SECOND NATIONAL CONFERENCE ON SUBSTANCE ABUSE AND COEXISTING DISABILITIES

Facilitating Employment for a Hidden Population

June 3 – 5, 2001, Baltimore, Maryland

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Facilitating Employment for a Hidden Population

Edited by

Eileen Wolkstein, Ph. D., CRC

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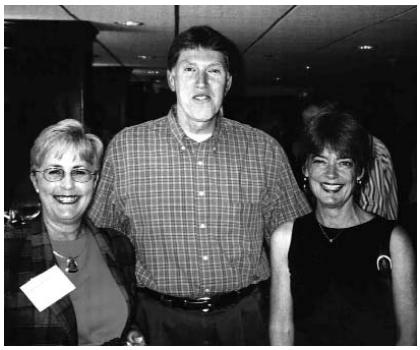





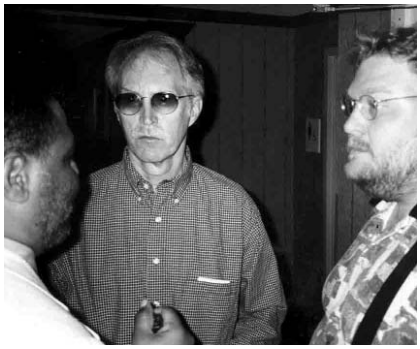


Conference Participants

Sue Rohrer, CSAT opening remarks.

CHAPTER ONE

INTRODUCTION

Despite passage of the Americans with Disabilities Act (ADA), a lack of programmatic, attitudinal, and architectural access continues to bar individuals with substance abuse problems and coexisting disabilities from participating in most State and Federally funded treatment programs. Further, although work provides individuals in recovery with the opportunity to enhance self-esteem, build confidence, and reintegrate as productive members of society, substance abuse treatment programs have traditionally paid very little attention to employment outcomes (Platt, 1995). This combined lack of access to treatment and low emphasis on vocational rehabilitation creates significant barriers to meaningful recovery for persons with coexisting disabilities. It is incumbent on the systems that serve these individuals to strengthen collaborative efforts, with the goals of increasing access to services and prioritizing employment as an integral part of successful treatment. Key systems include, at a minimum, substance abuse treatment, vocational rehabilitation, mental health treatment, and others whose missions include the preparation of individuals with coexisting disabilities for placement in the work force. Effective communication across disciplines is the first step toward shedding light on the extent of this staggering, yet hidden problem. The next step is a plan to remedy it.

The Second National Conference on Substance Abuse and Coexisting Disabilities

On June 3-5, 2001, nearly 150 leaders in the fields of treatment, policy, research, and consumer advocacy convened in Baltimore to work toward consensus on issues that have the potential to improve recovery and employment services for individuals with multiple disabilities. The invited participants represented consumer and disability advocacy groups, community-based organizations, government agencies, and academia. All have demonstrated a strong commitment to the advancement of knowledge and practice related to substance abuse, coexisting disabilities, and vocational rehabilitation.

This document presents the process and outcomes of this second national conference on substance abuse and coexisting disabilities, entitled "Facilitating Employment for a Hidden Population". The conference was sponsored by the joint efforts of:

Frank Corrigan, NIDRR opening remarks

- The Substance Abuse and Mental Health Services Administration, Center on Substance Abuse Treatment (SAMHSA/CSAT), through a Knowledge Dissemination Conference Grant
- The Rehabilitation Research and Training Center (RRTC) on Drugs and Disability, funded by NIDRR
- The National, DC/Delaware, Mid-Atlantic and Prairielands Addiction Technology Transfer Centers (ATTCs), funded by (SAMHSA/CSAT)
- The National Association on Alcohol, Drugs and Disability (NAADD), and
- The National Council on Rehabilitation Education (NCRE)

The Conference Web Site

Prior to the conference, a web site was established to provide an ongoing opportunity for dialogue and dissemination of information on substance abuse and coexisting disabilities. (See www.danya.com/rrtc). Discussion themes on this issue were introduced on a message board and online dialogue was encouraged. An Internet exchange on employment needs in treatment was one result of this opportunity for dialogue.

In the future, the web site will serve as a vehicle for dissemination of conference proceedings and consensus statements. Continued dialogue related to outcomes available to all stakeholders. This electronic forum has allowed for input from all groups in shaping the tone of the conference and it will continue to evolve in response to the needs of the multidisciplinary fields represented.

The Change Process

Conference participants were chosen to accomplish this step for change: organize a team for addressing the problem. From The Change Book (CSAT, 2000)

The 2-day conference included a presentation by Dr. Steve Gallon, Director of the Northwest Frontier ATTC, on the context and strategies necessary for effective change. His remarks were based on a synthesis of research on change published in The Change Book: A Blueprint for Technology Transfer (CSAT, 2000). These concepts are summarized in Chapter 4 of this document: The Conference Change Process. With this foundation, Dr. Gallon then presented the framework within which those in attendance would be asked to achieve conference objectives.

Work Groups on Day 1 were be asked to focus on consensus building around promising methods for addressing the treatment and rehabilitation needs of persons with substance abuse and coexisting disabilities. On Day 2, the Work Groups were charged with formulating specific

action plans for change based on the outcomes of Day 1. All Work Groups were structured to include both a facilitator and a content expert, with content experts providing brief summaries of best practices in a particular content area and serving as a resource to the group, and facilitators helping the group accomplish a structured set of objectives. Dr. Gallon explained that the full participant group would be asked to reconvene after their individual sessions to formulate final consensus statements.

Identifying the Problem and Articulating Desired Outcomes: The Plenary Sessions

Plenary Sessions Addressed These Steps for Change: 1) Assess the organization or agency, 2) Identify the problem
From The Change Book (CSAT, 2000)

During the plenary sessions, participants heard from leaders in a variety of disciplines, who presented their perspectives on treatment and rehabilitation approaches for persons with substance abuse and coexisting disabilities. The sessions began with an identification of the problem, specifically addressing the relationship between employment rates and coexisting disabilities. Subsequent plenary sessions presented the field's expertise in the following areas:

- Assessing the sociopolitical environment for treatment, rehabilitation, and employment
- Identifying desired outcomes in treatment and rehabilitation; and
- Identifying desired outcomes in employment, education, and training.

Issue-Focused Work Groups

Day 1: Work Groups Addressed These Steps for Change: 1) Assess the organization or agency and specific audience(s) to be targeted, 2) Identify the approach most likely to achieve the desired outcome.
From The Change Book (CSAT, 2000)

Following the plenary presentations on research and practice, participants reconvened in five issue-focused Work Groups. On Day 1, the goal was for each group to identify three outcomes for change, listed in order of priority. Each of the Work Groups was charged with addressing one of the following areas: 1) Integrated Substance Abuse and Rehabilitation Services; 2) Employment Needs and Outcomes; 3) Dual Substance Abuse and Mental Disorders; 4) Substance Abuse and Cognitive, Physical, Sensory, and HIV Disabilities; and 5) Access to Treatment for Individuals with Coexisting Disabilities.

Action-Focused Work Groups

Day 2 Work Groups Addressed This Step for Change: Design action and maintenance plans for your change initiative. From The Change Book (CSAT, 2000)

On Day 2, action-focused Work Groups were formed with participants from Day 1 reassigned to different groups. They were asked to recommend action steps and strategies for at least two of the top priority outcomes identified by the previous day's Work Groups. The goal was a prioritized set of strategies that will contribute to the foundation of a national action plan for change. Topics addressed fell within the areas of: 1) Education and Training; 2) Policy and Advocacy; 3) Research Initiatives; 4) Professional Practice/Case Management; and 5) Integrated Programs and Approaches.

Subsequent to the development of the action plans, the groups proposed:

- Specific entities to take the lead in implementing the action plans (such as the Local, State, or Federal government; or private organizations),
- Time frames for completing the action plans (such as 6 months or 1 year), and
- A means for evaluation of the effectiveness of the proposed strategies (how out comes could be demonstrated).

The action strategies were presented to all participants at the conclusion of the conference. The Rehabilitation Research and Training Center (RRTC) pledged to move selected initiatives forward, with the ongoing assistance of the Work Groups. Conference delegates made individual commitments to assist with these national initiatives.

Summary

There is a large gap between the current knowledge, programming, and advocacy for individuals with coexisting disabilities and what we know is needed. Traditional substance abuse and rehabilitation service delivery systems will require bold changes if barriers and stigma are to be reduced, policy is to become more equal in opportunity, programs are to become more inclusive, and research is to define what works and what does not work.

The cross-representation at this conference was a meaningful step toward facilitating these types of changes. The various disciplines present informed each other, identified interagency barriers, and worked together toward a national plan that has the potential to improve access to treatment and employment for individuals with coexisting disabilities.

The RRTC will serve as the national coordinator of this effort and monitor progress in enhancing access to treatment for people with coexisting disabilities, integrating vocational concerns into substance abuse treatment settings, and improving employment outcomes for treatment graduates.

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Introductions: Dennis Moore and sign language interpreter

Participants

CHAPTER TWO

BACKGROUND AND NEED

Persons with one or more disabilities currently comprise approximately 14.5 percent of the population in the United States (LaPlante, 1992). Because of related functional limitations and the social stigma placed on those with disabilities, this population has continuously struggled with barriers to employment and a lack of access to community services (Nightingale, 2000). Many of these individuals also have substance abuse problems. The number of persons affected by the additional disability of substance abuse is grossly under-identified.

DiNitto and Schwab (1993) found that within the State vocational rehabilitation system, one third of those who had not been identified by an assigned rehabilitation counselor as having substance abuse problems screened positive for substance abuse. Other researchers believe the rates of substance abuse in this population are even higher, due to rehabilitation counselors' underestimation of the incidence of alcohol problems among clients with physical trauma (Ingraham, 1992). Twenty-five to sixty-eight percent of traumatic brain injury (TBI) patients have addiction histories (Sparadeo & Gill, 1990).

Persons with disabilities in need of substance abuse treatment often face a host of other life problems that create complex barriers to recovery. Secondary conditions requiring attention may include: unemployment, poverty, and a lack of education; HIV/AIDS or other medical conditions; a history of abuse, neglect, or violence; or involvement with the criminal justice system (Siegal, 1996; Simpson et al., 1999; Rounds-Bryant et al., 1999). Increasing percentages of persons in treatment are struggling with mental health disorders, traumatic brain injury, learning disabilities, or attention deficit/hyperactivity disorder. Recent data from the New York State Office of Alcoholism and Substance Abuse Services (OASAS) database revealed that the percentage of individuals in treatment with coexisting disabilities is approximately 33 percent (OASAS, 1998; RRTC, 1995). Substance abuse treatment programs face nearly insurmountable challenges when attempting to provide the full range of medical and ancillary services needed by these clients. With limited program resources and within the time constraints imposed by managed care and Medicaid, client needs must be prioritized to facilitate access to services that will yield the most significant outcomes.

Employment is considered the primary vehicle for reintegrating clients into the community as productive and contributing members of society (Platt, 1995). Improvement in employment correlates positively with improvement in each of the seven areas examined by the Addiction Severity Index (Siegal et. al, 1996), including psychological status, family and social relationships, and alcohol/drug use (Comerford, 1999). Substance abuse treatment with employment-related components has been shown to positively impact post-treatment functioning in the number of days employed, monthly income, absenteeism, and on-the-job problems (Gerstein et al., 1994; Young, 1994). In addition to contributing to successful outcomes in treatment, employment plays a critical role in retention and in the reduction of the occurrence and severity of relapse (Peters, Witty, & O'Brien, 1993; Platt, 1995; Wolkstein & Spiller, 1998). As 70 percent of all individuals in treatment are currently unemployed (Comerford, 1999), the role of vocational rehabilitation in substance abuse treatment must become a high priority, one that is integral to the treatment process.

Substance abuse treatment programs face nearly insurmountable challenges when attempting to provide the full range of medical and ancillary services needed by clients with coexisting disabilities.

The Second National Conference on Substance Abuse and Coexisting Disabilities was held with the goal of recommending positive changes in the substance abuse treatment system, the vocational rehabilitation system, and other entities that work to improve employment outcomes for individuals with coexisting disabilities through policy, practice, education, and research. Through both plenary sessions and workshops, efforts were made to increase the knowledge and skills of substance abuse treatment and disability rehabilitation providers on promising and best practices related to employment outcomes for people with coexisting disabilities. The ultimate goal is to generate change in these areas on the Local, State, and National levels.

The following section details the information presented in the four conference Plenary sessions. These sessions provided a snapshot of current policies, practices, research, and education related to disability, substance abuse, and employment.

Topics included:

- The history of efforts to address coexisting disabilities
- The importance of employment for individuals with disabilities, and strategies for improved outcomes
- Current prevalence data on the problem
- The personal experience of a consumer of the substance abuse treatment and vocational rehabilitation systems
- Treatment of co-existing mental health and substance abuse disorders
- A program that allows students a dual career track for rehabilitation counseling and substance abuse treatment
- An integrated case management model for those with TBI disabilities and substance abuse disorders

- Research on public and private employment policy and practices affecting those with disabilities, and
- National, State, and Local policy issues, including a description of the barriers and opportunities presented by current Federal legislation.

This "report from the field" laid the groundwork for the workshop activities that followed during the 2-day conference.

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Plenary speakers: Dennis Moore, James Billy, John de Miranda

CHAPTER THREE

PLENARY ADDRESSES AND LUNCHEON PRESENTATIONS

PLENARY 1: PREREQUISITE FOR CHANGE: IDENTIFYING THE PROBLEM

Plenary 1, Session 1: Introduction to the Issues

Presenter: Dennis Moore, Ed.D., Director, RRTC on Drugs and Disability

There are significant discrepancies in the employment rate between individuals with disabilities and those without disabilities and among those who have substance abuse problems and those who don't. The relationship among these factors is fairly complex and requires multiple levels of analysis.

PREVALENCE OF SUBSTANCE USE DISORDERS, DISABILITY, AND UNEMPLOYMENT

Based on U.S. Census Data for 2000, the employment rate for men without a disability in the years between 1994 and 1998 was 95 percent. For men with a disability, the employment rate during those same years was 36.2 percent. One conclusion of Substance Abuse and Mental Health Services Administration's (SAMHSA) 1999 National Household Survey on Drug Abuse was that "Unemployed persons 26 and older were almost twice as likely as full-time employed persons of that age to be heavy drinkers (12.6 percent compared to 6.2 percent)". The fact is, many with disabilities live in poverty, have poor access to treatment services, and are risk of being left further behind.

Following are several assumptions about substance abuse among persons with co-existing disabilities:

- There is a high prevalence of substance use disability (SUD) among persons with disabilities that seek employment. There is some debate about whether substance use is higher among those with disabilities.

- However, persons with disabilities certainly have difficulty accessing appropriate chemical dependency treatment.
- Several stigma issues impede progress. Stigma plays a role in how we see the situation and how we formulate solutions.
- Successful approaches must be interdisciplinary and cross-cultural.
- Involvement of the disability community is pivotal to success. Advocates have been reluctant to enter this field in the past.
- The government needs to play a pivotal role in finding solutions in terms of both policy and funding. The Federal role is important due to this problem's cost and complexity.

The epidemiology and prevalence data on co-existing conditions is not clear. There are few studies on the rate of SUD among persons who are deaf or blind.

We need to explore better methods for identifying and referring individuals with alcohol and other drug (AOD) problems. Currently, treatment and employment approaches for co-existing issues vary from one program to another and from one office to another, even within the same State system. These different systems need a common language and terminology and more standardization in the type and phasing of treatment components. We need improved methods for collaborating across agencies, populations, and services. One of the greatest barriers for people with disabilities is access to existing AOD and community resources. We need paradigms for describing and educating people about these issues.

One of the greatest barriers for people with disabilities is access to existing AOD and community resources. We need paradigms for describing and educating people about these issues.

To address these problems, we need a thorough understanding of the roles of the single State substance abuse agencies (SSAs) and of legislation such as Americans with Disabilities Act (ADA) and Temporary Assistance to Needy Families (TANF). Analysis of the resources within these agencies and the requirements of current legislation could lead to innovative solutions to some of the problems we face.

Incidence and prevalence data are unclear, in part because persons with disabilities, collectively and as separate disability groups, are not well understood relative to substance abuse disorders. There are many persons with co-existing conditions already in AOD treatment but the disability is not reported at intake and clients are not getting the services they need. How do we identify the number that needs treatment?

NEW YORK OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES DATA

The State of New York has probably done the best job in the country of serving this population. They have been proactive in this field for over 10 years. The following data comes from New York's single State agency for substance abuse treatment (known as OASAS) for the year 1999.

Based on these data, we see that if an individual has only one disability, it is not mental illness in 70 percent of these cases. We need to better address the needs of these individuals.

DISABILITY REPORTED AT INTAKE BY LICENSED CD PROGRAMS

(N=146,782)

Persons Entering Treatment:	**12.3%**	Have Another Disability
Persons Entering Treatment:	**17.7%**	Have Two or More Other Disabilities
TOTAL **30.0%**		
CD+ One Other Disability:	**28.3%**	The Disability is Mental Illness
CD+ Two or More Other Disabilities:	**91.7%**	Mental Illness is One of the disabilities

(Moore, D. & Weber, J., 2000)

For the year 1999, SAMHSA estimated the number of persons with disabilities in the U.S. needing AOD treatment services using a formula based on the number of persons currently served and the estimated SUD rates in the general population. The estimate for all individuals needing AOD treatment is 3 to 5 million. The estimate for those with disabilities in need of AOD treatment is from 396,000 to 660,000. This is based on the assumption that persons with disabilities are equally likely to experience SUD problems as the general population, and averages disability prevalence from the U.S. Census, S.I.P.P., and the Department of Education.

However, data from New York State (based on the observed rate of recorded disability in the OASAS 1999 treatment episode data set) estimates that 903,000 to 1,505,000 individuals with disabilities are in need of treatment. Compare this number (one and a half million individuals with disabilities needing treatment) to the total number of ALL people receiving AOD treatment last year: 1.8 million.

CLASSIFICATION OF PERSONS WITH DISABILITIES AND SUBSTANCE USE DISORDER PROBLEMS

Classification of persons with disabilities and substance use disorder (SUD)problems may be seen as falling into three categories:

- A. SUD is primary and acknowledged
- B. SUD is acknowledged but not the focus of service
- C. SUD is hidden, active, and not identified or treated

The course of rehabilitation and prognosis is quite different for each. Those in category A. are ideal candidates for a vocational rehabilitation (VR) counselor. Those in category B. enter treatment with multiple conditions; substance abuse disorders are often not coded or are secondary. In category C., individuals are actively hiding their substance abuse disorder.

Those diagnosed with SUD as either primary or secondary represent 10 percent of the vocational rehabilitation population, according to official records. However, the number that self-identify as drug addicts or alcoholics in recovery is nearly 25 percent of all consumers we survey, regardless of the officially listed disability. Of most concern is the number of individuals that don't tell their counselor about prior SUD problems: 41 percent with an acknowledged problem report not telling the counselor about this problem.

ALCOHOL AND OTHER DRUG (AOD) TREATMENT BARRIERS

Barriers to AOD treatment are of several types. Attitudinal barriers are very pervasive. Substance abuse treatment counselors may state, "They just don't come to our door." Discriminatory policies and practices constitute another significant barrier. Communication barriers arise when the counselor cannot communicate in a way the consumer understands. Individuals with brain trauma or ADHD could represent a substantial number of people in treatment. And finally, architectural barriers prevent physical access.

Barriers to AOD treatment are of several types:

- Pervasive attitudinal barriers
- Discriminatory policies and practices
- Communication barriers between counselors and clients
- Architectural barriers that prevent physical access

Current changes in American's With Disabilities Act (ADA) interpretation, legislative responses to substance abuse, and reductions in Federal data-gathering responsibilities may impede progress:

- The ADA qualification based on "corrected" state may be problematic for persons with mental illness (Petrila and Brink, 2001) or substance use disorders.
- Changes such as SSA rules for "drug addicts and alcoholics" may make the most vulnerable individuals even more disenfranchised (Gresenz, et al. 1998).
- Reductions in Federal roles in AOD or VR systems may make it more difficult to compile national databases.

Plenary 1: James Billy (left) & Dennis Moore

These policy changes fall most heavily on those who need services the most. The Federal government is giving more power to the States and decreasing the Federal database we need to make a case for increased services.

Future prevalence of substance abuse may increase in disability and rehabilitation censuses due to:

- Social conditions (e.g., poverty)
- Increasing co-morbidity
- Inaccessible or inflexible treatment
- Lack of cross-trained personnel
- Health care cost containment leading to short duration of treatment
- Lack of policies to address co-existing conditions.

For all of these reasons, we may see an increase in treatment problems in the future. These are issues we need to keep in mind as work together during the next 2 days.

Plenary 1, Session 2: Looking Back, Surveying the Present, Moving Forward

Presenter: John de Miranda, M.Ed., Executive Director, National Association for Alcohol, Drugs and Disability

The late Grateful Dead member, Jerry Garcia once said, "What a long, strange trip it's been." I share this sentiment when I think of the time some 17 years ago when I stumbled upon the alcohol, drugs, and disability issue by attending a meeting at Stanford University made up of individuals who were concerned about the lack of access to alcohol and drug services in my county. Over the course of the long, strange trip that I have traveled to get here today, I have met some extraordinary individuals. I call these individuals the heroes of the alcohol, drug, and disability movement. There have been dozens, but I'd like to tell you about just a few of these heroes.

- Pete Anderson worked at a large alcohol treatment program in Los Angeles. A community organizer and political activist in the late 1980s, he was a constant thorn in the side of California State government for their failure to ensure compliance with Section 504 of the Rehabilitation Act. Finally, frustrated with the pace of change and armed with a new tool, The Americans with Disabilities Act of 1990 (ADA), Pete filed a lawsuit that required a massive effort on the part of our State AOD agency over 3 years to improve compliance with the law.
- The late Alex Boros, a professor at Kent State University, developed an approach to translating the abstract concepts of treatment and recovery into pictures of understanding and access for people who are deaf or have cognitive impairments. When we needed a speaker at our first local conference on Attention Deficit Disorder (ADD) in San Mateo, CA, we looked out across the United States and saw only Alex. He came at our beckoning and challenged us to get to work.
- John Callahan, cartoonist, recovering person, and quadriplegic, who inspired us with his autobiography of spinal cord injury, recovery, and humor, "Don't Worry, He Won't Get Far on Foot: The Autobiography of a Dangerous Man." When I was writing a book on spinal cord injury and addictions, John generously gave me permission to use some of his wonderful, outrageous cartoons.
- Judy Smith, founding member of the internationally acclaimed abled/disabled Axis Dance troupe, who graciously shared her story of recovery when I was trying to understand the many and varied roads into recovery that people with disabilities are often forced to travel because of the inaccessibility of traditional recovery services. In Judy's case, when the 12-step meeting she was attending moved upstairs in a building with no elevators, her martial arts instructor challenged her to develop a personal program of movement and spirituality that would sustain her as she made the transition to a sober life.

And there are many, many more folks I have met along my strange trip, and I'm sure that many of you could add to that list of heroes.

THE NATIONAL ASSOCIATION OF ALCOHOL, DRUGS, AND DISABILITY (NAADD)

Our organization, the National Association of Alcohol, Drugs, and Disability, has been at the center of much of the activity in recent years to improve AOD services for people with disabilities. I would like to tell you about our work and some of the accomplishments that we have shared with many of you in this room.

The purpose of the National Association on Alcohol, Drugs and Disability, Inc. is to promote awareness and education about issues of substance abuse among people with disabilities and to foster full access to all prevention and treatment services. NAADD is the only national organization exclusively focused on the issue of alcohol and drug problems among people with disabilities. Our mission is to remove barriers to alcohol and drug treatment and prevention services for people with disabilities. We accomplish this mission through the collaborative efforts of committed individuals and organizations nationwide.

NAADD holds the following values:

- People with disabilities have a right to accessible alcohol and other drug services.
- Alcoholism and addiction are disabilities.
- All programs and services should be fully accessible: physically, attitudinally, and programmatically.

Members of our Board of Directors are from California, Oregon, Kansas, Arizona, Illinois, Massachusetts, Arkansas, New York, New Jersey, Florida, Wisconsin, Tennessee, and Texas. Fifty-one percent of our Board must be composed of people with disabilities. The disabilities represented include blindness, quadriplegia, HIV, cerebral palsy, and addiction.

NAADD networks with individuals and organizations to share information, strategies, resources, and ideas. We provide a Federal, State and local presence to increase funding opportunities for high-quality research and innovative programming. We also generate, disseminate, and archive information through a national newsletter, the Internet, and journal articles. We convene regional and national conferences and trainings and advocate for policy recommendations designed to improve access and increase awareness.

MILESTONES

NAADD was formed in Chicago in 1996 at the first national conference on drugs and disabilities. In January 1999, the Access Limited report was released (National Press Club, Washington, DC). The Access Unlimited Coalition was also formed that year. In 2000, CSAT's Treatment Improvement Protocol (TIP) 29 on substance abuse treatment for persons with disabilities was produced. Also in 2000, the National Access project was funded by the Robert Wood Johnson Foundation and the Silent Storm video was produced. This year, the California Technical Assistance Project began.

Other recent milestones include the opening of the Belmont, California office, the growth of the Access Unlimited Coalition to more than 100 member organizations, and NAADD trainings

conducted in Oregon, Arizona, Ohio, California, and Florida. The Oregon and Ohio Attention Deficit Disorder (ADD) Stakeholder Coalitions were formed as part of the National Access Project and the Second National Conference on Drugs and Disabilities was held.

THE FUTURE

We have collectively traveled a long road to get here today. Despite the title of this conference, national meetings of people concerned with alcohol, drugs, and disability issues have actually occurred five times since the mid-1980s. After each of these gatherings we have seen renewed energy and a burst of activity. What might we see in the near future, in addition to the change that comes from the collective efforts as a result of this conference?

1. Standing: Perhaps most importantly, we are not going away. We have achieved critical mass. Our fledging network has become a movement, and our collection of advocates is on the cusp of becoming a professional field. Expect to see the mergence of the institutions that support a "field." Possibilities include a professional journal, regular national meetings, and a robust presence at national policy development tables.
2. Litigation: The promise of the Americans with Disabilities Act (ADA) will be kept. The disability community and the disability rights field are finally awakening to the fact that most Federal, State, and locally funded AOD service agencies are breaking the law. I believe we will see more complaints and a broadening of defendant categories to include Federal AOD policy and leadership bureaucracies.
3. Grassroots Leadership: People with disabilities in recovery are participating in the recovery advocacy movement. An excellent example of this is Harry Kressler's Pima Prevention Partnership in Tucson, as well as the efforts of NAADD Board members Hector DelValle and JR Harding in Florida. Look for more people with disabilities in recovery to assume positions of leadership as we move forward.
4. Funding: The Nation's largest health care philanthropy, The Robert Wood Johnson Foundation, is investing in us. State and Federal alcohol and drug and rehabilitation agencies are coming to the party. A glance at the list of conference sponsors and attendees here bears this out. Look for more funding and more interdisciplinary collaboration.

NAADD networks with individuals and organizations to share information, strategies, resources, and ideas. We provide a Federal, State and Local presence to increase funding opportunities for highquality research and innovative programming.

When I spoke at the last conference in Chicago in 1996 I said that I thought we had passed through the dark age and were poised at the start of a "golden age" for people with disabilities and access to services. Never one to shirk from affirming the accuracy of my pronouncement, I think I was right, and I think your collective participation in this historic event today is the evidence.

Plenary 1, Session 3: The Consumer's Perspective

Presenter: James Billy, M.A., CRC, Independent Living Branch Chief, Rehabilitation Services Administration

Good morning and welcome to the Second National Conference on Substance Abuse and Co-Existing Disabilities. I currently hold the position of Branch Chief for Independent Living at the Rehabilitative Service Administration at the Department of Education in Washington, DC. I state that for identification purposes only. The opinions I may express do not necessarily reflect the policy of the U.S. Department of Education and no official endorsement should be inferred. Prior to my appointment to the Department of Education, I was the Executive Director at the Harlem Independent Living Center in New York City. In addition, I was a Substance Abuse and Vocational Counselor at Odyssey House and at Veratas Residential Treatment Center.

My task today is to speak to you from a different perspective, and for the most part, this view is not always considered by today's service providers. Today I will share with you a view from the other side of the desk...the consumer's point of view.

But first we must acknowledge the fact that the real problem here is not just the abuse of substances, but the how and why substance abuse becomes an avocational/vocational goal and a pragmatic choice for many people who have disabilities. And why there is little evidence to support the notion that anything will change in the near future.

If we are to have a serious discussion about disability and substance abuse, we must begin with the flaws of the system, which are rooted in an archaic model of treatment coupled with longstanding stereotypes about people with disabilities.

The destruction and havoc manifested by the lifestyle of substance abuse and disability is well documented. Articles in rehabilitation journals point out the failures of the system. In some cases, vocational counselors detail at length the reasons why so many clients have achieved unsuccessful closures, and the beat goes on and another one bites the proverbial dust.

A vocational rehabilitation counselor once said, "It's harder to place a person with a coexisting disability of substance abuse than it to place a C4 quad." Persons with disabilities who also have substance abuse problems are always in and out of recovery, and they often fail to attend treatment.

The issue is not one of an individual's inabilities or limitations, but rather one of a hostile and unadaptive society. There are many obstacles that prevent inclusion into the mainstream, and this includes substance abuse treatment centers.

Why would an individual choose such a lifestyle? It's not always considered the most viable choice, but the only choice by the many that engage in these practices. If we are to have a serious discussion of disability and substance abuse, we must begin with the flaws of the system, which are rooted in an archaic model of treatment coupled with longstanding stereotypes about people with disabilities. Vocational rehab counselors say that people with disabilities sometimes see drug use as the only way to "get out of themselves," and are a substitute for other recreational activities. Drugs work; they can take you away from the stresses of the moment.

For most people with a disability, being disabled in America can mean living on other people's terms and by other people's rules. That's because the money used to care for the disabled

is largely government money and the government therefore makes the decisions about how that money can be spent. (Joel Shapiro, April 16, 2001, All Things Considered, National Public Radio)

A newspaper article stated "An unidentified person was found floating in the East River and police speculate that the incident is drug-related." The sensational aspect of this story is that the individual in the East River had been panhandling as a bilateral amputee in a wheelchair. However, he was actually a fraud. He had two fake prosthetic limbs and had been masquerading as a person with a disability to get money. He was appealing to what we call public sympathy. I bet the next time you see a poor handicapped individual soliciting money in the streets you will all probably wonder, "Hmmmmm..."

Now that's not to say that all the people with apparent disabilities who are attempting to supplement their fixed incomes by panhandling, or that the people seen on a "sympathy" telethon that raises millions of dollars over the years are frauds. But it does tend to perpetuate the negative public opinion that people with disabilities are to be pitied and can't help themselves.

Typically, people get their ideas about disability from a distance from non-disabled people who are "experts" or "specialists." But let's you and I talk somewhat first-hand. In my neighborhood, growing up in Harlem, there was "Cross-Eyed Dot," "Mike the Fin," who had one arm, "Lefty," Michael (a.k.a. "Step-and-a-Half)," and "Turtle Kelly," who stuttered. At the time, we didn't realize we were disabled, but we formed our own group because we didn't fit into the mainstream. All of these children developed extremely sophisticated compensatory strategies that allowed them to find a place in the street-life subculture. One child became a great basketball player.

Most treatment centers are working with people who have a disability without realizing it.

The requirements to join this "country club" were much less stringent than those of the typical mainstream social group, in which parents or money or elite schools gave them acceptance. Individuals with disabilities could act like the disability was no big deal and tell jokes about themselves or allow jokes to be played on them. If you did that, you were cool. This was the admissions card to the club and membership had its privileges. Often, a person with a disability becomes the group's mascot and is beloved by all.

Most treatment centers are working with people with disabilities without realizing it. At the Veritas Treatment Center, two thirds of the people tested had three things in common: they were mandated by the courts to a treatment center, they had problems with substance abuse, and all probably had a form of learning or physical disability.

The turning point in my career came when I was a vocational counselor. I had the opportunity to work with VR counselors who were also substance abuse counselors. A client called "Dorothy Two-Legs" wanted substance abuse treatment, but that presented a problem because the treatment program was situated upstairs. The staff didn't know how to work with her and they decided she wasn't "suitable for treatment." This client put up a fight to get treatment, but eventually she gave up and left. She felt it wasn't worth the fight and many other consumers also feel it isn't worth the fight. All she required was some assistive technology. But the system is not set up to deal with people with disabilities.

People with disabilities are five times more likely than non-disabled people to say that they are dissatisfied with their lives (24 percent versus 5 percent among adult respondents of the Harris survey). Although social integration is a main goal of disability policy, isolation is a problem for half of all people with disabilities. This social isolation is a major reason for unhappiness, second only to financial worries. Although families often provide critical support and assistance to members with disabilities, they are twice as likely as non-disabled people to live alone. People with disabilities tend to be hidden away and segregated from mainstream society, either in institutions or shut in at home. In the past, disability was treated purely as a medical issue; a pathological condition to be attended to by doctors, nurses, and rehabilitation specialists.

And today, people with disabilities socialize less with friends, including eating out, going to the movies, shopping, and attending church much less often than non-disabled people. Small, qualitative studies suggest that disability limits the ability of women, in particular, to find romantic partners and thus to form families. In addition, women who experience severe disability may be more likely to see their relationships dissolve as a result of the disability. In one study, half of the women who had relationships prior to their spinal cord injury endured the break-up of the relationships following their injury.

In closing, let me suggest that an alternative framework is needed to adequately describe the complexity of designing treatment programs to meet the needs of the person with the dual disabilities of substance abuse and disability. There is a need for better training and more cross-training. This may sound like an Americans with Disabilities Act (ADA) issue, and yes, this is true. But more importantly, and before the ADA is to have any real meaning, service providers need to understand the real needs of this population. Currently, those with disabilities often want to keep their substance abuse a secret because it will be one more strike against them. I ask you to work on creative strategies to deal with these issues. We have the power to make a change in the system.

PLENARY 2: ASSESSING THE SOCIOPOLITICAL ENVIRONMENT FOR TREATMENT, REHABILITATION, AND EMPLOYMENT

Plenary 2, Session 1: Policy Issues

Presenter: Dennis McCarty, Ph.D., Professor, Department of Public Health and Preventive Medicine, Oregon Health Sciences University

The work that needs to be done on these issues is messy, as this is largely uncharted territory. There is a high rate of unemployment for those with substance abuse disorders and disabilities. Linkages between service systems tend to be weak or non-existent. Today I will address key State and Federal policies currently in operation, as well as examples of strategies, barriers, and opportunities.

POLICY ENVIRONMENT AND ISSUES

The major legislation affecting policy in this area is the Americans with Disabilities Act (ADA), which requires physical access and encourages employment of people with disabilities. However, Congress recently decided that individuals with substance use disorders are no longer eligible for disability benefits. Yet many people are still not in the work force.

The Temporary Assistance to Needy Families (TANF) legislation replaced the AFDC welfare system. The TANF requirements assume work must be done to earn monetary benefits, which will terminate in 5 years. This system ultimately transfers responsibility to the States and away from the Federal government. Although the prevalence of drug problems in the disabled population is higher than the general population, it is even higher on the State welfare rolls. Those with the most serious problems are likely to remain on the welfare rolls, as they are least prepared for employment.

Although the prevalence of drug problems in the disabled population is higher than the general population, it is even higher on the State welfare rolls. Those with the most serious problems are likely to remain on the welfare rolls, as they are least prepared for employment.

There are problems in bringing various service systems together, as individuals may not meet the eligibility criteria for all systems. Systems that emphasize small, specialized, independent services will have a greater challenge coordinating care. In addition, there is a lack of economic and human resources, evidenced by the fact that most of the people working on these problems can fit in one hotel.

WASHINGTON STATE: LINKING VOCATIONAL AND AOD SERVICES

In Washington State, vocational and AOD services are linked. The Alcohol and Drug Abuse Treatment and Support Act (ADATSA, 1987) targeted indigent adults deemed unemployable and incapacitated because of addiction. The law required 6 months of chemical dependency treatment over a 2-year period. There was financial support while in treatment, but no welfare benefits for those not in treatment. The State Community Service Office determined financial eligibility and referred clients for an alcohol or drug assessment, if necessary.

The assessment determined whether there was "severe dependence" that left an individual unemployable, which was required by ADATSA for program eligibility. Those who qualified had a clinical substance abuse treatment plan approved and entered a three-phase program that included primary treatment, reintegration into the community, and aftercare. Optional vocational services began at about 2 to 3 months into treatment.

An evaluation of ADATSA (Luchansky et al., 2000) examined the earnings of participants from 1987 through 1995 using State Department of Employment records. The evaluation assessed the influence of treatment completion and completion of vocational services on earnings.

Results indicated that:

- Treatment completion increased earnings
- Vocational services increased earnings
- Greatest earnings were achieved if both were completed
- Individuals who are unemployable because of addiction can become productive

Other findings indicate that the initial gains were modest, but improvements continue with stable employment. The study's authors suggested that vocational support be continued to maintain initial employment. However, vocational support for ADATSA clients was discontinued in 2001, after the Federal determination that alcohol- and drug-dependent individuals do not meet "severely disabled" eligibility standards. The State was therefore not able to continue support for this program.

ABSTINENCE LINKED TO VOCATIONAL TRAINING

In another study (Silverman et al., 2001), 40 pregnant and postpartum women in methadone treatment received vocational training if daily urine tests indicated they were not using heroin or cocaine. The salary started at $7.00 for 3 hours of work and increased $.50 a day for abstinence. Findings indicated that:

- The contingent group had more drug-free days (50% versus 27%)
- Salary for work can reinforce abstinence

This study indicates that there may be programmatic changes that can be used as incentives to stimulate clients in recovery.

IMPLEMENTATION CHALLENGES

Implementation of innovative program changes face numerous challenges. The stigma of addiction is exponentially complicated by the stigma of disability. Health care professionals are not routinely screening for alcohol and other drug (AOD) problems. Some family members and case managers support the continued use of drugs by those with disabilities.

The issue of physical access is the easy part. However, attitudes resist change. Education and training are required to change entrenched attitudes. We also need to develop screening and

referral mechanisms, other creative approaches, and exercise patience. The goal is persistent, steady improvements.

Opportunities for innovative policy strategies include:

- Building on welfare reform initiatives by promoting recovery and economic independence through links with VR services
- Responding to severe dependence as a disability
- Fostering physical and program access to AOD treatment

Plenary 2, Session 2: Workforce and Employment Policy

Presenter: James Jeffers, M.A., President, Jeffers Consulting

My interest in substance abuse and disabilities began when I was in Maryland, working for a vocational rehabilitation program in the State, and also because of my experience with the Social Security Administration. My perspective is not as a substance abuse provider. I have a background in workforce development and I directed programs in several States related to the passage of the Workforce Investment Act (WIA) of 1998. These States include West Virginia, Maryland, and Illinois.

We're all apprehensive about systems change because we have to adapt our perspectives. This type of change is not new to the rehabilitation and disability community. Deinstitutionalization of programs in the past closed down congregate facilities and community-based mental health programs evolved from asylums. Vocational rehabilitation in fact did change fundamentally in 1973 with consumer involvement, and finally the ADA, which is just beginning to have an impact in this country.

Plenary speaker Jim Jeffers, Consultant

The Workforce Investment Act of 1998

The Workforce Investment Act (WIA) was signed into law August 7, 1998.

The key principles of the Act are:

- Streamlining services by using One-Stop "silos." Services are often duplicated, but many generic administrative functions can be streamlined.
- Empowering individuals. Under the Act, the voucher is the individual training account. The consumer can "shop" for the services needed.
- Universal access. The Act "levels out" access for each individual.
- Increased accountability.
- New roles for local boards.
- State and local flexibility. WIA is not a block grant yet. There will be further integration of services with increased flexibility.
- Additional youth programs.

ASPECTS OF THE WORKFORCE INVESTMENT SYSTEM

The system provides the framework for national workforce preparation and employment. It was designed to meet the needs of businesses as well as job seekers. The law re-wrote the Federal statutes governing:

- Workforce system development – Title I
- Adult education and literacy – Title II. These educational linkages are not part of the Act yet.
- Wagner-Peyser- Title III
- Rehabilitation Act amendments – Title IV. This is very important to us and is now part of the WIA. In 2003, there will be further consolidation.

The Act is intended to provide a more coordinated, customer-friendly, and locally driven workforce development system.

WORKFORCE INVESTMENT BOARD

The Workforce Investment Board (WIB) is appointed by the Governor of each State and can allocate funding through the State. Each Board segments the State, usually representing counties. Each county has their own Workforce Board with skill training activities. In West Virginia, the Workforce Investment Board is composed of 64 members, including:

- The Governor
- Three members of each chamber of the State Legislature
- Representatives appointed by the Governor
- Business (which must be the majority)
- Three chief local elected officials
- Four chairs of the local Workforce Investment Boards
- Labor organizations
- State agency heads
- Individuals with related experience
- Others, as the Governor may designate

The Work Force Investment Act is intended to provide a more coordinated, customer-friendly, and locally driven workforce development system.

The duties and responsibilities of the Board in West Virginia are to assist the Governor in developing a 5-year strategic plan, continuously improving the system, and commenting on the vocational education State plan. They also designate local workforce investment areas, develop allocation formulas, develop State performance measures, prepare annual reports, develop a statewide employment statistics system, and apply for incentive grants.

The Governor established seven workforce investment areas to meet the workforce needs of West Virginia citizens. The local areas are closely aligned with economic development areas.

ESTABLISHMENT OF GWIO

In December of 1999, the Governor's Workforce Investment Office (GWIO) was established by Executive Order No. 16-99. GWIO serves as the lead on all statewide workforce investment matters. It directs the timely and comprehensive implementation of the Workforce Investment Act (WIA) and ensures coordination and cooperation among the West Virginia WIB and all State agencies and programs engaged in workforce investment activities.

More information about the Governor's Workforce Investment Office can be found at: www.WVGWIO.org

YOUTH COUNCILS

Youth councils were established as a subgroup of the local board in cooperation with local elected officials. These programs receive greater than 1/3 of WIA funding, as great emphasis is now placed on this population (ages 14 to 21). The council's members include:

- Local Board members with expertise on youth issues
- Youth service agencies and former participants
- Parents
- Job Corps
- Others

The duties and responsibilities of the Youth Councils are to develop the youth portion of the local plan, which is subject to the Board's approval. They recommend youth providers and grant workers, provide oversight, and coordinate youth activities

FOUR PRINCIPLES OF "ONE-STOP" SERVICES

Characteristics of One-Stop services provided under this system are:

- Universality
- Customer choice
- Integration
- Performance driven and outcome-based

Under WIA, One-Stop service delivery must be established in each local area, overseen by the One-Stop system. Local communities have flexibility in designing the system, but each local system must be comprised of partners that provide core services. Each local area must also have at least one comprehensive center and may be supplemented by other centers (called electronic access points).

Some One-Stop Partners include:

- WIA - Title I Programs
- Wagner-Peyser

- Adult education and literacy activities
- Title I of the Rehabilitation Act
- Welfare-to-Work
- Title V of the Older American Act
- Post-secondary vocational education
- Trade act
- Veterans programs
- Community Services Block Grant Act
- Housing and Urban Development
- Unemployment compensation

WIA STATEWIDE ACTIVITIES

WIA specifies three funding streams to States and local areas: adults, dislocated workers, and youth. Fifteen percent of funds from each of these three funding streams may be reserved for statewide activities and these funds may be merged. Twenty-five percent of the dislocated worker fund is reserved for statewide rapid response activities, which is one of the required activities. Others include:

- Maintaining a list of eligible providers of training services
- Monitoring and oversight
- Providing technical assistance
- Assisting in the establishment of One-Stop delivery systems
- Developing fiscal and management accountability information systems
- Providing additional assistance to local areas

FUTURE CHALLENGES FOR WORKFORCE SYSTEM DEVELOPMENT

Major changes are just beginning and the reauthorization will bring substantial changes. For example, rehabilitation as part of WIA, devolution of policy to the local level (Boards, employers, etc.), more integrated service delivery, and an emphasis on performance-based outcomes (what happened to clients). There will be more customer focus with the voucher concept, as clients will have increased power to determine the services and provider they want. There will be increased focus on 14-to 21-year olds with substance abuse problems and disabilities. Finally, there will be enhanced involvement of the business and employment community.

ADDITIONAL INFORMATION

Additional information can be obtained from:

Governor's Workforce Investment Office
1900 Kanawha Boulevard East, Building 6, Room B-617
Charleston, West Virginia 25303
1-877-WORK4WV (toll-free), Phone: (304) 558-7024, Fax: (304) 558-7029
www.WVGWIO.org or www.WORK4WV.org

Plenary 2, Session 3: State Vocational Rehabilitation Commentary

Presenter: June Gutterman, Ed.D., Interim Administrator, Ohio Rehabilitation Services Commission

I've been the director of the Ohio Rehabilitation Service Commission's (ORSC) Bureau of Vocational Rehabilitation since 1988. Prior to that, I was the director of ORSC's Bureau of Services for the Visually Impaired and superintendent of a County Board of MRDD in Ohio.

As we think about achieving employment outcomes for people with disabilities who have coexisting substance abuse problems, we have to do so in the context of the larger environment. The structure of how we work has changed due to the devolution of policy from the national perspective to the local perspective; we are now in a system that is less macro and more micro. We are reacting to try to isolate needs at the local level, and as a result we're dealing with the realities of fragmented service delivery across a State.

We are in the beginnings of a worker shortage that is being driven by the demographics of age. This will be the key that drives our economic prosperity in this country over the next decade. We have to grow workers, yet the supply is fixed. We simply will not have enough new workers entering the labor force to compensate for the larger number of baby boomers who will be leaving the workplace. The challenges will be to prolong the work life of boomers and to bring new workers into the system as quickly as possible (productivity). Since the supply of new workers is essentially fixed, we have to look at programs that will tap into under-utilized portions of the current labor supply. e.g., people with disabilities. Due to archaic public policy, and many times, professional practice, the productivity potential of people with disabilities has so far been untapped. Simply stated, we've got to move people with disabilities from the dependency side of the equation to the productivity side.

When social security was first implemented in the 1930's, life expectancy was 65, which by design coincided with the traditional age of retirement, i.e., 65. As we evolved, we now have people who are on social security for long-term periods of time. Eventually, we will have fewer workers contributing to social security than those who are drawing from it. The Work Incentives Improvement Act of 1999 (TWIA), also known as "the Ticket-to-Work," the Workforce Investment Act (WIA), and Temporary Aid to Needy Families (TANF), all have at their roots an attempt to address the economic need to increase the number of people who can be part of the workforce; the need to increase worker productivity.

Think for a moment about how TANF emerged, and how its requirements moved people into the workforce. Think about the impact of "devolving a massive State-driven service delivery program to one that is locally driven." Most of our strategies reflect systems that are either nationally or State driven, because the "critical mass" of people with severe disabilities could only be really felt at that level.

How do we change our tactics and strategies to impact policymakers at a local level where that "critical mass" of people with severe disabilities may not by present? So we can deliver the depth of services needed by this population to ensure that they can gain and maintain employment? The TANF and WIA legislation create systems that operate at the Local level. Because of the built-in time limitations, the work requirements of these laws are intended to achieve results in a shorter time frame. The intent is to move a large number of people into the workforce

quickly. There is no long-term public policy view on how to create systems change on employment. We're "reactive." We're dealing with Local governments and we are subject to the vagaries of the local region.

How do we get long-term change at the local level? We need to acknowledge the underlying premise of change. Employers will be the driving force. Their needs are not for entry-level workers, but for incumbent workers. As an employer, if I spend my money to train somebody, it comes out of my bottom line. This leaves those with complex problems and the hard-to-serve out of the employment equation.

We need to convince those on local workforce boards not to exclude those individuals with severe and complex disabilities from accessing employment services that will not only give them access to enter the workforce, but also make gains within that labor force. We need to convince them that this population holds part of the answer that labor needs. First, however, we need to convince ourselves that the people we serve are in fact part of the answer to the labor problem.

We need to convince those on local workforce boards not to exclude those individuals with severe and complex disabilities from accessing employment services that will not only give them access to enter the workforce, but also make gains within that labor force. We need to convince them that this population holds part of the answer that labor needs.

We have to get sharp at developing a common lexicon and understand what an integrated system looks like. We have to present a common front to multiple local and State funders, and that message is: given the appropriate level of services, people with severe disabilities are a viable answer to their labor needs.

We have to be mindful that the workforce and Ticket-to-Work legislation places an emphasis on performance-based outcomes. If employers have the majority control of funds, they'll define the outcome. We have to deliver individuals to employers who are ready to work. We have to acknowledge how substance abuse and disability and workforce issues come together for the people who come to us for services. If not, we won't be able to receive the long-term funding needed for many of them to become employed.

I'll close by saying we need to change tactics on how we work together. We have to collaborate using aggressive, long-term strategies. We have to become more macro. If we compete among ourselves for diminished resources, we'll fail those with disabilities.

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PLENARY 3: IDENTIFYING DESIRED OUTCOMES IN TREATMENT AND REHABILITATION

Plenary 3, Session 1: Community-Based Treatment of Substance Abuse Following Traumatic Brain Injury

Presenter: John D. Corrigan, Ph.D., Professor, Ohio State University

I'm working as the Principal Investigator on a SAMHSA grant to study methods for engaging persons with substance abuse problems and traumatic brain injury (TBI) in treatment. Today I'll provide an overview of the treatment program, describe the population served, and discuss the usefulness of this model to clients.

SUBSTANCE ABUSE AND TBI

We know that 1/4 to 1/3 of persons hospitalized with TBI has a BAC of .10, but we have minimal data on other drug screens. The point is that there is an important correlation between TBI and drug and alcohol use. One study indicated that those with TBI who were admitted for acute rehabilitation showed a high association with unemployment, living alone, engaging in criminal activity and having low subjective well being. Numerous studies (for example, Baguley, et al., 1997) support the idea that there is an additive effect on the brain for those who have TBI and who drink socially. One problem seems to compound the other. Therefore, abstinence is important for those with TBI.

COMMUNITY-BASED TREATMENT: THE TBI NETWORK

The "TBI Network," which began in 1991, uses proactive methods for getting involved with TBI clients over the long term. We are involved in active case finding, resource and service coordination, and the education of community providers. This community-based program has been found effective and has been replicated both as a freestanding program and as a treatment approach within other programs.

Six guiding principles shaped the TBI network:

1. Persons are eligible for involvement with the program regardless of their current readiness to change concerning substance use. We use the transtheoretical model of "stages of change," which can be applied to employment issues as well as to substance abuse.
2. Involvement with clients is holistic. All problems of community integration must be addressed, not just those thought to be related to TBI or to substance abuse. The program was funded as a substance abuse/vocational rehabilitation program and will work with clients on many aspects of their lives. We try to be a consistent agent throughout the treatment process and after, staying with the client as they work with different providers.
3. The client and family are the decision makers regarding goals and objectives. Staff provide information and facilitate.

4. The attitudes, beliefs, and skills acquired in a person's home community are more likely to be sustained in that community than attitudes, beliefs, and skills learned elsewhere that require generalization. The point is: will clients be able to use the new skills in another context? It's better to change complex sets of behaviors in the settings in which they'll be used.
5. When facilitated through case-specific consultation, the expertise of local service providers is extremely applicable to the problems of substance abuse following traumatic brain injury. An emphasis on working in an interdisciplinary manner is the "glue" that provides consistency. We advocate the use of the existing substance abuse treatment system, not a separate one for those with disabilities.
6. The client, family, and service providers are a team whose efforts need to be actively coordnated. Everything is done as part of an interdisciplinary team process. We are proactive in forming an ad hoc community team that includes the providers and the client's support system.

CHARACTERISTICS OF PERSONS WITH SUBSTANCE ABUSE PROBLEMS AFTER TBI

The typical brain injury population has the following demographics:

- 76% male, 24% female
- 77% Caucasian, 22% African American, 1% Other
- Age 31 to 40 has the highest incidence at 38%
- Age 41 to 50 accounts for 28%
- Age 21 to 30 accounts for 26%

Causes are often attributable to motor vehicle accidents (45%) and assaults (26%) (not including gunshot wounds, which account for an additional 5%). Most clients have come into the system through the ER, rather than through the AOD system. Substance abuse problems usually begin within 1 year post-injury (46%) or 2 to 5 years post-injury (21%).

The drug of choice used by this population is primarily alcohol (72%) and beer is preferred. About 60 percent of persons with Traumatic Brain Injury (TBI) and substance abuse disorders indicate that beer is their drug of choice.

Only 16% of this population have employment as a primary source of income. This means that 80 % have an employment need. Other sources of income include social security, family members, or Temporary Assistance for Needy Families (TANF), and 16 percent have no income.

There are a number of coexisting risk factors found in this population, including dropping out of school (43%), being physically abused as a child (30%), being a victim of domestic violence (29%), having a developmental disability (21%), or being sexually abused as a child (18%). Sixteen percent test positive for HIV or AIDS.

Plenary participant

Involvement in the criminal justice system is evidenced in the arrest rate for drug charges, assault, weapons-related charges, and shoplifting (one of these arrests has occurred in about 20 percent of this population). Burglary or breaking and entering are found in the history of an additional 16 percent.

TBI OUTCOMES: THREE MONTHS POST-DISCHARGE

A study of the Traumatic Brain Injury (TBI) Network examined three outcomes: abstinence, productivity, and life satisfaction at 3 months post-discharge. Approximately 60 percent were abstinent at this point and 75 percent were employed.

A study of the TBI Network examined three outcomes: abstinence, productivity, and life satisfaction at 3 months post-discharge. Approximately 60 percent were abstinent at this point and 75 percent were employed.

About half of the clients successfully discharged are with us for about 2 years. This is not a short-term intervention and will not be popular with those looking for a short length of stay. The good news is that if you look at the cost per client, it is under $3000.

In terms of discharge status, 28 percent leave the program with all treatment goals met, while 27 percent are never engaged and are essentially untreated. Forty-five percent achieve some, but not all treatment goals.

IN SUMMARY

In summary, the TBI Network appears to be an effective and efficient model of treatment for substance abuse following TBI. However, both the nature of the target population and the duration of treatment lead to significant dropout rates. More research is needed on ways to engage clients in treatment and maintain them there.

Plenary 3, Session 2: Dual Substance Abuse and Mental Disorders

Presenter: Diana M. DiNitto, Ph.D., Cullen Trust Centennial Professor in Alcohol Studies and Education, University of Texas at Austin, School of Social Work

Numerous terms and acronyms are used to describe coexisting mental and substance use disorders, some of which are:

- Dual diagnoses
- Multiple diagnoses
- Substance abuse and co-occurring mental disorders
- CAMI/MICAA/MIDAA® (for details, see the web site at http://users.erols.com/ksciacca)

These terms all mean that an individual has a diagnosis of one or more mental disorders and one or more substance use disorders.

PREVALENCE

The Epidemiologic Catchment Area (ECA) Study indicated that of those with a lifetime mental disorder, 22 percent also had alcohol dependence or abuse and 15 percent had drug dependence or abuse. Those with a mental disorder were more than two times as likely to develop an alcohol use disorder and more than four times as likely to develop a drug use disorder than those without mental illness (Regier et al., 1990). Substantial co-occurrence was seen with antisocial personality disorder (84%), schizophrenia (47%), affective disorders (32%), and anxiety disorders (24%).

The National Comorbidity Survey (1996) has higher figures than the ECA. It indicated that, of those with a lifetime substance dependence or abuse disorder, 41 to 66 percent had at least one mental disorder. Of those with at least one lifetime mental disorder, 51 percent also had a substance dependence or abuse disorder (Kessler et al., 1996).

APPROACHES TO TREATMENT

Several approaches to treatment of this population have been used: sequential, parallel, and integrated. With sequential treatment, the individual receives treatment for either the mental illness or the substance use disorder and then receives treatment for the other illness. Often the clients go back and forth between the two treatment systems, because treating one illness without treating the other is ineffective. This makes the client into a human ping pong ball. In parallel treatment, both systems serve the client concurrently. The preferred method is integrated treatment. Providers of integrated treatment are skilled in treating both types of problems at the same time.

The principles of treatment for this population according to Drake, et al. (1993) are:

- Assertiveness
- Close monitoring
- Integration
- Comprehensiveness
- Stable living situation
- Flexibility and specialization
- Stages of treatment
- Longitudinal perspective
- Optimism

STUDIES OF DUAL DIAGNOSIS TREATMENT

Studies of the effectiveness of dual diagnosis treatment have used a variety of treatment approaches, including residential programs, therapeutic communities, and group and outpatient treatments. Of four studies that used random assignment, DiNitto et al. (in press) and Lehman et al. (1993) showed no significant differences between experimental and control groups on outcome measures. The only difference that Burnam et al. (1995) showed was that experimental groups had fewer days of alcohol use than the control group at the 3-month followup. Drake et al. (1998) found that Assertive Community Treatment (ACT) subjects improved more on some

substance abuse and quality of life measures, but not on most measures, compared to those receiving Standard Case Management.

Studies using non-random assignment had the following results:

- Blankertz & Cnaan, 1994: Comparing two residential treatment models, the experimental group had more successful program exits (sobriety, hospitalizations, and permanent residence).
- Bond et al., 1991: More ACT and Reference Group subjects than controls were engaged in treatment at 18 months; there were few other differences (e.g., alcohol use, life satisfaction).
- Drake et al., 1997: Compared to the Standard Treatment group, the Integrated Treatment group had fewer institutional days, more stable housing, and greater substance abuse recovery, but the groups were similar in drugs other than alcohol. There were minimal differences in some other areas and no employment differences.
- Jerrell & Ridgely, 1995: There were more positive outcomes for the Behavioral Skills Group than other treatments, but differences on many outcome variables were not significant. Experimental subjects did not do better than controls on work outcomes.
- Nuttbrock et al., 1998: Therapeutic Community clients were more likely than Community Residence clients to be drug free and improved more on psychiatric symptoms.
- Webb, 1994: Experimental subjects receiving a group treatment for dual diagnoses were less likely to leave a residential program prematurely, but there were no other differences.

Most studies have not looked thoroughly at employment differences.

ADDICTION SEVERITY INDEX

The Addiction Severity Index (ASI), an assessment instrument designed by McClellan et al. (1985), takes employment into account in multidimensional assessment and substance abuse treatment planning. The ASI also looks at medical, alcohol, drug, legal, family/social, and psychiatric issues. Treating the substance abuse problem is not always enough to make a difference in all these areas.

DIFFERENCES IN TREATMENT

We call both mental illness and chemical dependency brain diseases, but we've treated them differently over time. Those with mental illness may receive:

- Professional care
- Individual treatment
- Medications

- Life-long treatment
- Sheltered employment

Those with a chemical dependence problem receive:

- Self-help approaches
- Group treatment
- No medications
- Additional treatment only for relapse
- Expectation of competitive employment

In the chemical dependency field, even those with severe substance dependence are expected to work.

Outcomes of clients receiving state vocational rehabilitation services

There are positive findings for the dually diagnosed receiving vocational rehabilitation services. In one study, the combination of disabilities and their severity did not seem to affect successful case closure (Schwab & DiNitto, 1993).

Some studies address employment for this population. Moggi et al. (1999) indicated that programs with a stronger dual diagnosis orientation showed higher rates of employment (34% versus 25%). De Leon et al. (2000) found some evidence to support the idea that modified TCs improved employment outcomes compared with treatment as usual.

A systematic review by Crowther et al. (2001) indicated that supported employment was more effective than prevocational training in helping clients with severe mental illness obtain competitive employment.

And finally, a 1995 article by Baron recommended redefining work for those with mental illness to allow for more flex time, job sharing, and other options that could address the "staggering rate of unemployment among persons with long-term mental illness." Employment should be a primary and not a secondary concern.

Critical components are:

- Rapid movement into a real job
- Intensive support for stabilization
- Ongoing assistance on the job
- A greater role for consumers in the service delivery system

Disability policy should be changed so that everyone can participate in meaningful employment.

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Plenary session

PLENARY 4: IDENTIFYING DESIRED OUTCOMES IN EMPLOYMENT, EDUCATION, AND TRAINING

Plenary 4, Session 1: Identifying Desired Outcomes in Employment

Presenter: Susanne M. Bruyere, Ph.D., Director, Program on Employment and Disability, Cornell University

National longitudinal surveys suggest that there are continuing disparities in employment rates for Americans with disabilities. The goal we're discussing today is getting and maintaining employment for people with disabilities in the U.S. The research I'll be presenting is from Cornell University. Cornell conducts employment policy and practices research and examines private and Federal sector employer responses to disability and civil rights legislation.

RESEARCH ON EMPLOYMENT PRACTICES IN PRIVATE AND FEDERAL SECTOR ORGANIZATIONS

Employers are crying for a new source of labor. The Federal workplace is the largest employer in the country. There are several incentives to hire people with disabilities that were implemented as Executive Orders in the Clinton administration.

Individuals concerned about equal employment opportunities for people with disabilities can now better leverage our advocacy position based on several key pieces of legislation:

- The Rehabilitation Act of 1973
- The ADA
- The Workforce Investment Act

Much of the Cornell research work done on employment and disabilities in the workplace focuses on Human Resources (HR) professionals, as they are informants on the status of the workplace. There is, on the average, one HR professional for every 100 employees. HR professionals routinely deal with facets of the employment process in which disparities can occur at every step of the way, from the application process through the grievance process. This provides us with a way to get inside the workplace.

It's clear that many HR professionals are unaware of the protections of the ADA and of the accommodations that might be helpful. They also are often unaware of how to access resources for people with disabilities.

Based on our research, it's clear that many HR professionals are unaware of the protections of the Americans with Disabilities Act (ADA) and of the accommodations that might be helpful. They also are often unaware of how to access resources for people with disabilities. Cornell conducted two telephone surveys of HR personnel on compliance with the ADA. One survey used a stratified sample of HR staff in the private sector and one sampled all HR staff in the Federal government.

A full report and Executive Summary of the Federal sector disabilities employment nondiscrimination study conducted by Cornell University is available on our web site. A comparison of the private and Federal sector employer HR representatives' responses to these respective

surveys is also available, as well as full reports of the private sector surveys. Click on the following link: http://www.ilr.cornell.edu/extension/files/download/comparison16REVISED.pdf

SURVEY METHODOLOGY

Two 10-page parallel surveys were conducted covering issues dealing with the employment provisions of the ADA, and for Federal sector organizations, the Rehabilitation Act of 1973 as amended, was also addressed. Surveys were used with a random sample of the membership of major human resources professional organizations and Equal Employment Opportunity personnel.

Private sector personnel were surveyed from the Society for Human Resource Management (SHRM) and the Washington Business Group on Health (WBGH). A sample of 1,042 names, addresses, and telephone numbers was obtained from SHRM, randomly selected based on the size of the organization they worked for. The goal was to have a random sample of individuals from small, medium, and large organizations in the U.S. Of the original sample, 1116 were eligible respondents and 813 responses were received (a 73 percent response rate). Response rates were similar for each size group. Similarly, a study was conducted with members of the WBGH. A 32 percent response rate (n=52) was received.

Suzanne Bruyere, plenary speaker

For the Federal sector agency representatives, a list was obtained of all human resources and Equal Employment Opportunity personnel across all 96 U.S. Federal agencies. A total of 403 surveys were completed out of 415 agency representatives who were contacted (a 97 percent response rate).

SURVEY RESULTS

Both private organizations and Federal agencies are responding to the Americans with Disabilities Act (ADA) by making accommodations for applicants and employees with disabilities. Of the 11 areas asked about, survey respondents most commonly reported changes in the following areas: making existing facilities accessible, being flexible in the application of HR policies, and restructuring job and work hours. Other frequently made changes by both groups included modifying the work environment and making transportation accommodations.

The accommodations least often made were in the areas of modifying training materials and making changes in supervisory methods. There was a statistically significant difference in the groups' responses to making changes in all 11 categories, with Federal agencies more likely to have made each change. This may be a function of the longevity of government agencies in their experience in accommodation with the Rehabilitation Act of 1973. Private sector organizations were much more likely to indicate they had "never needed" to make the change.

Areas that respondents indicated were more difficult to change in both sectors were making information accessible for people with visual or learning impairments and making information accessible for people with hearing impairments. For the applicant interview process, respondents across both groups were familiar with requirements for framing questions about job tasks

and restrictions on eliciting medical information, but they were much less familiar with adapting print materials for people with visual impairments and the use of TTY/text telephones to set up interviews. Federal sector respondents had a much greater familiarity with accessing sign language interpreters than their peers in the private sector.

Respondents were presented with seven possible barriers to the employment and advancement of people with disabilities. The largest continuing barriers reported by both private and Federal sector employers were lack of related experience and lack of requisite skills and training in the person with a disability. The next most often cited barrier was supervisor knowedge of how to make accommodations. Attitudes or stereotypes among co-workers or supervisors was seen as the third most significant barrier among Federal respondents and fifth among private sector respondents. In both groups, the change most often attempt-ed but considered most difficult to make was changing these stereotyped attitudes toward the employee with a disability.

The largest continuing barriers to employment reported by both private and Federal sector employers were lack of related experience and lack of requisite skills and training in the person with a disability.

Means for reducing barriers that were considered most effective were: visible top management commitment, staff training, mentoring, and on-site consultation or technical assistance. Tax incentives were seen as the least effective method for reducing barriers.

Employers are still uncertain about the interplay among different pieces of legislation affecting people with disabilities. In the private sector survey, interviewees were asked about the interaction of the ADA, the Family and Medical Leave Act (FMLA), Workers Compensation, the Occupational Safety and Health Act (OSHA), and the Drug-Free Workplace or Omnibus Transportation Employee Testing Acts. In the Federal survey, the same questions were asked, and additional information was elicited about the uncertainty respondents experienced about the Rehabilitation Act's requirements on affirmative action and purchasing accessible technology and equipment (Section 508). Private sector respondents reported significantly more uncertainty about the ADA and other employment and safety and health legislation than their Federal counterparts. Results were similar in both sectors, however, concerning the coordination of the ADA and the Family Medical Leave Act and the interplay between the ADA and work-related injuries.

IMPLICATIONS AND FUTURE DIRECTIONS

Survey results indicate that while much progress has been made, barriers remain to the recruitment, hiring, retention, and career advancement of adults with disabilities in the workforce. Changes are clearly needed in the areas of interview considerations for those with visual or auditory impairments. Another area for further exploration is workplace supports for persons with psychiatric disabilities. Respondents in both sectors indicated a need for more information on accommodations for these employees.

Some remaining barriers are in the workplace itself. Attitudes toward people with disabilities continue as a workplace integration issue, even though most organizations in both sectors have attempted changes. Perhaps this area can be merged with diversity programming or addressed independently with continued training across all personnel.

It is imperative that supervisors' lack of knowledge about accommodations for people with disabilities be addressed through training, as supervisors are integral to the accommodation process in the workplace.

Formal or informal disability management programs have made some contributions to the implementation of civil right laws. This area should be further explored as a programmatic structure to support workplace disability nondiscrimination policies and practices. Unions can also be beneficial in the accommodation process. Focus groups with unions may be a good way to continue information gathering. Through the unions, we may learn more about barriers and ways to engage unions to address continuing attitudinal issues toward persons with disabilities.

FULL SURVEY REPORTS AVAILABLE

A copy of the full survey report is available from the Cornell University Program on Employment and Disability at 607-255-7727 (Voice); 607-255-2891 (TTY); 607-255-2763 (Fax); or e-mail Susanne M. Bruyere at smb23@cornell.edu

A copy of the full survey report is available online at: http://www.ilr.cornell.edu/ped/projects/ADA_Projects/PPFSO/

Plenary 4, Session 2: Identifying Desired Outcomes in Education

Presenter: John Benshoff, Ph.D., Professor, Rehabilitation Counseling, Rehabilitation Institute, Southern Illinois University

In the mid-1970s I taught a course on substance abuse and disabilities and I took it to a rehabilitation conference. At that time, the audience didn't want to help those that had, in their opinion, "brought their disabilities on themselves."

ISSUES

Today I'll talk about our Counselor Training Program in the Rehabilitation Institute at Southern Illinois University (SIU). It's a large program that prepares individuals to become Alcohol and other drug (AOD) counselors. It allows students a dual career track for rehabilitation counseling and substance abuse treatment. The breadth and depth of focus is spread across the curriculum. As this program was developed, we asked, What's the role of the internship and of the practicuum? How deeply do you immerse AOD information in rehabilitation work?

The Counselor Training Program in the Rehabilitation Institute at Southern Illinois University allows students a dual career track for rehabilitation counseling and substance abuse treatment.

The decision was made to train rehabilitation counselors who have a specialty in substance abuse treatment. The notion of being holistic is extremely important for any counselor. For those working in the field, there are elements missing. We want to prepare people adequately, but there are also ramifications. What kind of jobs will people get? How does the program establish a curriculum? Where is it going?

I'm a CRC, and when we look at State credentials for AOD counselors, the requirements differ tremendously. Our program is degree-specific. You have to be in an MA program that is very focused on rehabilitation. MSWs can take some courses also, but we want to expose them to rehabilitation ideas, such as getting people jobs as part of recovery. Many substance abuse agencies have jobs very low on the priority list. Concerning the importance of vocation, we don't talk about solutions like rehabilitation does. Vocational issues are central.

We have students with varying types of recovery status. Some are recovering from substance abuse, some from disabilities problems, some from both. It's an accessible university, so that aspect is not a problem. When substance abuse recovery students first came in, there were new issues. We had to ask, what was the meaning of their contribution?

EDUCATIONAL MODELS

There are several models used for training in this field. The "stand-alone" model teaches substance abuse and rehabilitation issues in parallel. The "integrated" model infuses both types of issues across the curriculum (horizontal integration) or layers them on top of the curriculum (vertical integration). Continuing education takes place in settings such as this conference.

RESEARCH AND THE LITERATURE

There are several coexisting disabilities that get a lot of play in the literature, such as traumatic brain injury (TBI) and mental illness/substance abuse (MISA) disorders. Beyond that, the literature is fairly sparse. Some of my students have attempted to research specific topics and there is no literature at all. We need to publish more.

There has been a shift concerning monographs. In the early 1990s, there was quite a bit published on rehabilitation and now we're seeing strong involvement from CSAT, which strengthens this trend. The book I co-authored with Dr. Timothy Janikowski, The Rehabilitation Model of Substance Abuse Counseling, is currently the only book out there that thoroughly addresses disabilities and rehabilitation. Otherwise, books that address these issues are rare.

FIELD WORK EXPERIENCES

Concerning field work, do we have sites and supervisors that work for students? Many of those supervising don't have Masters degrees. Regulations differ by State agency, and so these settings may not make good field sites. In addition, those with a criminal justice history (which could be related to past drug use) are not allowed to work in some State agencies. These are all concerns that need to be addressed.

Plenary 4, Session 3: Identifying Desired Outcomes in Research to Practice and Technology Transfer

Presenter: Stanley Sacks, Ph.D., Director, Center for Integration of Research and Practice, National Development and Research Institute, Inc. (NDRI)

The Technology Transfer Model follows a continuous loop that connects an identified problem, the programmatic response to the problem, research on the effectiveness of model programs, the development of knowledge and tools, and new applications.

THE PROBLEM

The problem used to exemplify the Technology Transfer Model is the co-occurrence of mental illness and substance abuse (MISA) disorders.

1. The prevalence of co-occurring disorders is increasing; the National Comorbidity Survey indicates that as many as 10 million people may have both a lifetime addictive disorder and a lifetime mental illness disorder.
2. Co-occurring disorders have five defining features:
    - Both a mental illness and a substance abuse problem are present
    - Problems are evident in several areas, such as work and social life (a multidimensional disorder)
    - Impaired functioning (clients may function cognitively at a low level)
    - Disaffiliation from the mainstream
    - A need for long-term treatment
3. Certain treatment implications follow from an understanding of these features. These are the need to treat both disorders, the need for ancillary services, the need to simplify treatment protocols, the need to promote value changes, and the need for continuity of care.
4. Some symptoms of mental illness are:
    - Flat or labile feelings, or a full range of feelings
    - Persecutory thoughts that may be concrete or tangential
    - Behaviors that may be either agitated, calm, withdrawn, or irritable
    - Hallucinations or other sensory experiences
5. The characteristics of addictive disorders are:
    - Poor tolerance (frustration or discomfort with delayed gratification)
    - Low self-esteem
    - Problems with authority
    - Guilt concerning the self, others, or society
    - Poor impulse control; difficulty coping with feelings
    - Unrealistic ideas
    - Deficits in reading, writing, attention, or communication; and
    - Dishonest, manipulative, or self-deceptive tendencies.

6. An important difference between Axis I and Axis II disorders must be understood to plan appropriate treatment. Axis I includes schizophrenia, major mood disorders (depression or bipolar disorder), and anxiety disorders (panic, phobia, or post-traumatic stress); Axis II includes major personality disorders (borderline, narcissistic, or antisocial personality disorders).

THE PROGRAM RESPONSE

1. A variety of promising models will be described in an upcoming Treatment Improvement Protocol (TIP) on dual disorders, which is being published by CSAT. These models include:
    - Comprehensive Integrated Treatment (CIT), which is well documented.
    - Assertive Community Treatment (ACT), in which community outreach teams provide crisis intervention and referral.
    - Intensive Case Management (ICM), a model that requires low caseloads and good linkages to other resources.
    - Modified Therapeutic Community (MTC).
2. Other treatment approaches that are often included within larger treatment models are ancillary/adjunctive services, self-help, educational approaches (inherent in almost any treatment), contingency management, and psychosocial rehabilitation.

BEST PRACTICES

Best practices include a number of components that cut across all treatment models.

1. First, a recovery perspective recognizes that recovery proceeds through stages, takes a long time, and requires a lot of empathic support.
2. All treatment should be integrated, comprehensive, and continuous.
3. Providers should use a phased approach that includes engagement, treatment, and aftercare.
4. Self-help principles and approaches (AA and therapeutic communities) that allow peers to help one another should be employed.
5. Clients need help to resolve concrete life problems around employment, children, and other areas of concern.
6. Clients with functional impairment need simplified and structured services.
7. Treatment should include building a community where people in recovery can relate to each other.
8. Housing is not just another service but fundamental to treatment, in the same way that psychotropic medications are.

EVALUATION

Evaluation is the next step in the technology transfer loop. The study examined the effectiveness of a modified therapeutic community (TC) of moderate intensity, a modified TC of low intensity,

and treatment as usual (TAU). Referrals came from a pool of homeless individuals with mental illness and substance abuse disorders. Participants were sequentially assigned to one of the two TC conditions. Both modified TC conditions included peer self-help and viewed the therapeutic community as the healing agent. The results showed that improvement for the modified TC groups was significantly greater than TAU on measures of drug and alcohol use and employment. These outcomes hold promise that the severely mentally ill can return to work when appropriate treatment is provided.

The costs of the modified TC approach were comparable to treatment as usual. TAU cost $29,638 compared with $29,255 for modified TC. However, the modified TC also has an incremental benefit of. The total net benefit per client over time was $252,114, with a cost-benefit ratio of 13 to 1, or $13 of benefit for every dollar spent.

KNOWLEDGE AND TOOLS

Several important tools resulted from this work, including

1. A program manual entitled Modified Therapeutic Community for Homeless Mentally Ill Chemical Abusers.
2. An implementation guide that described development of the project team and provided a field demonstration format. This guide describes the use of TC and specialized staff, integration within the system (policy, guidelines, constraints, and involving stakeholders) and integration within the agency (organizational readiness, encouragement of program change, and collaboration). It describes methods for designing, launching, and implementing a modified TC program, including the need for a planning group, client and staff orientation, and training/technical assistance.
3. A training curriculum that addresses the questions:
    - What is a TC?
    - What is a modified TC?
    - What do we know about Mentally Ill Chemical Abuser (MICA) treatment?
    - What is the role of the staff?
    - What are the main interventions/activities?
    - What is it like to be in a TC?
    - How do we implement the program?
    - How do clients change?
    - How do we assess and diagnose co-occurring disorders?

CONSENSUS BUILDING

The study followed a consensus-building process at several levels: the city, the State, and within the program. The consensus-building model that resulted includes system stakeholders, develops a representative steering committee, works within the system and agency, meets system needs, and follows a stepwise process.

NEW APPLICATIONS

The knowledge and tools developed and evaluated in the program led to several new applications.

1. Settings in which the modified TC can be applied in homeless shelters, TC drug treatment programs, community residences, prison, HIV/AIDS programs, and women and children's programs.
2. The program has been replicated in several locations: Montreal, New York City, Philadelphia, Colorado, and Auckland, New Zealand.

RESEARCH AGENDA

In the future, the research areas that need focus are:

- Length of treatment
- Critical comparative tests
- Diagnostic issues
- Treatment adherence
- Progress and outcomes
- System studies
- Economic studies
- Technology transfer
- Policy impact

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LUNCHEON PRESENTATIONS:

Luncheon: Day 1
The Federal Treatment Focus

Presenter: Sheila Harmison, DSW, Special Assistant to the Director, Center for Substance Abuse Treatment (CSAT)

Thank you for inviting me to give the Center for Substance Abuse Treatment perspective on the issues of substance abuse, disabilities, and employment. I bring greetings from Dr. H. Westley Clark, the Director of CSAT, and from Dr. Joseph L. Autry, the Acting Administrator of SAMHSA. On their behalf, I will be giving you an overview of what SAMHSA, and in particular CSAT, is working on concerning these issues.

CSAT is very much aware of the importance of this conference and the fact that the coordination of substance abuse treatment, employment, and coexisting disabilities services has only just begun to be examined. To address some of these issues, CSAT developed and disseminated the publication TIP #29, Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities. This is a compilation of best practice guidelines and is intended to facilitate the understanding and delivery of effective treatment services to people with disabilities. In TIP #29, it is noted that coexisting physical or cognitive disabilities may affect up to 40 percent of all clients served by the substance abuse treatment systems.

A key area of concern for many people with disabilities is employment. It has been estimated that an approximately 60 to 70 percent of people with disabilities are either underemployed or unemployed (Taylor et al., 1986 and LaPlante et al., 1997). Though the lack of employment may be an issue in substance use, overcoming barriers to employment, with the aid of partnering among all those involved (family, community, religious and service entities) will improve the chances for recovery and should be addressed as a key component of treatment planning.

We must continue to stress the importance of employment considerations in treatment planning. Current barriers to comprehensive treatment and eventual employment for this population involve:

- Severity of the disorders
- Lack of access to services
- Lack of providers trained to work with people with disabilities
- Lack of sufficient resources available in the health delivery system, and
- Lack of coordination among State and local entities, including treatment centers, community health centers, educational centers, and vocational rehabilitation agencies.

For too many years, those of us in the substance abuse field working with clients with physical and cognitive disabilities have been forced to defer to fragmented organizational and political systems, which takes the focus off the needs of our clients. Most States operate separate mental health, substance abuse, and physical health agencies. Furthermore, social services, housing,

and vocational needs are often managed in yet other agencies. Each of these areas usually has different missions, treatment philosophies, and requirements for providers, with varying administrative structures and funding mechanisms. This makes it very difficult to provide quality and timely services to people in need.

Additionally, the approach to treatment is critical and the drug counselor should always consider the relevance of addressing vocational issues at every stage in the client's treatment. To address employment issues more directly, CSAT has developed TIP #38, Integrating Substance Abuse Treatment and Vocational Services. This document recommends the need for vocational services as an integral component of all substance abuse treatment programs. It addresses pathways to careers, job satisfaction, and overcoming barriers to employment.

TIP 38 also highlights the requirements of the Americans With Disabilities Act (ADA)(42 USC '1201 et seq. (1992). The ADA is the first Federal law initiated and championed by persons with disabilities. The ADA puts the onus of accommodation on society rather than on the individual with a disability. This legislation guarantees equal opportunity for individuals with disabilities in public and private sector services and in employment. It is a comprehensive antidiscrimination law that extends to all sectors of society and every aspect of daily living. This Federal civil rights act provides the same basic civil rights protections to persons with disabilities as to all other Americans.

Equal access to services, goods, and employment is assured through this law. However, in order for employment to be acquired and sustained with this population, appropriate substance abuse treatment is necessary. Accordingly, SAMHSA and CSAT have worked to examine some of the gaps that exist for those with disabilities.

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (MCDPDHHI) is one example. The program, fashioned to meet the communications and cultural needs of deaf and hearing-impaired persons in chemical dependency treatment, is the recipient of a Critical Population Grant from CSAT. Initial funding was awarded in 1990 and subsequent renewal of these monies enabled program staff to provide training, develop and modify materials, and provide treatment to deaf and hard of hearing individuals.

The program operates on a 12-Step philosophy. Staff members are fluent in sign language and knowledgeable of and sensitive to the deaf culture. Written materials are modified and video materials are presented with sign, voice and captions. TTYs (which allow deaf people to communicate on the phone), assistive listening devices, and decoders for television are among the special equipment provided for clients.

In March of 2000, funds from a CSAT conference grant supported MCDPDHHI's convention for substance abuse treatment professionals, called "Stepping Forward: A National Substance Abuse Conference Focusing on Issues of Deaf and Hard of Hearing People." Among the topics considered were:

- Clinical approaches effective in treating deaf and hard of hearing clients
- Techniques most useful in outpatient recovery
- Deaf cultural differences and their impact on substance abuse treatment
- Methods to reduce the risk of HIV and other sexually transmitted diseases

To dismantle barriers to treatment, the concept of "no wrong door" needs to be accepted. Whether we are in the substance abuse treatment field, the mental health community, or the primary health care community, we must recognize the need to diagnose and treat patients for substance abuse, mental health, or coexisting disabilities, regardless of where they enter the system.

"No wrong door" is one of the five guidelines of the National Treatment Plan Initiative adopted by CSAT and the entire spectrum of the substance abuse treatment field, including input from researchers, practitioners, the recovery community, and families who have loved ones who suffer from the effects of substance abuse. The National Treatment Plan's goals for "No Wrong Door to Treatment" include requiring appropriate assessment, referral, and treatment in all systems serving people with substance abuse and dependence problems no matter where they come into the health system.

It is often so difficult to bring into treatment those who are severely impaired. We must have integrated systems of referrals, and cross-training of staff and other cooperative programs if we are to treat the whole human being. Unfortunately, for years our delivery system has offered few incentives for true partnerships. Each component of the system has been preoccupied with its own survival and its own funding streams. Mental health and substance abuse financing alone has been severely affected by the reluctance of larger society to invest in the treatment needs of those suffering from either condition. Physical and cognitive disabilities have most certainly been a part of this also.

Sheila Harmison, luncheon speaker day 1

These services must focus on recovery, not just symptom reduction, and they must be available to all persons suffering from substance abuse, mental health, or coexisting disabilities. CSAT and its sister Centers in SAMHSA are embarking on several programs to help us attain that goal. We know that we need more knowledge. For years there has been some insight into how substance abuse complicates treatment of mental illness. But there is very little corresponding knowledge on how physical, cognitive, sensory, or affective disorders complicate the treatment of clients dealing with substance abuse issues.

We know that currently many substance abuse programs are not designed to cope with these clients. There are those in the treatment field, for instance, who do not understand the role of medications in the treatment of mental and physical disabilities and are uncomfortable managing treatment programs for substance abusers who are using medications that are vital to their mental health.

We also know that cross-training of staff is needed so they can understand the fundamentals of substance abuse treatment for a client with coexisting disorders. At a minimum, mental health care providers and substance abuse treatment providers must both learn to assess and diagnose their clients for physical, cognitive, sensory or affective disabilities.

One of the major problems has been the existence of disparate funding streams. SAMHSA has been in the forefront of educating State and Local authorities that SAPT Block Grant funds can be used to treat dually diagnosed clients, for example, as long as each Block Grant's funding is allocated to the type of treatment required by the grant.

A larger problem is the relative amount of money spent on substance abuse and mental health problems and the alternative financing available for substance abuse and mental health services. In 1997, our Nation spent one trillion dollars on all health services, with only $82.2 billion of that amount allocated to substance abuse and mental health services.

Of these, the public paid for 58 percent of both mental health and substance abuse services and 46 percent of all health services (includes Block Grant, Medicaid, Medicare, State and local funding). The private sector paid for 42 percent of both mental health and substance abuse services and for 54 percent of all health services.

Unfortunately, the mental health and substance abuse dollar is also fractured dramatically. The $82.2 billion spent on mental health and substance abuse separates out to $11.4 billion for substance abuse and $70.8 billion for mental health. Of these dollars, the public sector picks up the cost of 64.3 percent of substance abuse treatment and 57.3 percent of mental health services.

The relative difference between public funding through the substance abuse and mental health block grants is thus misleading. In 1997, the substance abuse block grant was an estimated $900 million dollars, compared to $245 million in the mental health block grant. Still, the total national expenditures for mental health services are approximately $70 billion, compared to the $11 billion spent for substance abuse treatment and prevention services. These differences create confusion and tensions, which affect administrative and clinical willingness to cooperate when a client with coexisting disabilities presents for treatment.

Another problem that needs to be addressed is case management. We need a system in which a professional case manager is available to ensure that clients receive substance abuse treatment that addresses their special needs in relation to acquiring the appropriate education and skills training to prepare the client to enter the workforce. A treatment plan should be developed that addresses the client's vocational training, rehabilitation, and employment needs at every stage of the plan.

We have learned from research to date that this vulnerable population has to be educated to understand its barriers to resources. We also know that mentors, monitors, and navigators are needed to accomplish the established goals. This means that staff must be trained properly as a person with a physical disorder or mental disorder of thought, feeling, or trust may have a difficult time deciding on treatment strategies.

As new knowledge is developed on best practices for treating those with coexisting disabilities, CSAT is determined to spread this information to the field. We are providing technical assistance to States as well as training. Through the Targeted Capacity Expansion grantee program, CSAT has formed various cluster groups for those grantees servicing consumers who are most similar to those of the proposed caseloads. The existing cluster groups are: Adolescents, Co-occurring Disorders, Criminal Justice, Methadone, Native American, TCE/HIV, HIV Outreach, Women, and the Co-Occurring and Other Functional Disorders (COFD).

The CSAT COFD cluster group is comprised of TCE grantees that serve consumers having

co occurring substance related and other disorders that impair functioning and recovery. Co-occurring disorders include mental health disorders, physical disabilities, and developmental disabilities. The mission of the COFD is to enhance the quality of life for individuals with co-occurring and other functional disorders by promoting and developing professional and community competency. The COFD cluster group has identified a set of activities that will contribute to improved treatment for people with co occurring and other functional disorders. While common evaluation is a primary core for cluster activities, the COFD cluster will build upon experiences and comparable data to develop products designed to benefit consumers, providers, and policymakers.

Planned products include:

- Consumer-oriented literature (e.g., brochures)
- A description of barriers to integrated treatment and proposed solutions
- A description of the nature and extent of the problem of co occurring disorders and other functional disorders
- Translation of guiding principles into practice
- Core competencies for staff

In 1999, CSAT funded a 3-year community treatment program grant that looks at increasing substance abuse treatment compliance for persons with traumatic brain injury. It is conducted through the Ohio State University Research Foundation, Health Sciences Office, and examines three different methods of intervention to increase retention in treatment for persons with traumatic brain injuries who have substance abuse problems. I would like to recognize Dr. John D. Corrigan, who is the Principal Investigator on this project. He will be speaking to you this afternoon and I am sure can address any questions you might have on this project.

The literature on substance abuse treatment compliance and retention has focused primarily on client characteristics, the substance abuse disorder, or the therapeutic alliance. This proposal asks the question "What can be done to keep individuals in treatment long enough for the therapeutic alliance to develop and the initial rewards of behavior change to be experienced?"

Previous studies through Ohio State University have found that persons with a history of alcohol or other drug abuse are less likely to be working or back in school 1 year following discharge from rehabilitation, and are more likely to be socially isolated. These findings show that retention in substance abuse treatment is critical.

The goal is to determine which of the following three types of interventions merit attention as a method of sustaining participation in treatment for this population:

- Reduction of logistical barriers
- Motivational interviewing
- Provision of financial incentives

This project will use the early treatment relationship (the period from intake to signing an individualized service plan) for this preliminary test of efficacy. The results of this and any subsequent projects are aimed at assisting substance abuse treatment providers that have difficulty trying to serve individuals who have impaired cognitive, emotional, and/or physical functioning.

CSAT is also funding a Women and Violence Study, in collaboration with the Center for Substance Abuse Prevention and the Center for Mental Health Services that is seeking a seamless system of care for women with substance abuse disorders who have been victims of the trauma of violence. This study is addressing the needs of women with co-occurring disorders and histories of and sexual abuse, who are often high-end users of services. The study will also look at the needs of their dependent children. This 5-year program will be carried out in two phases. Phase one will produce manuals, reports, and working papers that describe an integrated system of care for these women and children. We hope to identify in Phase I the most promising service intervention models for these patients.

The second phase will allow sites to implement these intervention models and evaluate them. We anticipate a final product that will identify differences in outcomes among users of these new integrated services compared to clients of currently available services.

Luncheon

CSAT and CMHS are also collaborating to fund a center to provide resources to communities dealing with people with co-occurring disorders in the justice system. The center provides practical assistance to communities that are designing, implementing, and operating integrated systems of mental health and substance abuse services in the criminal justice system.

CSAT is also involved in a SAMHSA-wide effort invested in bridging issues of mental health, substance abuse, primary health care, and aging. When we speak of disabilities of physical and cognitive states, we must include aging in this context. As people age, disorders of motor function and cognition increase, therefore increasing the possibility of substance abuse within this population.

All three SAMHSA Centers (CSAT, CSAP, and CMHS), as well as the Department of Veterans Affairs, the Health Care Financing Administration, and the Health Resource Services Administrations Bureau of Primary Health Care are invested in this program. It has the goal of evaluating alternative models for delivery and financing of mental health and/or substance abuse services for older adults (65 plus) through primary health care clinics.

Clients are screened and, if appropriate, assessed for substance abuse, mental health, or co occurring illness. They are then referred to one of the following models in which outcome differences will be evaluated:

- Referral to specialty mental health/substance abuse services outside the primary health care setting (Referral Model), or
- Providing such services within the primary care setting itself (Integrated Model).

This 4-year program involves a Coordinating Center and 6 study sites funded by SAMHSA and 5 study sites funded by the Veterans Administration. Results are showing that providing these services within the clinic setting has better outcomes with this population.

Our Addiction Technology Transfer Centers (ATTCs) are also working to develop curriculum and educational materials that can be used to enhance treatment of co-occurring disorders. We have 13 ATTCs around the country working on various addiction problems. This meeting is co-sponsored by four of those ATTCs.

CSAT recognizes that there are still many questions about how to organize treatment with a focus on employment services for those who must overcome substance abuse disorders and coexisting disabilities. What we do know is that the entire spectrum of the medical and mental health fields, starting with primary care, will have to get involved if we are to succeed in addressing the needs of those with substance abuse and coexisting disabilities.

We are committed to and currently working on more proposals for the future. We know we will not eliminate the barriers of addressing the employment needs while treating patients with these multiple conditions overnight. However, with evidence-based treatment strategies and a willingness to commit to meeting the needs of those with substance abuse and co existing disabilities, we can make a difference.

If you create cross-training for staff at substance abuse treatment programs, mental, physical, and cognitive disability programs and vocational programs, you will begin to see improved employment outcomes.

Knowledge in the hands of front-line staff will be translated into attention to all issues presented by the client. You have the power to initiate efforts to improve access for adequate funding and put the client first. This will not be easy. We are challenging comfortable patterns in the substance abuse, mental health, physical health, and disabilities fields. But, together, we can be change agents for others.

When we create a seamless treatment system we will be far better able to reach the vulnerable, the confused, and the distrustful—the whole gamut of substance abusers with coexisting mental and physical disabilities who are now consigned to living on the margin.

September is Recovery Month for CSAT. More formally, it is called "The National Alcohol & Drug Addiction Recovery Month". We encourage the observance of Recovery Month to promote awareness of the societal benefits of substance abuse treatment, to laud the contributions of substance abuse providers, and to promote the message that recovery from substance abuse in all its forms is possible.

We encourage community forums across the country to raise awareness. It is clear to me that our topic today belongs in that arena of celebrations and activities—promoting recovery for those who experience both substance abuse and coexisting disabilities.

I encourage you to think about participating in Recovery Month.

Luncheon: Day 2
Hiring Individuals With Disabilities

Presenter: Connie Ciliberti, Senior Staffing Manager, Time Warner Cable

Time Warner Cable (TWC) is part of the newly merged company of AOL Time Warner. We employ more than 3,000 employees in multiple sites in Manhattan, Brooklyn, Queens, Staten Island, Mount Vernon, and New Jersey. We serve over 1.2 million diverse subscribers throughout our franchise areas. Approximately 40 percent of our staff members fulfill technical roles, the majority of which are unionized positions. More than 400 people are employed in customer service.

The commitment to hiring individuals with disabilities is imbedded in the culture of our organization. Long before I started with TWC in 1979, the company, then known as Manhattan Cable TV, had an established relationship with the International Center for the Disabled (ICD). Over the years, we have continued to work with ICD while also developing relationships with other groups that focus on placing people with disabilities in viable jobs. We have used counselors at ICD as a training resource to conduct attitude awareness workshops to help people identify their own biases in hiring people with disabilitiesCand then educate them on how people with disabilities can fit into the workplace.

Our recruiting mission is to maintain a workforce that mirrors the communities we serve. Our goal is to recruit and retain a diverse group of people. In order to do that, for each job posted, we contact more than 30 different schools and community-based organizations that have training programs or placement services available to their clients. This takes place in addition to traditional recruiting methods. The list is reviewed annually to ensure that we are working with

groups that understand our business, the types of positions customarily available, and the type of person who succeeds in our organization. We communicate this information by conducting informational "breakfast" meetings with representatives from each organization. The presenters include managers from various hiring departments, human resources staff, and learning and development personnel to discuss our in-house training programs. We are able to describe the job and the person best suited to the job, and the agency can then prepare their clients for positions that actually exist.

As the recruiters work with each referring agency, they develop relationships with the counselors, and this has resulted in referrals before positions are even available in our organization. In addition, as other companies were feeling the crunch last year in a very competitive job market, these relationships helped us fill positions in a tough market.

Through these affiliations, we were able to attend programs that demonstrate assertive technology that helps us enlighten department heads on how a candidate can do a job with minimal disruption. Through the years, the costs for accommodations have been minimal for new hires, because either the major-ity of the expense was funded by the placement agency or because the accommodation was as simple as ordering an electronic stapler from the local stationary supplier.

Connie Ciliberti, luncheon speaker day 2

In the year 2000, we were able to hire candidates from NADAP, the Coalition for the Homeless First Step Program, and the Lighthouse. These employees were hired to fill technician positions, administrative support positions, and customer service jobs.

Members of our human resources staff participate on several business advisory boards. They include ICD, the Epilepsy Foundation, the Rusk Institute for Rehabilitative Medicine, NADAP, and several school-based advisory councils. Through monthly meetings, we are able to meet a panel of job candidates and determine if they can be considered as applicants for any available positions. We are also able to provide input in tailoring training programs so they prepare people for positions in today's job market. As a result of the relationships formed through these meetings, TWC has been helpful in creating internships for clients to allow the placement counselor the opportunity to assess whether or not a client is ready to join the workplace. The client is able to test out skills and develop current work experience in today's market.

As a result of our membership on the ICD council, I was introduced to a counselor from their kidney dialysis unit. At the time, there were a number of openings at a high hourly wage, but with no benefits. Some of clients could not risk losing their benefits but wanted to work. It was a win/win situation for all of us. They filled administrative support positions and customer service jobs.

We have a well-developed internship program with the Coalition for the Homeless First Step Program. Each training cycle for the clients lasts approximately 4 months. The first month involves developing computer skills, preparing resumes, learning how to interview, and learning

how to dress for a business environment. The next 3 months involves an onsite internship. We have been working with the First Step program for the last 2 years. Though not every internship program is a success, we have been lucky enough to hire more than eight women through the program. If a position does not exist for an intern at the end of their internship, inevitably, when a department head has an opening, they always want to hire their First Step intern.

Hopefully, you have all been able to take some time to read about Debra Bounsell, a receptionist at TWC who was hired as a result of her internship in our Human Resources Department. These internships give the employer the opportunity to get to know someone for who they are, and not judge them on other factors. The article I refer to fully disclosed Debbie's 20-year battle with crack that resulted in homelessness and, ultimately, incarceration. When the article was published, Debbie showed it to me first, and asked that I not judge her. After reading the article, I was concerned about the reaction within the company. I breathed a sigh of relief when we received praise from every level of management, both at our offices, and at the corporate office, for our work in this community.

I spoke with Debbie recently regarding the reaction from co-workers. Unfortunately, as with and other "family," there are some small-minded people who stopped speaking to her. Debbie assured me that there wasn't anything anyone could say or do that was going to stop her from moving forward in developing her career and staying clean. She attributes this attitude to the to the endless support available to her through the First Step program. Having worked with Debbie during her internship, I have come to respect her for her dedication to her job, and was unaware of her background. To this day, when the reception area is slow, she comes in and asks if there are any projects she can help with.

Training programs cannot end their relationships with the client once the placement has been made. They need to be available to the employer and the client to help work through job problems as they occur after placement. Ten years after a client had been placed by ICD at TWC as a mail clerk, I called to have the counselor speak to the employee about reasonable and realistic promotional opportunities in our company. As a result, the person moved from mail clerk to purchasing clerk.

We have found that when we hire individuals with disabilities they are loyal, dedicated workers. Just as important, or even more so, is the buy-in from your hiring managers, as well as your recruiting team, to source out the best possible candidates for each opening. We are lucky to have both.

CHAPTER FOUR

THE CHANGE PROCESS

Introduction

Steve Gallon, Ph.D. Director, Northwest Frontier Addiction Technology Transfer Center (ATTC)

The introduction of change in an organization can be unsettling. Systems tend to function best when tasks and processes are clearly defined, when instructions are clear, and when the participants are able to rely on one another to accomplish their responsibilities in a timely and accurate fashion. Change tends to destabilize a system's functioning. There can be uncertainty in job expectations, mistakes are likely until workers are comfortable and skillful in implementing the change, and a lack of trust or predictability among co-workers is natural until the change is fully integrated. Change is, therefore, a threat to the day-to-day stability of an organization. When the status quo is threatened, even by new procedures designed to improve the organization's functioning, multiple barriers surface.

One very predictable barrier is resistance. It should be expected and planned for as part of any change strategy. People resist change when it is not totally understood and when it appears to threaten their security. Thorough knowledge of the rationale and proposed change process, an opportunity to participate in decisionmaking, and clear two-way communication among organizational layers in the system will help reduce resistance and provide a safer climate for the adoption of new ways of doing business.

Change is not optional in most business settings and the field of social services is no exception. Substance abuse treatment agencies are familiar with the need to adjust their service designs to accommodate new scientific discoveries, comply with managed health care directives, and demonstrate treatment effectiveness to regulatory agencies, advocacy groups, and funding sources. The ability to adapt to these forces of change and be innovative in response to their challenges is becoming an increasingly essential survival skill for treatment organizations today. And yet, historically, there has been little guidance given to the substance abuse treatment field for

structuring and facilitating the change process. An easy-to-use guide or blueprint for change that identifies key steps and strategies for implementing new administrative and direct service policies and procedures was not available.

CONTEXT AND PRINCIPLES

In response to the need for a descriptive guide to organizational change, the federally funded Addiction Technology Transfer Centers, in collaboration with key experts and officials from the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (SAMHSA/CSAT), published The Change Book (CSAT, 2000). It describes a change process that incorporates current knowledge about how individuals and organizations adapt new discoveries and technology to fit their needs.

Consistent with the notion that effective change strategies address multiple levels of a system or organization, The Change Book suggests that administrators, direct service staff, and clients, at a minimum, should be included in a process that examines and decides how best to address issues facing the organization. That process provides the context or framework for change. It often includes:

- Policies that provide incentives for adopting innovative changes
- System administrators who are knowledgeable and supportive of the proposed innovations
- Agency directors willing to adapt their service designs to a new model
- Supervisors skilled in implementing new practices
- Opinion leaders who endorse the proposed system change
- Service providers skilled in the new practice
- Opportunities for staff input and feedback, and
- Opportunities for client input and feedback.

Principles that guide successful change efforts have been identified by researchers in a variety of disciplines. While they may be familiar to many doing organizational development work, they still require commitment, resources, and time to fully realize the value they bring to any system improvement project. With tight budgets, lean staffing, and pressure to do more with less, the utilization of proven change principles requires vision and a willingness to invest in a process that to some may seem expendable. The principles include the need for the targeted change to be relevant and practical, timely, clear, and credible. The process itself should address the readiness of multiple levels within the system to make the proposed change, be continuous over a sufficient period of time to secure the desired outcome, and include bi-directional communication between those targeted for change and those facilitating the process. Adherence to these principles tends to increase the success potential of most projects.

POTENTIAL BARRIERS

Barriers to change arise at each level within the system. They tend to surface even when sound change principles guide the effort. Each barrier that presents itself should be addressed. When

seen as opportunities, barriers provide a focus for interventions or adjustments to the change plan that are designed to lessen the threat posed by the barrier to the success of the initiative. Here are a few sources of barriers that can contribute to the slowing or derailing of a change strategy:

- System Structure – The treatment system can be fragmented at the local, State, or Federal level, leading to poor communication and agencies that work at cross-purposes.
- Policymakers – Agencies often receive funds from number of sources, making them subject to different sets of regulations and policies. Those regulations may not be consistent with the application of new scientific discoveries.
- Research Community – Researchers report their findings in scientific journals. Those publications typically do not meet agencies' needs for practical descriptions of new tools and ways to apply them in real world settings.
- Agency Staff – Experienced administrators and clinicians may misunderstand new treatment strategies, or simply prefer methods with which they are familiar. The may lack incentives to adopt new practices, suffer from funding limitations, or be generally skeptical of change.
- Client Population – People suffering from substance use disorders have a high potential for relapse during treatment. They are resistant to change and often suffer from multiple disorders. Little research has been done on such populations, limiting the degree to which scientific discoveries tested on more homogeneous populations truly generalize to more troubled groups.

All these potential barriers also present opportunities for those designing change initiatives. When understood, strategies for reducing, neutralizing, or eliminating these barriers can be developed.

THE SECOND NATIONAL CONFERENCE ON SUBSTANCE ABUSE AND DISABILITIES

This conference provided an invited group of national leaders in substance abuse, disabilities, and employment with an opportunity to review what is known about the relationship between substance abuse, coexisting disabilities, and employment, and to collaborate on the identification of priority issues and strategies for improving treatment access and employment outcomes.

Plenary sessions, panels, and work groups focused on identifying needed systemic changes. Each speaker summarized the current status of substance abuse, coexisting disabilities, and employment within their areas of expertise and proposed initiatives essential to system improvement. Conference delegates met in work groups each day to identify and prioritize objectives and strategies that could guide a national system development initiative. By the conclusion of the conference, a consensus set of priority outcomes and proposed activities for change initiatives was identified. Conference planners pledged to move those priorities forward as a national agenda.

Key to the success of the conference was the Work Group concept. Five Work Groups met simultaneously each day with a facilitator and a content expert. The content experts provided brief summaries of best practices in a particular content or functional area and served as a content resource to the group. Facilitators helped the group accomplish a structured set of objec-

tives that would yield a prioritized set of outcomes and strategies that could contribute to the foundation of a national action plan. Groups on the first day focused on key issues related to access to treatment, specific disabilities, and employment. The goal was for each group to identify three prioritized preferred outcomes for change. On the second day the Work Groups focused on functional responsibilities of the conference delegates. Their goal was to recommend action steps and strategies for at least two of the top priority outcomes identified by the previous day's Work Groups.

The action strategies were presented at the conclusion of the conference. The Rehabilitation Research and Training Center (RRTC) then pledged to move selected initiatives forward, with the ongoing assistance of the functional work groups. Conference delegates made individual commitments to assist with the national initiatives. The RRTC will serve as the national coordinator and monitor progress in enhancing access to treatment for people with coexisting disabilities, integrating vocational concerns into substance abuse treatment settings, and improving employment outcomes for treatment graduates.

CHAPTER FIVE

RECOMMENDATIONS FOR ACTION

In June 2001, national leaders and content specialists in substance abuse, disabilities, and employment convened in Baltimore at the Second National Conference on Substance Abuse and Coexisting Disabilities. As described in preceding chapters of this monograph, the goal of this two-day conference was to develop recommendations and strategies for improving treatment access and employment outcomes for persons with substance abuse and coexisting disabilities. Workgroup sessions interspersed with short plenary presentations allowed conference participants to define and prioritize objectives and strategies that could serve as the foundation for these recommendations.

The consensus-building process used at the conference was based on the principles outlined in *The Change Book: A Blueprint for Technology Transfer* (SAMHSA, 2000). This document describes a process by which technological innovations and research discoveries can be implemented to effect changes in a field's practice. This process is described in detail in Chapter 4.

Because of the broad scope of the recommendations that emerged from the conference and the relative brevity (two days) of the meeting, several post-conference steps were undertaken to complete the recommendations. Immediately after the conference, an evaluation team directed by an expert in qualitative analysis reviewed the process and outcomes of the conference. This team reviewed data comprising group and individual notes and charts. A total of 968 comments from participants were recorded and categorized within each of three main areas: (1) context, or the general nature of the comment or recommendation (i.e., unmet need, necessary change, desired outcome, barrier, or action step); (2) theme, or the type of action indicated by the recommendation (e.g., integration, service delivery); and (3) leadership, or the parties responsible for acting on the recommendation (e.g., NAADD or ATTC). Appendix C describes the methodology used in this analysis.

After a detailed analysis of the content with Atlas TI software, a separate panel of four content experts edited the results to eliminate redundancies and assigned logical groupings based on the frame of reference of consumers and practitioners in the field. A committee of

conference attendees then reviewed the recommendations to ensure that they were representative of the discussions of the conference work groups.

Preceding chapters of this monograph describe the background and need for the conference (Introduction), the plenary presentations (Chapter 1), and the change process used by the work groups (Chapter 4). This chapter presents recommendations for the field based on the conclusions of the workgroups and the results of subsequent review and evaluation. Appendix E, Glossary, defines the acronyms that appear throughout this chapter.

The agencies and organizations cited as leaders are no means an exhaustive list. They represent the input from the conference participants. In the context of implementation, additional resources will become apparent.

RECOMMENDATIONS

An overarching theme that emerged consistently throughout the conference and the subsequent analyses was the importance of developing strong and integrated linkages among all the systems that serve people with coexisting disabilities. These linkages can then serve as the basis for improving treatment access and accommodations and can help these individuals to achieve employment objectives. Many of the action steps created during the conference and detailed here are directly related to the development of these linkages. The plenary sessions also repeatedly addressed this issue from various perspectives.

Within the overarching theme of integrated systems linkages, the following five recommendations emerged:

1. Ensure that the disability community receives an equitable share of all available government resources, funding allocations, and substance abuse treatment services across National, State and Local delivery systems.
2. Establish a shared vision of employment as both an integral part of recovery and an outcome goal among systems that serve persons with disabilities, including substance abuse treatment systems.
3. Provide education, in a consistent and integrated manner, to consumers, service providers, employers, policy makers, and legislators on effective strategies for reducing stigma and discrimination and increasing employment opportunities for individuals with coexisting disabilities.
4. Define, implement, and evaluate models at the National, State, and Local levels for integrated service delivery systems that include VR and substance abuse treatment services.
5. Ensure the clinical and fiscal integration of substance abuse, mental health, and vocational rehabilitation services and streamline administrative processes.

John de Miranda, Ed. M, Executive Director, National Association on Alcohol, Drugs and Disability (NAADD), provided the following historical perspective on the conferences outcomes.

It is important to view the results of this conference in context. The major theme and resultant five objectives are resoundingly echoed in proceedings from previous important policy development gatherings, including:

1990	Third National Prevention Research and Training conference: People with Disabilities, National Prevention Network, Scottsdale, Arizona.
1991	National Policy and Leadership Development Symposium, Institute on Alcohol, Drugs and Disability, Stanford, California.
1992	Alcohol, Drugs and Disability Issue Forum, Office for Substance Abuse Prevention, Alexandria, Virginia.
1993	Creating Linkages with the Disability Community, Center for Substance Abuse Treatment, Rockville, Maryland.
1994	National Policy and Leadership Development Symposium II, Institute on Alcohol, Drugs and Disability, Marlborough, Massachusetts.
1996	First National Conference on Substance Abuse and Co-existing Disabilities, Anixter Center, Wright State University, Chicago, Illinois.

Below are selected examples of policy recommendations from previous deliberations that reflect the objectives derived from the Second National Conference in Baltimore.

Objective 1: Funding Equity

1990	Encourage the federal funding agencies to add a disability access set aside to existing requirements which includes an allocation for prevention and training.
1991	Federal block grant set-asides for people with disabilities should be established.
1993	Establish people with disabilities as a special target population and establish set-asides for that population.

Objective 2: Primacy of Employment

1991	Advocate for alcohol and drug training incorporation into curricula of rehabilitation counseling programs.
1993	Fund investigations of the feasibility and possible methods of adding vocational rehabilitation components to treatment programs to increase the success of treatment and economic independence.

Objective 3: Reducing Stigma and Discrimination

1991	File complaints with the state when aware that access to services has been denied.
1992	OSAP should recognize people with disabilities as a distinct minority population and use language and communication techniques that are sensitive to and include people with disabilities in legislation, RFAs, publications, and information services.

1992	Develop public service announcements featuring role models with disabilities and focus on alcohol and other drug abuse during Disability Awareness Month to reduce stereotypes and stigmas related to alcohol and other drug abuse and disability.
1993	Require ADA compliance by state programs and grantees including physical and programmatic accessibility.
Objective 4: Integrated Service Systems	
1990	Each state should develop a high- level task force or interagency coordinating council to examine alcohol, drugs and disability issues.
1991	National and regional task forces should be created to analyze and report on the extent to which relevant service systems do or do not interface for this collaboration. Strategies for remediating any lack of collaboration and effecting systems changes should be developed.
1993	Facilitate interagency collaboration on alcohol and other drug abuse and disability.
Objective 5: Clinical and Fiscal Integration of Substance Abuse, Mental Health and Vocational Rehabilitation	
1990	Improve interagency coordination among state and federal agencies responsible for programs/services for persons with disabilities and the alcohol and other drug abuse field.
1991	Given that current and future resources for people with disabilities are limited, it is imperative to maximize effective utilization of existing resources through sharing of those resources across agency and organizational boundaries to improve services to people with disabilities and alcohol and other drug problems.
For more than ten years consumers and professionals have been working to identify strategies and initiatives to improve alcohol and drug services for people with disabilities. These proceedings continues the tradition of documenting these endeavors, as it also illuminates the path for future efforts.	

Exhibits 1 through 2 present these recommendations from a variety of perspectives, allowing the reader to focus on specific areas of specialization within the context of integrated systems and the changes necessary to achieve integration:

1. Exhibit 1 presents the five recommendations and their related elements:

    a. *Action steps*, which describe the specific activities to be undertaken in order to implement each recommendation .
    b. *Leadership*, which indicates the stakeholder groups at the National, State and Local levels who are best positioned to take a leading role in implementing the recommendations
    c. *Targets* for changes that need to be made in policy, programs, and funding
    d. *Outcome measures*, or the means by which the recommendations' effectiveness can be assessed; and the expected *time frames* needed for implementation of the recommendations at the National, State and Local levels

2. Exhibit 2 focuses on the action agendas of leadership groups — their particular areas of concern, the informational and organizational needs that must be met in order for them to take action, and the specific actions they can undertake to bring about change.

PERSONAL ACTION PLANS

Change is difficult to achieve and ultimately relies on the efforts of individuals working in their own settings. Recognizing the need to consider change on both a macro (organizational) level and a micro (staff) level, conference participants were challenged to develop action plans for both the field at large and for themselves as individuals. Specifically with regard to the latter, each conference participant was asked to submit a personal action plan reflecting what he or she would do upon returning to the workplace to continue the dialogue from the conference and contribute to the change process.

In the course of the conference, each participant detailed the steps involved in implementing their own plans. The full list of these steps appear in Appendix D, Attachment C. They are organized according to the themes of employment, education, information dissemination, interagency collaboration, research, integrated approaches, and funding. The personal action plans demonstrate that the objectives that participants set for themselves reflect the broader goals for the field, such as providing more integrated services, educating the work force to better understand the issues at stake, and generating the funding for additional research, practice, and educational opportunities.

Exhibit 1A: Recommendation 1

Recommendation 1:
Ensure that the disability community receives an equitable share of all available government resources, funding allocations, and substance abuse treatment services across national, state, and local service delivery systems.

Action Steps:

1.1 Build coalitions across disability groups; support consumer advocacy; create e-mail system for informing disability community about opportunities for funding; identify risks for substance abuse among persons with disabilities.

1.2 Target national, state, and local organizations and government agencies for block parity; ensure that they set aside expanded funds to include the integration of coexisting disabilities in all aspects of treatment and rehabilitation; generate and disseminate list of AOD funding to consumer groups so they can advocate for representation.

1.3 Create an inventory of existing and potential funding streams by types of disabilities and target populations; study their emphasis and distribute inventory to disability agencies.

Leadership: Based on expertise in category

Local	***State***	***National***
Independent living centers *Community-based organizations* *AOD treatment and VR service providers*	*State independent living organizations; Disability consortiums; Consumer advocates*	*NAADD RRTC on Drugs and Disability NCIL, TBI Network, NOD, NCD*

Target: For changes in policy, program, and funding

Local	***State***	***National***
AOD treatment; community-based agencies; disability agencies	*DOL; institutions and organizations representing AOD treatment; office of mental health; single state agencies for substance abuse and VR*	*CSAVR, NASADAD, NIDA, NIDRR, RSA, SAMHSA/CSAT*

Outcome Measures:	***Time Frame:***
Consumer organizations demonstrate advocacy about substance abuse and coexisting disabilities; more programs demonstrate access to treatment; advocates take lead in promotion of concerns; more consumers take advantage of treatment; more consumers are employed; consumers increase participation in collaborative grant writing; federal guidelines for treatment include disability aspects.	*Local level: 3–6 months* *State level: 1 year* *National level: 2–3 years*

Exhibit 1B: Recommendation 2

Recommendation 2:
Establish a shared vision of employment as both an integral part of recovery and an outcome goal for systems that serve persons with disabilities, including substance abuse treatment systems.

Action Steps:

2.1 Train business, substance abuse, VR, WIBs, and mental health partners on integrated treatment, employment as an integrated whole. Use education to gain equal access to WIIA and other work benefit programs to approach the needs of individuals with coexisting disabilities on

2.2 Develop inventory of funding streams by types of disabilities; target populations and sources or levels of funding; study emphasis of funding streams on employment to ensure that employment is fully integrated into treatment as a process and as an outcome

2.3 Market importance of vocational goals and employment in sustained recovery to key stakeholders, including providers and consumers.

2.4 Ensure that interest groups are represented at conferences where they collaborate with funding streams to conduct study.

2.5 Identify AOD treatment programs that integrate employment goals and study best practices; encourage research on treatment models that include employment as part of the process.

Leadership: Based on expertise in category

Local	***State***	***National***
Community-based organizations, professional organizations, educational bodies, research institutes, advocacy groups, employers, disability-based employment agencies, AOD treatment with workable models, NCIL	*Professional organizations; advocacy groups; state agencies for substance abuse, mental health, VR, labor*	*NAADD; ATTCs; Professional organizations; NCRE; CASA; NCIL*

Target: For changes in policy, program, and funding

Local	***State***	***National***
Business councils, WIBs, welfare-to-work programs, WIIA initiatives, AOD treatment employers	*Single state agencies for substance abuse, mental health, VR, labor*	*SAMHSA/CSAT, NIAAA, NIDRR, RSA, Washington Business Group on Health, NIDA*

Outcome Measures:	***Time Frame:***
Requests for proposals presented by federal and state entities; research conducted on alternative models of care; interagency collaboration in response to RFPs; funding available for integrated approaches; stakeholders communicate about the need for integrated approaches; curricula are developed and available; models are forthcoming	*Local level: 6 months* *State level: 2–3 years* *National level: 3 years*

Exhibit 1C: Recommendation 3

Recommendation 3:
Provide consistent and integrated education to consumers, service providers, employers, policy makers, and legislators concerning effective strategies for reducing stigma and increasing employment opportunities for individuals with coexisting disabilities.

Action Steps:

3.1 Generate research findings related to evidence-based practice and effective integrated program and system models for replication.

3.2 Produce wide range of training and educational resources at the degree-granting and continuing-education levels. Ensure that curricula emphasize an integrated approach across systems and within treatment. Incorporate research-to-practice models.

3.3. Provide cross-training within agencies and across systems and disciplines.

3.4 Use technology transfer research-to-practice models in all educational efforts.

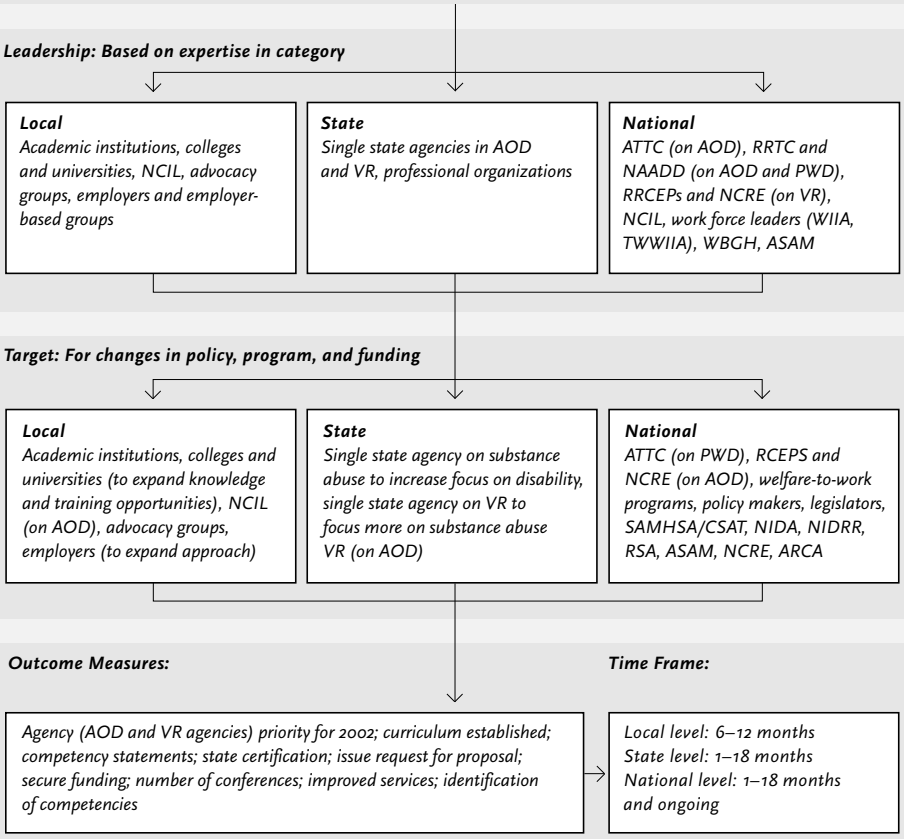


Exhibit 1D: ***Recommendation 4***

Recommendation 4:
Define, implement, and evaluate models for integrated national, state, and local service delivery systems that include VR and substance abuse treatment services.

Action Steps:

4.1 Define what is meant by an integrated model.
4.2 Conduct research on integrated models.
4.3 Establish collaborative funding for integrated treatment, research, and dissemination.
4.4 Identify obstacles to integrated approach: mission, funding, resources.

Leadership: Based on expertise in category

Local	***State***	***National***
Research organizations, leaders in integrated AOD treatment, VR, employment initiatives	*Single state agencies for substance abuse, VR*	*ATTCs, RCEPs, NAADD, RRTC on Drugs and Disability, CASA, NIDA, NIAAA, AMERSA, HRSA*

Target: For changes in policy, program, and funding

Local	***State***	***National***
AOD programs, employment initiatives, TANF offices	*Single state agencies for substance abuse, mental health, VR*	*SAMHSA/CSAT, NIDA, NIAAA, NIDRR, RSA, AMERSA, HRSA*

Outcome Measures:	***Time Frame:***
Substance abuse treatment programs integrate PWD through access, programs, and policies; VR agencies integrate persons with substance abuse disorders and coexisting disabilities; TANF offices recognize coexisting disabilities; National Freedom Initiative incorporates substance abuse	*Local level: 3–12 months* *State level: 6–18 months* *National level: 12–18 months and ongoing*

Exhibit 1E: *Recommendation* 5

***Recommendation* 5:**
Integrate the clinical and fiscal aspects of substance abuse, mental health, and VR services and streamline administrative processes.

Action Steps:

5.1 Establish employment as an integral component of all processes and outcomes, as a matter of policy for all agencies and systems.

5.2 Have all government initiatives incorporate coexisting disabilities and integrated approaches in all funding opportunities and policy actions.

5.3 Target national, state, regional, and local political entities for block grant parity, set-asides, and expanded funds to address substance abuse and PWD.

5.4 Examine federal and state legislation and policies to identify those that support successful integrated treatment and those at cross-purposes with this goal. A) Provisions of ADA, WtW, TANF, TWWIIA, WIA that cause barriers; B) examine workplace regulations relative to their support of integrated treatment; C) draw upon and encourage grassroots advocacy to encourage policy shifts; D) demand substance abuse treatment as societal right.

Leadership: Based on expertise in category

Local	***State***	***National***
Local NCILs (disability advocates), TANF programs, community-based organizations, NAMI, substance disability advocates	*Single state agencies for substance abuse, VR, mental health, policy and planning*	*RRTC on Drugs and Disability; NAADD; NCIL; CASA; RCEPs and ATTCs, RSA, NAMI*

Target: For changes in policy, program, and funding

Local	***State***	***National***
Work force initiatives, government entities	*Single state agencies and state VR, DOL, policy and advocacy organizations*	*SAMHSA/CSAT, RSA, NIDA, NIDRR, White House, WBGH*

Outcome Measures:	***Time Frame:***
TANF guidelines equally recognize coexisting disability categories; National Freedom Initiative identifies provisions for substance abuse and coexisting disabilities; NIDRR and SAMHSA/CSAT, as well as NIDA and NIAAA, share in funding initiatives in this category; NCIL and NAMI collaborate in advocacy	*Local level: 3–12 months* *State level: 6–18 months* *National level: 12–18 months and ongoing*

Exhibit 2: Action Agenda by Category

Disability Community *(especially NAADD, NCIL, Local Independent Living Centers, Vocational Rehabilitation Agency and Local Providers of Disability Related Services, NCMMR, NOD, NCD, TBI Network, DD Association)*

RECOGNIZE THE NEED FOR:	ACTION STEPS:
• Determining the extent and consequences of substance abuse among constituents • Determining the risk for substance abuse among constituents • Sending a coordinated message • Determining the consequences of the lack of an integrated message about the consequences of coexisting disabilities?	• Educate constituents about risks and consequences of substance abuse and disability and support integrated treatment • Advocate for equitable share of treatment and research dollars. • Acknowledge coexisting disabilities by all stakeholder groups and government bodies. • Achieve consensus on prevalence of coexisting disabilities.

Research Community *(especially NIDA, NIDRR, NIAAA, SAMHSA, RRTC, NCMMR, Educators, Foundations [eg: Robert Wood Johnson], Federal, State and Local Research Centers, [eg: NDRI, CASA])*

RECOGNIZE THE NEED FOR:	ACTION STEPS:
• Evidence-based integrated practice • Evidence-based model of integrated programs, with cost factors, demonstrating impact of undiagnosed disability on outcomes • Best models for integrating employment services as a treatment process and outcome	• Develop evidence-based models that emphasize the benefits of an approach that is integrated in terms of disability and employment. • Conduct epidemiological studies within the AOD treatment community and the broader disability community. • Publish findings.

Education and Training *(especially ATTCs, RCEPS, Universities, NCRE, RRTC on Drugs and Disability, AMERSA, HRSA, HHS, NADAC, ARCA)*

RECOGNIZE THE NEED FOR:	ACTION STEPS:
• Informed stakeholders in all groups (education, research, practice, and policy) • Curriculum on substance abuse and coexisting disabilities based on evidence-based practice, with emphasis on integrated models • Interdisciplinary cross-training options within and across agencies	• Develop evidence-based curricula that educate all stakeholder groups about the risks and consequences of substance abuse, especially for individuals with disabilities. • Develop curricula providing adequate training in assisting recovering individuals to return to employment, recognizing the specific challenges they face, regardless of the existence of a coexisting disability. • Expand range of programs offering specialization at undergraduate, master, and doctoral levels of substance abuse treatment. • Integrate coexisting disabilities into all curricula. • Create curricula that emphasize a cross-discipline, cross-agency focus to promote collaboration and integration. • Make new information and research-based service models available to the appropriate provider communities.

Exhibit 2: Action Agenda — Continued

Policy *(especially NIDRR, NIAAA, NIDA, CDC, NASADAD, NAADAC, RSA, SSA, HHS, SAMHSA/CSAT, and the White House)*

RECOGNIZE THE NEED FOR:	ACTION STEPS:
• Policies that make clear the need for inclusion of individuals with coexisting disabilities • Policies that promote tolerance and support for substance abuse alone and with coexisting disabilities and for treatment • Policies that reduce stigma and provide equal access to treatment and rehabilitation	• Develop policy at the Federal, State, and Local levels that addresses the inclusion of individuals with coexisting disabilities in treatment without stigma. • Work toward consistent policies across organizations so that there is an evenness from access to treatment through to employment opportunities.

Funding Entities *(especially CDC, NIDA, NIAAA, SAMHSA/CSAT, RSA, NIDRR, OSERS, NICHD, HCFA)*

RECOGNIZE THE NEED FOR:	ACTION STEPS:
• Support for research, education, and practice in substance abuse and coexisting disabilities and an integrated approach • Equal access to funding by all disability groups, especially groups related to substance abuse and coexisting disabilities • Targeted funding to bring the AOD and disability issue into parity with other funding opportunities	• Provide funding appropriate to the magnitude of the problem. • Designate funding that supports the needs of individuals with coexisting disabilities. • Develop approaches and vehicles for cross-agency funding. • Ensure that funding guidelines include opportunities for individuals with disabilities as a focus.

State Systems *(especially Single State Agencies in AOD, VR, Mental Health, Criminal Justice, CILs)*

RECOGNIZE THE NEED FOR:	ACTION STEPS:
• Memos of understanding among substance abuse, VR, mental health, and departments of education and labor • Policies that provide equal access to services for substance abuse and coexisting disabilities within the state VR system	• Develop memos of understanding among agencies. • Improve collaboration in developing policies, programs, and staff education.

Employment Community *(WIA, TWWIIA, TANF, WBGH, WIB, Chambers of Commerce, DOL, Employers, NADAP)*

RECOGNIZE THE NEED FOR:	ACTION STEPS:
• Increased employment opportunities for individuals with coexisting disabilities • Equal access to TANF, WIIA, WIA, and WIB dollars to reduce stigma in the workplace and to create employment opportunities • Incentives to advance opportunities for individuals with coexisting disabilities	• Provide equal access to employment. • Expand workplace outreach and prevention. • Establish cooperatives between business and treatment. • Educate employers about substance abuse treatment and the role of employment and decrease stigma against substance abuse and disability.

Exhibit 2: Action Agenda — Continued

Treatment and Rehabilitation Community *(Single State Agencies in AOD and VR, SAMHSA/CSAT, AMERSA, HRSA, Community Based Rehabilitation Agencies and Providers)*

RECOGNIZE THE NEED FOR:	*ACTION STEPS:*
• Certainty that mission statements recognize coexisting disabilities and need for employment services as integral to the treatment process • Reduction of turf barriers between disability community and AOD treatment community • Change of policies and practices that support interdisciplinary collaboration and provide equal access to treatment and treatment resources for individuals with disabilities	• Engage in inter- and intra-agency collaboration. • Examine obstacles to inclusion of individuals with coexisting disabilities in treatment programs and to integration of employment services. • Rewrite policies and practices to support AOD and coexisting disabilities. • Support partnership with business community, employment initiatives, rehabilitation agencies, and AOD treatment providers. • Develop approaches to integrate employment as a treatment process and outcome.

Summary

Of the many prevailing themes emerging from the conference, the idea that arose most consistently was the importance of collaboration between systems to integrate the provision of substance abuse treatment and disability services. Integrated treatment means the following:

From the AOD perspective, integrated treatment provides equal access to individuals with disabilities and does not permit stigma related to disability. Equal access requires unhindered access to the treatment facility and to all program elements, whether these are provided in-house or in collaboration with community resources. Employment should be integrated into substance abuse treatment and should be established as a treatment outcome. Integrated treatment requires cross-discipline and cross-agency integration so that individuals' special needs will be met effectively. It also requires interdisciplinary education so that all stakeholders can fully understand the needs of individuals in treatment and can support the collaboration that is required for positive outcomes. Integrated treatment involves coordination in accessing and extending resources, as well as sharing new information and evidence-based models.

From the disability perspective, integrated treatment means understanding and accepting substance abuse as a risk and a consequence of disability. It involves working to eliminate the stigma of substance abuse among individuals with disabilities. Advocacy efforts must then take an integrated view of disability and must discourage internecine competition for attention, financial resources, and employment. Service providers should be knowledgeable about all disabilities, including substance abuse. Integrated treatment requires support for equal access to employment regardless of disability and the equitable sharing of funding opportunities. It also involves collaboration of efforts in public education.

Highlights of what needs to be done to achieve the integrated approach:

1. Reduce stigma against individuals with substance abuse and coexisting disability.
2. Support research that helps to identify the extent of the problem of substance abuse and co-occurring disability, as well as the factors that mitigate against treatment access and retention for individuals with co-occurring disabilities, and that develops and tests strategies for providing integrated treatment, including employment services.
3. Increase the availability of evidence-based practices.
4. Provide adequate resources to conduct research and implement the treatment approaches that are most effective.
5. Improve education and training by creating new curricula and integrating curricula on coexisting disabilities into all substance abuse curricula. Conduct these activities at both the in-service and the degree-granting levels.
6. Develop opportunities for continuing professional education and cross-training to foster collaboration both within and across programs. Make training and education available to substance abuse providers, VR providers, disability advocates, and employers.
7. Expand the work force of individuals who are skilled in addressing issues of coexisting disabilities and employment needs for individuals in recovery. Provide skills training to existing staff as well as new professionals entering the field.

8. Extend outreach and collaboration with the business community, making use of work force initiatives that have been promulgated at the National, State, and Local Levels.
9. Develop policies at the national, state, and local levels that support the needs of individuals with coexisting disabilities for treatment and rehabilitation.

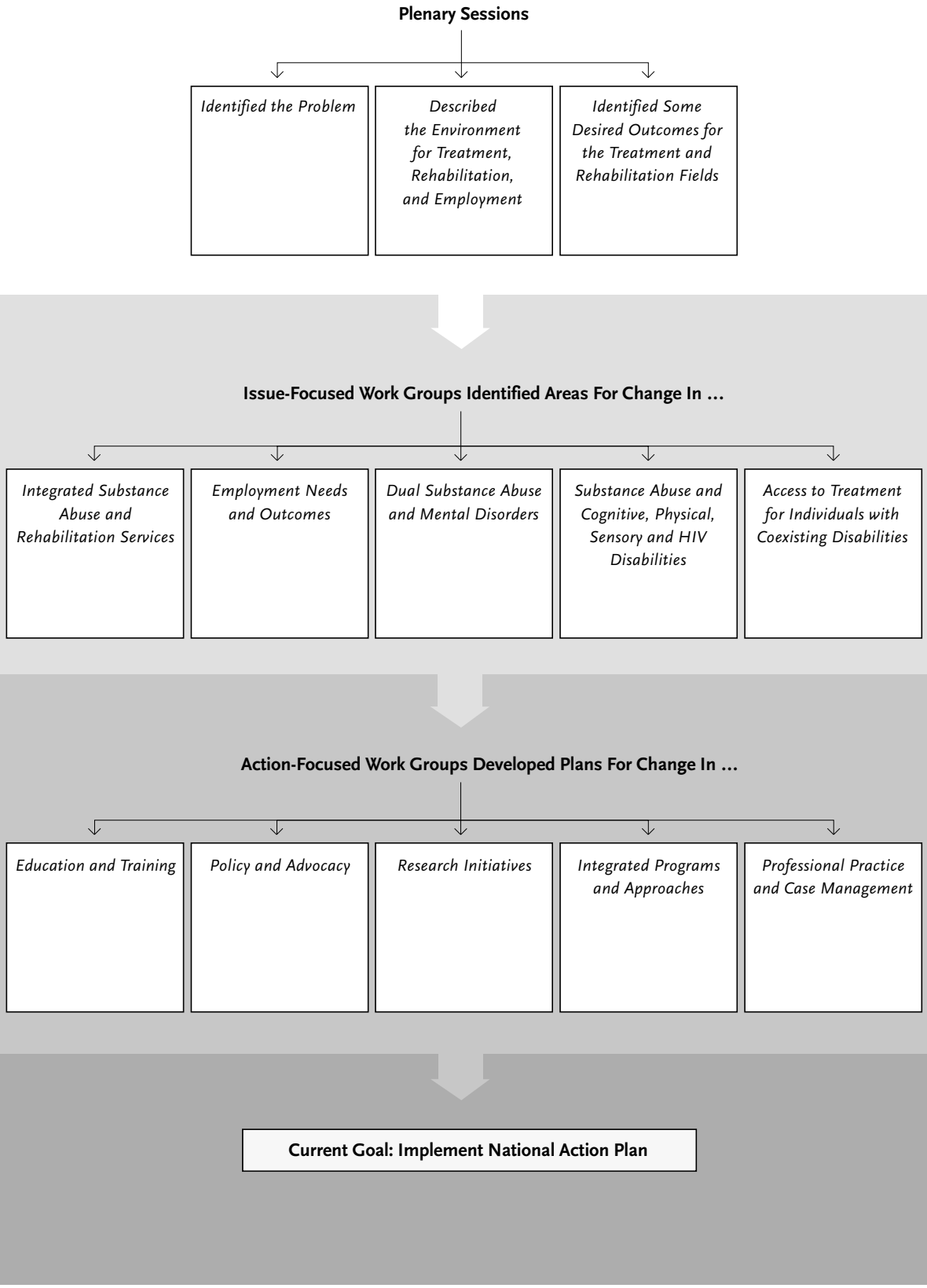
Efforts will be needed at the National, State, and Local Levels to achieve these objectives and to fulfill the Action Agenda detailed in Exhibit 3.

How will we know that success is being achieved?

1. Systems will form partnerships.
2. Voices of consumers will be heard.
3. Policy statements will be inclusive of substance abuse, disability, and employment.
4. Research will be appropriately supported.
5. Cross-agency funding will become available.
6. Appropriate curricula will be incorporated at the undergraduate, master, doctoral and continuing professional education levels.
7. Evidence-based practice models will be adopted and disseminated.
8. Risks and consequences of substance abuse and coexisting disabilities will be minimized and/or appropriately treated at all levels.
9. Stigma will be reduced.
10. Turf divisions will be minimized and collaboration will be more frequent.
11. Individuals in recovery will have greater access to employment and will achieve increased employment success.
12. Substance abuse will be addressed at rehabilitation conferences and meetings; disability will be addressed at substance abuse conferences and meetings.

APPENDIX A:

CONFERENCE CHANGE PROCESS



APPENDIX B

CONSENSUS PROCESS GUIDELINES

WORK GROUP FACILITATION PROCESS GUIDELINES

Conference Process Guide

This conference will provide an invited group of national leaders in substance abuse, disabilities, and employment an opportunity to come together to accomplish two primary objectives:

1. Review what is known about the coexistence of substance abuse and disabilities, and
2. Collaborate on the identification of priority issues and strategies for improving treatment access, policy, research, practice, and professional education.

Plenary sessions, panels and work groups will all focus on *change*. Each speaker will summarize the current status of their topic and propose changes essential to system improvement. Conference delegates will meet in work groups to identify and prioritize objectives that will guide a national system development initiative. At the conclusion of the conference there will be *consensus* surrounding priority issues related to improving treatment and employment outcomes for people having substance use disorders and coexisting disabilities.

Success in achieving the conference objectives is dependent in large measure on the effectiveness of the small group processes designed as an integral part of the conference experience. Each day will feature work group sessions that include a sequence of activities that will lead to consensus recommendations from the participants.

THE WORK GROUPS

Key to the success of the conference is the work done by the work group leaders and facilitators. The leaders will set the stage with a presentation on best practices and a literature review. Throughout the session they will assure keeping the focus on the issue and continue to provide content input (see guidelines for Work Group Leaders, page 84). Facilitators will be responsible

for helping the work groups accomplish their assigned tasks within the time allowed in the conference agenda. It is critical that the group facilitators understand their role and the instructions for each working session. They will need to be clear also on the role played by the leaders.

DAY 1 OVERVIEW

Five work groups will meet for 2 hours in the afternoon following the third plenary session of the day. Each group will represent one of the following interest areas:

- Integrated Substance Abuse and Rehabilitation Services
- Employment Needs and Outcomes
- Dual Substance Abuse and Mental Disorders
- Substance abuse and Cognitive, Physical, Sensory and HIV-related Disabilities
- Access to Treatment for Individuals with Co-existing Disabilities

Each of the five will include two leaders and two facilitators. Participants will self select their group according to interest. It is hoped the groups will be of comparable size, approximately 20-25 persons each. During the afternoon, each group will be divided into two smaller groups, each with a leader and a facilitator.

The goal for the afternoon's work is for each of the five work groups to come to agreement on a prioritized list of no more than six preferred system change outcomes and barriers to achieving each. Those outcomes need to be directly related to the interest area represented by the work group and be related to employment. For the highest priority outcome, the group will give additional attention to identifying barriers to achieving that outcome.

DAY 2 OVERVIEW

Following a plenary session on "identifying desired outcomes in employment, treatment and education" the results of the Day 1 work groups will be reported, identifying the top priority desired outcome and potential barriers for each. Conference participants will then be oriented to the new work groups for Day 2. They include:

- Education and Training
- Policy and Advocacy
- Research Initiatives
- Professional Practice and Case Management
- Integrated Programs and Approaches

These groups represent functional areas critical to the field. Each group's goal will be to reach consensus on recommended action steps and strategies for two of the selected outcomes developed during Day 1. After reviewing the 5 top priority outcomes identified on Day 1, the work groups will prioritize those 5 outcomes and select the top two. At that point the group will divide into two smaller groups. Each sub-group will address one priority outcome and develop a strategic plan to achieve that outcome.

WORK GROUP FACILITATORS

Facilitators are encouraged to consider these tips for effectively filling their role:

- Make it explicit that you will not manipulate or influence the content
- Do not talk too much
- Be an energizer, set a positive tone
- Keep the group moving toward the goal of each activity
- Listen closely and encourage group members to listen to each other
- Encourage participation by all
- Protect members from personal criticism and from one person's domination

To achieve the objectives for the work groups a set of facilitator guidelines and group discussion questions have been developed. Please use them to help provide structure and leadership during the discussion. You will also need to solicit several volunteers for roles that will help keep the group on task as you proceed through the agenda. You will need:

a. A *Recorder* to record the group's decisions on flip chart paper. You will be provided with markers, paper and masking tape for posting the group's work,
b. A *Reporter or Reporters* to share your group's work with the other small group(s), and
c. A *Timekeeper* to help assure the group sticks to the timeline for each activity and gives balanced attention to each of the discussion questions.

The group will address each of the issues identified in their handout, and record key points on flip chart. The facilitator helps the group prioritize its ideas and responses to each question and encourages input from every member of the group. Staying within the time limit suggested for each question/issue to be discussed will be essential to completing the group's work successfully.

On each day the work groups will start out with two facilitators then break into small groups with one of you going with each group. The groups will merge back and again there will be two facilitators. I suggest that you either agree, in advance, to move through each step when you are together in rotating fashion or have one of you do the opening section and the other do the closing section when the groups come together again.

DAY I - SEQUENCE OF ACTIVITIES AND OUTCOMES

MORNING: Two plenary sessions in which "the problem" is identified and "current policy issues" related to treatment, rehabilitation and employment are considered. Defining the key players in a change process will also be addressed briefly during the morning.

AFTERNOON: A third plenary on "models for integrated treatment" immediately precedes an orientation to the work groups that will meet for the remainder of the afternoon. The orientation will include the idea that instituting effective change processes requires key stakeholders

participating in a sequence of activities designed to assure a thorough, systematic and orderly transition to an agreed upon preferred state.

The five work groups will each include two leaders and two facilitators. Those folks will be introduced, as will the expected outcomes of the group work about to be undertaken. The five groups will be constituted according to participant interest. It is hoped that the small groups will be of comparable size, 20-25 persons each. The interest areas include:

1. Integrated Substance Abuse and Rehabilitation Services
2. Employment Need and Outcomes
3. Dual Substance Abuse and Mental Disorders
4. Substance abuse and Cognitive, Physical, Sensory and HIV-related Disabilities
5. Access to Treatment for Individuals with Co-existing Disabilities

A total of 2 hours has been allotted for the small groups to complete the activities and produce the products described in the next section.

DAY 1: WORK GROUP FACILITATOR GUIDELINES

A description of the sequence of activities and instructions to the work group facilitators follow. Each of these activities is critical to the success of the group. Work groups should not depart from this plan.

1. *Introductions:* One of the two facilitators convenes the group, introduces self, the other facilitator and the two leaders. Each participant is then asked to introduce themselves by name and organization only (10 mins).
2. *Orientation to the Work Group and Best Practice Information:* A facilitator briefly introduces the work group's agenda as:

    a. learning about best practices in this interest area
    b. learning who the resources are in the work group
    c. utilizing a guided process to identify 3 preferred system change outcomes and barriers to achieving them

The leaders are invited to share an overview of the "best practice" literature (20 mins total for the two leaders). Facilitator then leads a brief response discussion (10 mins). Total time available for this portion of the program is 30 minutes.

3. *The facilitators next divide the work group into two smaller discussion groups:* Each small group has a process facilitator and a content expert. The group moves immediately into the small groups. (5 mins)
4. *Introductions:* The facilitator first asks members to briefly introduce themselves, acknowledging their areas of expertise and the strengths they bring to the interest area (15 mins).

5. *Purpose of the small group:* Facilitator next presents the purpose for this portion of the program as: *"coming to agreement on a prioritized list of 3 preferred system change outcomes and barriers to achieving each. Those outcomes need to be directly related to the interest area represented by the work group and be related to employment."* (2 mins)
6. *Need for Volunteers:* To accomplish that goal the group will need several volunteers. Needed are a reporter or reporters to share the results of the group's work with the other small group, a recorder to record the group's decisions on flip chart paper, and a timekeeper to make sure the group gives balanced attention to each of the discussion questions. The discussion questions are quickly reviewed before moving on to the discussion and answering of each. (5 mins)
7. *Goal:* The goal of the small groups is for each group to identify three preferred out comes of change initiatives, prioritized in order of importance. A total of 60 minutes is available for this next activity, estimated as follows:

The group answers and the recorder documents on flip chart, the group's answers to the following questions:

1. *Brainstorm:* Based on your own knowledge, the plenary presentations and the research you have heard presented today, what do you think are the most pressing unmet needs regarding employment outcomes for individuals with substance abuse and co-existing disabilities in relation to your topic? How do we know they exist? (10 mins)
2. *Brainstorm:* What changes in clinical or administrative practice or policy related to your topic would have the most impact on improving substance abuse services to achieve employment outcomes for individuals having disabilities? (10 mins)
3. Next, from among the group's ideas, *prioritize the three most important changes* that need to be made in order to improve desired employment outcomes. Then, *for each* of the three prioritized changes, *identify and describe:*

    a. The most important outcome for each of the prioritized changes,
    b. Any potential barriers the group can identify that might prevent or limit success fully achieving that outcome

Barriers can include:

- National policies or a lack thereof
- Local policies or administrative procedures
- Funding structures and limitations
- Knowledge and skill deficits in administrative and/or direct service personnel
- Need for technical assistance or outside expertise to plan or implement the change
- Attitudes or beliefs of key individuals, organizations, or whole systems
- Lack of/or poor interagency collaboration

4. Prepare a brief report on your three priority changes and their desired outcomes by completing the matrix provided. Include potential barriers to achieving each outcome, and how your group reached agreement. (40 mins)
8. *Merge back to the work group:* Facilitators lead the group in the following activities (25 mins):

    a. *Small group reporters* share their prioritized change recommendations and the desired outcome for each.
    b. The work group's task is to *prioritize those six outcomes.* The two facilitators will work cooperatively to achieve the prioritization.
    c. Then, *for the work group's top priority outcome only,* the group discusses and makes additions or changes to the most significant barriers to achieving that out come. The question is: What significant barriers need to be addressed in order to achieve the outcome we have identified as our top priority?

9. *That concludes the work group activity for the afternoon.* Thank the group for their good work!
10. *At end of day:* The two facilitators and leaders are responsible for handing in to conference administrators prior to departing on Day 1:

    a. Notes taken during the work group and small group activities,
    b. The flipchart pages used in making the small group reports on their top three priority outcomes and barriers,
    c. The prioritized list of 6 outcomes and the outcome designated as top priority for the larger work group discussion,
    d. The expanded list of barriers for the top priority outcome.

DAY 2: SEQUENCE OF ACTIVITIES AND OUTCOMES

Morning: A fourth plenary on "identifying desired outcomes in employment, treatment and education" will precede a report to the conference on Day 1 outcomes. The 10 area experts from the previous day will be asked to report the results of the work groups, identifying the top priority desired outcome and the barriers for each.

Conference participants will then be oriented to the new work groups for Day 2. They include the following functional areas of responsibility:

- Education and Training
- Policy and Advocacy
- Research Initiatives
- Professional Practice and Case Management
- Integrated Programs and Approaches

Each group's goal will be to reach consensus on recommended action steps and strategies for at

least two of the top priority outcomes developed during Day 1. They will have the remainder of the morning to complete the assignment, using a structured sequence of activities described in the next section.

Each work group will again include two leaders and two facilitators. The work groups will each break into two sub-groups, each taking a different selected outcome, and developing strategies and action steps to effect change, considering the barriers identified on Day 1. The groups will then reconvene to hear reports from the smaller groups and to refine the strategies developed. Each sub-group will have a facilitator, a content expert, and a specific agenda of issues and questions that need to be addressed for each outcome. The work groups will have approximately 2 hours to complete the process.

Afternoon: Each of the 5 work groups reports its priority action plans in some detail to the large group. (45 mins)

In the final session, the conference planners will respond to the recommendations and lead a reaction discussion with all conference participants. The goal here is to solicit feedback on the plans presented, identify resources within the group for help with implementation, and individual commitments from conference participants. The RRTC will take the lead in overseeing the implementation process. The RRTC will select one outcome action plan and it will be their priority for Year 5. In closing, conference planners will identify the next steps to be taken. (45 mins)

Conference evaluations will be completed prior to adjournment.

DAY 2: WORK GROUP FACILITATOR GUIDELINES

The facilitator in each of the subgroups will lead the following activities within the suggested timeframe.

1. *Introductions:* Help group members know who is in the group by asking group members to introduce themselves and briefly identify one strength or resource they bring to the group. (10 mins)
2. *Introduce leaders:* The leaders will summarize the important role played by the functional area they represent and will define its potential for facilitating improved outcomes in the treatment and rehabilitation process. (10 minutes each for a total of 20 mins)
3. *Review the tasks to be accomplished:* (5 mins)

    a. Review and prioritize the 5 priority outcomes from Day 1
    b. In small groups develop a strategic plan for achieving one of the top priority outcomes
    c. Small groups report their work to each other and make additions, revisions, improvements
    d. Individuals complete a personal action plan, identifying how each will contribute to the realization of the priority outcomes

4. *Review a handout that summarizes the 5 top priority outcomes* that were the product of the 5 small groups that convened on Day 1, and facilitate a prioritization of those 5 outcomes. (10 mins)
5. *Divide the work group into at least two smaller subgroups.* Each subgroup is charged with responsibility to develop a strategic plan to achieve the outcome for the selected priority. The subgroup must select one of the top two priorities. The priority selected must be different from the one(s) being addressed in the other subgroup(s) (10 mins)
6. *In the sub-group, the facilitator uses a set of structured questions on a separate handout to facilitate the development of the strategic plan.* Before beginning, review the process for accomplishing the task. That process includes:
    - Identifying relevant barriers.
    - Strategies and action steps to overcome barriers.
    - Who are the leaders and the allies of the change process?
    - Establish a timeline for outcome achievement.
    - How will the process be evaluated?

    Identify roles for volunteers (including a recorder, presenter(s), and a timekeeper) to assist with the process, and soliciting volunteers. Identify who will present the group's plan to the other sub-group. Proceed with developing the plan. (30 mins)
7. *The work group next reconvenes.* The leader from each sub-group presents their plan for achieving the assigned outcome. Facilitate a discussion of each plan, making revisions as necessary, and the preparation of a report to the afternoon session of the whole conference. (30 mins)
8. *When the plans are finalized each individual in the work group completes the personal action planning form* on which each will commit to a plan of action in support of the group's plan, following the conference. Individuals are invited to share their commitment with other members of the group. (10 mins)
9. *Before closing the work group session, facilitate the identification of two individuals from the work group who are willing to be the group's representative to the national planning body and to maintain correspondence within the group* following the conference. The intent here is to be clear that the impact of this conference will continue as the plans evolved at the conference move toward implementation. The small groups are expected to have a role in the planning and implementation of change processes designed to achieve the prioritized outcomes. (10 mins)
10. *Congratulate the work group for a job well done. Return to the larger conference room.*

That's It! Good Job!

Work Group Facilitators Reminder Sheet: Day 1

GOAL: For the interest area, come to agreement on three preferred outcomes of change initiatives related to employment, prioritized in order of importance. For each priority outcome, identify barriers to achieving that outcome.

PROCESS: The sequence of activities outlined below will help provide structure and a timeline for accomplishing your goal.

SEQUENCE OF ACTIVITIES: Total time available for the work group is 2 hours.

1. *Introductions:* One facilitator takes lead, introduce self, other facilitator and the two leaders. Ask each participant to introduce themselves by name and organization only (10 mins).
2. *Orientation and Best Practice Information:* Briefly introduce work group's agenda. Leaders share overview of "best practice" literature (20 mins). Facilitator leads a brief response discussion (10 mins).
3. *Divide into two smaller groups:* Each small group has a process facilitator and a leader (5 mins)
4. *Introductions:* Ask members to briefly introduce themselves, acknowledging their areas of expertise and the strengths they bring to the interest area (15 mins)
5. *Introduce purpose of the small group:* "Coming to agreement on a prioritized list of 3 preferred system change outcomes and barriers to achieving each."
6. *Volunteers:* Please solicit several volunteers for the following roles. (5 mins)

    a. A Recorder to record group member contributions and group decisions on flip chart paper.
    b. A *Reporter or Reporters* to share your group's work with the other small group(s).
    c. A *Timekeeper* to help assure the group follows the suggested timeline for each activity.

7. *Review the following assignment and steps for achieving it*
8. *Identify three preferred outcomes of change initiatives, prioritized in order of importance.* (60 minutes is available for this next activity, estimated as follows)

The group answers and the recorder documents answers to the following questions:

1. *Brainstorm:* Based on your own knowledge, the plenary presentations and the research you have heard presented today, what do you think are the most pressing unmet needs regarding employment outcomes for individuals with substance abuse and co-existing disabilities in relation to your topic? How do we know they exist? (10 mins)
2. *Brainstorm:* What changes in clinical or administrative practice or policy related to your topic would have the most impact on improving substance abuse services to achieve employment outcomes for individuals having disabilities? (10 mins)
3. Next, from among the group's ideas (40 mins) Identify and describe:

    a. The *most important changes that need to be made*
    b. The *most important outcome for each* of the prioritized changes,
    c. Any *potential barriers* that might prevent full achievement of that outcome. Barriers can include:

- National policies or a lack thereof
- Local policies or administrative procedures
- Funding structures and limitations
- Knowledge and skill deficits in administrative and/or direct service personnel
- Need for technical assistance or outside expertise
- Attitudes or beliefs of key individuals, organizations, or whole systems
- Lack of/or poor interagency collaboration

Summarize your three priority outcomes and potential barriers on the matrix provided and prepare to present it to the larger work group.

9. *Merge back to the work group:* Small group reporters share their prioritized change recommendation and the desired outcome for each. (5 mins)
10. *Work group prioritizes those six outcomes:* Facilitators work cooperatively to achieve the prioritization. (10 mins)
11. *For the top priority outcome only,* the group reviews and revises the most significant barriers to achieving that outcome. (10 mins) *The question to be asked is: What significant barriers need to be addressed in order to achieve the outcome we have identified as our top priority?*
12. *This concludes the work group activity for the day.* Thank the group for their good work.

Wrap-up responsibilities: Facilitators and leaders are responsible for handing in to conference administrators prior to departing:

a. Notes taken during the work group and small group activities,
b. The flipchart pages used in making the small group reports on their top three priority outcomes and barriers,
c. The prioritized list of 6 outcomes and the outcome designated as top priority for the larger work group discussion,
d. The expanded list of barriers that need to be addressed for the top priority outcome.

Work Group Facilitators Reminder Sheet: Day 2

GOAL: Each work group's goal will be to reach consensus on recommended action steps and strategies for at least two of the selected outcomes developed during Day 1.

PROCESS: The sequence of activities outlined below will help provide structure and a timeline for accomplishing your goal. A total of 2 hours is available.

SEQUENCE OF ACTIVITIES:

1. *Introductions:* Help group members know who is in the group. (10 mins)

2. *Introduce leaders:* The leaders will define the functional group's potential for facilitating improved outcomes in the treatment and rehabilitation process. (10 minutes each for a total of 20 mins)
3. *Process:* Review the tasks to be accomplished. (5 mins)
4. *Review a handout that summarizes the 5 top priority outcomes* identified on Day 1. Facilitate the group's prioritization of those 5 outcomes. (10 mins)
5. *Divide the work group into at least 2 smaller sub-groups.* Assign each subgroup 1 of the 5 priority outcomes and charge them with the responsibility to develop a strategic plan to achieve that outcome. Assure that the groups take on different priority outcomes. If the group wants to break into more than two groups, with each tackling a different outcome, that is acceptable. In that case the facilitators will give directions to the full group before splitting off and will go from group to group to assure adherence to times. Leaders will do the same. Each group will have to appoint a nominal leader, time keeper and note taker. The leader can be the presenter when the groups merge. (10 mins)
6. *In the sub-groups, use a set of structured questions* on a separate handout to facilitate the development of the strategic plan. First, review the process for accomplishing the task:
    - Identifying relevant barriers.
    - Strategies and action steps to overcome barriers.
    - Who are the leaders and the allies of the change process?
    - Establish a timeline for outcome achievement.
    - How will the process be evaluated?

    Next, identify roles for volunteers (including a recorder, presenter(s), and a time-keeper), and solicit volunteers. Then, proceed with development of the plan, using the Strategic Planning Questions. (30 mins)
7. *Work group reconvenes.* Leader from each sub-group presents the plan for achieving the assigned outcome. Facilitate a discussion of each plan, making revisions as necessary, and the preparation of a report to the afternoon session of the whole conference. (30 mins)
8. *Each individual next completes the personal action planning form* on which each will commit to a plan of action in support of the group's plan, following the conference. Individuals are invited to share their commitment verbally with other members of the group. (10 mins)
9. *Before closing the work group session, facilitate the identification of two individuals from the work group who are willing to be the group's representative* to the national planning body and to maintain correspondence within the group following the conference. The intent here is to be clear that the impact of this conference will continue as the plans evolved at the conference move toward implementation. The small groups are expected to have a role in the planning and implementation of change processes designed to achieve the prioritized outcomes. (10 mins)
10. *Afternoon session:* The leaders for each of the 5 work groups report their group's priority action plans to the large group (45 mins)

The leaders are responsible for handing in the identity of the two volunteers from each work group who will serve as communication links between other members of the work group and Dr. Wolkstein at RRTC.

Guidelines for Work Group Leaders

DAY 1: ISSUE FOCUS

Overview of the work group and its goal: To inform you about the dynamics and intentions of the work group, I have enclosed the map of the conference and the guidelines to facilitators. The guidelines document articulates the goals of the work groups and the process that will be followed. In brief it is the intention of work groups on Day 1 to review the "best practices" and information relevant to the topic based on the expertise of you as content leaders but also the input from the participants who have much to share from their expertise. After the review of the "bests" the work groups will work to coming to consensus on *changes* that are necessary to move the field forward in the specific area of your work group and *desired outcomes* for those changes and the potential *barriers to change*.

For example: if the topic issue is Substance Abuse, Coexisting Disabilities and Vocational Rehabilitation the desired *CHANGE* might be to have vocational rehabilitation integrated into all treatment programs; the *desired outcome* would be that all treatment programs will have a designated vocational rehabilitation program including professional staff and the *barriers to change* might be money, lack of available staff, reliance on the state VR agency.

At the beginning of the session you will each have 10 minutes to make a presentation. The presentation should include a reference to the literature and current practice related to the topic area. You need to be in contact with the co-leader so that between the two of you the most important aspects of the topic are presented without duplication. Your goal is to provide an overview and to set the stage for the dialogue that will continue. You can make reference to the plenaries that have preceded the work group and integrate content and references that you found relevant and useful to comment upon.

Once the larger group breaks into two smaller groups you will continue to be the content expert, working closely with the facilitator to keep the dialogue flowing but assuring that the content area remains the focus and that the concerns raised are relevant and reflect the needs of the field.

Remember that the conference has as a theme achieving employment outcomes. With this in mind, please be sure to make reference to employment and employment needs and preparation in your remarks and, as the dialogue continues, to keep mindful of the implications of the comments of others on employment.

DAY 2: ACTION FOCUS

The goal of this session is to come to consensus on action strategies to effect changes in response to the desired outcomes and barriers developed on Day 1. These will be presented to each group and through a process of discussion the group will decide which desired outcomes it

chooses to address and what resources it intends to apply to each desired outcome. A group of 20 could decide to address all five of the desired outcomes and break into five smaller groups of four individuals each. As the content expert, it is you first task to define for the group how the functional area can impact the change process.

For example: how research can be a tool to address the desired outcome of integrated vocational rehabilitation in all substance abuse treatment programs. If this was one of the desired outcomes from Day 1, you would set the stage as to how research can begin to address this issue.

Once the larger group has decided on its smaller composition, each of you will go with one of the two smaller groups or will float if there are more than two smaller groups. Your role in the groups is to help the facilitator in steering the process toward continuance of the focus on the functional area and how it can be mobilized as part of accomplishing the strategic plan.

Strategic Planning Questions: To be used in Day 2 Work Groups

In the Day 2 work groups you are working with the group to develop a plan to achieve a specific outcome that will ultimately improve treatment effectiveness and employment status for people having a substance abuse problem and a coexisting disability. The desired outcomes were developed in Day 1. You also have a list of potential barriers related to achieving that outcome. To map a plan to achieve that outcome, consider these questions with the group:

1. Which of the potential barriers that could interfere with realizing the target outcome are most relevant to your functional group?
2. For each most relevant barrier, how could each be minimized? What specific strategies, actions, activities or initiatives need to be undertaken? Consider whether any of these issues need to be addressed:
    a. National, state or institutional policies
    b. Informational campaigns targeted to specific audiences
    c. Identifying information needed to "tip" the decisional balance
    d. Training and education of targeted groups
    e. Need for additional research
3. For each strategy or action, who should take a leadership role? Who are the allies who could participate in the change process?
4. How soon could the outcome be achieved?
5. How should the process be evaluated?

2nd National Conference on Substance Abuse and Coexisting Disabilities

Facilitating Employment for a Hidden Population

BUILDING CONSENSUS

Perhaps the most common hazard for teams is a lack of consensus. It is a particularly thorny problem, and brings a lot of teams to heated arguments, division and disaster. Bill Isaacs of the MIT Dialogue Project believes that ancient societies were highly skilled in making consensual decisions, but that we have largely lost their knowledge and ability. Corroborating this theory, Marlo Morgan, MD, has documented the extraordinary consensus-reaching abilities of the Australian aborigines. Both Isaacs and Morgan believe that we can, with training, rediscover and apply this ancient skill.

The word consensus comes to us from Latin roots meaning "shared thought." Consensus does not imply complete agreement, but does involve seeking a decision with which everyone is reasonably comfortable. To accomplish this, everyone will need a fair opportunity to be heard and latent issues much be explored to the satisfaction of the group.

Many different tools can be used to build consensus. In fact, all the tools used in quality management contribute to consensus. For example, a well-run brainstorming session can get lots of ideas out onto the table and give everyone a chance for input. Still, most groups approach a point where they must choose between options, or try to narrow a list from many items to just a few. For this, effective tools specifically for building consensus are used.

Effective tools will do the following:

- Help to structure discussion and to keep it from going in circles.
- Downplay the link between an idea and its "author"
- Discourage "gaming the system" behavior in which one faction tries to counterbalance another
- Reduce the tendency to conform to group opinion
- Protect against reprisals for open disagreement
- Support decision-making in a manageable framework of valid comparison
- Encourage respect for strong opinions
- Where applicable, follow valid mathematical rules

For long lists of items which must be whittled down to a few contenders, multivoting is one of the quickest tools. In a multivote, each voter picks a set number (often 1/3 or the total number of choices) of items from the pool. The items which are picked by the most voters stay on the active list; the others drop out. For shorter lists of choices (10 or less) other techniques come into play. Rank-ordering is used frequently, but it can be misleading since it forces intervals where there may be none and imposes equal interval ratings where they most likely don't reflect reality.

Rating scales, in which each item is rated on a scale from 1 to 5, or 1 to 6, or even as much as 1 to 10, tend to be more accurate. Wider scales encourage gaming, and may allow the votes of extremists to distort group decisions. Narrow scales, through, may not allow enough scope for voters to express their real judgements. Since voting is not intended to make a decision, but to structure discussion and narrower scales that dampen extremes of opinion are often most useful.

The bottom line in consensus building methods is really this: vote to reduce a list to a manageable size, not to make a decision directly; discuss to elicit the opinions of team members and to gain insight. A vote should not be the final step in the attainment of consensus; rather, a course of action should emerge, and everyone should have a chance to assent to the group's pursuit of it.

For this conference we encourage two main methods to support consensual decision-making. One is structured discussion, in which decision are carefully framed, alternatives systematically discussed, and notes taken. The second method involves the effective use of voting – rating systems and multivoting – to reduce lists and quantify opinions.

Building Consensus Steps

1. Write out the issue.
2. Suggest many alternative answers (candidates).
3. Reduce a long list (10+ items) using a multivote.
4. Carefully discuss the remaining candidates. Take notes on each.
5. Decide which criteria you will use to evaluate your candidates.
6. Do a rating vote.
7. Look at areas of disagreement, and discuss them further.
8. Vote again, if necessary.
9. Discuss the outcomes of the vote. Has everyone been heard?
10. Can everyone support the decision?

For full text, please visit http://www.skymark.com/resources/tools/building_consensus.asp

Process Guide: Building Consensus

Consensus is a strategy that involves everyone playing a role in the decision making of the group. In order for this to be successful it is important to be open to compromise!

GUIDELINES

- Trust each other. This is not a competition; everyone must not be afraid to express their ideas and opinions.
- Make sure everyone understands the topic/problem. While building a consensus make sure everyone is following, listening to, and understanding each other.
- All members should contribute their ideas and knowledge related to the subject.
- Stay on the task..

- You may disagree, that is OK and healthy. However, you must be flexible and willing to give something up to reach an agreement.
- Separate the issue from the personalities. This is not a time to disagree just because you don't like someone.
- Spend some time on this process. Being quick is not a sign of quality. The thought process needs to be drawn out some.

PROCEDURE

1. Agree on your objectives for the task/project, expectations, and rules (see guidelines above).
2. Define the problem or decision to be reached by consensus
3. Figure out what must be done to reach a solution.
4. Brainstorm possible solutions.
5. Discuss pros and cons of the narrowed down list of ideas/solutions.
6. Adjust, compromise, and fine tune the agreed upon idea/solution so all group members are satisfied with the result.
7. Make your decision. If a consensus isn't reached, review and/or repeat steps one through six.
8. Once the decision has been made, act upon what you decided.

WORK GROUPS

WORK GROUP DAY 1: FOCUS ON ISSUES

Small group consensus goal:

- Identify the three most important changes, the desired outcomes related to the change, and the barriers to the desired outcomes.

Full group consensus goal:

- Identify the one most important change and the desired outcomes and the barriers.

WORK GROUP DAY 2: FOCUS ON ACTION

Small group consensus goals:

- Select the desired outcomes and barriers to address
- Select the action strategies to address the barriers.

Full group consensus goals:

- Refine the action strategies related to chosen desired outcomes and barriers.

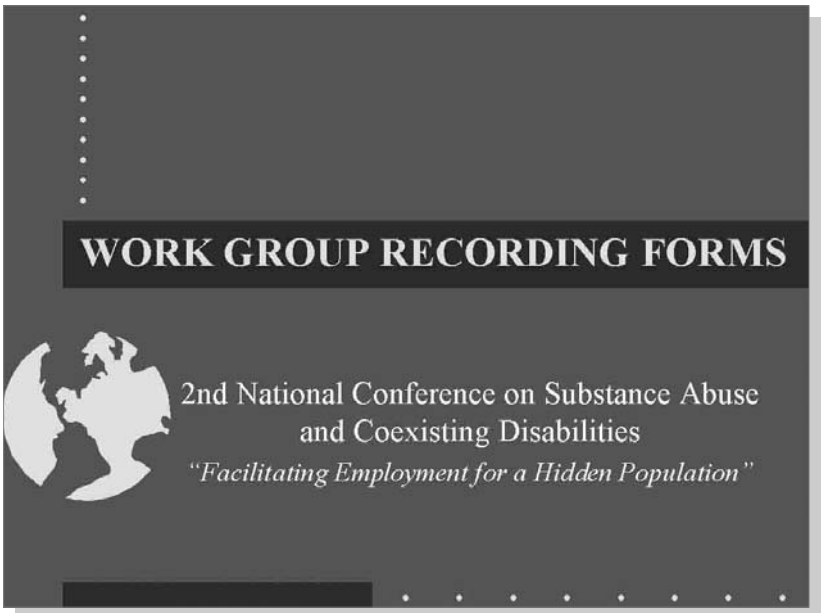
*For full text, please visit: http://projects.edtech.sandi.net/s...pss99/processguides/consensus.html

Needs of Individuals in the Work Groups

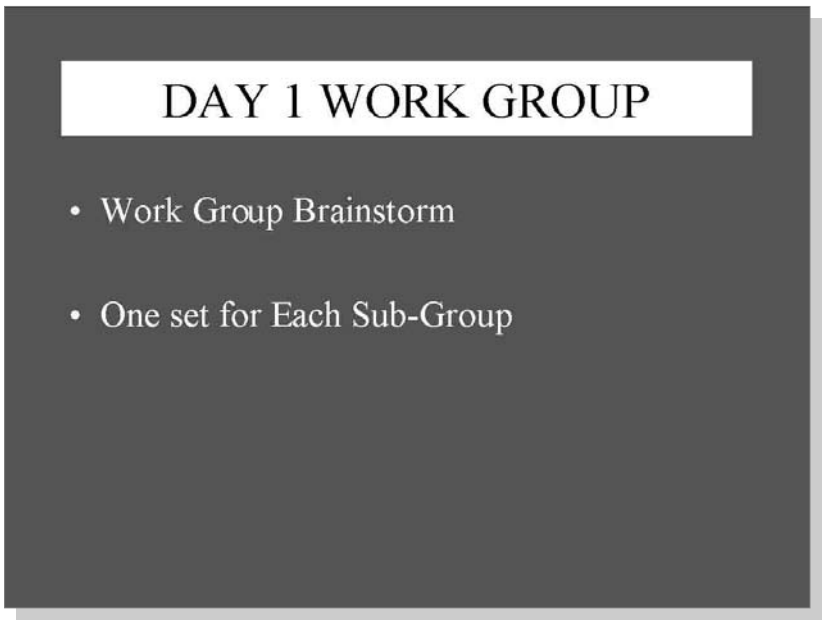
The following are important needs group members value:*

1. *Group members need to feel a sense of belonging.*
   Although retaining their individual autonomy, group members need to feel that they belong to a team, that they are valued members of it and receive a sense of security in the importance of their presence and their contribution to the group process.
2. *Group members need to feel a commitment to group goals.*
   The process of goal-setting and achieving some consensus on identified goals is a very important one. Group members achieve this commitment when they see the value of the goals selected, regard them as attainable, and clearly view themselves as having a part in refining those goals and directing the group process.
3. *Group members need a sense of progress.*
   Although members may work hard to achieve goals, it is important that there be concrete messages which convey systematic progress toward reaching those goals so that members can feel a sense of accomplishment..
4. *Group members need clarity of expectations.*
   It is important that team members are clear about the role which is expected of them in the group and have some say about altering that role should they find it uncomfortable or inappropriate. Coupling these clear expectations with meaningful assignments which are challenging yet within the scope of the person's ability is important in maintaining member interest and commitment.
5. *Group members need to have confidence in the leadership.*
   A good facilitator fosters a sense of security in group members through clarity of the role of the identified leader and maximum flexibility for group members to assume leadership where appropriate. The security of knowing that the person in charge is capable and trusting of group members will allow them a greater freedom to assume leadership and ultimately reduce the necessity for structure and control within the team.

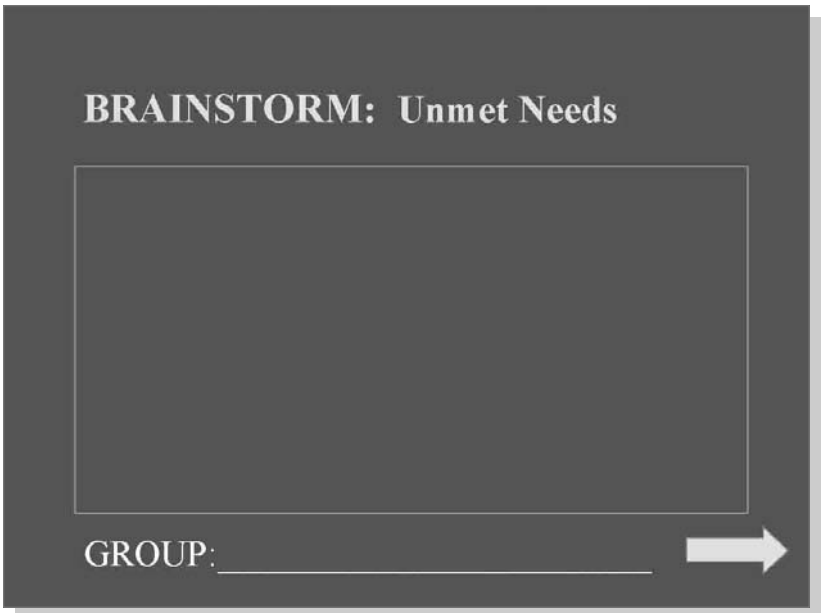
*For full text, please visit the web site http://www.wi-sdc.org/facil03.html and http://www.wi-sdc.org/facil01.html


WORK GROUP RECORDING FORMS
2nd National Conference on Substance Abuse
and Coexisting Disabilities
"Facilitating Employment for a Hidden Population"

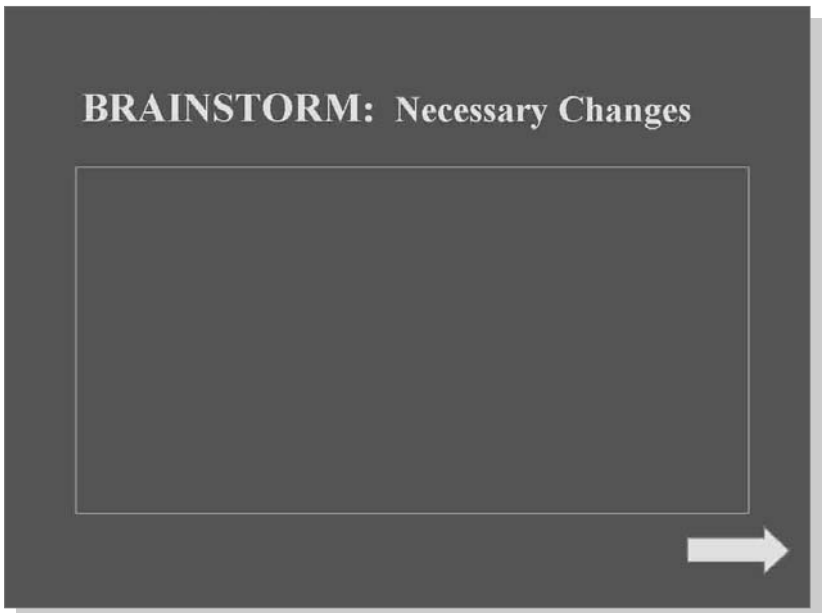
1


DAY 1 WORK GROUP
• Work Group Brainstorm
• One set for Each Sub-Group

2


BRAINSTORM: Unmet Needs
GROUP:_____

3


BRAINSTORM: Necessary Changes

4


TOP THREE CHANGES
1.
2.
3.

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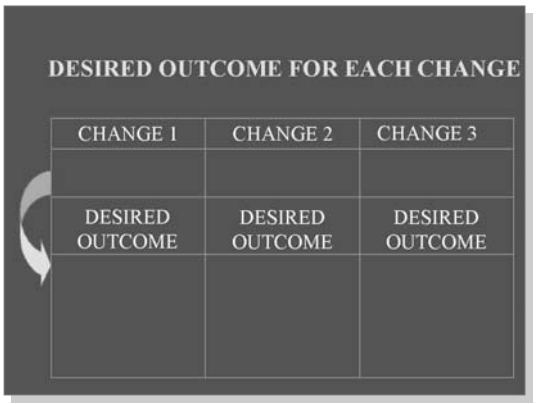
DESIRED OUTCOME FOR EACH CHANGE
CHANGE 1
CHANGE 2
CHANGE 3
DESIRED OUTCOME
DESIRED OUTCOME
DESIRED OUTCOME

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FINAL PRODUCT DAY 1 EACH SUB-GROUP
BARRIERS TO DESIRED OUTCOMES
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BARRIER
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BARRIER

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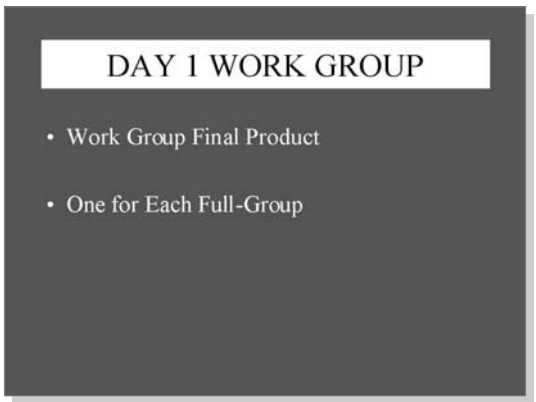
DAY 1 WORK GROUP
• Work Group Final Product
• One for Each Full-Group

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FINAL PRODUCT DAY 1
DESIRED OUTCOMES AND BARRIERS
GROUP: _____
DESIRED OUTCOME
BARRIERS

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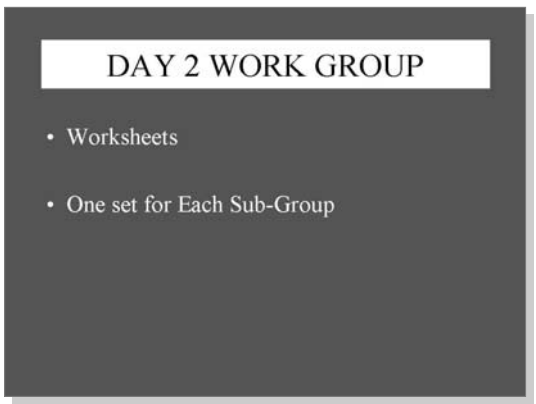
DAY 2 WORK GROUP
• Worksheets
• One set for Each Sub-Group

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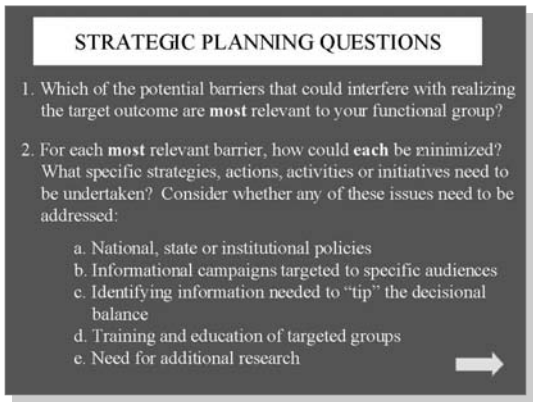

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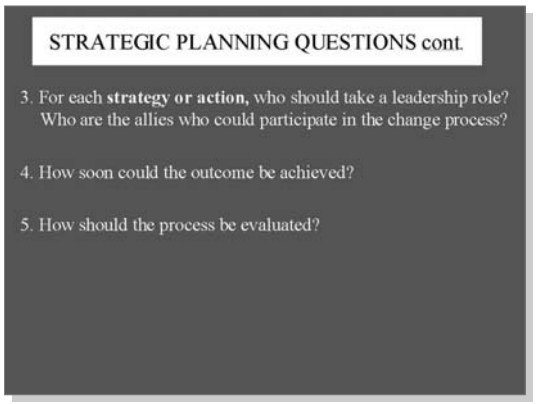

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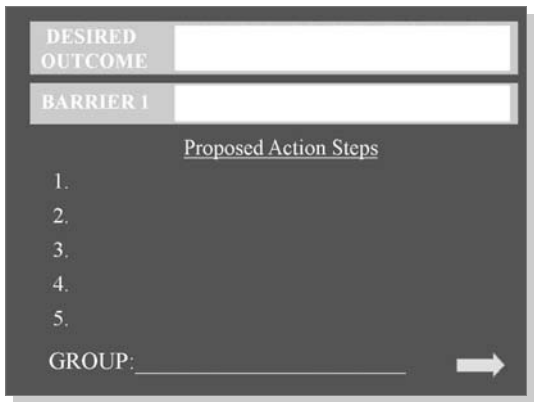

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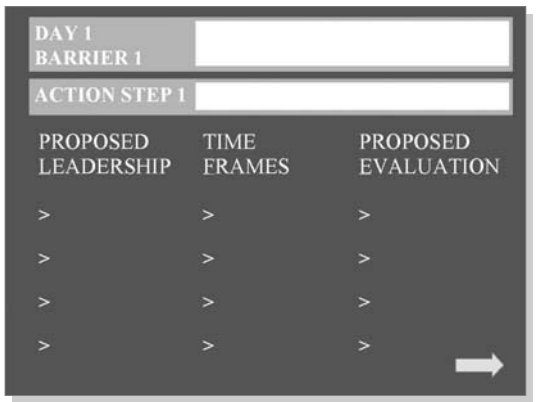

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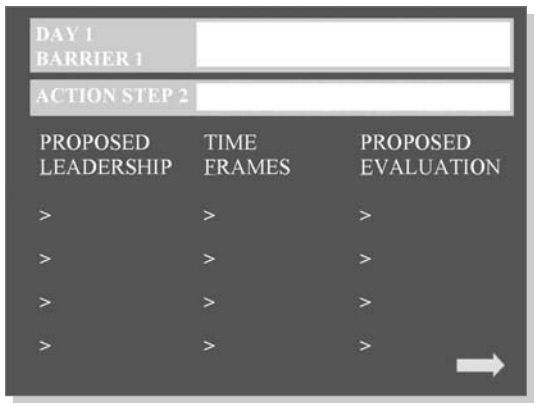

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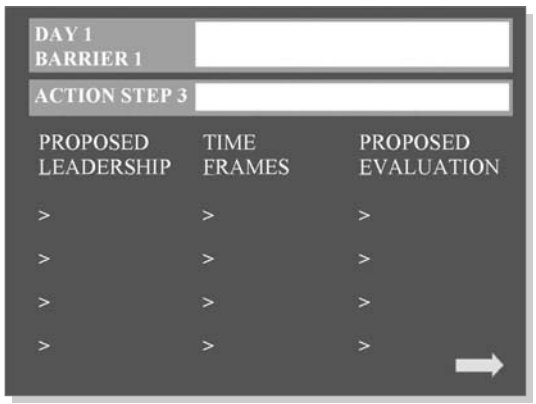

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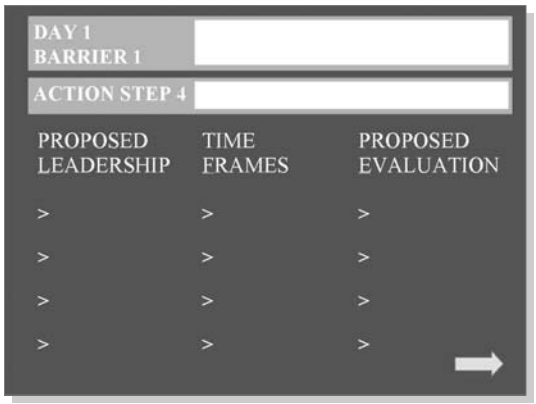

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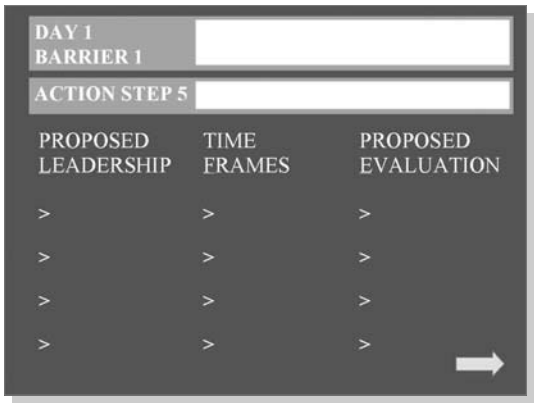

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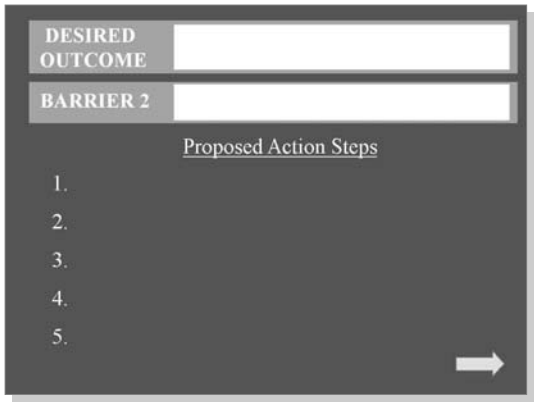

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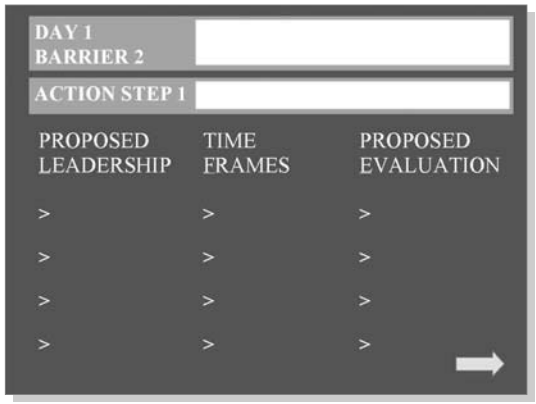

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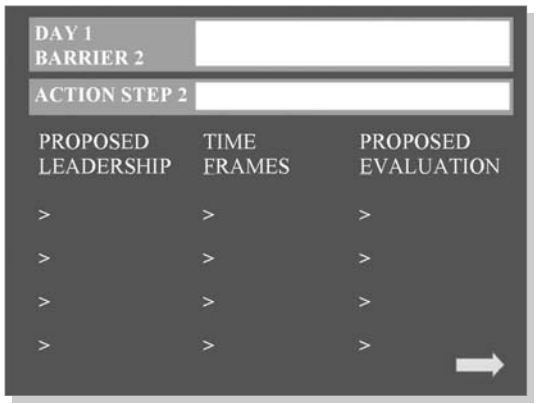

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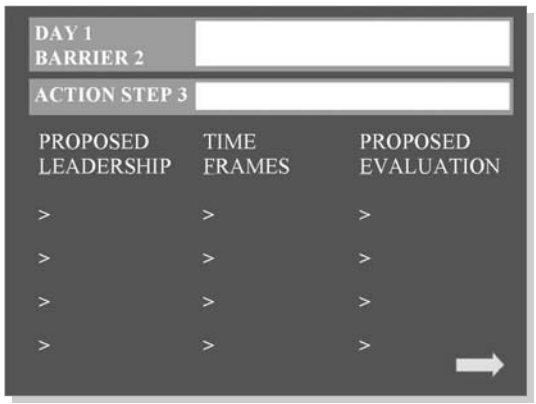

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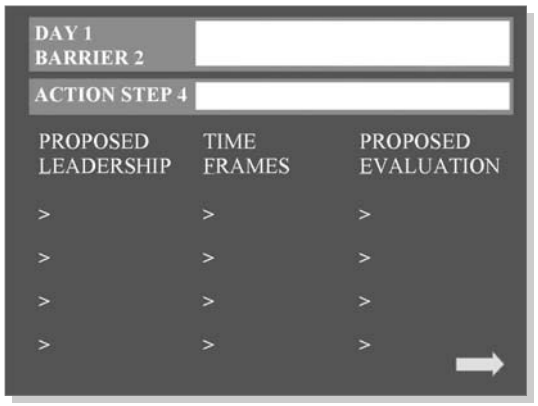

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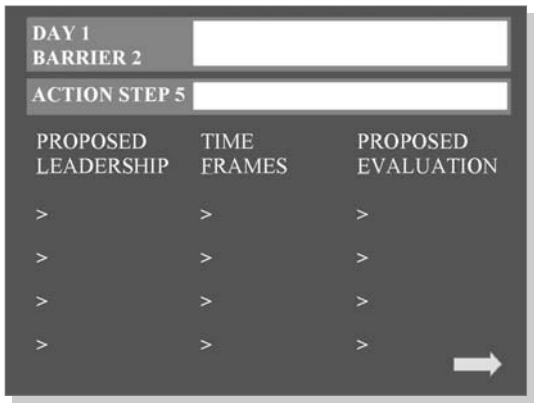

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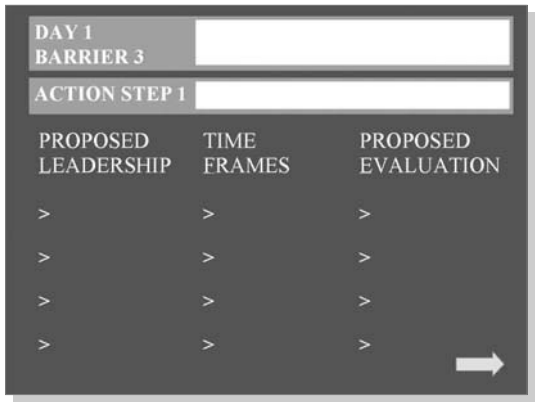

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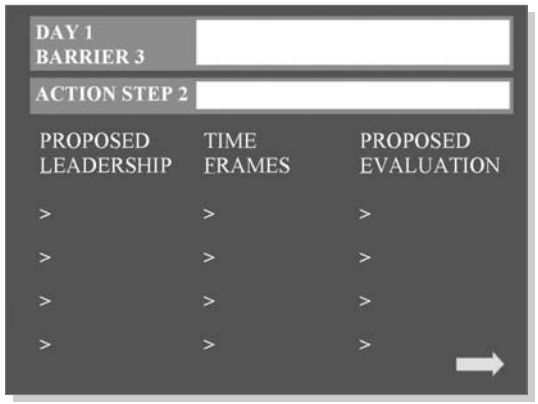

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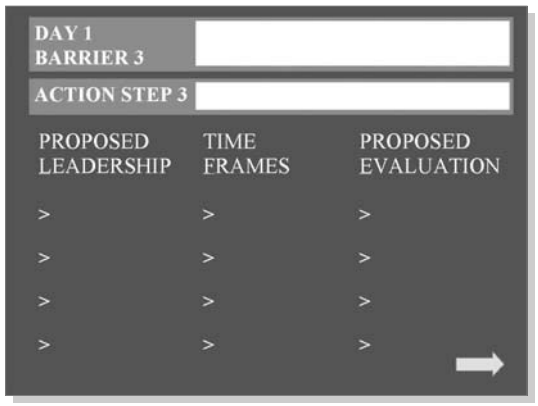

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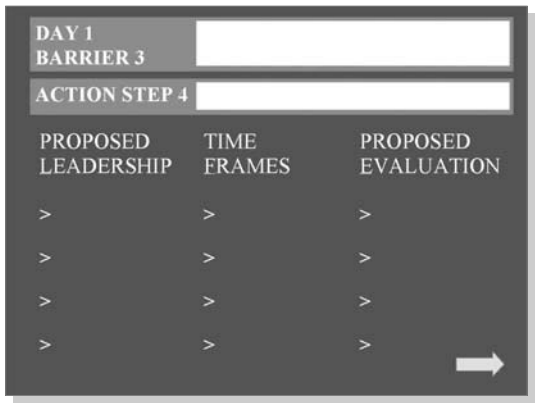

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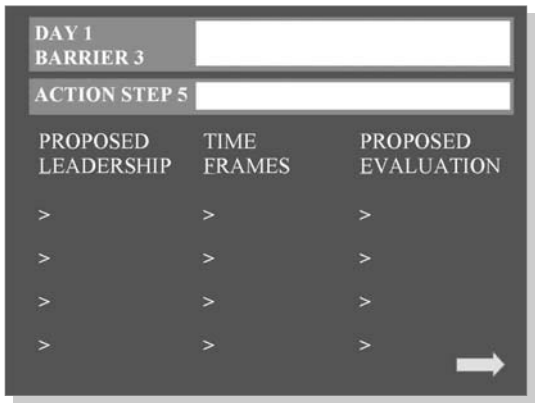
DAY 1
BARRIER 3
ACTION STEP 5
PROPOSED LEADERSHIP
TIME FRAMES
PROPOSED EVALUATION
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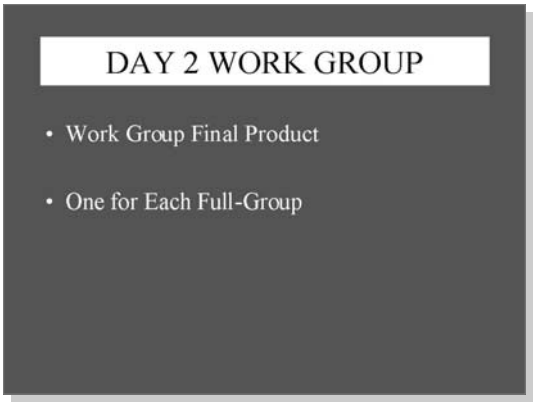
DAY 2 WORK GROUP
• Work Group Final Product
• One for Each Full-Group

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FINAL PRODUCT DAY 2
DESIRED OUTCOME
Barrier 1
Barrier 2
Barrier 3
ACTION STEP
LEADERSHIP
TIME FRAME
EVALUATION

31

APPENDIX C

CONFERENCE OUTCOMES

DATA ANALYSIS

Outcome Analysis

The overall goal of the Second National Conference on Substance Abuse and Coexisting Disabilities was to identify the most salient issues that challenge the field in the areas of successful treatment and employment access. An evaluation team, led by an independent consultant, reviewed the goals of the conference and the information obtained through plenary sessions and work groups to determine an effective means to present the recommendations that emerged through the conference change process.

Conference participants used the change process described in Chapter 3 to achieve consensus on conference outcomes. Consensus statements for the work of Day One and Day Two appear in Attachment 1 and Attachment 2 of this Appendix. After careful consideration of all conference elements, the evaluation team chose to focus not only on these consensus statements, but also to examine the content of the discussions that led to them. This approach assured that valuable participant input was not lost.

To achieve the most comprehensive and meaningful reporting of these results, the evaluation team selected a methodology to analyze the data in its full capacity and develop recommendations that can be applied at the local, state, regional, and national levels. (Chapter 5 presents these recommended action steps, describes the level of leadership appropriate for each type of action, presents suggested time frames for implementation of these actions, and lists evaluation criteria by which success in each area can be measured.)

Data Analysis Method

All transcripts, notes, and materials generated during the conference (products generated by the conference participants) were analyzed using Atlas TI, a qualitative analysis software application. Atlas TI allowed for the input of the wealth of material produced by the conference. In addition, this program organized the data in ways that reflected the richness and complexity of conference discussions and conclusions. The conference aimed to build consensus; however, such efforts can be hindered by the challenges inherent in the group process, as well as by limited time. However, the selected methodology affirmed the work of the conference consensus process, since the final statements generated using Atlas TI were parallel to the consensus statements found in Attachments 1 and 2.

Analysis Process

A total of 968 comments were generated by participants and assigned the following:

- A "context code" (a code which describes where in the conference the comment emerged, that is, what charge was given to the participants when they stated the comment eg., identify unmet need, necessary change, desired outcome, barrier, action step, leadership, or time frame),
- One or more "theme code(s)" (such as integration or service delivery), and
- One or more "leadership code(s)" (such as NAADD or ATTC).

If a comment was relevant to more than one area, it was assigned several themes and leadership codes. This topic was related to several different themes and could be considered the responsibility of several different leaders. The coding was independently reviewed by three coders to ensure consistent use. Any discrepancies in coding were resolved through discussion by the coders. For example, the desired outcome statement: Funding set up to require collaboration between agencies/departments or additional funding granted to groups/programs that collaborate was initially assigned the code of funding. After review by other coders, a code for collaboration was also assigned, as it was determined that this comment was relevant in both areas. This approach allowed for further refinement of context, themes, action steps, leadership, time frames, and evaluation criteria, resulting in a more accurate presentation of the data.

Context codes were assigned to one of the five following categories:

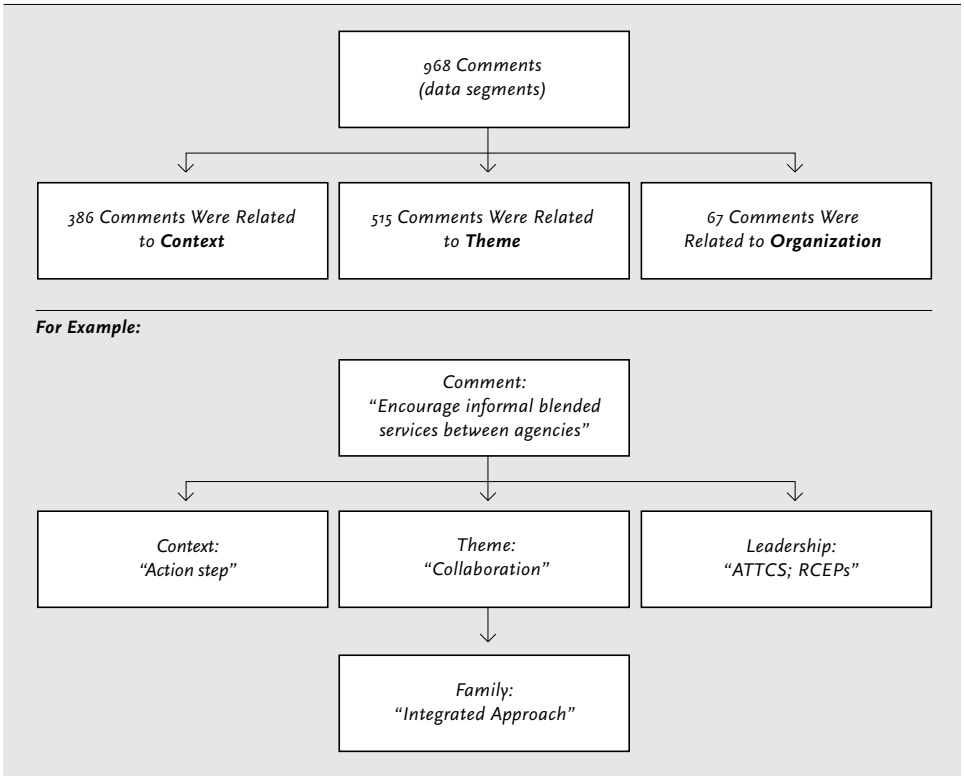
- Unmet needs
- Necessary changes
- Desired outcomes
- Barriers
- Action steps

Theme codes were grouped into a "family" (the term used by the Atlas TI software program). A final list of 12 family themes emerged. (See Attachment A for a summary of families, theirsub-categories, and the frequency with which each was referred to by participants.) These families are:

- Integrated Approach
- Education
- Consumers/Disability
- Employment
- Treatment
- Funding
- Agency
- Performance Monitoring
- Information Dissemination
- Policy
- Research
- Systems

Leadership codes were then grouped in relationship to these 12 categories.

The following flow chart portrays the process of analysis of all data segments, with each segment coded as context, theme, or leadership.



Presentation and Discussion of Work Group Outcomes

This section provides a discussion of each of the top five families that emerged from an analysis of conference information. As described in the preceding section, the data obtained from participant comments were organized into 12 families.

General Discussion of Conference

Exhibit 1 presents the top five families ("top" refers to the context areas most frequently cited in each family) and the frequency of the context in which they occurred.

Exhibit 1: Top Five Families and Frequency of Context

FAMILIES	TOTAL	NECESSARY CHANGES	DESIRED OUTCOMES	BARRIERS	ACTION	EXAMPLE OF COMMENT
Integrated Approach	14%	20%	15%	4%	15%	Change in communication between and within agencies.
Education	14%	17%	9%	15%	13%	Adequate dissemination of knowledge about integrated systems of service delivery
Consumers/ Disability	13%	13%	13%	17%	12%	Organizational attitudes and stigma
Employment	11%	6%	18%	7%	11%	Establishing a shared vision of employment as an integral part of recovery and as an outcome goal among systems that serve persons with disabilities, including substance abuse
Treatment	10%	15%	10%	4%	11%	A change in counseling approach to add comprehensive benefits counseling that explains the "big picture" to persons with disabilities

Underlined percentage represents the context in which the family was most frequently mentioned.

Discussion of Exhibit 1 by Family

Integrated Approach • The Integrated Approaches and Education families received the highest number of comments.

Integrated Approach • Integrated Approaches was highest in priority as a necessary change.

Education • Education was highest in priority as a necessary change.

Treatment • Treatment was highest in a priority as a necessary change.

Consumers/Disability • Consumers/Disability was most often cited in the barriers category.

Employment • Employment was most often named as a desired outcome.

Integrated Approach, Education, Treatment, Consumer/Disability, and Employment were the focus of 64 percent of all comments.

Discussion of Exhibit 1 by Context:

Necessary Changes, Desired Outcomes, Barriers, Action Steps

NECESSARY CHANGES

Comments related to Integrated Approach were the most frequently mentioned necessary changes, with 20 percent or 11 comments dealing with some aspect of an integrated approach to treatment. Next was Education (17 percent or 9 comments). Treatment was the next most frequent topic of discussion (representing 15 percent or 8 comments). Some examples of responses related to necessary changes were:

- Need for an increase in treatment capacity.
- Need training geared toward integration of service delivery.

DESIRED OUTCOMES

Employment was the most frequently cited desired outcome (18 percent or 12 comments). Integrated Approach followed Employment (15 percent or 10 comments) and Consumers / Disability placed third (13 percent or 9 comments). The following comments are examples of desired outcomes:

- Establishing a shared vision of employment as an integral part of recovery.
- Competency-driven set of policies and procedures for integrated service systems at the national, State, and local levels.

BARRIERS

Agencies emerged as the most frequently cited barrier (20 percent or 9 comments). Education followed Agencies (15 percent or 7 comments). Funding placed third, representing 13 percent of barriers (6 comments). The following are examples of some of the barriers described:

- Lack of inclusion and exposure to substance abuse and disability material in universities.
- Difficulty in changing organizational attitudes.

ACTION STEPS

Integrated Approach was the most frequently named action step (15 percent or 14 comments). Education as a means to achieve desired outcomes was the second most cited family (13 percent

or 12 comments). Consumers/Disability emerged as an action step 12 percent of the time (11 comments) primarily through consumer advocacy (11 percent or 10 comments). The following are examples of action steps proposed by participants:

- Establish a shared vision of employment as an integral part of recovery and as an outcome goal among systems that serve persons with disabilities, including substance abuse.
- Increase professional development/capacity.
- Concern for client experience over staff and agency.
- Remove disincentives to employment.
- All agencies involved in case management of clients need to provide resources that support employment, including assessment, exploration, housing, transportation, etc.

While the final presentation of the outcomes concentrates on the families, specific categories within the families emerged as highly relevant to the ultimate goal of making recommendations to improve the field. Exhibit 2 portrays the most frequently mentioned comments and the related subcategory.

Exhibit 2: Most Frequent Application of Context Components Within Subcategories of Families

S = subcategory
F = family

CONTEXT	*MOST FREQUENT FAMILY*	*COMMENT RELATED TO CONTEXT*
Unmet Need	**S:** Knowledge **F:** Education	Don't know what models of service delivery there are at local zlevels. There is no transfer of knowledge down to the field, nor is there a transfer of knowledge from local agencies up
Necessary Change	**S:** Integrated Treatment **F:** Integrated Approach	Need to cross-fertilize at the local level among agencies
Desired Outcome	**S:** Employment **F:** Employment	Systemwide approach to vocational rehabilitation with employment as the goal and emphasizing innovative reward and performance monitoring
Barrier	**S:** Funding **F:** Funding	Lack of funding for training and education
Action Step	**S:** Collaboration and Consumer **F:** Integrated Approach and Consumers/Disability	Advocacy Consumer advocacy to reduce barriers and stigma through education, information sharing, and participation at the local, State and national level

The following sections present a more in-depth discussion of the top five families: Integrated Approach, Education, Consumers/Disability, Employment, and Treatment. A brief discussion is presented on Funding, which raised several key concerns for conference participants. Other comments reflecting desired outcomes for the remaining families are discussed last.

DISCUSSION

Integrated Approach

Integrated Approach emerged as the family most frequently referred to across all change components. Integrated Approach refers to streamlined services that incorporate multiple disciplines working in collaboration with the consumer to provide the necessary array of treatment and rehabilitation services.

UNMET NEEDS

Fifteen percent of unmet needs related to Integrated Approach; this issue was raised within all work groups. The following unmet needs were identified:

- Needed services are not under one roof.
- Professionals don't talk to each other.
- There is no team approach within or across agencies.

NECESSARY CHANGES

Twenty percent of necessary changes suggested fell within this family. The following were proposed:

- A blueprint for a service continuum integrating treatment and employment.
- A shared mission of treatment and employment.
- A common language. Mental health professionals need to talk to vocational rehabilitation professionals and consider the importance of employment in recovery.
- The need to integrate vocational services into planning and programs.
- Training geared toward integration of service delivery.
- The need to have a national perspective communicated to local groups.

DESIRED OUTCOMES

Repeated desired outcomes mentioned clinical, fiscal, consumer, professional communication, linkages and collaboration issues. Integrated Approach was presented as a desired outcome for 15 percent of the comments. There were calls for:

- Establishing a shared vision of employment as an integral part of recovery and as an outcome goal among systems that serve persons with disabilities, including substance abuse.
- Competency-driven set of policies and procedures for integrated service systems at the national, State and local levels.

BARRIERS

Four percent of barriers related to this family. The following were described as barriers:

- Disciplines have their own cultures and formulations about problems and these differ widely.
- Resistance to an integrated approach.
- Lack of funding and demonstration of a cost-benefit analysis.

Education

The family of Education was the second most highly cited issue at 14 percent, and included such subcategories as certification, cross-training, and knowledge. Topics related to education were evident in all aspects of the conference. Almost one-quarter of comments related to education were associated with competencies.

UNMET NEEDS

Approximately 21 percent of unmet needs related to education. Such phrases as "lack of, little awareness of," and "not a priority," framed the context in which concerns about education were discussed across all work groups. Participants also addressed:

- The lack of education and background knowledge of substance abuse and disability by those who work with this population.
- The need for transfer of knowledge from national to local levels and from the local level up.
- The fact that cross-training between mental health and substance abuse staff does not usually occur.
- Some professionals have an "avoid it at all costs" attitude toward learning about substance abuse in the disability community.

NECESSARY CHANGES

Sixteen percent of necessary changes referred to Education with recommendations to:

- Increase training for paraprofessionals.
- Institute cross-training between mental health and substance abuse agencies.
- Increase professional development.
- Adequately disseminate knowledge.

According to participants, an increase in training among all systems can yield better staff, reduced turnover, and achieve better treatment outcomes.

DESIRED OUTCOMES

Education represented 9 percent of desired outcomes. The following were identified:

- A set of competency policy and procedures for integrated service systems at the national, State, and local levels
- Cross-training to reduce instability at agencies.
- An increase in education and training to colleges, institutions, vocational rehabilitation counselors, teachers, prep programs, consumers, and policymakers.
- An adequate supply of competently trained professionals to serve individuals with coexisting disabilities.

BARRIERS

Barriers to Education were cited approximately 18 percent of the time. The following barriers were mentioned most frequently:

- A lack of funding for training and education.
- A lack of inclusion and exposure to substance abuse and disability material in universities.
- Disagreement on competencies.
- Treatment program counselors do not see the value of the vocational rehabilitation field's contribution to the overall labor market

Consumers and Disability

Consumer and Disability as a family refers to individuals with disabilities who are also challenged by substance abuse. This family was the third most prominent, and factored most heavily in discussions on consumer advocacy and on stigma related to disability as a barrier to treatment and employment. Consumer advocacy issues represented 11 percent of the action steps.

UNMET NEEDS

Consumers and Disability represented 10 percent of unmet needs. These included:

- Isolation.
- Stigma.
- Prejudice.
- Uninsurability.
- Lack of transportation to jobs for persons with disabilities.

NECESSARY CHANGES

Comments concerning this issue emphasized community, treatment, and activism. This family represented approximately 13 percent of necessary changes. In regard to community (the community of individuals with disabilities), the following were identified as necessary changes:

- More sensitivity to community needs.
- More community involvement.
- Increased community programs.
- More community coalitions.
- Grassroots activism.
- Individualized treatment with a consumer focus.
- More informed consumers.

DESIRED OUTCOMES

Thirteen percent of desired outcomes related to Consumers and Disability. They were expressed from several perspectives, including outcomes in the treatment system, improved education, quality of life issues, and funding resources. Comments included:

- More strengths-based systems are needed that recognize the consumer's ability to help determine their treatment.
- Systems are needs/deficit driven; therefore service providers have the knowledge, but not the consumer.
- Better access to treatment and more fluid access.
- The needs of the clients and their families from their point of view should be considered, as well as the professional point of view.
- Need for more educated consumers, service providers, employers, policymakers, and legislators to reduce stigma and increase employment opportunities for individuals with coexisting disabilities.
- The disability community needs to have a fair share of funding.
- Need an improved quality of life for clients as well as better employment.

BARRIERS

Barriers accounted for 17 percent of comments in this family. Barriers to these outcomes are seen as:

- States fail to help consumers even though there are currently sufficient resources, but attitudes get in the way.
- Stigma and overall lack of knowledge.
- Organizational and cultural biases.
- Fragmentation in the disability community; specific disabilities fight for competing attention.

- Need to recognize that persons with disabilities are a heterogeneous group and one cannot assume common interests.

Employment

The fourth most frequently mentioned family was Employment, i.e., issues related to consumers obtaining and retaining employment as a treatment outcome. Employment was discussed by three of the five Day One groups and by four of the five Day Two action-focused groups. As an action step, it was most frequently addressed by the work groups Integrated Programs and Approaches and Research. Helping consumers obtain and retain employment is seen as a need, a desired outcome, and an action.

UNMET NEEDS

Thirteen percent of brainstorming about unmet needs addressed Employment. Unmet needs related to employment are highlighted in the following:

- Employment is not well understood in treatment.
- Clients do not get employment services soon enough.
- There are no incentives for employers to hire the disabled.
- There is not sufficient identification of willing employers.
- Disincentives to work because of income replacement systems such as Social Security should be addressed.

NECESSARY CHANGES

Six percent of necessary changes related to Employment. The following three statements reflect the essence of the changes identified:

- There needs to be a reexamination of transitional outcomes to make going to work an incentive rather than a disincentive. Individuals with disabilities often lose their benefits and settle for lower pay when they start working.
- Employment should be considered as a treatment outcome and a process within treatment.
- Need for a systemwide approach to vocational rehabilitation with employment as the goal, emphasizing innovative reward and performance monitoring.

DESIRED OUTCOMES

Eighteen percent of desired outcomes included Employment. One comment reflects the desired changes that emerged from numerous groups:

- Must have establishment of a shared vision of employment as an integral part of

recovery and as an outcome goal among systems that serve persons with disabilities, including substance abuse.

BARRIERS

Seven percent of barriers related to Employment:

- Work disincentives in the systems at the program and government levels.
- Agencies do not have employment as a goal; this is an attitudinal issue.
- Treatment counselors do not share the value of employment as a high priority with vocational rehabilitation counselors.

Treatment

The family of Treatment (i.e., best practices, service delivery, and case management) received the fifth highest frequency of discussion across the work groups. This family was addressed by all of the Day One work groups and three of the five Day Two work groups.

UNMET NEEDS

Approximately 10 percent of unmet needs related to Treatment. The following were mentioned as concerns:

- There is a need to keep cases open longer.
- There is not enough followup after treatment to link individuals to support that can help reintegration into a new life.
- The system needs to better serve consumers.
- Professionals lack the knowledge to treat the disability population and therefore have an 'avoid-it' type of attitude.

NECESSARY CHANGES

Treatment represented approximately 15 percent of necessary changes. The following were discussed:

- A non-threatening hotline for treatment facilities.
- A change in counseling to include comprehensive benefits counseling to explain the "big picture" to persons with disabilities.
- A change in technology transfer on best practices.
- Increasing both treatment and professional capacities.
- Pathways to treatment should be more clearly defined to educate the community on available resources and strategies.

DESIRED OUTCOMES

Ten percent of desired outcomes related to Treatment. The following outcomes were proposed:

- A coherent service delivery protocol.
- Employment viewed as an essential factor in recovery.
- Streamlined administration process.
- Encouragement, creation, and implementation of innovative and experimental programs for substance abuse and persons with disabilities.

BARRIERS

Ten percent of barriers related to Treatment. The following were identified:

- Relapse factors are not recognized and factored into planning.
- Inertia of organizing cultures, philosophy, and policy.

Additional Themes

Funding. The theme of Funding was mentioned in almost 9 percent of all statements from the primary documents created during the conference. It was the sixth most frequent theme, and was also mentioned frequently in relation to action steps (see Chapter 5). The issue of funding was raised throughout all facets of the conference process as an unmet need, a necessary change, a barrier, and as central to the action steps. Finally, despite the frequency of discussions about funding, it was rarely identified as a desired outcome, suggesting that in most participants' minds funding is a means to an end and not an end in and of itself.

In addition to the need for more funding, conference participants repeatedly suggested the following:

- More flexible funding (braided funding mechanisms or tiered funding to support services to individuals with multiple needs).
- Funding that was not defined categorically and requires collaboration between agencies/departments.
- Diversified funding sources (lack of funding for training and education).
- Clear identification of funding streams and the outcomes they were designed to fund.
- More equitable distribution of funding.
- Funding to support cost-benefit and outcomes-based research.

Highlights of recommendations in other families are presented below and provide additional examples of comments. Each of these comments was suggested as desired outcomes.

AGENCY

- Development of cross-training that reduces instability at agencies.
- Adequate supply of professionals in the service arenas competent to serve individuals with substance abuse disabilities in an integrated system.
- Coherent service delivery protocol.

PERFORMANCE MONITORING

- Consider the needs of clients and their families from their point of view, as well as the "professional" point of view
- Define criteria for effectiveness

INFORMATION DISSEMINATION

- Increase available technology.
- Advocates should work together to develop and implement a marketing campaign for a shared vision through conferences and meetings.
- Market to key stakeholders, including providers and consumers.
- Bring in business experts to advise on this marketing of the field's work.

POLICY

- Reduce stigma and lack of knowledge among service providers, legislators, and the general public to increase employment opportunities for individuals with coexisting disabilities.
- Target national, State, and local political entities for block grant parity and set-aside funding.
- Generate treatment money.
- Influence policy at the statewide level.

RESEARCH

- Develop model program demonstration projects.
- Define outcomes of successful programming.
- Define the criteria for effectiveness.
- Define outcomes: quality of life and employment.

SYSTEMS

- Systemwide approach to vocational rehabilitation with employment as the goal and emphasizing innovative reward and performance monitoring.
- Creation of linkages between the AOD discipline and programs and employment disciplines and programs.
- Definition of competencies for client, counselor, supervisor, administrators, and other stakeholders; identify concrete needs of clients.

The data presented and discussed provide insight into the conference process and outcomes. They serve as a vehicle for generating a better understanding the complexity of the challenge inherent in achieving the goals of access to treatment and employment outcomes for individuals with coexisting disabilities. (See Chapter 5 for further distillation of this information into specific recommendations for action at the local, state, and national levels.)

ATTACHMENT 1

CONSENSUS STATEMENTS ON PRIORITY CHANGE OUTCOMES

INTEGRATION OF SUBSTANCE ABUSE AND REHABILITATION SERVICES

DESIRED OUTCOME:
Competency driven set of policies and procedures for integrated service systems at the national, State and local levels.

BARRIERS:
1. Organizational cultural barriers
2. Money
3. Lack of agreement on the competencies
4. Local level policy and procedures
5. Professional parochialism
6. Consumer resistance to labeling and stigmatization

COGNITIVE, SENSORY, PHYSICAL AND HIV DISABILITIES

DESIRED OUTCOME:
More educated consumers, service providers, employers, policymakers, and legislators to reduce stigma and increase employment opportunities for individuals with coexisting disabilities.

BARRIERS:
1. Lack of funding
2. Policies
3. Staff turnover
4. Burnout
5. Isolation
6. Stigma
7. Resistance
8. Prejudice
9. Lack of collaboration
10. Insurability

EMPLOYMENT SYSTEMS, POLICIES AND APPROACHES

DESIRED OUTCOME:
Establishing a shared vision of employment as an integral part of recovery and as an outcome goal among systems that serve persons with disabilities, including substance abuse.

BARRIERS:
1. Difficulty in changing organizational attitudes
2. Turf issues
3. Limited resources/staff
4. Separate funding streams
5. Different cultural traditions among agencies

DUAL SUBSTANCE ABUSE AND MENTAL DISORDERS

DESIRED OUTCOME:

"One stop shopping" that includes:

a. Clinical and fiscal integration of substance abuse, rehab, primary care, mental health, and social service treatment systems with braided funding streams.
b. An accountability system that rewards collaboration and cooperation
c. Interdisciplinary collaboration in treatment planning and services
d. Strength-based, consumer driven treatment and after care, including meaningful employment as an outcome
e. Streamlined administrative processes

BARRIERS:

1. Categorical funding
2. Turf issues
3. Professional differences in terminology, perspective, and values
4. Scare resources
5. Politics
6. Self-perpetuating bureaucracy

ACCESS TO TREATMENT FOR INDIVIDUALS WITH COEXISTING DISABILITIES

DESIRED OUTCOME:

Disability community should receive an equitable/ fair share of government resources and funding allocations.

BARRIERS:

1. Organized treatment industry groups invested in status quo
2. Stigma
3. Competition among groups with common goals
4. Government perceives self as expert as opposed to experts being in the field (consumers/providers)
5. Community does not know grant mechanisms; there is a lack of resource development skills
6. No united voice in the field from disabilities groups that substance abuse treatment should be a priority
7. Requirements to get funding are too complex and burdensome
8. Industry lobbyists with interest in the status quo

ATTACHMENT 2

CONSENSUS STATEMENTS ON ACTION STEPS RELATED TO DESIRED OUTCOMES

EDUCATION AND TRAINING:

Group 1

OUTCOME SELECTED:
More educated consumers, service providers, employers, policymakers, and legislators, to reduce stigma and increase employment opportunities for individuals with coexisting disabilities.

BARRIER 1:
Stigma and lack of knowledge

ACTION STEP:
1. Develop pilot CD training module and apply for seed money.

BARRIER 2:
Inertia of organizational cultures

ACTION STEP:
1. Bring relevant organizations together for dialogue and identification of best practices.

Group 2

OUTCOME SELECTED:
Competency-driven set of policies and procedures for integrated service systems at the National, State and Local levels.

BARRIER 1:
Lack of agreement on essential competencies

ACTION STEPS:
1. Cross-training
2. Convening of ATTCs and RRCEPs

POLICY AND ADVOCACY:

Group 1

OUTCOME SELECTED:
Disability community should receive equitable/fair share of all government resources and funding allocations

BARRIER I:
No united voice within the disability community

ACTION STEPS:
1. Target national, State, local political entities for block parity, set-asides, and expanded funds
2. Coalition building within disability community with a defined agenda/outcome
3. Generate e-mail petition through National Centers on Independent Living and DIMNET to President, Congress, Federal Agencies for equitable share of treatment money.
4. Secure sign-off by Centers on Independent Living in State AOD plans to Federal government
5. Promote social entrepreneurship by joining grant writers and disability organizations

Group 2

OUTCOME SELECTED:
Establishing a shared vision of employment as an integral part of recovery and as an outcome goal among systems that serve persons with disabilities, including substance abuse.

BARRIER I:
Difficulty in changing organizational attitudes

ACTION STEPS:
1. Examine mission
2. Cross pollination
3. Develop model program demonstration project
4. Provide rewards and incentives
5. Market to key stakeholders, including providers and consumers

ATTACHMENT 2: CONTINUED

PROFESSIONAL PRACTICE/CASE MANAGEMENT:

Group 1

OUTCOME SELECTED:
Employment as a goal.

BARRIER 1:
Professional differences in terminology, perspectives, and values

ACTION STEPS:
1. Training business, substance abuse, vocational rehabilitation, WIBS, and mental health partners
2. Conference with business partners and service providers
3. National Listserv

Group 2

OUTCOME SELECTED:
Clinical and fiscal integration of substance abuse, mental health, and vocational rehabilitation; streamlined administrative processes

BARRIER 1:
Professional differences in terminology, perspective, and values

ACTION STEPS:
1. Cross-training
2. Apply to present at conferences outside your professional discipline
3. Build partnerships and working agreements
4. Develop treatment plans addressing all three specialties
5. Collaborative effort of existing organizations to conduct research projects

INTEGRATED PROGRAMS AND APPROACHES:

Group 1

OUTCOME SELECTED:
Competency-driven policies and procedures

BARRIER 1:
Organizational, cultural, stigma

ACTION STEPS:
1. Training concurrently at local, State and national levels
2. Specifically identify each system's cultural/stigma barriers
3. Collaborative funding

BARRIER 2:
Funding

ACTION STEPS:
1. Formalized blended funding
2. Demonstration projects
3. More flexible funding
4. Training in grant writing

BARRIER 3:
Lack of agreement on competencies

ACTION STEPS:
1. Cooperative service agreements
2. Demonstration projects
3. Interagency training (share core competencies and involve academia)

ATTACHMENT 2: CONTINUED

RESEARCH INITIATIVES:

Group 1

OUTCOME SELECTED:
Competency-driven set of policies and procedures for integrated service systems at the national, State and local levels.

BARRIER 1:
Funding, providing cost-benefit of integrated service systems

ACTION STEPS:
1. Define integrated models leading to comparison studies
2. Integrated system vs. sequential system vs. parallel system: define cost of model
    - Cost of model practices within integrated systems
3. Define effectiveness
4. Demonstrate cost benefit of model
5. Nature of existing and potential funding streams

BARRIER 2:
Disagreement on definitions and outcomes of successful programming

ACTION STEPS:
1. Define treatment characteristics
2. Define client characteristics that prevent treatment and employment
3. Define outcomes: quality of life and employment
4. Define employment/productive activity

BARRIER 3:
Disagreement on competencies

ACTION STEP:
1. Define competencies according to client, counselor, supervisor, and other stakeholders

Group 2

Establish a shared vision of employment as an integral part of recovery

OUTCOME SELECTED:

Competency-driven set of policies and procedures for integrated service systems at the national, state andlocal levels.

BARRIER SELECTED 1:

Separate funding streams

ACTION STEPS:

1. Develop inventory of funding streams by types of disabilities, target populations and sources or levels of funding
2. Study emphasis of funding streams on employment
    - Develop a tool to identify key programmatic elements by funding sources (employment, consumer role, nature of treatment)
3. Interest groups represented at conference collaborate with funding streams to conduct study.

BARRIER SELECTED 2:

Difficulty in changing organizational attitudes and culture

ACTION STEPS:

1. Identify cultures within each setting
2. Encourage research on treatment models that include employment as part of the model

ATTACHMENT 3

SUMMARY OF FAMILIES

Shaded areas do not represent subcategory totals; some quotations have multiple codes if they relate to different content area(s) within a family theme.

Family and Subcategory	Unmet Need	Necessary Change	Desired Outcome	Barrier	Action Step	Total
Integrated Approach	**6 15%**	**11 20%**	**10 15%**	**2 4%**	**14 15%**	**43 14%**
Collaboration	2	1	2	0	13	
Communication	3	4	1	0	0	
Integrated Model	0	0	4	2	1	
Integrated Treatment	2	7	1	0	0	
One-Stop	0	0	2	0	0	
Strengths-Based	0	0	1	0	0	
Education	**8 21%**	**9 17%**	**6 9%**	**7 15%**	**12 13%**	**42 14%**
Academia	0	0	0	0	2	
Certification	1	0	0	0	0	
Competencies	1	2	3	3	2	
Cross-Training	1	3	1	0	1	
Curriculum	0	0	0	0	3	
Education and Training	1	4	1	3	5	
Knowledge		4	1	1	1	0
Consumers/Disability	**4 10%**	**7 13%**	**9 13%**	**8 17%**	**11 12%**	**39 13%**
Access to Treatment	1	0	2	0	0	
Coexisting Disabilities	1	0	2	0	0	
Community	0	4	0	0	0	
Competition	0	0	0	1	0	
Consumer Advocacy	0	1	3	0	10	
Consumer Issues	1	2	4	3	0	
Labels	0	0	0	1	0	
Quality of Life	0	0	1	1	0	
Stigma	1	0	1	4	1	
Unrecognized Need	0	0	0	0	0	
Employment	**5 13%**	**3 6%**	**12 18%**	**3 7%**	**10 11%**	**33 11%**
Employers	1	0	1	0	4	
Employment	3	2	10	1	5	
Employment outcomes	0	0	3	0	2	
Incentives	1	1	0	1	0	
VR	0	0	0	1	0	
Work=incentive	1	2	0	1	0	
Treatment	**4 10%**	**8 15%**	**7 10%**	**2 4%**	**10 11%**	**31 10%**
Best Practices	0	1	0	0	2	
Bureaucracy	0	0	2	1	0	
Case Management	0	0	0	0	1	
Denial	1	0	0	0	0	
Followup Treatment	2	0	0	0	0	
New Programs	0	0	3	0	1	
Recovery	0	0	1	1	0	
Relapse	0	0	0	1	0	

Family and Subcategory	Unmet Need	Necessary Change	Desired Outcome	Barrier	Action Step	Total
Service Delivery	0	0	2	0	3	
Treatment	1	6	0	0	3	
Vocational Planning	0	1	0	0	0	
Funding	**2** **5%**	**6** **11%**	**3** **4%**	**6** **13%**	**10** **11%**	**27** **9%**
Funding	2	6	3	6	9	
Grant Writing	0	0	0	0	1	
Agency	**3** **8%**	**2** **4%**	**7** **10%**	**9** **20%**	**2** **2%**	**23** **8%**
Attitudes/ Organizational	1	0	2	5	2	
Competition	0	0	0	2	0	
High Turnover Rates	1	1	1	1	0	
Policies/Procedures	0	0	4	0	0	
Staff	0	1	0	0	0	
Turf	1	0	0	1	0	
Performance Monitoring	**1** **3%**	**1** **2%**	**8** **12%**	**3** **7%**	**4** **4%**	**17** **6%**
Cost-Benefit	0	0	1	1	2	
Needs Assessment & Screening	1	0	1	0	0	
Outcomes	0	0	7	2	3	
Information Dissemination	**2** **5%**	**2** **4%**	**0** **0%**	**2** **4%**	**7** **7%**	**13** **4%**
Marketing	0	0	0	0	5	
Resources	0	0	0	2	1	
Technology Transfer	2	2	0	0	1	
Policy	**1** **3%**	**2** **4%**	**4** **6%**	**2** **4%**	**3** **3%**	**12** **4%**
Educational Policy	0	0	1	0	1	
Enforcement	0	0	0	1	0	
Government	0	0	2	1	1	
Policy	1	1	1	0	1	
Regulations	0	0	1	1	0	
VR Eligibility	0	1	1	0	0	
Research	**2** **5%**	**1** **2%**	**0** **0%**	**0** **0%**	**8** **9%**	**11** **4%**
Systems	**1** **3%**	**2** **4%**	**1** **1%**	**2** **4%**	**3** **3%**	**9** **3%**
Linkages	0	0	0	0	1	
Mission/Goal	0	0	0	0	1	
Stakeholders	0	0	0	1	1	
Systems Change	0	2	1	1	0	
TOTALS	**39**	**54**	**67**	**46**	**94**	**300**

APPENDIX D

SUMMARY: CONFERENCE EVALUATION

Introduction

BACKGROUND

The focus of the conference was the intersection of substance abuse, coexisting disability and employment outcomes. The context for the focus was change and how it has impacted the field and what changes are necessary to meet the needs of individuals with substance abuse and coexisting disabilities particularly in regard to access to treatment and employment processes and outcomes. Through plenary sessions and work groups, the conference was designed to address the current state of the field and the changes that are necessary to bring about the desired outcomes. The plenary sessions were designed to follow the change paradigm that has been developed by the Center for Substance Abuse Treatment (CSAT) with a structure that progresses from Problem Statement to Political/Social Context and Outcomes. The work groups followed a structured change process that built on the plenary addresses, and were expanded by the input of the participants. In the work groups, the participants were charged with defining desired outcomes, barriers to change and strategies to bring about change. The Day 1 work group focused on topic areas most relevant to the field: Integrated Substance Abuse and Rehabilitation Services, Employment Needs and Outcomes, Dual Substance Abuse and Mental Disorders, Substance Abuse and Cognitive, Physical and HIV Disabilities and Access to Treatment. Day 2 work groups focused on the functions of Education and Training, Policy and Advocacy, Research, Clinical Practice and Case Management and Programs and Approaches. The final goal was to arrive at consensus on defining the most critical desired outcomes, barriers and action steps. Action steps were further developed by defining leadership, time frames and the processes for evaluating change. In addition to the conference itself, a pre- and post- conference web site was designed to gather input from the field to inform the conference and to serve as a vehicle for posting outcomes and inviting responses.

PURPOSE OF EVALUATION

The purpose of the evaluation was to capture both process and outcome. The intention was to generate information from the participants as to the learning that occurred, the means by which the learning occurred, obstacles to learning, and recommendations for the future. The use of open-ended comments provided the vehicle for capturing each participant's personal experience with all aspects of the conference. Another purpose of the evaluation was to learn more about the change process that was employed. CSAT and particularly the National Addiction Technology Transfer Center have developed a change process that has been introduced in a number of settings but never in a conference and never to the extent employed in this conference. Therefore, it was very important to evaluate the effectiveness of that process in this context and be able to offer recommendations for future development and application of the model.

LIMITATIONS

The limitations in the evaluation process include the enormity of the information gathered by the plenary session, work group and overall conference evaluations and the relative inability to thoroughly analyze all the responses provided. Another limitation occurred in relation to the web site. There was no vehicle for analyzing the web site usefulness and activity other than the identification of visitors and review of postings. Since the conference introduced a new approach it was not possible to anticipate all the positive and negative aspects that would emerge. Therefore, the evaluation processes, while extensive, were incomplete in addressing in sufficient detail the application of the change process. Despite the persistence of conference organizers in asking participants to return completed evaluations both during and after the conference, 50% (n=75) of participants submitted evaluations and personal action plans.

AUDIENCE

The conference participants were all individuals with experience in at least two of the three conference themes: substance abuse, coexisting disability and employment. In addition, selection for attendance was based on achieving a broad representation in discipline, function, organizational affiliation, diversity and geography.

Focus of the Evaluation

The focus of the evaluation was on process and outcome for each component of the conference and on the overall conference experience. The evaluation packet (Attachment A) provided the key instrument for evaluation. However, the work products from each work group also provided a highly significant outcome from the conference and the vehicle for the clear articulation of desired outcomes, barriers and action steps along with leadership, time frames and evaluation approaches. The amount of information gathered from these means contributed to the evidence of the effectiveness of the process and outcomes. Another area of focus for evaluation was Personal Action Plans. Participants were asked, at the time of application, to indicate how they

would use the conference outcome. In the evaluation packet there was opportunity for action plans to be clarified and submitted so that the conference organizers could refer to those plans as both examples of steps that could be taken and as a vehicle for following up with each participant and the steps taken to carry out the plan. Long-term evaluation of the outcome of the conference will also be derived from input from the field and statements from the participants as to the impact and effectiveness of the action steps they have taken. The pre- and post-conference web site was another vehicle for evaluation. The number of web site postings before and after the conference were aggregated either through the web site or through the conference list servs that were created.

Evaluation Approach Procedures

The evaluation approach has been to analyze all of the data received in response to all the conference components: the plenary sessions, the work groups, the overall conference and the web site. In addition, an analysis was conducted of the open-ended questions that were part of the evaluation of the overall conference, the plenary sessions and the work groups. In addition to the data, the discussion sections of this chapter contribute to the understanding of the information provided. In addition, each participant was asked to complete a Personal Action Plan. These are summarized in Attachment C according to conference themes. Over the next six months, the conference committee will maintain contact with the participants and continue to obtain feedback on their experiences in meeting the goals of their Personal Action Plans. This will be accomplished through electronic communication and postings on the post-conference component of the web site. Attachment D includes examples of actions taken to date. In addition applications for technical assistance grants to help accomplish the Personal Action Plans represents another evaluation approach. The outcomes of this also appears in Attachment D.

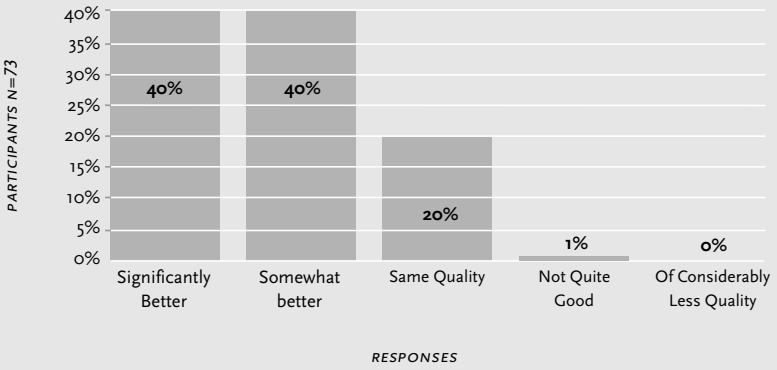
Results of the Evaluation

The initial questions posed as part of the conference evaluation were: "How well received was the conference?" and "Did the participants feel its goals were accomplished?" The results indicate the overall conference evaluation in comparison to other professional conferences and the impact of the conference with regard to eight conference goals. Participants rated the conference "Significantly Better" or "Somewhat Better" than other professional conferences in the last year. In addition, respondents felt the conference was "Very Successful" or "Successful" in achieving conference goals. The results are summarized in Exhibit 1A and B, respectively. Direct quotes of and responses for the highest and lowest rated goals appear in Exhibit 2.

Attachment B-1 includes comments related to the overall conference.

Exhibit 1: Overall conference evaluation

A) Compared to other professional conferences you've attended in the last year, how would you rate the overall quality of this conference?



B) How would you rate the conference's impact with regard to your...

FAMILIES	N'S	VERY SUCCESSFUL	SUCCESSFUL	NOT VERY SUCCESSFUL	UNSUCCESSFUL	
a) Understanding of substance abuse and coexisting disabilities?	74	42%	53%	5%	0%	
b) Understanding of the importance of work as an integral part of substance abuse treatment?	74	58%	37%	4%	1%	
c) Awareness of the field of substance abuse and coexisting disabilities at the national level?	75	49%	48%	3%	0%	
d) Awareness of the change process in the field of substance abuse and coexisting disabilities?	69	36%	49%	15%	0%	
e) Understanding of keys to instituting the change process in the organizations / systems you represent?	70	29%	54%	16%	1%	
f) Bringing about programmatic improvements in the field of substance abuse and coexisting disabilities?	70	31%	52%	17%	0%	
g) Commitment to make or recommend necessary changes in the organization and/or system you represent?	74	47%	46%	7%	0%	
h) Networking and forming of new associations with other professionals in the field?	75	56%	40%	4%	0%	

Exhibit 2: Participants' comments and concerns related to conference goals

GOAL	PERCENTAGE: "VERY SUCCESSFUL" OR "SUCCESSFUL"	COMMENTS
Higher ratings with positive comments		
a) Understanding of substance abuse and coexisting disabilities?	95%	▸ "Learning the details on substance abuse and coexisting disabilities was the most positive aspect of the conference" ▸ "The conference succeeded in highlighting the needs of this important population"
b) Understanding of the importance of work as an integral part of substance abuse treatment?	95%	▸ "The conference was effective in helping to learn more about integrating employment into treatment" ▸ "It was great to learn more about the importance of employment as part of substance abuse treatment"
c) Awareness of the field of substance abuse and coexisting disabilities at the national level?	97%	▸ "Learning about the 'state of the field' was a positive aspect of the conference and it provided great access to ideas, materials, resource centers, etc." ▸ "The quality of information and the amount of knowledge on the field of substance abuse and coexisting disabilities were excellent"
g) Commitment to make or recommend necessary changes in the organization and/or system you represent?	93%	▸ "I returned to my office with many ideas and have already enlisted the help of several in the community who are equally as excited about what we may be able to accomplish"
h) Networking and forming of new associations with other professionals in the field?	96%	▸ "This was a great opportunity for voices from various back ground to overhear each other and begin to align with each other to actualize change" ▸ "A positive aspect of the conference was the professionals and consumers coming together to make a commitment to improving services"
Lower ratings with positive comments		
d) Awareness of the change process in the field of substance abuse and coexisting disabilities?	85%	▸ "I would have liked to hear more about other states' activities" ▸ "The conference should involve more persons with disabilities who represent consumer perspectives"
e) Understanding of keys to instituting the change process in the organizations / systems you represent?	83%	▸ "How do we get the employers to focus on mutual benefits?" ▸ "How do we get mental health, substance abuse treatment and vocational rehabilitation integrated in ways that share responsibility and funding?" ▸ "How to upgrade disability awareness in substance abuse treatment professionally"
f) Bringing about programmatic improvements in the field of substance abuse and coexisting disabilities?	83%	▸ "More consumer viewpoints were needed" ▸ "More single-state agency providers"

ASSESSMENTS OF DIFFERENT CONFERENCE COMPONENTS.

As indicated in the accompanying conference description, there were three major components that operationally defined the conference. These were the Plenary Sessions, the Day 1 Issue Focused Work Groups, the Day 2 Action Focused Work Groups and the web site. Each component was evaluated by the conference participants. The results of these component-by-component assessments are summarized in the materials that follow. Overall, the plenary sessions were rated as the strongest aspect of the conference. (An analysis of the "excellent" ratings for the different components yielded an average rating of 40% for the plenary sessions collectively.

PLENARY SESSIONS

Exhibit 3 contains the summaries of the participants' assessments of the four plenary sessions. Plenary 2: "Assessing the Social/Political Environment" received the highest rating of the four sessions with 85% of the participants rating it as "Excellent" or "Very Good." The ratings given to the other three plenary sessions were roughly equivalent. Several overall comments made by participants regarding the plenary speakers included "highly effective", "powerful", "wealth of information", "excellent portrayal of the consumer perspective" and "needed more time to get the benefit of what they had to say." All the comments secured relative to the plenary sessions are summarized in Attachment B-2.

Exhibit 3: Assessments: Plenary Sessions

		PERCENTAGE DISTRIBUTION				
SESSIONS	N's	EXCELLENT	VERY GOOD	GOOD	FAIR/POOR	
Plenary 1: Identifying the Problem	71	42%	34%	21%	3%	
Plenary 2: Assessing the Socio-Political Environment for Treatment, Rehabilitation and Employment	67	46%	39%	10%	5%	
Plenary 3: Identifying Desired Outcomes in Treatment and Rehabilitation	70	37%	39%	21%	3%	
Plenary 4: Identifying Desired Outcomes in Employment, Education and Training	68	34%	44%	13%	9%	

DAY 1 - ISSUE FOCUSED WORK GROUPS

A review of the summary data provided in Exhibit 4 related to this component of the conference reveals that the strongest part of the overall component, as well as the Process element, was "the ability of the participants to contribute." Eighty-five % of the respondents rated this element as either "Excellent" or "Very Good." In regard to the Outcome element, the highest rating was for

"Value of the information and ideas among work group participants to my work," which received a 70% rating across "Excellent" and "Very Good." In the element noted as Other Areas, the skills of the leaders and facilitators both received a rating of 71% across the "Excellent" and "Very Good" categories. The weakest aspect of Day 1 was in the area of "Contributions session will make to effect changes in my work" which received a rating of 35% for "Good" to "Fair." Again this might reflect the participants' perception of their ability to effect change.

Several attendees' comments related to this component of the conference include:

"The Day 1 Focus Group was the single most positive aspect of the conference"
"The Day 1 interactive work groups were excellent"
"The breadth of information available from this work group was great"
"The discussion/process flowed best with small group activity"
"Too much was expected of work groups"

(A full summary of comments related to Day 1 Work Groups is provided in Attachment B-3.)

Exhibit 4: Assessments: Day 1 - Issue Focused Work Groups

		PERCENTAGE DISTRIBUTION				
FACTORS ASSESSED	N's	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
1) Process						
a) Overall format of session?	71	34%	38%	23%	4%	1%
b) Quality of action planning activities?	68	35%	35%	21%	9%	0%
c) Opportunity for me to contribute?	72	42%	43%	11%	0%	0%
2) Outcome						
a) Value of information & ideas shared among work group participants to my work?	71	38%	32%	24%	24%	12%
b) Value of the desired outcomes developed by participants to my work?	76	34%	22%	29%	4%	1%
c) Contributions sessions will make to effect changes in my work?	54	26%	35%	24%	1%	3%
3) Other Areas						
a) Skills of Work Group Leaders?	68	43%	28%	25%	4%	0%
b) Skills of Work Group Facilitators?	65	40%	31%	20%	0%v	0%

DAY 2 WORK GROUPS: ACTION FOCUSED

This aspect of the conference was the least effective. In reality, there was an overly ambitious plan and it was realized in Day 2. Unfortunately, the approach did not allow for the continuation of the hard work and the accomplishments derived in Day 1. However, this was a new and experimental application of the change process and important lessons can be learned and will be articulated in

the "Conclusions and Recommendations" section. As in Day 1, the strongest area in the Process component was the "Opportunity for me to contribute" which attained a 70% "Excellent" to "Very Good" rating. The "Quality of the action planning activities" was the weakest process aspect with a rating of 29% for "Excellent" to "Very Good." In regard to the Outcome evaluation, the stronger response was "My commitment to take the next step in implementing one or more of those plans" with a rating of 53% for "Excellent" to "Very Good" as compared to "Relevance of action plan developed by the work group members to my work" which received a rating of 46% for "Excellent" to "Very Good." In the Other Areas aspect, the stronger response was the "Skills of the work group leaders" with a rating of 56% for "Excellent" to "Very Good" as compared to "Skills of the facilitators" with a rating of 50%.

Comments related to this section of the work groups include:

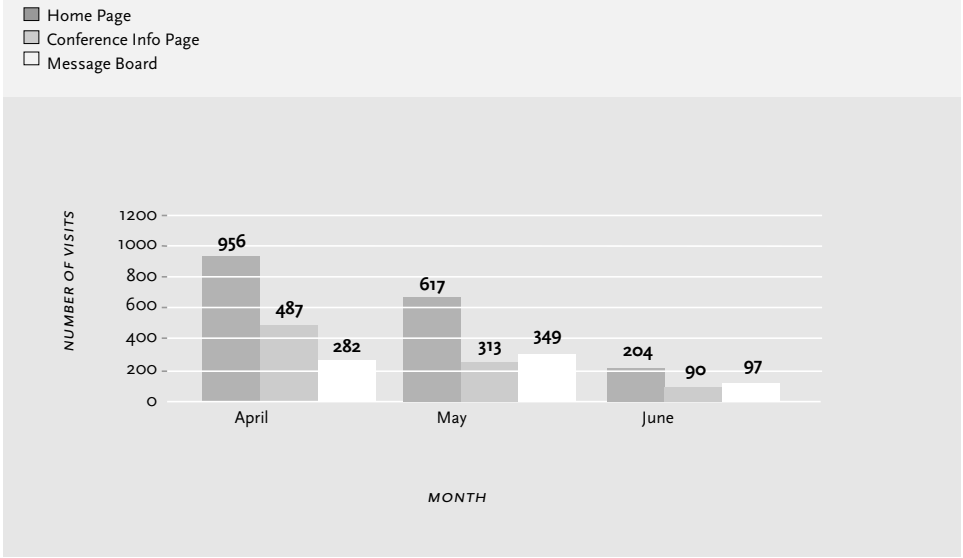
"Enjoyed engaging in discussion within work groups"
"When you have small focus groups, the organizers really need to designate the participants. I found my group to be unbalanced"
"Should have had the Day 2 work groups brainstorm on how to achieve the desired outcomes rather than address barriers – more positive approach"
"Too much was packed into Day Two"
"Tasks, particularly on Day Two, seemed to get in the way of some thoughtful discussion"

(A fuller summary of comments related to Day 2 Work Groups are in Attachment B-4)

Exhibit 5: Day 2 - Action Focused Work Groups

		PERCENTAGE DISTRIBUTION				
FACTORS ASSESSED	N's	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
1) Process						
a) Overall format of session?	65	14%	34%	18%	22%	12%
b) Quality of action planning activities?	65	17%	22%	23%	25%	14%
c) Opportunity for me to contribute?	68	32%	38%	18%	9%	3%
2) Outcome						
a) Relevance of action plans developed by the work group members to my work?	65	21%	25%	30%	16%	8%
b) Value of the desired outcomes developed by participants to my work?	65	28%	25%	28%	14%	6%
3) Other Areas						
a) Skills of Work Group Leaders?	59	36%	20%	20%	14%	10%
b) Skills of Work Group Facilitators?	56	30%	20%	21%	16%	13%

Exhibit 6: Number of Visits to Web Site



As occurred with the Day 1 Work Groups, the strongest element in this component of the conference, as well as the Process area, was the "Opportunity for me to contribute," which received a combined "Excellent" and "Very Good" rating of 70 %. The "Quality of the action planning activities," another Process-related element, was rated as the weakest aspect of the overall conference (a rating of 39 % on "Excellent" and "Very Good" combined). It, in combination with the other Process element "Overall format of session" and the Outcomes element "Relevance of action plans developed by the work group members to my work," were the three weakest elements identified in regard to the Day 2 Work Groups.

WEB SITE

This aspect of the conference was mildly successful. Exhibit 6 presents the number of monthly visits for the following web site components: home page, conference information page, and message board. While there were numerous visits, there were only 25 postings in total. The postings included input from participants and other stakeholders. They reflected attitudes and beliefs about the field, employment and the conference. For example, in response to a question posed by the conference committee ("Why is employment considered late in the treatment process? Why is more consideration not given to career choice and long-term employment goals?"), there were six replies, four from participants and two from other stakeholders.

CONCLUSIONS AND RECOMMENDATIONS

As shown via the preceding materials, the evaluation effort yielded a number of salient findings and related recommendations. Those findings and recommendations are summarized below.

The major finding evolving from the evaluation is that the conference was basically well received by the attendees. For many participants, the opportunity to learn from each other as individuals from a variety of disciplines was very rewarding. The participants clearly increased their knowledge about the interrelationship between substance abuse and coexisting disabilities and about the need for integration of services. The recognition of the benefits of integration of services was a major outcome. Related to this is the knowledge that integration requires the collaboration of diverse organization and overcoming issues of turf. Another important area of learning was the importance of employment for individuals in recovery and for individuals with disabilities. The change process was overall well received and recognized as offering promise for future development and application. After participants left the conference they reported feeling motivated to take action in their individual organizations. Networking was another positive outcome. The need for increased consumer voices in support of this issue and more participation by employers in the education and planning process were comments obtained in the evaluation.

At the same time, however, the data suggest that there is room for improvement. For example, while participants generally felt the conference was successful in relation to attainment of its specified goals, there were three goals where reservations were noted. Those three goals dealt with participants' awareness of the change process, understanding how to implement that process in specific settings, and knowing how to actually bring about programmatic change in specific settings. These represent specific areas where it probably would have been productive to share additional information and/or provided additional training to participants prior to the conference. Such additional attention might well have served as an "advanced organizer" and better prepared the participants to productively engage in the activities designed for the Day 1 and Day 2 Work Groups.

The concerns regarding the change process alluded to above were also somewhat evident in the assessments of the three major operational components or segments of the conference. For example, although the plenary or "information-sharing" sessions and the Issue Focused Work Groups held on Day 1 were both well received by participants, concern with their understanding of the change process and subsequent ability to effect changes in their work were reflected to some degree in related assessments. These concerns emerged most directly in regard to the assessment of the Day 2 - Action Focused Work Groups and that component received the lowest overall rating of the three conference segments. The single most prevalent suggestion offered in relation to improving the conference was to reduce the overly ambitious plan, especially as related to the Day 2 Work Groups, but also with regard to the time allocations for plenary sessions and networking. The conference was unable to realize all of its goals to the level desired. This conference was an experimental process never before attempted. It constituted the best "guess" of the conference personnel on the adaptation of the ATTC change process to a conference format. Since it was a trial, we expected that much would be learned that could make subsequent efforts

stronger. As an ambitious first effort, the conference accomplished a great deal. We do suggest, however, that the specific recommendations be considered by others who wish to use this process in future conferences.

In the future the attendees suggested that the conference planners:

- have an agenda that is able to be accomplished in the allotted time
- allow sufficient time for each plenary speaker
- explain the change process; explain it to the participants in advance so they are allowed sufficient time for understanding and their working through the process more effectively
- reconsider the consensus building process; much was lost as the groups were required to synthesize many important and salient recommendations
- keep work groups together for two days; by reconstructing groups process was interrupted
- determine in advance whether the outcomes to be developed related to a national, state or local level
- continue to identify knowledgeable plenary speakers who are appreciated
- allow more time for networking
- assure that facilities allow for ease in accessibility when there are numbers of persons with disabilities
- assure a sufficient number of interpreters when break out groups are planned
- if using a pre-conference web site, assure that is very easily accessed and user friendly

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ATTACHMENTS

Attachment 1 – Evaluation Packet
Attachment 2 – Comments Related to Conference Components
(A) Overall Conference
(B) Plenary Sessions
(C) Work Groups:
Day 1 Issue Focused Work Groups
Day 2 Action Focused Work Groups
Attachment 3 – Summary of Personal Action Plans
Attachment 4 – Post Conference Follow-Up

Evaluation Packet

Evaluation Instruments

This packet includes all of the evaluation instruments for the conference. There is one page for each of the following:

Plenary Session 1
Plenary Session 2
Plenary Session 3
Plenary Session 4
Day 1 Work Groups
Day 2 Work Groups
Individual Action Plan Post Conference
Overall Conference Evaluation

You will have time (about 5 minutes) after each session to complete the evaluation for that session. There will be time at the end of the conference to return to earlier forms and add details and comments as you wish.

Application of the Evaluations

Your responses will be of significant value to the RRTC in its continued work. In addition, the results will benefit the field in that it will provide information regarding the pressing issues that need to be addressed, guidance for the effecting a process of change, and action plans that will have impact on the organizations and individuals represented. Your contribution to this effort is appreciated. The results will be analyzed and available in conference proceedings.

As a conference participant, I volunteer to provide the evaluation data requested in this booklet. I understand that I may choose to not respond to portions of the evaluation, without penalty. Furthermore, I have been informed that all data I provide will be treated as confidential and only group, not individual, results will be presented in any formal reports of similar materials evolving from the evaluation.

Name _____

Organization _____

Plenary 1: Identifying the Problem

1) Which of the following functional categories is most closely related to your work?

___ Research ___ Education/Training ___ Policy/Advocacy ___ Clinical Practice
___ Integrated Programs and Approaches

2) For the functional category you checked (i.e., the category most closely related to your work), briefly respond to each of the questions below.

a) How effective was this session in helping your define the problem?

_____
_____
_____

b) What problem areas did you particularly take note of?

_____
_____
_____

c) In what new ways does the problem need to be defined?

_____
_____
_____

3) Overall, how would you rate the quality of this session? (Check one)

Excellent	☐
Very Good	☐
Good	☐
Fair	☐
Poor	☐

Plenary 2: Assessing the Socio-political Environment for Treatment, Rehabilitation and Employment

1) Which of the following functional categories is most closely related to your work?

___ Research ___ Education/Training ___ Policy/Advocacy ___ Clinical Practice
___ Integrated Programs and Approaches

2) For the functional category you checked (i.e., the category most closely related to your work), briefly respond to each of the questions below.

(a) How effective was this session in identifying the socio-political issues related to the problem?

_____
_____
_____

(b) On what socio-political system issues did you focus concern on most?

_____
_____
_____

(c) What important socio-political issues were not addressed?

_____
_____
_____

3) Overall, how would you rate the quality of this session? (Check one)

Excellent ☐
Very Good ☐
Good ☐
Fair ☐
Poor ☐

Plenary 3: Identifying Desired Outcomes in Treatment and Rehabilitation

1) *Which of the following functional categories is most closely related to your work?*

___ Research ___ Education/Training ___ Policy/Advocacy ___ Clinical Practice
___ Integrated Programs and Approaches

2) *For the functional category you checked (i.e., the category most closely related to your work), briefly respond to each of the questions below.*

(a) How effective was this session in identifying the socio-political issues related to the problem?

_____
_____
_____

(b) On what socio-political system issues did you focus concern on most?

_____
_____
_____

(c) What important socio-political issues were not addressed?

_____
_____
_____

3) *Overall, how would you rate the quality of this session? (Check one)*

Excellent	☐
Very Good	☐
Good	☐
Fair	☐
Poor	☐

Day 1: Issue Focused Work Groups

What Content Topic was addressed by your Work Group? (Check one)

- ☐ Integrated Substance Abuse and Rehabilitation Services
- ☐ Employment Needs and Outcomes
- ☐ Dual Substance Abuse and Mental Disorders
- ☐ Substance Abuse and Cognitive, Physical, Sensory, and HIV Disabilities
- ☐ Access to Treatment for Individuals with Coexisting Disabilities

For items 1 to 3 below, please rate each of the areas listed.

	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
1) Process					
a) Overall format of the session?	☐	☐	☐	☐	☐
b) Quality of action planning activities?	☐	☐	☐	☐	☐
c) Opportunity for me to contribute?	☐	☐	☐	☐	☐
2) Outcome					
a) Value of information and ideas shared among work group participants to my work?	☐	☐	☐	☐	☐
b) Value of the desired outcomes developed by participants to my work?	☐	☐	☐	☐	☐
c) Contributions session will make to effect changes in my work?	☐	☐	☐	☐	☐
3) Other Areas					
a) Skills of work group leaders?	☐	☐	☐	☐	☐
b) Skills of work group facilitators?	☐	☐	☐	☐	☐

4) As a result of participating in this work group, what 1 or 2 Issues are you now considering that you had not previously thought about?

_____

_____

_____

Plenary 4: Identifying Desired Outcomes in Employment, Education and Training

1) Which of the following functional categories is most closely related to your work?

___ Research ___ Education/Training ___ Policy/Advocacy ___ Clinical Practic
___ Integrated Programs and Approaches

2) For the functional category you checked (i.e., the category most closely related to your work), briefly respond to each of the questions below.

(a) How effective was this session in identifying the desired outcomes in relation to employment, education and training?

_____

_____

_____

(b) On what desired outcomes in relation to employment, education and training did you focus most?

_____

_____

_____

(c) What desired outcomes in relation to employment, education and training do you believe were not addressed?

_____

_____

_____

3) Overall, how would you rate the quality of this session? (Check one)

Excellent ☐
Very Good ☐
Good ☐
Fair ☐
Poor ☐

Day 2: Action Focused Groups

What Content Topic was addressed by your Work Group? (Check one)

- ☐ Education and Training
- ☐ Policy and Advocacy
- ☐ Research Initiatives
- ☐ Professional Practice/Case Management
- ☐ Integrated Programs and Approaches

For items 1 to 3 below, please rate each of the areas listed.

	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
1) Process:					
a) Overall format of the session?	☐	☐	☐	☐	☐
b) Quality of action planning activities?	☐	☐	☐	☐	☐
c) Opportunity for me to contribute?	☐	☐	☐	☐	☐
2) Outcome:					
a) Relevance of action plans developed by the work group members to my work?	☐	☐	☐	☐	☐
b) Value of the desired outcomes developed by participants to my work?	☐	☐	☐	☐	☐
c) Contributions session will make to effect changes in my work?	☐	☐	☐	☐	☐
3) Other areas :					
a) Skills of work group leaders?	☐	☐	☐	☐	☐
b) Skills of work group facilitators?	☐	☐	☐	☐	☐

4) As a result of participating in this work group, what 1 or 2 issues are you now considering that you had not previously thought about?

_____

_____

_____

Personal Action Plan

Name _____

Organization _____

1) Which of the following "Issue Topics" did your Day 1 Work Group address? (Check one)

- ☐ Integrated Substance Abuse and Rehabilitation Services
- ☐ Substance Abuse and Cognitive, Physical, Sensory, and HIV Disabilities
- ☐ Employment Needs and Outcomes
- ☐ Access to Treatment for Individuals with Coexisting Disabilities
- ☐ Dual Substance Abuse and Mental Disorders

2) Based on your Day 1 Work Group's discussion, which "Desired Outcome" and which "Barrier" discussed were the most important to you?

a) Desired outcome:

_____

_____

_____

b) Barrier to Address:

_____

_____

_____

3) Which of the following "Action Topics" did your Day 2 Work Group address? (Check one)

- ☐ Education/Training
- ☐ Professional Practice/ Case Management
- ☐ Policy and Advocacy
- ☐ Integrated Programs and Approaches
- ☐ Research Initiatives

4) Based on your Day 2 Work Group's discussion, what "Action" developed in your group are you committed to take in the organization? and/or system you represent? Action I intend to take:

_____

_____

Overall Conference Evaluation

1) Compared to other professional conferences you've attended in the last year, how would you rate the overall quality of this conference?

Significantly Better	☐
Somewhat Better	☐
Same Quality	☐
Not Quite Good	☐
Of Considerably Less Quality	☐

2) How would you rate the conference's impact with regard to your...

	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
a) understanding of substance abuse and coexisting disabilities?	☐	☐	☐	☐	☐
b) understanding of the importance of work as an integral part of substance abuse treatment?	☐	☐	☐	☐	☐
c) awareness of the field of substance abuse and coexisting disabilities at the national level?	☐	☐	☐	☐	☐
d) awareness of the change process in the field of drugs and disabilities?	☐	☐	☐	☐	☐
e) understanding of keys to instituting the change process in the organizations/systems you represent?	☐	☐	☐	☐	☐
f) bringing about programmatic improvements in the field of substance abuse and coexisting disabilities?	☐	☐	☐	☐	☐
g) commitment to make or recommend necessary changes in the organization and/or system you represent?	☐	☐	☐	☐	☐
h) networking and forming of new associations with other professionals in the field?	☐	☐	☐	☐	☐

Please Briefly Respond to Each of the Following Questions

3) *What one thing would you have done differently when designing the conference to make it more effective?*

4) *In your opinion, what was the single most positive aspect of the conference?*

5) *What suggestions do you have for future conferences?*

6) *Do you have any additional comments you would like to provide regarding the conference?*

ATTACHMENT 2-A

COMMENTS RELATED TO OVERALL CONFERENCE

QUESTION #3

What one thing would you have done differently when designing the conference to make it more effective?

TIME:

- "It would be ideal to have a little more time for the overall process."
- "One more day would have made things less rushed"
- "You really had an overly ambitious agenda placed into two full days. I would have made the conference 3 days and had the first 1.5 days for presentations and information and the last 1.5 days for action planning and networking"

WORK GROUPS:

- "Do not split up focus groups into two separate small groups. It did not promote moving forward with the process and did not allow time to complete the agenda"
- "Keep small groups intact throughout; avoid over design of contemplative process"
- "Reduce the tasks of the work groups"

CHANGE PROCESS:

- "The change process was tough to implement in the work groups"
- "Better prepare the facilitators and attendees prior to the conference"

PARTICIPANTS:

- "Include the 'other side of the fence'– employers"
- "Include more minorities as participants and plenary speakers"
- "More consumer voice"

PLENARIES:

- "It may be more effective to invite less speakers and allow each speaker more time to get more in depth"
- "Agenda was too ambitious. Try fewer presentations and more time"

QUESTION #4

In your opinion, what was the single most positive aspect of the conference?

NETWORKING:

- "Networking with individuals outside of my field. I work with people with disabilities who have substance abuse problems. It was very helpful for me to learn about the employment difficulties of this group"
- "Met some wonderful people who 'taught me' a lot"
- "Networking and interactions in small groups"
- "Being able to network and find resources and to know I am not the only one frustrated with this issue"

SPEAKERS:

- "Increased knowledge of the problem from the perspective of other professionals working with the population"
- "The interaction with top professionals in the field – very stimulating."
- "Excellent speakers – outstanding, presentations."
- "The information presented was excellent. The speakers were all very knowledgeable in the field and have a high degree of expertise."

GROUPS/CHANGE MODEL:

- "Discussion groups (not necessarily product – but sharing)"
- "The people that were brought together – by far the best part – great discussions in groups but unfortunately not more time"
- "The change model was interesting"
- "Resulted oriented format"

PARTICIPANTS:

- "The cross-organizational, cross-role, cross disciplinary nature of the very talented invites"
- "The meeting of professionals throughout the country"
- "The intimate setting and the opportunity to network and share with key experts in the fields of disability and substance abuse"

QUESTION #5

What suggestions do you have for future conferences?

TIME:

- "Slow down the pace"
- "More time to work together"
- "Add a 3rd day!"
- "Allow more time for plenaries"

CONSUMERS:

- "More consumer voice"
- "More consumer viewpoints"
- "Have more consumer/community involvement"
- "Broaden the scope of disabilities to include clients who suffer from mental health issues such as depression, panic, anxiety disorders"

LOGISTICS:

- "Have larger group rooms"
- "Do evaluations after each plenary"
- "Start preparation for all participants before conference"

FOLLOW-UP:

- "Let's just make sure to follow-up"

PLENARIES:

- "Include more disciplines in the plenary sessions, criminal justice, LGBT, substance abuse treatment and prevention, healthcare, homeless, HIV/AIDS, etc."
- "Involve private business, disability carriers, issuers"
- "Provide more information about national efforts regarding S/A and disabilities"

PARTICIPANTS:

- "More balanced substance abuse and substance abuse rehabilitation"
- "Look at breakdown of groups – better balance"
- "Integrate employers and insurers in all phases of conference, including planning and goals"
- "More information from employer community"

QUESTION #6

Do you have any additional comments you would like to provide regarding the conference?

- "Too short."
- "Bring in more people from the Independent Living movement to future conferences and present at their conferences."
- "It was very well organized. I learned a lot of new information that I plan to use in my work."
- "Nice job everyone. Well organized. Goals clear. Time short. Facilities great."
- "Thank you for the opportunity to be a part of this change movement – I look forward to continued involvement."
- "Excellent conference. Well organized and conducted. I have been able to develop several ideas to take back to my agency for the development of several grant applications."
- "The small group process was cumbersome trying to keep braking down tasks – but don't have a better way to do it."
- "More information on multicultural issues. Access to service as it relates to ethnicity."
- "Please include spirituality – God heals us all."
- "Invite federal partners, i.e., Department of Labor Working Partners. Would have been a good resource as it relates to substance abuse and employment. It was good to have a brief description of WIA and Welfare-to-Work, however."

ATTACHMENT 2-B

COMMENTS RELATED TO PLENARY SESSIONS:

PLENARY 1: IDENTIFYING THE PROBLEM

Question A: How effective was this session in helping you define the problem?

- "Introduction to the extent of problem and overview of issues requiring further exploration were helpful"
- "It allowed me to see the problem on a national level"
- "It identified the problem at the discrete level and the many problems for the desired outcome at the mega level"
- "Realized more research is needed"
- "Gave me a lot of 'food for thought' because I didn't realize just how much of a problem this is"

Question B: What problem areas did you particularly take note of?

- "Difficulties people with disabilities have accessing services"
- "Large numbers of eligible persons unaccounted for due to criminal justice involvement'
- "I appreciated the fact that policy makers see that existing systems in the drug treatment system have often cut out and refused to treat other disabilities"
- "Lack of understanding in the CD and disability arenas as to the extent of the problem of coexisting disabilities"
- "Need for improved methods for problem identification and referral; cross-training needs among disability and AODA treatment professionals"
- "The high incidence of coexisting issues between substance abuse and disability"
- "Training – the denial treatment programs have with issues with people with disabilities"
- "The small % of people with severe co-existing disorders who are working"

Question C: In what new ways does the problem need to be defined?

- "Low incidence populations"
- "Persons with multiple problems including employability and substance issues present in virtually every type of human services"
- "The problem needs a way to be identified so that appropriate treatment can be rendered"
- "Outreach to family members, friends, caregivers to counteract enabling behaviors"
- "Varying degree of the issue among different disability groups"
- "Treatment programs need a non-threatening approach"
- "Make meaningful work a high priority for people with disabilities"
- "Substance Abuse as a response to barrier in society. It is not enough to treat the individual. Most must be done to make our society more hospitable to people with disabilities"

PLENARY 2: ASSESSING THE SOCIO-POLITICAL ENVIRONMENT FOR REHABILITATION AND EMPLOYMENT

Question A: How effective was this session in identifying the socio-political issues related to the problem?

- "Refreshing to hear shifting the focus of problem solving to the local level"
- "Effective, especially in addressing both opportunities and problems related to welfare/work reform initiatives"
- "I have already changed my focus when talking to groups on employment placements having an affect on both the economy and those seeking employment and we cannot ignore the stigmas attached to substance abuse and persons with disabilities"
- "Good resources were cited"
- "The different strengths and shortcomings of current laws as they were explained"

Question B: On what socio-political system issues did you focus concern on most?

- "Determination that AOD treatment was not meeting disability standards"
- "The need to encourage local participation in workforce investment"
- "Difficulty in developing a national policy when the WIA trend is toward localization, which encourages increasing fragmentation"
- "The need for money"
- "Workforce policy, especially Workforce Investment Act"
- "Changes in WIA; need to monitor these changes; lots of thought and research questions"
- "The dissemination of information via agencies and websites"
- "The lack of cooperation between the vocational and addiction fields"

Question C: What important socio-political issues were not addressed?

- "Criminal justice issues for persons with substance abuse and co-existing disabilities."
- "Stigma, prejudice across substance abuse and disabilities"
- "How do we integrate the values of rehabilitation/employment into substance abuse treatment"
- "Inaccessibility of most peer support groups"
- "More could have been said about the irrationality of the federal disability policy"
- "The issue of multi-disabled individuals and how to effectively advocate for the development of an all-inclusive treatment model"

PLENARY 3: IDENTIFYING DESIRED OUTCOMES IN TREATMENT AND REHABILITATION

Question A: How effective was this session in identifying the desired outcomes in treatment and rehabilitation?

- "Desired outcomes in treatment and rehabilitation were helpful"
- "Appreciate the focus on TBI and dual diagnosis"
- "Realized more dual treatment programs are needed"
- "Presentations were most beneficial for background content/statistics/treatment role model"
- "Provided me with new ideas about additional outcomes in regard to treatment"

Question B: On what desired outcome in relation to treatment and rehabilitation did you focus most?

- "Information on TBI was very valuable – funding is a key issue with federal, state and local barriers to service collaboration funding"
- "The training of counselors. MICA issues, especially the finding that the combination of disabilities did not affect the likelihood of successful case closure, nor did the severity of the disability"
- "Necessity for long-term treatment and supports; need for new ways to engage clients and prevent drop-out"
- "Having both treatment and advocates for people with disabilities discuss the issue and bring together a solution"
- "Lack of interface between mental health, chemical dependency and vocational service systems"
- "Probably substance abuse as a natural reaction to circumstances. Also, the importance of helping individuals develop a social life"

Question C: What important desired outcomes in treatment and rehabilitation were not addressed?

- "Criminal justice interface. Lack of information received by facilities at incarceration for multi-problem persons. Lack of adequate referral at sentence out dates"
- "What is the statistical correlation between disabled and non-disabled clients receiving long-term treatment and support?"
- "Would have liked more information on other disabilities"
- "Getting more input from the substance abuse field. Not all addicts need mental health"
- "Persons with physical or sensory disabilities and access to treatment issues"
- "Maintaining drug-free work place"

PLENARY 4: IDENTIFYING DESIRED OUTCOMES IN EMPLOYMENT, EDUCATION AND TRAINING

Question A: How effective was this session in identifying the desired outcomes in relation to employment, education and training?

- "Good overview and to know that programs with good results in place"
- "It was interesting to learn that the work places continue to have difficulty implementing ADA"
- "Very effective – Cornell information on ADA was good. Clear information on training consideration and therapeutic community approach"
- "Well done – good information and studies to back up information"
- "Now familiar with job accommodations for people with disabilities as it relates to the A.D.A."
- "The importance of employment as the main goal for rehabilitation"

Question B: On what desired outcomes in relation to employment, education and training did you focus most?

- "Upgrade CDC's to know about disability/rehabilitation and CRC's to know about CD/treatment"
- "Providing accommodations in the workplace so that people with disabilities can have access to equal employment"
- "Emphasis on supported work vs. vocational training and rehabilitation"
- "Employment as a treatment outcome"
- "The hiring of the disabled and the responsibility of the HR offices to ensure discrimination is kept to a minimum"
- "Moving from assistance with employment to self sufficiency"
- "More skill development for job development component of the rehabilitation curriculum and counselors need more of a business perspective in regards to marketing themselves and their clients"

Question C: What desired outcomes in relation to employment, education and training do you believe were not addressed?

- "Sustained employment for recovering persons was only briefly mentioned, but little information was provided regarding it a s a desired outcome of practice"
- "Where employers can get assistance in learning about disabilities and employment. Best practices for employers"
- "Redesigned job development curriculum to be more business focused, uniform with more time given to marketing clients and programs taught by business professionals"
- "It would be interesting to see more of a breakdown by disabilities and employment outcomes"

ATTACHMENT 2-C

COMMENTS RELATED TO WORK GROUPS

DAY 1 – ISSUE FOCUSED WORK GROUPS

As a result of participating in this work group, what 1 or 2 issues are you now considering that you had not previously thought about?

- "Employment as a defined clinical need and treatment outcome. The concept of 'braided' funding streams to maximize accountability of partnering agencies in collaborative efforts"
- "Categorical organization of federal and state government: financing and service delivery may discourage service integration identified as 'good.' Alternative service organization pilot may demonstrate greater quality of life outcome for service recipients"
- "How to bring groups that don't normally work together to the same table and begin to work together toward common goals. How to make sure that everyone who needs to be at the table is represented"
- "Pleased on consensus about the need for one funding stream, problem of 'turf' issues and training needs for clinicians"
- "Integration of systems working with recovering substance abusers and having employment as an integral part of recovery. Training on the university level and direct care staff level in aggressive job development from the business perspective"
- "Ways to improve the use of the CSAT grant funds. Ideas for the development of new grant proposals"
- "The view and/or opinions about the definition of disability. Substance abuse as a disease model verses a disability"
- "Other ways of furthering cross-systems collaboration"

DAY 2 – ACTION FOCUSED WORK GROUPS

As a result of participating in this work group, what 1 or 2 issues are you now considering that you had not previously thought about?

- "Definition of terms, clarity – important and often overlooked"
- "The 'CPR' media plan – social change plan model; Increased focus TBF and spinal cord injuries; Personal experience made me increasingly aware of courage I need for advocacy and training on all areas of disability"
- "A new research study on counselor competencies"
- "Making contacts with the business community. Networking with other agencies to affect change"
- "Reevaluation of competencies for Ma students with substance abuse specialization; How to better utilize the ATTC, CSAT and various organizations for enhanced training"
- "Spending more time with political leaders and advocating for the need of treatment for people with disabilities"
- "Incorporating more vocational content in my courses on substance abuse"
- "The issue of length of sobriety before having opportunities for vocational training. The centrality of vocational work to rehabilitation was a critical issue highlighted in the conference"
- "Scope of problem, specifically the lack of agency cooperation"
- "Taking the initiative to educate outside of the behavioral health discipline"

ATTACHMENT 3

SUMMARY OF PERSONAL ACTION PLANS

Employment	
EX-OFFENDERS	"Pursue opportunities to educate local employers and dispel myths about the hiring of an ex-offender"
STIGMA	"Becoming involved in cross training between business and rehabilitation services"
EMPLOYMENT AS TREATMENT OUTCOME	"Employment as a treatment outcome will be the focus with the paradigm of rehabilitation counselors introduced"
EMPLOYMENT AS GOAL	"Include employment as a goal of services and educate students about this"
MENTAL HEALTH & SUBSTANCE ABUSE	"To reach out to employers in the 5 county area to address the issues, concepts, ideas, and concerns of employment for people with particularly mental health and substance use co-existing disorders, in an effort to relieve better employment outcomes"
INTER-AGENCY BRIDGING	"Look into local WIB and see how this body can be approached to address bridging gap in agencies and educational understanding of the business perspective"
Education	
STIGMA	"Share information; raise consciousness; fight stigma"
TRAINING AOD & DISABILITY	"Incorporate co-existing disability issues into both basic training and advanced training programs for AOD professionals"
STATE AGENCY AOD & DISABILITY	"Working with state agency to develop AOD/Disability Training"
PROFESSIONAL GROUPS	"Promoting several venues that will allow for cross training and communication across the professional groups"
INTER-AGENCY	"Continue and increase support for inter-agency cross training as well as joint training in topic of joint interest"
STATE COMMUNITY PROVIDERS	"To provide a statewide training event for field staff (VR counselors) in collaboration with Dept. of MH and addiction Services field staff – community providers on issues in employment – substance abuse and coexisting disabilities"
AOD & VR	"Emphasizing need for substance abuse training for VR counselors or those counselors who lack the training. Encourage more dialogue with local treatment centers"
CROSS-POLLINATION	"Continue cross-pollination efforts, including AOD specialists in initial training provided to disability specialists"
COLLABORATION	"Collaboration for training for service providers"
AOD, VR AND DISABILITY	"Develop cross training with VR for ATOD counselors and disabilities workers"

AOD and disability	"Help develop competencies, skills and knowledge necessary to treat people with disabilities and AOD"
Legal issues	"Continue to stress the importance of education and competencies in the area of persons with disabilities and the laws that govern the field as well as substance abuse ongoing"
Cross training/credentialing	"Work with students to develop an enhanced level of training on substance abuse treatment competencies as part of a cross-training model. Work on committee to develop credentialing competencies"
Curriculum	"Informed my plans for continued curriculum development"
AOD and disability	"Develop and implement a unit in my alcohol/substance abuse courses on disabilities and the issues surrounding recovery and rehabilitation efforts"
Information Dissemination	
Listserv	"Establish a listserv to continue the conversation"
ATTC	"Learn more about ATTC System"
Multiple organizations	"Present materials to multiple advisory groups, funders, and providers throughout the state"
Agencies	
Inter-agency integrated planning	"I have already set up a meeting with the commissioner of Mental Health, Mental Retardation and Alcoholism Services and his staff to address the issue of more integrated planning between the divisions of that city agency"
Integrated services	"Collaboration to integrate services and expand resources"
Employment criminal justice job fair	"Organize a committee of community agency representatives who are concerned about the barriers to employment for clients with co-existing disabilities and a criminal record. Seek to organize a community job fair for ex-offenders who are job ready"
Awareness & treatment	"Local level collaboration with substance abuse providers to raise awareness and services for persons with disabilities and substance abuse issues"
Services & resources	"Build collaborations for enhanced client services and resources"
Coordinated services	"Development of cooperative working arrangements with other service providers"
Substance abuse treatment	"Trying to get representation from the various disabilities groups to come together and focus on the issue of substance abuse treatment"
Community	"Creating a CPR like program to educate everyone from soccer moms to department chairs about addictions"

Research	
BLINDNESS & SUBSTANCE ABUSE	"Participate in agency-wide research project to identify extent of problem among blind/visually impaired population we serve"
GRADUATE STUDENTS	"I will have one or two masters students conduct research on projects on topics identified in group"
COMPETENCY WORK & RECOVERY	"Focus my research on counselor competency and continue my research in work and psychological health and importance of work and recovery"
COEXISTING DISABILITIES & EMPLOYMENT	"Gathering more information and research on substance abuse among people with disabilities and employment issues"
COST BENEFIT ANALYSIS INTEGRATED SERVICES	"Help to conduct and write up research on the different components of cost benefit analysis of integrated service systems, including the proposal action steps"
Integrated Approaches	
TREATMENT OUTCOMES	"Assist in developing a tool to identify key programs/elements using the SWORPS-UT data collection and analysis and the FSC director's cooperation in organizing pertinent report information to begin identification of successful outcomes"
MODELS	"Identify 'models' for integrated programs and disseminate these via trainings, website, and listservs"
Funding	
ACCESS TO TREATMENT & FUNDING	"To continue working with NAADD in making the state of Florida accessible for people with disabilities to go to treatment. Research and get government money for new programs"
FUNDING	"Continue to work to expand funding sources to address this issue"
FUNDING	"With NAADD and De Miranda and State of Ohio/Oregon, work to move agenda forward at focus group and advocate with management staff to fund ongoing efforts"
STRATEGIES	"Work with NADD in addressing strategies developed from conference"
Systems	
VENUES	"Promoting several venues that will allow for cross training and communication across the professional groups"
RESEARCH TRAINING & TECHNICAL ASSISTANCE	"We will begin to explore how to integrate substance abuse and disability co-existing issues into our research training, and technical assistance"
CULTURAL MEDIATION	"Facilitating cultural mediation"

ATTACHMENT 4

POST CONFERENCE FOLLOW-UP

There were three processes established to continue the dialogue with the participants post conference: a list serv for each work group led by work group leaders who self-selected to continue the dialogue with the work group; post-conference web site; and, seed money to provide assistance in the execution of post conference action steps. The following is a discussion of these processes:

POST WORK GROUPS DIALOGUE:

During work groups on Day 2, the conference participants selected leaders who would continue the dialogue that had been introduced at the conference. Each workgroup selected two representatives who would continue communication with the group members in the execution of their action plans. To facilitate this process, a list serv was created, one for all participants and one for each work group. Periodically during the three months after the conference, the selected leaders would establish contact with the respective participants to learn about their actions.

POST CONFERENCE WEB SITE:

The post-conference web site was designed to also serve the purpose of continuing dialogue. The site's format included conference participants as well as individuals from the field to learn from the conference process and the outcomes.

TECHNICAL ASSISTANCE GRANTS / SEED MONEY:

The conference was able to establish a competitive mechanism to issue awards for post-conference action that was consistent with the conference goals. A committee to establish evaluation guidelines and criteria for selection was formed by selecting a diversified group of conference participants. See Appendix G for summary of technical assistance/seed money projects.

Outcomes

HIGHLIGHTS OF THE OUTCOMES FOLLOW:

List serves were created for each work group as well as the full list of conference participants. Volunteers assumed the responsibility to continue the dialogue. For example, representatives from one work group wrote to all their fellow group members asking for follow-ups on the actions they took. These responses were then circulated to the full list serv and are posted on the post-conference web site.

The web site became operational on September 10th. It has been constructed to serve not only the conference participants but the field as well. The site's message board will serve as a resource to facilitate communication across all stakeholder groups.

The conference committee has sent periodic messages to the participants updating them as the outcomes of the conference have been analyzed.

Four applications for technical assistance grants were awarded at the end of August. These projects will begin during the month of September and will be completed by December, 2001. They include a tri-state consolidation of coexisting disability resources, an interstate work group formed to examine coexisting disability resources within the state, an employer job fair and an employer survey of hiring practices regarding individuals with coexisting disabilities. The processes and outcomes of these awards will be posted on the web site.

The conference coordinator has been invited to co-chair a symposium at the American Psychiatric Association's national conference that will highlight coexisting disabilities, mental illness and other functional disabilities.

Five participants have reported reaching out to their local and state entitities to communicate the conference results and consider means for changing the approach to serving individuals with coexisting disabilities.

In September, the conference staff will be in contact with all participants to acquire an update on all post-conference application of action plans. This information will be reported on the conference web site.

APPENDIX E

GLOSSARY OF ACRONYMS

Frequently Referenced Organizations

ATTC **Addiction Technology Transfer Center**
http://www.nattc.org/
A national network which transmits the latest knowledge, skills and attitudes of professional addiction treatment practice.

ADD **Administration on Developmental Disabilities**
http://www.acf.dhhs.gov/programs/add/
The Administration on Developmental Disabilities ensures that individuals with developmental disabilities and their families participate in the design of and have access to culturally competent services, supports, and other assistance and opportunities that promotes independence, productivity, and integration and inclusion into the community.

ADA **American Disability Association**
http://www.adanet.org/
The mission of the ADA is to meet the informational needs of Americans with diverse disabilities, to promote awareness of disability culture by building bridges of understanding among all people, to enhance our collective quality of life and access to freedom.

APS **American Pain Society**
http://www.ampainsoc.org/
APS is a multidisciplinary scientific and professional society. Its mission is to improve the quality of life of people with pain by providing practical information for patients, raising public awareness and understanding of pain, and advocating against barriers to effective treatment.

ARCA **The American Rehabilitation Counseling Association**
http://www.nchrtm.okstate.edu/arca/
ARCA is an organization of rehabilitation counseling practitioners, educators, and students who are concerned with improving the lives of people with disabilities. Its mission is to enhance the development of people with disabilities throughout their life span and to promote excellence in the rehabilitation counseling profession.

ASAM **American Society of Addiction Medicine**
http://www.asam.org
Medical specialty society dedicated to educating physicians and improving the treatment of individuals suffering from alcoholism and other addictions

AMERSA **Association for Medical Education and Research in Substance Abuse**
http://www.amersa.org
A multidisciplinary organization of health care professionals dedicated to improving education in the care of individuals with substance abuse problems.

BIA **Brain Injury Association**
http://www.biausa.org/
The mission of the Brain Injury Association is to create a better future through brain injury prevention, research, education and advocacy

CDC **Center for Disease Control**
http://www.cdc.gov
Lead federal agency for protecting the health and safety of people – at home and abroad, providing credible information to enhance health decisions, and promoting health through strong partnerships.

CMHS **Center for Mental Health Services**
http://www.samhsa.gov/centers/cmhs/cmhs.html
Charged with leading the national system that delivers mental health services.

CROWD **Center for Research on Women with Disabilities**
http://www.bcm.tmc.edu/crowd/
The Center for Research on Women with Disabilities (CROWD) is a research center that focuses on issues related to health, aging, civil rights, abuse, and independent living. CROWD's purpose is to promote, develop, and disseminate information to expand the life choices of women with disabilities so that they may fully participate in community life.

CSAP **Center for Substance Abuse Prevention/SAMHSA**
http://www.samhsa.gov/centers/csap/csap.html
Provides national leadership in the development of policies, programs, and services to prevent the onset of illegal drug use, to prevent underage alcohol and tobacco use, and to reduce the negative consequences of using substances.

CSAT **Center for Substance Abuse Treatment/SAMHSA**
http://www.samhsa.gov/centers/csat/csat.html
Charged to improve the lives of individuals and families affected by alcohol and drug abuse by ensuring access to clinically sound, cost-effective addiction treatment that reduces the health and social costs to our communities and the nation.

CSAVR **Council of State Administrators of Vocational Rehabilitation**
Members only web site
Organization of state administrators of vocational rehabilitation services.

DOE **Department of Education**
http://www.ed.gov
In partnership with states, communities, institutions, and other Federal agencies, to carry out its responsibilities to effectively and efficiently support educational excellence and equity for all children.

DOL **Department of Labor**
http://www.dol.gov
Charged with preparing the American workforce for new and better jobs, and ensuring the adequacy of America's workplaces. It is responsible for the administration and enforcement of over 180 federal statutes.

DREDF **Disability Rights Education and Defense Fund**
http://www.dredf.org
The Disability Rights Education and Defense Fund, Inc. (DREDF) is a national law and policy center dedicated to protecting and advancing the civil rights of people with disabilities through legislation, litigation, advocacy, technical assistance, and education and training of attorneys, advocates, persons with disabilities, and parents of children with disabilities.

GRI **Gallaudet Research Institute**
http://gri.gallaudet.edu/
The GRI is internationally recognized for its leadership in deafness-related research.

HHS **Health and Human Service**
http://www.hhs.gov
Principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves

HRSA **Health Resources and Service Administration**
http://www.hrsa.gov
Directs national programs that improve the Nation's health by assuring equitable access to comprehensive, quality health care for all.

MCDPDHHI **Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals**
http://www.mncddeaf.org/index.html
An inpatient chemical dependency program specializing in treatment for Deaf and Hard of Hearing persons.

MSCIS **Model Spinal Cord Injury Systems**
http://www.ncddr.org/rpp/hf/hfdw/mscis/
The Model Spinal Cord Injury Systems (MSCIS) Doorway provides an entrance to the various spinal cord research systems funded by the National Institute on Disability and Rehabilitation Research (NIDRR).

NAMI **National Alliance for the Mentally Ill**
http://www.nami.org
Supports persons with serious brain disorders and to their families; advocacy for nondiscriminatory and equitable federal, state, and private-sector policies; research into the causes, symptoms and treatments for brain disorders; and education to eliminate the pervasive stigma surrounding severe mental illness.

NAADAC **National Association of Alcohol and Drug Abuse Counselors**
http://www.naadac.org
Global organization of addiction focused professionals who enhance the health and recovery of individuals, families and communities.

NAADD **National Association on Alcohol Drugs and Disability**
http://www.naadd.org
Promotes awareness and education about substance abuse among people with co-existing disabilities.

NADAP **National Association on Drug Abuse Problems**
http://www.nadap.org
Provide individuals with the opportunity to become self-sufficient, productive, employed. Work toward insuring that individuals fulfill their potential by living and working in environments free from substance abuse.

NASADAD **National Association of State Alcohol and Drug Abuse Directors, Inc.**
http://www.nasadad.org
Fosters and supports the development of effective alcohol and other drug abuse prevention and treatment programs throughout every State.

NOD **National Organization on Disability**
http://www.nod.org
Promotes the full and equal participation and contribution of America's 54 million men, women and children with disabilities in all aspects of life.

CASA **National Center on Addiction and Substance Abuse at Columbia University**
http://www.casacolumbia.org
A think/action tank that engages all disciplines to study every form of substance abuse as it affects our society.

NCDDR **National Center for the Dissemination of Disability Research**
http://www.ncddr.org/
NCDDR includes activities in the areas of research, demonstration, dissemination, utilization and technical assistance.

NCMRR **National Center for Medical Rehabilitation Research**
http://www.nichd.nih.gov/about/ncmrr/ncmrr.htm
Fosters development scientific knowledge needed to enhance the health, productivity, independence, and quality of life of persons with disabilities

NCPEDP **National Center for Promotion of Employment for Disabled People**
http://www.ncpedp.org
NCPEDP's mission is to advocate and promote equality for people with disabilities in all spheres of life, through education, communication, appropriate training and a barrier-free environment for gainful employment.

NCD **National Council on Disability**
http://www.ncd.gov
An independent federal agency making recommendations to the President and Congress on issues affecting 54 million Americans with disabilities.

NCIL **National Council on Independent Living**
http://www.ncil.org
A membership organization that advances the independent living philosophy and advocates for the human rights of, and services for, people with disabilities to further their full integration and participation in society.

NCRE **National Council on Rehabilitation Education**
http://www.nchrtm.okstate.edu/ncre/
A professional organization dedicated to quality services for persons with disabilities through education and research.

NDRI **National Development and Research Institute, Inc.**
http://www.nchrtm.okstate.edu/ncre/
A non-profit research and educational organization founded to advance scientific knowledge in the areas of drug abuse, HIV, AIDS, therapeutic communities, related areas of mental and public health, criminal justice, urban problems, prevention and epidemiology.

NFB **National Federation for the Blind**
http://www.nfb.org/
The nation's largest and most influential membership organization of blind persons.

NICHCY **The National Information Center for Children and Youth with Disabilities**
http://www.nichcy.org
NICHCY is the national information and referral center that provides information on disabilities and disability-related issues for families, educators, and other professionals. Our special focus is children and youth (birth to age 22).

NIAAA **National Institute on Alcohol Abuse and Alcoholism**
http://www.niaaa.nih.gov
Supports and conducts biomedical and behavioral research on the causes, consequences, treatment, and prevention of alcoholism and alcohol-related problems.

NIDRR **National Institute on Disability and Rehabilitation Research**
http://www.ed.gov/offices/OSERS/NIDRR
Provides leadership and support for a comprehensive program of research related to the rehabilitation of individuals with disabilities. All programmatic efforts are aimed at improving the lives of individuals with disabilities from birth through adulthood.

NIDA **National Institute on Drug Abuse**
http://www.nida.nih.gov
The generator and repository of scientific knowledge about drug abuse and addiction.

NOD **National Organization on Disability**
http://www.nod.org
Promotes the full and equal participation and contribution of America's 54 million men, women and children with disabilities in all aspects of life.

NRCA **The National Rehabilitation Counseling Association**
http://nrca-net.org/
NRCA is a professional association that began in 1958 and is a division of the National Rehabilitation Association. NRCA represents professionals in the field of rehabilitation counseling in a wide variety of work settings.

NCSIA **National Spinal Cord Injury Association**
http://www.spinalcord.org/
The mission of The National Spinal Cord Injury Association (NSCIA) is to educate, and empower survivors of spinal cord injury and disease through our toll-free help-line, nationwide chapters and support groups to achieve and maintain higher levels of independence.

NWHIC **National Women's Health Information Center**
http://www.4woman.gov/wwd/
NWHIC has created this site to help women with disabilities overcome the many challenges and barriers they face. It puts a wealth of useful information together into one place for women with disabilities, caretakers, health professionals, and researchers.

OSERS **Office of Special Education and Rehabilitation Services**
http://www.ed.gov/offices/OSERS/index.html
Committed to improving results and outcomes for people with disabilities of all ages. Provides a wide array of support to parents and individuals, school districts and states in three main areas: special education, vocational rehabilitation and research

RCEP **Rehabilitation Continuing Education Program**
http://www.ed.gov/offices/OSERS/RSA/PGMS/RT/catrcep.html
A network of regional training centers that serve a federal region by providing a broad integrated sequence of training activities that focus on meeting recurrent and common training needs of employed rehabilitation personnel.

RRTC **Rehabilitation Research and Training Centers**
http://www.ed.gov/offices/OSERS/NIDRR/Programs/res_program.html#RRTC Conduct coordinated and integrated advanced programs of research targeted toward the production of new knowledge, which may improve rehabilitation methodology and service delivery systems, alleviate or stabilize disabling conditions, or promote maximum social and economic independence for persons with disabilities.

RSA **Rehabilitation Services Administration**
http://www.ed.gov/offices/OSERS/RSA
Charged with providing national leadership for, and administration of, basic state and formula grant programs, service projects and rehabilitation training discretionary grant programs geared toward serving persons with disabilities.

SSA **Social Security Administration**
http://www.ssa.gov
Nation's primary income security agency

SAMHSA **Substance Abuse and Mental Health Services Administration**
http://www.samhsa.gov
Charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

TBI **Traumatic Brain Injury Model Systems**
http://www.tbims.org/
The TBI Model Systems (TBIMS) are involved in a prospective, longitudinal multi-center effort to examine the course of recovery and outcomes following TBI. Each center provides a coordinated system of emergency care, acute neurotrauma management, comprehensive inpatient rehabilitation and long-term interdisciplinary follow-up services.

WBGA **Washington Business Group on Health**
http://www.wbgh.org/whoweare/index.html
National non-profit organization exclusively devoted to representing the perspective of large employers and providing practical solutions to its members' most important health care problems.

Frequently Referenced Acronyms

ACT	Community Treatment
ADA	Americans with Disability Act
AOD	Alcohol and Other Drugs
CIT	Comprehensive Integrated Treatment
COFD	Co-Occurring and Other Functional Disorders
ICD	International Center for the Disabled
ICM	Intensive Case Management
MICA	Mentally Ill Chemical Abuser
MISA	Mental Illness and Substance Abuse Disorders
PWD	Person With Disability
RFP	Request For Proposal
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TAU	Treatment as Usual
TC	Therapeutic Community
TCE	Targeted Capacity Expansion
TIP	Treatment Improvement Protocol
TTW	Ticket to Work
TTY	Teletypewriter
TWWIIA	Ticket to Work and Work Incentives Improvement Act
VR	Vocational Rehabilitation
WIA	Workforce Investment Act
WIB	Workforce Investment Board
WIIA	Work Incentives Improvement Act

APPENDIX F

PARTICIPANT LIST

Shari Aldridge MSW
Manager, Special Populations Unit
Ohio Department of Alcohol
and Drug Addiction Services
Two Nationwide Plaza
280 North High Street, 12th Floor
Columbus, OH 43215
(614) 644-8428
aldridge@ada.state.oh.us

Craig Andler LSW, ICADC, CCS, CADACII
Project Manager
The ACES Project, Indiana Behavioral
Health Choices
4701 N. Keystone Avenue, Suite 150
Indianapolis, Indiana 46205-1585
(317) 205-8251
candler@kidwrap.org

John J. Benshoff Ph.D., CRC
Professor
Southern Illinois University at Carbondale
Rehabilitation Institute, Rehn Hall 317
Carbondale, IL 62901-4609
(618) 453-8281
jbenshof@siu.edu

James J. Billy M.A., CRC
Independent Living Branch Chief
Department of Education OSERS/RSA
330 C Street, SW, Switzer Bldg. Room 3326
Washington, DC 20202
(202) 205-9362
james_billy@ed.gov

Pamela Block Ph.D.
Postdoctoral Fellow
Brown University, Box G-BH
Providence, RI 02912
(401)444-1832
Pamela_Block@brown.edu

Barry Blood LCPC
Addiction Counselor
Family Service Foundation
2310 North Charles St.
Baltimore, MD 21218
(410) 889-8040
Drblood@earthlink.net

Pete Bragg
Training Specialist
Matrix Research Institute
100 North 17th Street, 10th Floor
Philadelphia, PA 19103
(215) 569-2240, ext. 202
mripete@aol.com

Gene I. Brooks Ph.D.
Social Science/Humanities
Research Associate
University of Texas at Austin
11604 Crosstimber Drive
Austin, TX 78750
(512) 258-3901
iran@utxvms.cc.utexas.edu

Susanne M. Bruyere Ph.D.
Director, Program on Employment
and Disability
Cornell University School of Industrial
and Labor Relations
106 ILR Extension Building
Ithaca, NY 14853-3901
(607) 255-7727
smb23@cornell.edu

Cynthia Buitrago
Director of Children's and Vocational
Programs
Graduate Student, San Francisco State,
Rehabilitation Counseling
168 Dolores Street
San Francisco, Ca 94103
(415) 487-0199
buicy@aol.com

Cynthia A. Burley M.P.A./ L.P.A.
Supervisory Vocational
Rehabilitation Specialist/Special Assistant
Rehabilitation Services Administration
810 First Street, NE
Washington, DC 20002
(202) 442-8494
Cynthia.Burley@dc.gov

Marylee Burns M.Ed., M.A., CRC
Senior Management Consultant
NYC Health & Hospitals Corporation,
Office of Behavioral Health
125 Worth Street, Room 430
New York, NY 10013
(212) 788-3458
burnsm@nychhc.org

Michael Butler M.A.
Workplace Specialist
Workplace Helpline
5640 Nicholson Lane, Suite 300
Rockville, MD 20852
(800) 967-5752
AEARL@samhsa.gov

Angela M. Caristo M.A.
Prevention Specialist
Cerebral Palsy Associations of New Jersey
354 South Broad Street
Trenton, NJ 08608
(609) 392-4004 ext. 590
acaristo@ucpanj.org

Elena M. Carr M.A.
Program Analyst
U.S. Department of Labor, Office of Policy
200 Constitution Ave., N.W., Rm S-2312
Washington, DC 20210
(202) 693-5078
carr-elena@dol.gov

Doborah Casati M.Ed.
Training Specialist,
Human Resources Development
Texas Commission for the Blind
4800 North Lamar
Austin, TX 78756
(512) 377-0658
Debbie.Casati@tcb.state.tx.us

Dale Chadwick MBA
Project Director, MHQ Translation
Plan Central Arkansas Veterans
Healthcare System
1623 N. Harrison Street
Little Rock, AR 72207
(501) 257-1068
rousmanieredalec@uams.edu

Connie Ciliberti
Senior Staffing Manager
Time Warner Cable
120 East 23rd Street
Hartford, CT 06114

Pamela Clark M.A.
Evaluator, Central and Eastern
Oregon Juvenile Justice Consortium
606 Court Street
The Dalles, Oregon 97058
(541) 296-4449
clark_pamela@yahoo.com

Shawn Clark
Workforce Development Manager
Office of Alcohol & Drug Abuse Programs
3414 Cherry Avenue, NE, Suite 100
Salem, Oregon 97303
(503) 373-1650 ext. 229
Shawn.clark@state.or.us

E. Finney Clarkson J.D., LADAC
Family Services Counseling A&D
Coordinator TN Department of Human
Services/ Families First
Citizen's Plaza Bldg., 12th Floor
400 Deaderick St.
Nashville, TN 37248
(615) 313-5760
efinlizzie@hotmail.com

Tom Colthurst
Co-director, Pacific Southwest ATTC
University of California, San Diego
and Silver Gate Group/ Prevention File
4635 West Talmadge Drive
San Diego, CA 92116-4834
(858) 551-2951
Tomc@silvergategroup.com

John D. Corrigan Ph.D.
Professor, Department of Physical Medicine
& Rehabilitation, Ohio State University
2145 Dodd Hall, 480 West 9th Avenue
Columbus, OH 43210
(614) 293-3830
corrigan.1@osu.edu

Fred Cowell
Staff Director, Health Policy Department
Paralyzed Veterans of America
801 18th Street, N.W.
Washington, DC 20006
(202) 416-7602
fredc@pva.org

Patrice Cromwell
Program Development Fellow, Workforce
& Economic Development
Open Society Institute
201 North Charles Street, Suite 1300
Baltimore, MD 21201
(410) 234-1091
pcromwell@sorosny.org

John de Miranda Ed.M
Executive Director
National Association on Alcohol, Drugs
and Disability (NAADD)
2165 Bunker Hill Drive
San Mateo, CA 94402-3801
(650) 578-8047
solanda@sbcglobal.net

Hector Del Valle
Activist, NAADD, Orlando UCF
719 Myrtle Lake Ct. #106
Orlando, FL 32825
(407) 381-7932
HDVINFL@aol.com

Lauri DiGalbo M.Ed., CRC, LPC
Consultant/Substance Abuse
Bureau of Rehabilitation Services
BRS/DSS 25 Sigourney Street
Hartford, CT 06106
(860) 424-4872
laura.digalbo@po.state.ct.us

Diana DiNitto Ph.D.
Professor (Cullen Trust Centennial Professor
in Alcohol Studies and Education)
University of Texas at Austin,
School of Social Work
1925 San Jacinto Blvd.
Austin TX 78712
(512) 471-9227
ddinitto@mail.utexas.edu

Tom Doub Ph.D.
Director of Research and Development
Dual Diagnosis Management
1302 Division St., Ste. 101
Nashville, TN 37203
(615) 312-1467
tdoub@dualdiagnosis.org

Pam Eisert
Research Assistant/Employment Specialist
University of Kentucky-Center on Drug
& Alcohol Research
643 Maxwelton Court
Lexington, KY 40508-4012
(270) 846-0945
pseisert@yahoo.com

Jennifer Ellingwood MPA
Project Manager - Evaluation
Addiction Technology Transfer Center
National Office
UMKC, 5100 Rockhill Road
Kansas City, MO 64110
(816) 482-1196
jelling@nattc.org

Macrina Fazio CRC
Vocational Rehabilitation Manager
State of Alaska Division
of Vocational Rehabilitation
1016 West 6th Avenue, Suite 102
Anchorage, AK 99501-1963
(907) 269-3585
macrina_fazio@labor.state.ak.us

Georgia D. Fegley M.S., CRC, CADC, NCC
District Administrator
Division of Vocational Rehabilitation
37 Antioch Court
New Castle, DE 19720
(302) 322-8509
gfegley@dvr.state.de.us

Paul B. Feuerstein CSW
President/CEO
Barrier Free Living
270 East Second Street
New York, NY 10009-7815
(212) 677-6668 ext. 123
pbfbflnyc@aol.com

Jennifer Fiedelholtz
Public Health Analyst
Substance Abuse and Mental Health Services Administration (SAMHSA)
5600 Fishers Lane, Room 12C-06
Rockville, MD 20857
(301) 443-5803
jfiedelh@samhsa.gov

Arthur Fleitman CRC, LICSW, BCD
Partner/Clinician
Transitions
3 Greenbriar Drive, #307
North Reading, MA 01864
(978) 828-1952
afleitman@earthlink.net

Scott W. Forbes Rh.D.
Program Manager
Region 5 RCEP
Mailcode 6703, SIU
Carbondale, IL 62901
(618) 453-4061
Wsforbes@siu.edu

Lyle E. Forth M.S.
Treatment Program Director
COPE Behavioral Services Inc.
1101 E. Broadway
Tucson, AZ 85719
(520) 624-0898
lyleforth@copebhs.com

Dan Fox M.Ed.
Program Specialist for Mental Health, Developmental Disability and Substance Abuse
Division of Vocational Rehabilitation
4521 Wingate Drive
Raleigh, NC 27609
(919) 773-3364
dan.fox@ncmail.net

Roman Frankel Ph.D., CCGC
President, Executive Director
New Start, Inc.
5839 W. Maple, Ste 112
West Bloomfield, MI 48322
(248) 855-3919
RomanNSI@aol.com

Jane Franks RN, LPC, MAC
Director, Behavioral Health Services
Norton Sound Health Corporation
P.O. Box 21
Nome, AK 99762-0021
(907) 443-3483
franks@nshcorp.org

Steve Gallon Ph.D.
Director, Northwest Frontier ATTC
3414 Cherry Avenue, NE, Suite 100
Salem, Oregon 97303
(503) 373-7348
steve.gallon@state.or.us

Stephanie Garduno
Management Analyst IV
NM Division of Vocational Rehabilitation
435 St. Michaels Dr., Bldg. D
Santa Fe, NM 87505
(505) 954-8510
stephanie.garduno@state.nm.us

Gerald R. Garrett Ph.D.
Chair and Professor,
Department of Sociology;
Director, Alcohol & Substance Abuse Studies
University of Massachusetts, Boston
100 Morrissey Blvd
Boston, MA 02125-3393
(617) 287-6260
skyman40@msn.com

Margaret K. Glenn Ed.D.
Associate Professor and Coordinator
of Rehabilitation Counselor Education
West Virginia University
113 Orchard Crossings
Morgantown, WV 26505
(304) 293-3807
mglenn@acninc.net

Noreen M. Glover Rh.D., CRC
Assistant Professor, Syracuse University
260 Huntington Hall
Syracuse, NY 13057
(315) 443-9646
nmglover@sued.syr.edu

Debra Guthmann Ed.D.
Family Services Counseling
A&D Coordinator, NAADD; CA School
for the Deaf; MN CD Program
for Deaf/Hard of Hearing
39350 Gallaudet Drive
Fremont, CA 94538
(510) 794-3684
Dguthmann@aol.com

June K. Gutterman Ed.D.
Interim Director, Bureau of
Vocational Rehabilitation
Ohio Rehabilitation Services Comission
400 E Campusview Blvd.
Columbus, OH 43235
(614) 438-1250
RSC_JKG@rscnet.a1.state.oh.us

J.R. Harding Ed.D.
Government and Customer Relations
OAOC/VR Services
2002 Old St. Augustine Rd., Building A
Tallahassee, FL 32399
(850) 410-1919
Hardinj@vr.fdles.state.fl.us

Sheila Harmison D.S.W.
Special Assistant to the Director, Center for
Substance Abuse Treatment (CSAT)
5600 Fishers Lane, Rockwall II, Suite 880
Rockville, MD 20852
(301)443-7524
sharmison@samhsa.gov

John G. Harper M.Ed., LPC, CRC
Supervisor, Mental Health Services
Missouri Division
of Vocational Rehabilitation
3024 Dupont Circle
Jefferson City, MO, 65109
(573) 526-7040
jharper@vr.dese.state.mo.us

Connie Hart
Wright State University
connie.hart@wright.edu

Brandy L. Hassett
Physical Therapy Student
The George Washington University
15437 Tindlay Street
Silver Springs, MD 20905
(240) 460-5865
bhassett@gwu.edu

Barry Hawkins Ph.D., CASAC
Director of Chemical Dependency Services
Orange County Department
of Mental Health
30 Harriman Drive
Goshen, NY 10924
(845) 291-2616
Bhawkins@co.orange.ny.us

Allen W. Heinemann Ph.D., ABPP
Professor, Department
of Physical Medicine and Rehabilitation
Northwestern University Medical School
345 East Superior Street
Chicago, IL 60611-4805
(312) 238-2802
a-heinemann@northwestern.edu

Craig M. Helbok M.S., CRC, NCAC
Doctoral Student - Counseling Psychology
West Virginia University
1648 Blue Horizon Road
Morgantown, WV 26501
(304) 328-6084
chelbok@wvu.edu

Jacqueline Hendrickson MSW
Public Health Advisor
OPAT, CSAT, SAMHSA
5600 Fishers Lane
Rockville, MD 20875
(301) 443-1109
jhendric@samhsa.gov

Anne M. Herron M.S., CRC, CASAC
Director, Treatment Programming
New York State Office of Alcoholism
and Substance Abuse (OASAS)
1450 Western Ave.
Albany, NY 12203-3526
(518) 402-2846
anneherron@OASAS.State. NY.US

Angelia Holloway M.A., CRC
Director of Program and Client Services
Binding Together, Inc.
200 Hudson Street, 10th Floor
New York, NY 10013
(212) 334-9400
aholloway@bindingtogether.org

Holly E. Hopper MRC
Project Coordinator/Interventionist
University of Kentucky Center on Drug
and Alcohol Research
645 Maxwelton Court
Lexington, Kentucky 40506-0350
(859) 257-5213
hehopp2@pop.uky.edu

Ruth Howell
BRS/DMNAS Employment Project
Coordinator
Bureau of Rehabilitation Services
25 Sigourney Street
Hartford, CT 06105
(860) 424-4882
Ruth.Howell@po.state.ct.us

Kathleen Hruszko M.A.
Program Planning
and Development Specialist
Division of Vocational Rehabilitation
135 E. State Street
Trenton, NJ 08625-0398
(609) 292-7439
khruszko@dol.state.nj.us

John L. Hulick MS, CPS
Director of Public Affairs and Policy,
NCADD - New Jersey
1675 Whitehorse- Mercerville Road, St 205
Hamilton, NJ 08619
(609) 689-0599 ext. 153
jhulick@ncaddnj.org

Tim Janikowski Ph.D.
Associate Professor and Department Chair
University of Buffalo, Department of
Counseling
and Educational Psychology
404 Baldy Hall
Buffalo, NY 14260
(716) 645-2484, ext. 1055
Tjanikow@buffalo.edu

James S. Jeffers M.A.
President
Jeffers and Associates
Jeffers' Cabin, Sandy Run Road
Shirley, WV 26434
304-758-4640 (cabin), 304-758-4640 (cell)
parajim@excite.com

Peg Jeffries
Executive Director
Action Toward Independence
2927 Rte. 6
Slate Hill, NY 10973
(845) 355-2030
ati@warwick.net

Edith J. Jungblut
Public Health Advisor
USDHHS/SAMHSA/Center
for Substance Abuse Treatment/DPSD
1291 Deleware Ave., SW
Washington, DC 20024-3905
(301) 443-6669
ejungblu@samhsa.gov

Lily Kaufmann CADC
Comm. Officer, Addictions, Deaf and Disabilities
Dept. of Health and Senior Services, Division of Addiction Services
P.O. Box 362
Trenton, NJ 08625
(609) 984-3311
lkaufmann@doh.state.nj.us

Brenda G. Kaulback M.A.
Consultant for Center on Addiction and Substance Abuse at Columbia University
Harpswell East Associates (CASA)
289 East Middle Turnpike
Manchester, CT 06040-4361
(860) 649-6159
Eastharp@aol.com

Mary R. Keegan CRC, LPC
Southwest Area Manager
Ohio Rehabilitation Services Commission
617 Vine Street, Suite 925
Cincinnati, OH 45202
(513) 852-3260 x. 254
RSC_MRK@rscnet.al.state.oh.us

Deborah Keenan M.S.W.
Instructor, Region 7 RCEP,
University of Missouri, Columbia
625 West 67th Terrace
Kansas City, MO 64113
(816) 361-4023
Keenand@missouri.edu

Joseph E. Keferl, Rh.D., CRC
Assistant Professor and Advisor of the Rehabilitation Counseling and Chemical Dependency Program
Wright State University, Department of Human Services, M052 CAC
Dayton, Ohio 45435-0001
Phone 937-775-2076
TDD 937-775-3153
Fax 937-775-2042
joseph.keferl@wright.edu

Karen Kelly Ph.D., LPC, MAC
President, CEO, Clinician,
Circle of Recovery, Inc
P.O. Box 360515
Decatur, GA 30056
(404)243-5576
kkellywood@aol.com

Nancy J. Kennedy Dr. P.H.
Director, Office of Managed Care
Center for Substance Abuse Prevention/
SAMHSA/DHHS
5600 Fishers Lane, Rockwall II, Suite 920
Rockville, MD 20857
(301) 594-0788
Nkennedy@SAMHSA.gov

D. Shane Koch Rh.D., CRC, LCDC, AAC
Director of Training, Addictions Studies
Institute, Department of Rehabilitation,
Social Work, and Addictions
PO Box 310919
Denton, TX 76210
(940) 565-3465
Dskoch@unt.edu

Paul Kordonsky LCSW-C
Coordinator of Integrated Services
Man Alive Research, Inc.
2100 North Charles Street
Baltimore, MD 21218-5798
(410) 837-4292

Harry Kressler M.A.
Executive Director, PIMA
Prevention Partnership
330 N. Commerce Park Loop #160
Tucson, AZ 85745
(520) 791-2711

Rekha Kurikoti
Human Resources Coordinator
Time Warner Cable
120 East 23rd Street
Hartford, CT 06114

Gary L. Lamb-Hart MDiv
Center Manager, Ohio Valley Center for Brain
Injury Prevention & Rehabilitation
1166 Dodd Hall, 480 W. 9th Avenue
Columbus, OH 43210
(614) 293-7142
Lamb-hart.1@osu.edu

Herman Largo
Department Director, Navajo Nation Dept.
of Behavioral Health Services
P.O. Box 709
Window Rock, AZ 86515
(520) 871-6235
lmnLargo@yahoo.com

Deborah Larson M.A., CADAC
Executive Director
Granada House, Inc.
70-72 Adanson St
Allston, MA 02134
(617) 696-1558
Mustangdebl@aol.com

Jane Latane
Project Director
United Cerebral Palsy of Southern Arizona
9150 East Helen Street
Tucson, AZ 85715
(520) 603-2477
lja25@qwest.net

Anita Leal-Idrogo Ph.D., CRC
Associate Professor, Coordinator,
Rehabilitation Counseling Program
San Francisco State University
1600 Holloway Avenue, BH 524
San Francisco, CA 94132
(415) 338-2282
Jlatane@pimaprevenion.org

Stephen T. LeBlanc
Public Affairs Specialist, Center for
Substance Abuse Treatment (CSAT)
5515 Security Lane, Room 6-A 33
Rockville, MD 20852
(301) 443-0294
sleblanc@samhsa.gov

Petros Levounis M.D.
Clinical Assistant Professor of Psychiatry
New York University School of Medicine
328 West 17th Street, #5W
New York, NY 10011-5038
(212) 562-4097
petros.levounis@med.nyu.edu

Erika Lohmiller LCPC, CADC, MISA II
Staff Therapis, Ravenswood Community Mental Health Center
2312 West Irving Park Road, Building B
Chicago, IL 60618
(773) 769-6200
elohmiller@rhmc.com

Christopher F. Luther
Director, Tohono O'oham Nation Vocational Rehabilitation
P.O. Box 100
Sells, AZ 85634
(520) 383-8790

La Mirldred Mackabee-Anderson M.A.
Executive Director, Iris Center Women's Counseling and Recovery Services
3777 Lorena Ave. #5
Castro Valley, CA 95926
(510) 583-5848
LaMirl@aol.com

David A. MacLeod M.A.
Adjunct Faculty, University of Maryland Eastern Shore, Department of Rehabilitation Services
603 Hunting Park Drive
Salisbury, MD 21801
(410)749-6945
davem@shore.intercom.net

Kali Mallik M.S.
President/CEO
Alliance, Inc.
7701 Wise Avenue
Baltimore, MD 21222
(410) 282-5900
kmallik@allianceinc.org

Carl L. Marshall CRC
Administrator, Drug and Alcohol Programs and Special Projects
Office of Vocational Rehabilitation
909 Green Street
Harrisburg, PA 17102
(717) 783-3129
carmarshal@state.pa.us

Debra Maslansky M.S.
Director of Case Management
Cerebral Palsy of New Jersey
354 S. Broad St.
Trenton, NJ 08608
609-392-4004

Lou Ann Mattison M.S., CVE
Vocational Rehabilitation Counselor
State of Alaska, Division of Vocational Rehabilitation
3600 Bragaw
Anchorage, AK 99508
(907) 269-2064
louann_mattison@labor.state.ak.us

Theresa Mayer M.S.
Consumer Liaison, SARDI
School of Medicine/ Department of Community
Health, Wright State University
3940 State Road 370
Yellow Springs, OH 54387
(937) 775-1484
theresamayer@voyager.net

Kimberly S. Mayer MSSW
Program Manager
Contra Costa Health Services Department
597 Center Ave, Suite 320
Martinez, CA 94553
(925) 313-6322
kmayer@hsd.co.contra-costa.ca.us

Dennis McCarty Ph.D.
Adjunct Professor
Oregon Health Sciences University
3181 SW Sam Jackson Park Road, CB 669
Portland, OR 97201-3079
(503) 494-1177
Mccarty@ohsu.edu

Connie Miller MSW, CDP
Clinical Director, Spokane Regional Health District/SATTS Program
1101 W. College St.
Spokane, WA 92201
(509) 323-2845
cmiller@spokanecounty.org

Dennis C. Moore Ed.D.
Director, RRTC on Drugs and Disability
Wright State University, School of Medicine
P.O. Box 927
Dayton, OH 45401-0927
(937)775-1484
dennis.moore@wright.edu

Diana Morris JD
Director, Open Society Institute
201 North Charles Street, Suite 1300
Baltimore, MD 21201
(410) 234-1091
dmorris@sorosny.org

Ruth A. Morton
Clinician Coordinator of a Mobile Adolescent Treatment Team
Norton Sound Health Corporation
P.O. Box 21
Nome, AK 99762-0021
(907) 443-3304
rmorton@nshcorp.org

Howard Moses
Administrator, Medical Buy-In for Disabled Workers, Kansas Department of Social and Rehabilitation Services
915 SW Harrison, 6th Floor
Topeka, KS 66612
(785) 296-5217
Hxxm@srskansas.org

Ali Mostashfi
Research Assistant, SARDI Program
Wright State University, School of Medicine
P.O. Box 927
Dayton, OH 45401-0927
(937) 775-1484
ali.mostashfi@wright.edu

Catherine Mullaly
Steinhardt School of Education
35 West 4th Street, Suite 1200
New York, NY 10012
cem251@nyu.edu

Lawrence F. Murray CSW
Fellow, The National Center on Addiction and Substance Abuse at Columbia University
633 Third Avenue
New York, NY 10013
(212) 841-5208
lmurray@casacolumbia.org

Gil Naranjit M.A.
Workplace Specialist
Workplace Helpline
5640 Nicholson Lane, Suite 300
Rockville, MD 20852
(800) 967-5752
AEARL@samhsa.gov

Michael Nelipovich Rh.D.
Director, Wisconsin State Bureau
for the Blind
1 W. Wilson St., Room B275
PO Box 7851
Madison, WI 53707
(608) 266-3109
nelipmi@dhfs.state.wi.us

Steven Neumiller M.A., NCC
President
Inland NW Proposal Development
P.O. Box 1801
Spokane, WA 99210-1801
(509) 747-1251
neumillers@aol.com

Linda Nicholas
Project Manager
Great Lakes ATTC, University of Illinois at
Chicago
808 S. Wood Street (MC 799)
Chicago, IL 60612
(312) 355-2731
lnichola@uic.edu

Robert E. Olson M.S.
Director
NAADD, California Alcohol, Drug & Disability
Technical Assistance Project
490 El Camino Real, Suite 218
Belmont, CA 94002-2140
(650) 631-1576
naadd@juno.com

Robert W. Oppermann M.Ed.
Project Supervisor
South Carolina Department of Vocational
Rehabilitation, Holmesview Center
P.O. Box 14675
Greenville, SC 29610
(864) 295-5440
Bobbyop@bellsouth.net

Makah Patterson
Intern, Center for Substance Abuse Prevention

Kenneth Perez
Upstate Coordinator, Vocational Rehabilitation
and Employment Services
NYS OASAS
1450 Western Avenue Room 200
Albany, NY 12203
(518) 485-2156
Kenperez@oasas.state.ny.us

Kim Plavsic
Federal Project Officer, SAMHSA/CSAT
Office of Evaluation, Scientific Analysis
and Synthesis
Rockwall II Building, Suite 840
5600 Fishers Lane Rockville, MD 20807
CSAT/SAMHSA
301-443-7916
kplavsic@samhsa.gov

Deborah G. Polasek M.A.
1615 Manchester Lane, NW
Washington, DC 20011
dgpolasek@yahoo.com

Anthony Porter
Director of Addiction Services
Nyack Hospital
160 North Midland Ave.
Nyack, NY 10960
(845) 348-2078
portert@nyackhospital.org

Larry D. Raper MBS, MA, ACADC, CCS
Director of Compliance and Outcome
Monitoring, Arkansas Dept of Health, Alcohol
and Drug Abuse Prevention
900 Vinson Street
Little Rock, Arkansas 72205-1531
(501) 221-2839 , wk (501) 280-4504
lraper@healthyarkansas.com

Valerie E. Robinson M.S., LPC
Director of Training, DC/Delaware ATTC;
Deputy Director, Danya International, Inc.
8737 Colesville Road, Suite 1200
Silver Spring, MD 20910
(301) 565-2142
Vrobinson@danya.com

Susanne R. Rohrer RN, BSN, MBA
Public Health Analyst
Center for Substance Abuse Treatment
4201 Landing Lane
Dunkirk, MD 20754
(301) 443-8521
Srohrer@samhsa.gov

Carolyn Rollins Rh.D., CRC, NCC
Assistant Professor in Rehabilitation
Florida State University
215 Stone Bldg.
Tallahassee, FL 32306-4458
(850)-644-1285
Crollins@mailer.fsu.edu

Douglas Rosenberry
Director of Addiction Technology Transfer
NYS Office of Alcoholism
and Substance Abuse Services
1450 Western Avenue
Albany, NY 12203
(518) 457-5527
dougrosenberry@oasas.state.ny.us

Edward Ross LCSW
Administrator, Behavioral Health Division
International Center for the Disabled
340 East 24th Street
New York, NY 10010
(212) 585-6275
Lhawkins@nyp.org

Ronald L. Rudberg M.S., CRC, CAC Diplomate
Vocational Rehabilitation Counselor II
Pennsylvania Office of Vocational
Rehabilitation
201 W. Wheeling St.
Washington PA 15301
(724) 223-4454
Rrudberg@stargate.net

Stanley Sacks Ph.D.
National Development
and Research Institutes, Inc. (NDRI)
7 W. 23rd Street, 8th Floor
New York, NY 10010
(212) 845-4400
stansacks@ndri.org

Michael Salabiye
Facility Planner
Navajo Nation Dept. of Behavioral Health
Services
P.O. Box 709
Window Rock, AZ 86515
(520) 871-6235
mrsalabiye@yahoo.com

Eddie B. Sample, Jr. M.S.Ed
Research Associate
SARDI/RRTC on Drugs & Disability
Wright State University, SOM-SARDI
Program,
P.O. Box 927
Dayton, OH 45401-0927
(937) 775-1484
eddie.sample@wright.edu

Thetius A. Saunders M.Ed.
Special Assistant to the Director
of the Office of Client Services
Maryland Division of Rehabilitation Services
2301 Argonne Drive
Baltimore, MD 21218
(410) 554-9109
tsaunders.md.dors.@visto.com

Robert M. Schacht Ph.D.
Research Associate
American Indian Rehabilitation Research and Training Center (RRTC)
P.O. Box 5630, Northern Arizona University
Flagstaff, AZ 86011-5630
(520) 523-1342
Robert.Schacht@nau.edu

Anne Schneider ACBSW
Director of Quality Assurance
United Cerebral Palsy Associations of New Jersey
354 South Broad Street
Trenton, NJ 08520
(609) 392-4004 ext. 535
aschneider@ucpanj.org

Linda Schroeder M.S.S, NCC, CRC, LPC
Coordinator of Staff Development
Ct Bureau of Rehabilitation Services
DSS/BRS 25 Sigourney St., 11th Floor
Hartford, CT 06106
(860) 424-4880
Linda.schroeder@po.state.ct.us

Robert Schwartz M.D.
Medical Director
Friends Research Institute
716 Stoneleigh Road
Baltimore, MD
(410) 823-5116
rzschwartz@aol.com

John J. Scott
Safety and Risk Manager
Melwood Horticultural Training Center
5606 Dower House Road
Upper Marboro, MD 20772
(301)599-4578
jscott@melwood.com

Ian A. Shaffer M.D., M.M.M.
Chief Operating Officer
University Alliance for Behavioral Care, Inc.
12131 Chancery Station Circle
Reston, VA 20190-5800
(703) 736-0352
ianshaffer@earthlink.net

Steven Shevlin
Executive Director
Signs of Sobriety, Inc.
31 Buttonwood Street
Ewing, NJ 08638-2911
(609) 882-7177 tty
stevens581@aol.com

Laura Smith R.N., MBA
Senior Quality Analyst
Allegheny Health Choices, Inc.
306 Fourth Avenue, Suite 800
Pittsburgh, PA 15222-2000
(412) 325-1100 x786
lsmith@ahci.org

Cheryl Smith MSW
Vice President of Programs
Anixter Center
6610 N. Clark Street
Chicago, IL 60626
(773) 973-7900 ext. 230
csmith@anixter.com

Mary A. Spengler CRC
Assistant Area Manager, SE/BVR
Ohio Rehabilitation Services Comission
617 Vine Street, Suite 925
Cincinnati, OH 45202
(513) 852-3260
RSC_MAS@rscnet.al.state.oh.us

Dace Svikis Ph.D.
Associate Professor, Dept. of Psychology,
Virginia Commonwealth, University/Executive
Director of Research, Center for Addication
and Pregnancy
Johns Hopkins University School of Medicine
P.O. Box 980109, Addiction Medicine
Richmond, VA 23298
(804) 827-1184
dssvikis@hsc.vcu.edu

William B. Talley Rh.D., CRC
Director, Institute for Social
& Rehabilitation Services
Assumption College
500 Salisbury Street
Worcester, MA 01609
(508) 767-7219
wtalley@assumption. Edu

Gail E. Viamonte Ph.D.
Project Manager
Northeastern States Addiction
Technology Transfer Center
Nelson A. Rockefeller College,
University at Albany,
135 Western Avenue, Draper-314
Albany, New York 12222
(518) 442-5702
gviamonte@pdp.albany.edu

Elizabeth Viglione M.A., CRC
Director of Vocational Services
Mt. Sinai Hospital,
Narcotics Rehabilitation Center
65 Highview Drive
Carmel, NY 10512
(845) 225-3972
causter8@aol.com

Jean H. Walker M.S.
Vice President, Behavioral Health Services
Alliance, Inc.
7701 Wise Avenue
Baltimore, MD 21222
(410) 282-5900 ext. 3055
jwalker@allianceinc.org

Angela K. Warner
Executive Director
Institute for Professional Development
in the Addictions
125 Wolf Rd. Suite 118
Albany, NY 12205
warneram@aol.com

Alan Warner CCDC III E
Coordinator of Special Populations
Ohio Department of Alcohol and Drug
Addication Services
280 North High Street, 12th Floor
Columbus, OH 43215
(614) 466-9021
warner@ada.state.oh.us

Delores L. Watkins
Program Specialist
US Department of Education,
OSERS, NIDRR
330 C Street S.W., Room 3426
Washington, DC 20202
(202) 205-9195
deloreswatkins@ed.gov

Enid Watson M.Div.
Statewide Substance Abuse/Welfare
to Work Specialist
Institute for Health and Recovery
349 Broadway
Cambridge, MA 02139
(617) 661-3991
work@healthrecovery.org

James Weber Ph.D.
Senior Research Scientist
RRTC on Drugs and Disability
Wright State University, School of Medicine,
P.O. Box 927
Dayton, OH 45401-0927
(937) 775-1484
james.weber@wright.edu

Genevieve Weber M.A.
Steinhardt School of Education
New York University
35 West 4th Street, Suite 1200
New York, NY 10012
(212) 998-5787
gw19@nyu.edu

Corinne Weinman M.A., CRC
Assistant Director NYU/OASAS Project
New York University
35 West 4th Street, Suite 1200
New York, NY 10012
(212) 998-5285
Cmw3@nyu.edu

Janice L. Williams M.R.E/ M.P.A.
Chief, Client Services Division
D.C. Rehabilitation Services Administration
810 First Street, NE, 9th Floor
Washington, DC 20002
(202) 442-8738
janice.williams2@dc.gov

Karen Wolffe Ph.D.
National Program Associate
American Foundation for the Blind
2109 Rabb Glen Street
Austin, TX 78704
(512) 707-0525
Wolffe@afb.net

Eileen Wolkstein Ph.D., CRC
Training Director, RRTC on Drugs
and Disabilities
New York University, Steinhardt
School of Education
35 West 4th Street, Suite 1200
New York, NY 10012
(212) 998-5294
eileen.wolkstein@nyu.edu

Amy M. Young
Communication Specialist
National Center for the Dissemination
of Disability Research
211 East Seventh Street, Suite 200, SW Tower
Austin, TX 78710
(512) 476-6861 ext. 380
ayoung@yahoo.com

Stephan Young LISW
Treatment Program Director
Consumer Advocacy Model
24 N. Jefferson Ave. Suite 400
Dayton, OH 45402
(937) 222-2000
Stephan.young@wright.edu

Susan Zitter M.A., CRC
Executive Vice President
National Association on Drug Abuse
Problems, Inc. (NADAP)
355 Lexington Ave.
New York, NY 10017
(212) 986-1170
szitter@nadap.org

Natalie Zubenko M.A., CADC, MISA II
Director
Anixter Center
2001 N Clybourn, Suite 402
Chicago, IL 60614
(773) 549-0208, ext. 223
nzubenko@anixter.org

APPENDIX G

SEED MONEY PROJECT REPORTS

Recipient 1: New York State Network on Substance Abuse and Co-Existing Disabilities

Seed Money Project Report Summary: Angela K. Warner, Executive Director, Institute for Professional Development in the Addictions

PROJECT OVERVIEW

The New York State Network on Substance Abuse and Co-existing Disabilities involves professionals working at all levels in vocational rehabilitation, disabilities, alcohol and drug abuse treatment and mental health fields to maximize their collective expertise to foster a culture of change that supports interdisciplinary practices to meet the needs of the people they serve. The primary goal of the Network is to strengthen and increase professional development opportunities that are integrated and interdisciplinary in both content and participation.

SUMMARY OF OUTCOMES

In October, a Network conference call was held to identify the focus of the Network and strategies to maximize the expertise and talent of the group to enhance professional development. The Network members discussed creating products targeted to professionals that promote integrated substance abuse and vocational rehabilitation program practices.

As a first step toward the development of resources to support training and education needs of professional staff, a survey of Addictions Treatment programs is about to be disseminated to (1) determine the nature and extent of people with disabilities in addictions treatment (2) learn the extent and type of functional limitations encountered and (3) gain a sense of what is or is not happening in treatment to contribute to overall treatment/vocational rehabilitation goals. The survey will also capture information about how capable clinicians perceive themselves to be in addressing functional limitations.

A graduate student and professor from the Counseling, Educational and School Psychology Department at the University of Buffalo are taking the lead on the survey design and implementation.

FUTURE PLANS

The survey design and implementation is targeted for completion by the end of February with preliminary data available in mid-March. A meeting with Network members will be convened to discuss the implications of the survey data and to formulate recommendations to address any education/training gaps indicated from the survey results.

Recipient 2: Northeastern States Addiction Technology Transfer Center

Seed Money Project Report Summary: Gail Viamonte, Ph.D, Project Manager

The NSATTC, with funding from the RRTC on Drugs and Disabilities, has been working on promoting the goals of the 2nd Annual National Conference on Drugs and Disabilities by researching and producing a directory of substance abuse treatment programs in New York, New Jersey and Pennsylvania that actively offer services to individuals with physical and cognitive disabilities, by providing either a) specialized treatment and outreach, or, at least, b) access to appropriate services.

Thus far the NSATTC has conducted extensive research into the status of treatment access for individuals with co-occurring disabilities in our region. This research has taken the form of web searches, phone surveys, and one to one conversations with individuals in the field. Sadly, while awareness of the issue is high, the number of treatment programs with offer specialized, or even appropriate, treatment remains small. The NSATTC has identified a number of these programs, and we hope that, as our calls continue, we will be made aware of others.

Next steps include conferring with members of the Conference Committee staff, as well as other experts in the field, to determine the specific format for our final product. After a survey form with this information is finalized, the NSATTC will follow-up with the programs we have already identified, as well as additional programs discovered during the survey process, and assemble the contact information into an easy to access directory.

Recipient 3: Report on Supported Work for Substance Abusers in the Workforce

Seed Money Project Report Summary: Dale Chadwick, NAADD and Peter Rousmaniere, Independent Consultant: Integrated Disabilities Management

This research project attempted to answer the question of how the private sector – private employers and insurers in particular – can facilitate return to gainful employment of people whose absence is due to substance abuse or whose disability has been aggravated and prolonged by a co-morbid condition of substance abuse. The focus of the research was the feasibility and utilization of supported work as a means of facilitating re-entry into the workplace.

The methodology was a review of the current literature of the peer reviewed literature on supported work, and interviews with selected experts from the following industries.

- A nationally recognized forestry products employer of over 100,000 workers: A team leader for Integrated Risk Management including Employee Assistance
- A 10,000 employee office furniture manufacturer: A staff therapist in a company counseling center
- The Medical director of a large occupational health service
- Executives of a web-based physician training service with prior diverse experience in worker health and safety
- Executive Director of a graduate-level vocational rehabilitation educational institute
- An EAP Director of a 50,000 state workforce
- Directors of a Supported Work project/construction team managed by a large public sector health care provider

The researchers confirmed the assumption that supported work, though said to be more effective than vocational rehabilitation programs among people with mental health disorders, has not been seriously tested for the target population studied, particularly in the private sector.

FINDINGS

The researchers found that it is highly likely that current data (National Health Interview Data published by Work Loss Data Institute, proprietary data and UNUM Provident Insurance Company, Portland, Maine) seriously underreport the prevalence of substance abuse disorders as a primary diagnosis for worker absenteeism and as a secondary diagnosis among workers who have other short or long term disabilities.

The use of case managers (typically RN's, or vocational and rehabilitation counselors) by employers or insurers is becoming more popular as a means of facilitating return to work of selected disabled workers (identified as high risk for a prolonged absence or disability). While these case managers are often able to determine a primary or secondary diagnosis of substance abuse, they are often reluctant to "expose" the worker due to confidentiality issues and stigma associated with substance abuse, and rarely advocate for or facilitate specialized treatment for the substance abuse problem due to the perceived expense of the treatment, or lack of confidence in the case managers' assessments by the insurer or employer.

Most of the experts interviewed did not think that primary care physicians, from whom workers seek treatment, are adept at diagnosing substance abuse.

RECOMMENDATIONS AND NEXT STEPS

Given the generally accepted prevalence rate of 24-25% of the US population over 18 has a problem with substance abuse, it is clear that the role of substance abuse in both causing and prolonging disabilities is obscured by mis- and under-reporting. We must focus more attention to the private sector's role in helping this "hidden population" return to competitive work. We

need to develop more concrete data about the incidence and costs of not treating substance abuse when it leads to employee absences, and co-morbid substance abuse when it prolongs absence from work because of another disability. Anecdotal data exist in abundance, but only when a people count and a hard dollar figure are attached to this problem will insurers and employers become involved.

Next steps could include:

1. Invite representatives from large employers and disability insurers to participate in national workshops and conferences, such as the one held in June, 2001;
2. Compile data from a representative sample of workers with frequent absences and those on short and long term disability to determine the extent and impact of the existence of substance abuse
3. Estimate the costs to employers and insurers of not treating substance abuse among absentee employees and those on short and long term disability.

Recipient 4: Report on Identifying Employment Opportunities for Ex-offenders with Co-existing Disabilities

Seed Money Project Report Summary: Holly Hopper, MRC, Project Coordinator/Interventionist, University of Kentucky Center on Drug and Alcohol Research.

The idea for this project was born out of shared concerns members of the drug treatment community, employment training programs, state vocational rehabilitation, the court system, and the UK Center on Drug and Alcohol Research program had regarding employment opportunities for ex-offenders with co-existing disabilities. Representatives from each of these programs invited members from state and federal probation and community training centers to form a committee and develop ways to enhance relationships with community employers and to increase employment opportunities for ex-offenders.

With the help of the seed money, this committee planned and held one community job fair for ex-offenders and two luncheons for employers. In addition, we chose five members of this committee to apply with the National Institute of Corrections to become certified Offender Workforce Development Specialists. We were chosen and have attended the first of three 5-day training sessions. Three of us plan to pursue certification.

Since the outcome of our luncheons reinforced our awareness that although many employers will hire ex-offenders on an individual basis, few are willing to publicly admit to this. Some expressed fears that ex-offenders would demand jobs from them and others feared that the general public would hesitate to give them their business. From the OWDS training, we hope to gain the skills necessary for us to present trainings to other professionals so that we can create an offender population that is work ready. Only after we have made progress in this area will we attempt to make a larger, more public attempt at recruiting employers. We believe that by taking small steps and increasing the awareness of our professionals, we can better help those we serve.

Our next steps are to complete the final two weeks of the OWDS training and to complete all assignments for this class. After we complete the certification, we will begin training local

professionals. We also plan to have another ex-offender job fair in Spring 2003. We hope to target employers on an individual basis throughout the year and by Fall 2004, hold "thank you" luncheons for employers who have worked with offenders over the years. To ensure that we stay on track with our goals, we will have quarterly meetings for the whole committee and monthly meetings for various sub-committees.

APPENDIX H

SUMMARY OF DISABILITY-RELATED LEGISLATIVE INITIATIVES

National Vocational Rehabilitation Act of 1920. Established state/federal system of rehabilitation services.

Social Security of Act of 1935. Established federal/state system of health services for "crippled" children; permanently authorized civilian rehabilitation program.

Wagner-O'Day Act of 1938. Authorized federal purchases from workshops for people who are blind.

Randolph-Sheppard Act of 1938. Authorized federal program to employ people who are blind as vendors on federal property.

Vocational Rehabilitation Act of 1954. Authorized innovation and expansion grants, and grants to colleges and universities for professional training.

Wagner-Peyser Act Amendments of 1954. Required federal/state employment security offices to designate staff members to assist people with severe disabilities.

Social Security Amendments of 1956. Established Social Security Disability Insurance Trust Fund and provided for payments to eligible workers who became disabled.

National Defense Education Act of 1958. Authorized federal assistance for preparation of teachers of children with disabilities.

Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. Provided grants for construction of mental retardation research centers and facilities; provided for training of educational personnel involved with youth with disabilities; authorized grants to states for construction of community mental health centers.

Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965. Established grant program to cover initial staffing costs for community mental health centers.

Social Security Act Amendments of 1965. Established Medicaid program for elderly people and for blind persons and other persons with disabilities.

Elementary and Secondary Education Act of 1965. Authorized federal aid to states and localities for educating deprived children, including children with disabilities. Elementary and Secondary Education Act Amendments of 1966.Created National Advisory Committee on Handicapped Children; created Bureau of Education for the Handicapped in U.S. Office of Education.

Fair Labor Standards Amendments of 1966. Established standards for employment of workers with disabilities, allowing for subminimum wages.

Elementary and Secondary Education Amendments of 1967. Authorized regional resource centers; authorized centers and services for deaf-blind children.

Handicapped Children's Early Education Assistance Act of 1968. Established grant program for preschool and early education of children with disabilities.

Vocational Education Act Amendments of 1968. Required participating states to earmark 10 percent of basic vocational education allotment for youth with disabilities.

Architectural Barriers Act of 1968. Required most buildings and facilities built, constructed, or altered with federal funds after 1969 to be accessible.

Developmental Disabilities Services and Facilities Construction Amendments of 1970. Expanded services to individuals with epilepsy and cerebral palsy; authorized new state formula grant program; defined "developmental disability" in categorical terms; established state-level planning council.

Urban Mass Transportation Act Amendment of 1970. Authorized grants to states and localities for accessible mass transportation.

Javits-Wagner-O'Day Act of 1971. Extended purchase authority to workshops for people with severe disabilities in addition to blindness; retained through 1976 preference for workshops for people who are blind.

Social Security Amendments of 1972. Extended Medicare coverage to individuals with disabilities; established Supplemental Security Income program for elderly people and for blind persons and other persons with disabilities.

Small Business Investment Act Amendments of 1972. Established the "Handicapped Assistance Loan Program" to provide loans to nonprofit sheltered workshops and individuals with disabilities.

Rehabilitation Act of 1973. Prohibited disability discrimination in federally assisted programs and activities and federal agencies; required affirmative action programs for people with disabilities by federal agencies and some federal contractors; established the Architectural and Trans-portation Barriers Compliance Board.

Education Amendments of 1974. Required states to establish plans and timetables for providing full educational opportunities forall children with disabilities as condition of receiving federal funds.

Headstart, Economic Opportunity, and Community Partnership Act of 1974. Required that at least 10 percent of children enrolled in Headstart be children with disabilities. Housing and Community Development Act of 1974.Established Section 8 housing program for low-income families, including individuals with disabilities and/or their families.

Developmentally Disabled Assistance and Bill of Rights Act of 1975. Described congressional findings regarding rights of persons with developmental disabilities; established funding for protection and advocacy systems; added requirement that state plan include deinstitutuionalization plan; required states to develop and annually review rehabilitation plans for all clients.

Education for All Handicapped Children Act of 1975. Required states to establish policy assuring free appropriate public education for children with disabilities as condition for receiving Part B funds; established procedural safeguards, procedures for mainstreaming children with disabilities to the maximum extent possible, and procedures for nondiscriminatory testing and evaluation practices.

Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978. Established National Institute of Handicapped Research; established National Council on the Handicapped; authorized grant program for independent living services; replaced categorical definition of developmental disability with functional definition; established minimum funding level for protection and advocacy services.

Civil Rights Commission Act of 1978. Expanded jurisdiction of Civil Rights Commission to disability discrimination.

Department of Education Organization Act of 1979. Established Office of Special Education and Rehabilitative Services in new cabinet-level Department of Education.

Civil Rights of Institutionalized Persons Act of 1980. Empowered Department of Justice to bring suit against states for allegedly violating rights of institutionalized persons with disabilities.

Job Training Partnership Act of 1982. Authorized training and placement services for "economically disadvantaged" individuals, including persons with disabilities. Education of the Handicapped Act Amendments of 1983.Authorized grants for training parents of children with disabilities.

Child Abuse Prevention Treatment Act Amendments of 1984. Required states' child protection agencies to develop procedures for responding to reports that newborns with disabling conditions were being denied treatment; established conditions for requiring such treatment. Developmental Disabilities Act of 1984. Shifted emphasis to employment in priority services; required Individual Habilitation Plan for consumers; increased minimum funding for protection and advocacy services.

Rehabilitation Act Amendments of 1984. Established Client Assistance Programs as formula grant programs; made National Council on the Handicapped an independent agency.

Consolidated Omnibus Budget Reconciliation Act of 1985. Expanded the definition of "habilitation" for Home and Community-Based Waiver recipients with developmental disabilities to cover certain pre-vocational services and supported employment for previously institutionalized individuals; authorized states to cover ventilator-dependent children under the waiver program if they would otherwise require continued inpatient care.

Education of the Handicapped Act Amendments of 1986. Authorized a new grant program for states to develop an early intervention system for infants and toddlers with disabilities and their families, and provide greater incentives for states to provide preschool programs for children with disabilities between the ages of three and five.

Handicapped Children's Protection Act of 1986. Authorizes courts to award reasonable attorneys fees to parents who prevail in due process proceedings and court actions under Part B of the Education of the Handicapped Act.

Employment Opportunities for Disabled Americans Act of 1986. Made the Section 1619(a) and 1619(b) work incentives a permanent feature of the Social Security Act; added provisions to enable individuals to move back and forth among regular SSI, Section 1619(a) and Section 1619(b) eligibility status.

Education of the Deaf Act of 1986. Updated statute establishing Gallaudet College and changed name to Gallaudet University; authorized Gallaudet University to operate demonstration elementary and secondary schools for deaf children; established Commission on Education of the Deaf.

Rehabilitation Act Amendments of 1986. "Severe disability" definition expanded to include functional (as well as categorical) criteria; defined "employability" for first time; added formula grant program for supported employment; renamed research branch the National Institute on Disability and Rehabilitation Research.

Air Carrier Access Act of 1986. Prohibited disability discrimination in provision of air transportation.

Protection and Advocacy for Mentally Ill Individuals Act of 1986. Authorized formula grant program for statewide advocacy services for person with mental illness, provided directly by, or under contract with, the protection and advocacy system for persons with developmental disabilities.

Developmental Disabilities and Bill of Rights Act Amendments of 1987. Raised minimum allotment levels for basic state grant program and protection and advocacy systems; increased minimum allotment for university-affiliated programs, basic state grant program, and protection and advocacy systems.

Technology-Related Assistance for Individuals with Disabilities Act of 1988. Provided grants to states to develop statewide assistive technology programs.

Fair Housing Act Amendments of 1988. Added persons with disabilities as a group protected from discrimination in housing and ensures that persons with disabilities are allowed to adapt their dwelling place to meet their needs.

Omnibus Reconciliation Act of 1989. Included major expansion in required services under Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).

Television Decoder Circuitry Act of 1990. Required new television sets to have capability for close-captioned television transmission.

Americans with Disabilities Act of 1990. Prohibited disability discrimination in employment, public services and public accommodations operated by private entities; requires that telecommunication services be made accessible.

Rehabilitation Act Amendments of 1992. Changed eligibility requirements and procedures for determining eligibility; strengthened requirements for interagency cooperation; strengthened consumer involvement requirements.

Family and Medical Leave Act of 1993. Allowed workers to take up to 12 weeks of unpaid leave to care for newborn and adopted children and family members with serious health conditions or to recover from serious health conditions.

National Voter Registration Act of 1993. Required states to liberalize their voter registration rules to allow people to register to vote by mail, when they apply for driver's licenses or at offices that provide public assistance and programs for individuals with disabilities such as vocational rehabilitation programs.

Goals 2000: Educate America Act of 1994. Provided framework for meeting national educational goals and carrying out systemic school reform for all children with disabilities.

Telecommunications Act of 1996. Required telecommunications manufacturers and service providers to ensure that equipment is designed, developed and fabricated to be accessible to and usable by individuals with disabilities, if readily achievable.

Health Insurance Portability and Accountability Act of 1996. Improved access to health care for some Americans by guaranteeing that private health insurance is available, portable and renewable; limiting pre-existing condition exclusions and increasing the purchasing clout of individuals and small employers through incentives to form private, voluntary coalitions to negotiate with providers and health plans.

Mental Health Parity Act of 1996. Included a provision that prohibits insurance companies from having lower lifetime caps for treatment of mental illness compared with treatment of other medical conditions.

Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Required work in exchange for time-limited assistance; Temporary Assistance to Needy Families (TANF) replaced the former welfare programs, ending the federal entitlement to assistance; states, territories, and tribes receive a block grant allocation with a requirement on states to maintain a historical level of state spending known as maintenance of effort.

Balanced Budget Act of 1997. Section 4733 provided a new Medicaid buy-in option for people with disabilities. This provision gives states the option to allow individuals with disabilities who return to work the ability to purchase Medicaid coverage as their earnings increase up to 250% poverty, based on an individual's net rather than gross income.

Individuals with Disabilities Education Act of 1997 (IDEA) Reauthorization. Formally called P.L. 94-142 or the Education of All Handicapped Children Act of 1975, IDEA required public schools to make available to all eligible children with disabilities a free appropriate public education in the least restrictive environment appropriate to their individual needs.

Workforce Investment Act of 1998. Required consolidation of several federal education, training, and employment programs; reauthorized Rehabilitation Act programs through fiscal year 2003 and linked those programs to state and local workforce development systems.

Quality Housing and Work Responsibility Act of 1998. The Quality Housing and Work Responsibility Act of 1998, affecting HUD-funded public and assisted housing, eliminated previously required Federal preferences shown to people with disabilities and some other groups but left any such previous preferences intact or optional at the local level. Public housing agencies, which provide HUD-funded public and assisted housing, must also develop Annual Plans and 5-Year Plans reflecting their preferences and other matters such as changes in the "disability-related tenant composition" of the housing those agencies offer and accessibility issues. Public housing agencies must also certify that their plans and implementation comply with all Federal civil rights and fair housing laws including those which cover persons with disabilities in addition to cove ring other protected classes.

Assistive Technology Act of 1998. Authorized State grant programs and protection and advocacy systems to address the assistive technology needs of people with disabilities; authorized the development of alternative financing mechanisms to assist people with disabilities in purchasing assistive technology.

Ticket to Work and Work Incentives Improvement Act of 1999. Allowed for Medicaid and/or Medicare benefits for many people with disabilities who go to work; provided for a "ticket to work and self-sufficiency" which allows Social Security beneficiaries with disabilities choice and expanded options in pursuing employment and employment supports.

Olmstead Supreme Court Decision: June 1999. Under certain circumstances, the Americans With Disabilities Act (ADA) requires states to provide community-based treatment for persons with disabilities. The court ruled that unjustified institutionalization of a person with a disability is discrimination under ADA. http://www.hcfa.gov/medicaid/olmstead/olmshome.htm http

New Freedom Initiative: February 1, 2001. A government-wide framework for helping people with disabilities with the tools tey need to fully access and participate in their communities. http://www.whitehouse.gov/news/freedominitiative.freedominitiative.
html://www.hhs.gov/progorg/ocr/mis.htm

Editor
Deborah J. Shuman, *Editorial Consultant*
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Steve Gallon, Ph.D, *Conference Consultant*
Colleen Gillespie, Ph.D, *Research Consultant*
Genevieve Weber, MA, *Project Assistant*

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John de Miranda Ed.M

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