.3 decoded: The nuts and bolts of clinically managed, population specific, high intensity residential services [PowerPoint slides]. Retrieved June 3, 2019, from www.cibhs.org/sites/main/files/file-attachments/asam_3.3_decoded.pptx
54. Dubovsky, D. (2016). Improving outcomes in psychiatric treatment by recognizing the impact of fetal alcohol spectrum disorders and modifying approaches [PowerPoint slides]. Retrieved June 3, 2019, from https://ubmm.med.buffalo.edu/uploads/MMU3/9-16-2016%20Buffalo%20Grand%20Rounds%20presentation%20September%2016%202016.pdf
55. Decker. (2016).
56. Network of Alcohol and Drug Agencies. (2013).
57. SAMHSA-HRSA Center for Integrated Health Solutions. (n.d.). Relaxation response. Retrieved June 3, 2019, from www.integration.samhsa.gov/health-wellness/wham/relaxation-response
58. Allan et al. (2019).
59. Hammink et al. (2015).
60. Network of Alcohol and Drug Agencies. (2013).
61. Decker. (2016).
62. Ficchi, G., Shaw, L. R., & Bauman, S. (2016). Physical disabilities. In Group work with persons with disabilities (pp. 169–178). Alexandria, VA: American Counseling Association.
63. Guthmann, D., & Sternfeld, C. (2013). Substance abuse treatment and recovery: Adaptations to best practices when working with culturally Deaf persons. In N. S. Glickman (Ed.), Deaf mental health care (pp. 234–267). New York, NY: Routledge/Taylor & Francis Group.
64. Ficchi, G., Shaw, L. R., & Bauman, S. (2016).
65. DiNitto & Webb. (2012).
66. Artman, L. K., & Daniels, J. A. (2010). Disability and psychotherapy practice: Cultural competence and practical tips. Professional Psychology: Research and Practice, 41(5), 442–448.
67. Kristofersson, G. K., Beckers, T., & Krueger, R. (2016). Perceptions of an adapted mindfulness program for persons experiencing substance use disorders and traumatic brain injury. Journal of Addictions Nursing, 27(4), 247–253.
68. Krueger, R. (2017). Integrated treatment of substance use disorders and mental health and cognitive challenges [PowerPoint slides]. Retrieved June 3, 2019, from http://biaw.org/wp-content/uploads/2017/04/Krueger-Integrated-Treatment-of-Subst-Abuse-.pdf
69. Alcoholics Anonymous General Service Office. (2016). A.A. guidelines: Accessibility for all alcoholics. Retrieved June 3, 2019, from www.aa.org/assets/en_US/mg-16_accessibilityforallalcoholics.pdf
70. Pearson. (2016).

Advisory

This Advisory was written and produced under contract number 270-14-0445 by the Knowledge Application Program (KAP) for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Suzanne Wise served as the Contracting Officer's Representative (COR), Candi Byrne served as the Alternate COR, and Kirk E. James, M.D., served as the Product Champion.

Substance Abuse and Mental Health Services Administration. (2019). Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities. Advisory.