Research Utilization Support and Help (RUSH) Project's
Research Utilization Award (RUA)

Dissemination of a mixed-utilization model for promoting substance use disorder screening in vocational rehabilitation

RRTC on Substance Abuse, Disability and Employment
Boonshoft School of Medicine
Wright State University
Dayton, Ohio

Dennis Moore, Ed.D., Mary McAweeney, Ph.D.,
Linda Lazowski, Ph.D., and Allen Heinemann, Ph.D.

October 15th, 2008

Final Report

Dissemination of a mixed-utilization model for promoting substance use disorder screening in vocational rehabilitation

Table of Contents

Background

In collaboration with the Rehabilitation Institute of Chicago (RIC) and the SASSI Institute, Wright State University (WSU) created the Substance Abuse in Vocational Rehabilitation-Screener (SAVR-S). The instrument was validated in 2006 and early 2007 using nearly 1,000 applicants to the vocational rehabilitation (VR) system. The SAVR-S in its current developmental form consists of a paper-pencil questionnaire consisting of 43 items, including some "subtle" items to determine if respondents are attempting to distort their answers to appear more favorable. The completed SAVR-S is faxed to the SASSI Institute where an individualized report is generated that addresses symptomology indicating whether the individual is suspected of having a substance use disorder (SUD).

The report also contains language on work-related issues that may face an individual based on their responses to substance use related questions. The screener provides a 'positive' or 'negative' profile; a positive indicates that the respondent may be abusing alcohol or drugs and further substance use assessment is recommended and a negative indicates no issues. The SAVR-S is designed to assist both the counselor and consumer in rehabilitation planning. It is accurate in identifying problems in approximately 85% of cases, which is comparable to some other well-validated substance abuse screening instruments. As a 'screening tool,' the SAVR-S is not intended to be a diagnostic instrument in itself. Additional assessment by a qualified professional is required if a Diagnostic and Statistical Manual of Mental Disorders (DSM) substance use diagnosis is desired. However, the instrument does provide valuable information in regard to consumer and case planning.

The project reported in this document was supported by the National Institute on Disability and Rehabilitation Research (NIDRR) though a funding mechanism of the Research Utilization Support and Help (RUSH) Project known as Research Utilization Awards or "RUAs". It constitutes an extension of a previous NIDRR-funded research project by extending implementation of the SAVR-S to VR programs in Kentucky, Utah and Virginia. The initial project involved training VR counselors in Illinois, Ohio and West Virginia. This final report encompasses the entire funding period of the RUA. The activities, as listed in the Memoranda of Agreement (MOA), include training, management meetings, screening of consumers (utilization reports), data management activities, and presentation and dissemination activities. In addition, this report includes question and answer (Q&A) pamphlets that were created for and distributed to VR counselors, and the results of a survey completed by counselors with respect to their experiences using the SAVR-S.

Specific goals of this RUA:

1. Develop a trainer of trainer system utilizing consultants with VR backgrounds in order to increase training capacity and further disseminate SUD screening practices in other VR systems.
2. Increase media representation of VR staff and consumer attitudes, beliefs, and practices in the training materials.
3. At the suggestion of the Council of State Administrators of Vocational Rehabilitation (CSAVR), double the number of VR state systems currently

employing systematized SUD screening for all applicants (from three to six states), thereby increasing the sample of state VR systems in the evaluation while also increasing knowledge transfer.

4. Expand the evaluation measures of the training impact on VR counselor knowledge, attitudes, and behavior, as well as further examine the impact of a statewide SUD screening policy on VR systems.

Activities are detailed below.

Training

A cadre of SAVR-S trainers with VR backgrounds had been trained during the previous round of SAVR-S administration. This concept was sparked by two factors: (1) we felt that persons with VR backgrounds would make the best VR trainers, as they are most familiar with VR culture and practice, and they understand case flow characteristics that can make SAVR-S use most effective as a tool; and, (2) the SASSI Institute relies on a national group of consultant trainers for their other instruments (e.g., SASSI 3), and identifying VR professionals who could join this larger group of consultants would better guarantee training capacity for other VR programs that might also adopt the SAVR-S. The following individuals were identified and trained in an intensive two-day session (with an average of two additional live training booster sessions for all new VR consultant trainers):

Barbara Schiedermayer, MS, CRC
Alfreda Bell, MRC, LPC, CRC
Mary Keegan, PC, CRC-CS
Carl Marshall, CRC, LPC
Margaret Glenn, Ed.D, CRC
Joseph Keferl, Rh.D
Dennis Moore, Ed.D

Some of the trainers, due to scheduling and logistical issues, had only limited experience in delivering training to VR staff (during the initial three state implementation). For this reason, additional training experiences and 'homework' were assigned to Bell, Keegan, Marshall, and Schiedermayer. The homework consisted of reviewing the training presentation and modifying it so it was more interactive and more effective in delivery. They reviewed the 'myvrtraining.com' website material to become more familiar with aspects of VR use of screening instruments, and they also reviewed archived video interviews of VR personnel as they talked about the VR process when addressing consumers with substance abuse issues. Finally, they were involved in conference calls and a booster training.

Less experienced trainers were paired with more experienced ones in order to increase the expertise of the entire team, and they were deployed in the three RUA states to complete trainings for all counselors in those states. Each state effort was debriefed with trainers in order to further refine the training model. The training was completed in approximately 3-4 days per state. In addition, upper level administrative staff attended the counselor trainings to support the project and emphasize the importance of it.

Among counselors in all six states implementing SAVR-S use, 965 counselors completed pre – post evaluation training surveys. The questions contained Likert style questions with responses ranging from 1 "strongly disagree" to 5 "strongly agree." Compared with counselors in the "early adopting" states (OH, IL, and WV), counselors from the "later adopting" states (Utah and Kentucky – RUA funding supported states) reported more favorable responses to the training and content areas and were statistically significant using chi-square tests. These differences were apparent for every question except one knowledge item before the training --- "My knowledge of SUD screening BEFORE attending the session." There was no difference between the two groups on this question indicating that both groups reported the same level of knowledge before the training. The questions are listed in Appendix A, Table 1.

Management Meetings

The research management team included personnel from the SASSI Institute, the Rehabilitation Institute of Chicago, and WSU. We met on a monthly basis and discussed issues related to the initial Rehabilitation Research and Training Center (RRTC) project and the RUA. Planning related to the trainings, data collection, implementation of the SAVR-S, logistics for reporting, screening consumers, and data analyses were covered during these meetings.

Consumer Screening and Utilization

Utah and Kentucky elected to strongly encourage *all* staff to complete a SAVR-S for every new applicant to the agency. To date, Kentucky has submitted 8,955 SAVR-S and Utah 5,930. These numbers represent the highest percentage of SAVR-S administered to total consumers taken into the VR program for any of the states involved in the project (see Table 2 in Appendix B). Approximately 124 counselors from Utah and 142 counselors from Kentucky were involved in screening consumers with the SAVR-S. Due to several factors, Virginia eventually decided to recruit volunteer counselors, and eventually 24 volunteer counselors received a video conference booster on April 28, 2008. However, policies in this agency resulted in the conceptualization of SAVR-S use as experimental and voluntary; therefore, an additional informed consent is required before administration. SAVR-S to date has been sufficiently low in number that this state is not included in the majority of data tables. It appears that several factors contributed to the low use, including not meeting directly with area managers and supervisors. However, the greatest impediment to wide-spread implementation was their insistence that use of the SAVR-S, in spite of the clinical validation, constituted 'research' instead of 'clinical' work.

The SASSI Institute provided monthly reports to WSU staff on SAVR-S utilization by VR office and individual counselor. WSU then forwarded these reports and the monthly Q&A information for counselors to the contact person in each of these states. The reports included screen-positive and negative rates for each state as well as refusal rates. Utah has had a high positive 'suspected substance use disorder' rate. This was investigated by Dr. McAweeney and Russ Thelin, the Director of Rehabilitation Services from Utah. They found that counselors were self selecting to whom they administered the SAVR-S; thus, those

whom they thought might have a problem completed the screener. Cumulative reports for Utah and Kentucky are located in Appendix B as well as in Table 2, which illustrates the summary of utilization for those two states.

Data Management Activities

Per the application, a variety of data were collected and analyzed for the RUA. Three databases were created:

1. WSU manages a database containing the counselors' data from the initial trainings. This includes pre- and post-test training scores.

2. SASSI manages all of the completed SAVR-S in a large database.

3. WSU and RIC manage a database containing the counselor satisfaction survey results. This database has both qualitative and quantitative data.

Presentation and Dissemination Activities

The RUA provided the Substance Abuse Resources and Disability Issues (SARDI) program at WSU with support to publish and present results from Kentucky and Utah's additional involvement. Results are being presented at the annual conferences of CSAVR, the Rehabilitation Services Administration (RSA), and the National Council of Rehabilitation Educators (NCRE). A manuscript on counselor training and survey results will be submitted to a peer-reviewed journal within the next two months. The RUA-funded states have been appended to data from the NIDRR-funded RRTC activities, as they provide another perspective on SAVR-S implementation. The RUA funding has been noted in all manuscripts to date.

RSA-911 Outcome Data

Utah and Kentucky's RSA-911 data from September 2006 thru September 2008 was delivered to WSU on October 21st, and September 24th, 2008 respectively, based on data use agreements. The primary and secondary diagnosis codes and other variables will be analyzed over the next several months. However, outcome data for Utah and Kentucky will not be available until September 2009. This is because most of the consumers who completed the SAVR-S are still open cases. We will wait an additional year so that these cases can close as either successful or unsuccessful and then collect and present the outcome data.

Q&A Pamphlets

A series of Questions & Answers (Q&A) lists were sent to counselors with their monthly reports, and they are also posted to and updated on the RRTC "myvrtraining" website, along with free CEU training in issues related to substance abuse among VR consumers. The Q&A content is based on questions and concerns that have been raised in focus groups conducted by JoAnn Ford with VR counselors, as well as questions emailed to

the RRTC from state coordinators. The RUA funding was especially helpful in generating the full Q&A list (some of which are not fully developed at this time due to length), as counselors in KY and UT routinely asked questions of the VR administration about SAVR-S use that were forwarded to WSU. Approximately 40% of the entire Q&A list came from these two states. The first six Q&As that were emailed to the states and posted on our website are presented in Appendix C.

Counselor Satisfaction Survey

The five states agreed to conduct an evaluation of how the SAVR-S assisted counselors in case planning and also whether it can positively impact successful closures. An on-line counselor survey was created and sent to these counselors via email in May, 2008. Since the counselors were trained at different times and the follow-up on-line survey was sent to counselors at the same time, the length of experience in administering the SAVR-S varied. The average experience using the SAVR-S was eight months. Illinois counselors comprised 9% of the respondents, Ohio 41%, West Virginia 20%, Kentucky 21% and Utah 9% of the respondents. Frequencies of each question are listed in Appendix D, and Table 3 presents the item means and t-tests between the early (OH, IL, and WV), and later adopters (Utah and Kentucky – RUA-funded states).

Compared with counselors in early adopting states, counselors from the late adopting (RUA-funded) states reported that the training was more helpful and the SAVR-S was easier to use. They were more likely to use a web-based version and to have office computers with internet access for consumers to complete web-based SAVR-S. They thought the results and their reporting were comparatively more helpful, and thought the screening would reduce employment barriers. These results can guide future trainings and management activities. The findings were so striking in contrast that a manuscript on these data is in preparation.

Outcomes of the RUA

1. *Develop a trainer of trainer system utilizing consultants with VR backgrounds in order to increase training capacity and further disseminate SUD screening practices in other VR systems.*

A trained cadre of SAVR-S trainers, all with extensive experience in working within VR programs, was thoroughly trained. At this time all have had multiple, live training experiences in delivering SAVR-S trainings to VR counselors (13 live trainings were conducted in three RUA states of KY, UT, & VA). These trainers also received training in multi-media PowerPoint presentations, and five of the seven trainers had experience in delivering both onsite and live telecast trainings that included embedded audio and video. The ability to deliver quality training via telecast will become increasingly important in the future, as much of VR is going to this format in order to save money and time. A final conference call is planned for November 2008 with all RUA-funded trainers in order to update them on implementation data, newer slides and perspectives they can add to their repertoire, and future scenarios for employing them as contract trainers.

2. *Increase media representation of VR staff and consumer attitudes, beliefs, and practices in the training materials*.

In spite of repeatedly informing VR counselors about the availability of free continuing education units (CEUs) on the myvrtraining website, the website has continued to see limited use. Approximately 10 counselors (of a potential group of over 1,000) have actually completed any of the two CEU modules. This is very disappointing, but it matches feedback from other Rehabilitation Continuing Education Programs (RCEPs) and other RRTCs regarding their on-line offerings to VR, regardless of content area. With the exception of offerings about topics related to returning veterans and ethics, there appears to be limited interest in completing on-line offerings by VR personnel. The reasons cited for this include: (1) counselors receive sufficient internal CEUs from program trainings that they have little interest in outside on-line offerings, (2) counselor caseloads have increased to the point where they won't take time for continuing education, and (3) counselors have limited motivation, either administratively or from a case services perspective, to pursue additional information on this topic. However, it is also possible that WSU RRTC postings about the online CEU availability did not reach anywhere near the 'market saturation' necessary to promulgate more users. The reminders about the courses were only sporadic in some states until the last five months when the availability of the course was embedded in all state monthly SAVR-S reports.

In light of limited use of the website, alternative media presentations and formats were identified. These include:

1. Bi-monthly email updates on substance abuse, disability, and employment.
2. Complete 90-page "substance abuse desk reference" and compilation of hyperlinks to each individual section (approximately two pages for each section).
3. Continued compilation of 'FAQ' and email updates for counselors biweekly.

3. *At the suggestion of the Council of State Administrators of Vocational Rehabilitation (CSAVR), double the number of VR state systems currently employing systematized SUD screening for all applicants (from three to six states), thereby increasing the sample of state VR systems in the evaluation while also increasing knowledge transfer.*

The RUA funding allowed for the enrollment of three new states; two actually administered the SAVR-S statewide, as described above. The results of the training evaluations, the counselor survey, and the utilization rates indicate that the "late adopter" states, Kentucky and Utah, benefitted from the trainings more than earlier states. This finding highlights the changes that were made to the context and style of the trainings as well as the quality of personnel and training that was comprised by the 'SAVR-S consultants.'

4. *Expand the evaluation measures of the training impact on VR counselor knowledge, attitudes, and behavior, as well as further examine the impact of a statewide SUD screening policy on VR systems*.

A total of 86 counselors in the RUA states (KY and UT) completed an online evaluation form that was developed following evaluation of training outcomes from these states. The results of this evaluation measure are presented in Appendix D. The results provide evidence that full, statewide implementation of the SAVR-S appears preferable to phased implementation in regard to training results and SAVR-S utilization. Appendix B, Table 2 provides data to show that full statewide implementation also results in more SAVR-S being administered in a shorter period of time.

Based on subsequent feedback from UT VR that they have decided to discontinue SAVR-S use due to counselor comments that the SUD screener is 'not useful' for case planning, a post-project focus group with supervisors and managers of this state program is being held by Mary McAweeney on October 23, 2008. We will be seeking additional information from staff regarding the challenges and barriers involved with SAVR-S use.

Conclusions

The RUA funding provided an excellent and rare opportunity to quickly validate and field test findings and suppositions about adoption of a substance abuse screener by state VR programs using a method of implementation that would more closely mimic post-research dissemination of this intervention. Based on the admittedly limited experiences with three state VR programs, the following conclusions are provided.

1. The RUA funding provides cost- and time-effective methods to test dissemination/utilization of promising interventions in rehabilitation. The RUA specifically tested implementation and dissemination of the intervention, whereas the original NIDRR RRTC project involved "delayed start controls" that did not fully represent the challenges associated with full adoption of this intervention in state VR programs.
2. Data collected to date indicate that full, statewide implementation of a substance abuse screener is more effective in delivering desired training results and fuller utilization of the intervention.
3. Even with the improved efficacy of this statewide 'all at once' approach, there remain substantial barriers to routine use of SUD screener in VR. These barriers appear to be perceptions of VR counselors that SUD screening of consumers is not sufficiently effective as a practice to justify the time involved with administering the instrument. This is in spite of consistent research finding that 25% of VR consumers likely have active SUD at the time they become eligible for VR.
4. Being able to implement the RUA in conjunction with the RRTC study likely saved an entire research cycle to discover the additional barriers that exist for full acceptance and implementation of this screener. Future research activities directed toward substance abuse screening in VR will include larger components associated with dissemination.

Appendix A
Pre-Post Training Results

Table 1. Responses to the pre – post training survey: Comparison between early adopters (Ohio/Illinois/West Virginia) and late adopters (Kentucky/ Utah) (n= 965)

Questions after the training	Chi-square
Have a better understanding of the goal of a substance use screening effort in my work in VR.	33.4**
Believe I can communicate to others how this screening project will support successful VR outcomes.	17.5**
Can discuss my agency's policy regarding serving people with substance use disorders.	22.6**
Understand strengths & limitations of substance abuse screening.	41.0**
Understand how to use/ interpret screening results.	30.3**
Am ready to act on implementing the screening project.	25.2**
My knowledge of SUD screening BEFORE attending the session.	3.4
My knowledge of SUD screening AFTER attending the session.	35.8**
The workshop facilitators were knowledgeable about the subject.	15.9**
The workshop facilitators answered questions in a clear manner.	24.6**
Overall, the workshop was a good introduction to screening for substance use disorders in vocational rehabilitation.	23.5*

* $p < .05$, ** $p < .001$; Kentucky and Utah had more positive responses.

Appendix B
Utilization of the SAVR-S

Table 2. Substance Use Screening by State through August 31, 2008

	IL	WV	OH	UT	KY
Project Launch	**9/2006**	**11/2006**	**3/2007**	**7/2007**	**8/2007**
Project Duration (months)	**24**	**22**	**18**	**14**	**13**
Total Number of Field Offices	**51**	**32**	**53**	**27**	**56**
Number of Participating Field Offices					
Official Count	**22**	**11**	**26**	**27**	**46**
Number zip codes w. submitted reports	**38**	**21**	**45**	**30**	**49**
Number of Counselors in Participating Field Offices (unchanged)	**153**	**54**	**164**	**117**	**144**
Number of Registered Counselors Utilizing SAVR-S	**173**	**86**	**337**	**133**	**149**
Number of Customers Screened	**3024**	**829**	**8855**	**5930**	**8955**
Average Customers Screened/Month	**126**	**38**	**492**	**423**	**689**
Refusal %	**9.23**	**25.81**	**19.45**	**9.22**	**19.98**
Screen Positive %	**20.36**	**19.67**	**21.93**	**47.78**	**38.29**

Appendix C
Q&A Pamphlets

Q&A I: Substance Use Disorders Among Consumers

For your consideration: It has been estimated that over **20%** of applicants to VR have an active or recent substance abuse problem. These include people with other disabilities such as traumatic brain injury, spinal cord injury, diabetes, and mental illness, to name a few. Substance abuse is an equal opportunity disorder – any one might have a problem and if it exists for someone, it's a significant barrier to being successful in obtaining employment and self-sufficiency.

1. ***What should I do if a consumer admits at the initial interview that she/he is actively participating in illegal drug use, or has a current problem with alcohol***?

It is important that you be aware of your potential to make quick judgments of the consumer. Maintain respect of the consumer and try not to react negatively, prematurely, or judgmentally to hearing this information. An open admission of a substance use disorder (SUD) by a consumer can be interpreted many ways. The admission may represent a consumer's genuine effort to be honest and upfront in her/his desire to receive VR services. It may also be seen as a request for help with the substance abuse problem. In some cases, it may be a sign that the consumer is anxious or unready to focus on work, and might be a way to sabotage the effort.

In order to accurately understand what such an admittance means, you should consider engaging the consumer in the following inquiry:

- What/how often/how much does the consumer admit to using?
- For how long have they been using?
- Has the consumer participated in any treatment services related to their use?
- If so, what was the outcome of treatment? When?
- How does the consumer's use affect her/his life?
- Does the consumer feel that their use would constitute a barrier to employment?

If no, explore why not. If yes, ask the consumer to tell you how they believe their use may create employment barriers.

- What are the consumer's motivations for slowing/stopping use in light of employment?
- Has their use been problematic in the past in terms of employment? How?

These and other helpful questions may be necessary in order to accurately interpret the consumer's relationship with substances. Allowing the consumer the opportunity to discuss the problem openly without fear your judgment, abandonment, or punishment will create a more powerful potential for developing a relationship. It also gives you the opportunity to begin exploring the consumer's motivations related to work, training, treatment, etc. Keep in mind that consumer's may not always share all of the details of their use. Minimization, rationalization, diversion, and other tactics are common-particularly during the beginning

stages of your relationship. Bottom line, interpreting the consumer's sharing of their habit as a **positive** can be the seed for discussing additional assessment needs, collaboration with other necessary service providers, and setting the course for achieving the best possible outcome in the VR process.

2. When should consumers participate in taking the SAVR-S?

Ideally, consumers should participate in taking the SAVR-S during the early stages of their VR participation. It should be presented to the consumer during the initial stages of the standard data-gathering process. Completing the SAVR-S early allows you access to relevant SUD information during the early stages of IPE development, when such considerations should be processed. Furthermore, bringing the SAVR-S into the VR process early provides a vehicle for discussing positive or negative findings in relation to how the consumer's use may impact their disability, employment, or other aspects of life. Presenting the SAVR-S to the consumer should be done within the context of needing to look at the consumer holistically so as to provide the most appropriate and effective services possible.

3. What should I do if the SAVR-S report states that the consumer has a high probability of a SUD?

As with any new information, the counselor should review the results of the SAVR-S with the consumer by presenting the information up front and without bias. Sharing the report with the consumer allows the consumer opportunity to affirm, reject, or question the meaning of the results. The process should allow for new discussion of their use and what it might mean in the VR process. Whether the reaction of the consumer is negative or positive, there remains the option to present the consumer with the possibility of pursuing additional diagnostic assessment that may either confirm or negate the SAVR-S report. If a consumer is concerned that the SAVR-S is inaccurately reporting a positive result, you may present the option of additional assessment as a way for the consumer to further justify her/his denial of a problem. Conversely, if the consumer does not argue the SAVR-S report, working with the consumer to schedule a formal assessment with a qualified provider can be a powerful tool to gaining additional insight into the person's issues. In either case, it is important that the information gained through the SAVR-S report is presented to the consumer properly. Always keep in mind (and remind the consumer) that the SAVR-S does not constitute a diagnosis-it is only a tool to detect the possibility of SUD, and that NO screener is 100% accurate. A positive SAVR-S report simply means that there may be a need to seek out assessment services.

Q&A II: Substance Use Disorders Among Consumers

1. What further diagnostics should be done after a screening for substance abuse (either paper/pencil or urine test) is positive?

Unless there is specific evidence of co-occurring mental illness, there is no need for a full psychological. Most SUD treatment programs conduct assessments that include assessment

of mental health functioning. This is because there is growing awareness of the co-existing nature of mental health and SUD problems, and many states now have special designations for their SUD treatment programs if they serve this type of "dual diagnosis". The report from the SUD assessment should include pertinent information. The above opinion may not apply to all geographic locations and treatment settings, in which case the decision falls to the VR counselor (and supervisor if requested) and consumer. After all, the best rehabilitation tool still is you.

2. What should I do if the consumer refuses to participate in a drug assessment or drug screen?

Do not over react. Maintain perspective on the refusal. Why is the consumer refusing? Are they fearful? Do they lack information about what the screen or assessment represents? What does the consumer fear will happen if she/he participates? These and other questions may need to be addressed in light of a refusal. When attempting to answer these questions, be sure that you do not inadvertently downplay or disrespect the consumer's concerns or choice to refuse. Better to try to process with the consumer the rationale behind the refusal so that you can provide them with additional information or answer questions if needed. If, after such attempts to facilitate discussion still results in a solid refusal, then the counselor should simply let the consumer know that their decision will be respected, however, not having the information may create additional challenges in the future in terms of developing the most effective and efficient VR plan possible. This information should not be presented as a threat or manipulation of the consumer, but as an informed sharing of information. Always let the consumer know that there may be opportunity in the future to revisit screening and/or assessment should such need arise.

3. ***What should I do if I suspect during the initial interview that a consumer is actively using illegal drugs, or has a problem with alcohol***?

The preferred course of action if you should suspect that the consumer has an substance problem varies depending on where they are in the initial interview. In some cases, you may be able to address their suspicions through a series of relevant questions that are part of the initial interview process. These may include Qs pertaining to health, finances, relationships, recreation, and others that have relevance to substance use. If the standard Qs in the interview process seem to be too generic, you can choose to ask the consumer questions that are more direct. If this route is taken, you may have better results if you pose the direct questioning in an empathic, non-judgmental fashion that elicits respect and dignity for the consumer. If you are able to comfortably present up-front questions related to the use of substances without portraying a sense of anxiety, taboo, or judgment over the issue, is much more likely to experience a positive reaction by the consumer. Any information gleaned from this approach should lead to follow-up questions and open dialogue to either support or refute your initial suspicions.

4. What should I do if I suspect that the consumer has SUD issues and the consumer denies it?

Denial in this situation is not uncommon. A consumer who denies alcohol or drug problems despite evidence to the contrary, may be doing so because she/he does not want to admit that they have a problem. She/he may recognize their problem internally, but may not feel comfortable allowing others to view them as having a problem. The consumer may not fully understand how their use may impact their life, and may need to gain additional education to grasp this perspective. They may fear that being honest about their use may create additional problems in their life which they would prefer to avoid. Whatever the root cause of why a consumer may deny substance abuse, it is important that you understand that denial in and of itself should **not** be considered negative. It is a basic human defense mechanism that most people rely on in their daily lives. You should not try to "break down" the consumer's denial through direct confrontation. Instead, turn your attention to listening closely to the consumer such that she/he feels more comfortable in sharing. When discrepancies in the consumer's story arise, gently, yet consistently present the discrepancy back to the consumer. Doing so in an empathic manner will demonstrate respect, trust, and investment in the relationship. Being a non-partisan sounding board for the consumer can help the person in denial come to a more realistic perspective of their situation. Lastly, always keep in mind that despite all of your counselor training and preparation, you can be wrong about a consumer's issues. As important as it is to follow your instincts, it is equally important that you check out our suspicions before you set your course of action with the consumer.

Q&A III: Substance Use Disorders Among Consumers

1. Why use the SAVR-S on all consumers?

The SAVR-S was requested by counselors who had limited options to objectively identify possible substance abuse in their consumers. Studies have consistently shown that approximately one quarter (or more) of VR consumers have an active SUD. In over 50% of the cases, the counselor may not know of this condition because the consumer did not mention it during intake and case planning.

2. ***Who is using the SAVR-S?***

The five state VR programs currently using the SAVR-S have agreed to conduct an evaluation of how the SAVR-S assists counselors in case planning and also whether it can assist the state in higher successful closures. (This activity is a clinical service evaluation, it is not "research" in any traditional sense.) The eventual goal is to develop a counselor-friendly system for detecting possible substance abuse in VR consumers

---

Q&A IV: Substance Use Disorders Among Consumers

1. Does the consumer need to sign an informed consent prior to completing the SAVR-S?

Current use of the SAVR-S by VR programs is a clinical, not research activity. It does not differ from any other clinical screening that VR may use, contract for, or purchase. The state

VR programs currently using the SAVR-S have agreed to conduct an evaluation of how the SAVR-S assists counselors in case planning and also whether it can positively impact successful closures. This activity is a clinical service evaluation, and it is exempted from human subjects "research". The evaluation of this screening process using de-identified SAVR-S data has been reviewed and approved as an exempted activity by the Human Subjects Committees at Wright State and Northwestern Universities. The eventual goal of this field trial is to develop multiple administration formats that are easy for counselors to administer.

2. What should a counselor do if the SAVR-S report states that the consumer has a high probability of a SUD?

Present the SAVR-S results up front and without bias. This allows the consumer the opportunity to affirm, reject, or question the meaning of the results, and discuss what the results might mean in the VR process. Remind the consumer that the SAVR-S does not constitute a diagnosis-it is only a tool to detect the possibility of SUD, and NO screener is 100% accurate. A positive SAVR-S report simply means that there may be a need to seek out assessment services.

If a consumer is concerned that the SAVR-S is inaccurately reporting a positive result, the counselor may present the option of additional assessment as a way for the consumer to further justify her/his denial of a problem. Conversely, if the consumer does not argue the SAVR-S report, working with the consumer to schedule a formal AOD assessment with a qualified provider can be a powerful tool to gaining additional insight into the person's issues.

3. What further diagnostics should be done after a screening for substance abuse (either paper/pencil or urine test) is positive?

There is no need for a full psychological unless there is specific evidence of co-occurring mental illness. Many states now have special designations for their SUD treatment programs if they serve this type of "dual diagnosis". If the above statement is not true for your geographic location or treatment setting, the decision will fall to the VR counselor (and supervisor if requested) and consumer. After all, the VR counselor remains best rehabilitation tool available!

Q&A V: Substance Use Disorders Among Consumers

1. What should a counselor do if the consumer refuses to participate in a drug assessment or drug screen?

Maintain perspective on the refusal. Why is the consumer refusing? Are they fearful? Do they lack information about what the screen or assessment represents? What does the consumer fear will happen if she/he participates? Do not downplay or disrespect the

consumer's concerns or choice to refuse. Explain the testing process to the consumer, addressing the rationale behind the refusal.

If the consumer still refuses, let the consumer know that their decision will be respected. However, the lack of this information may create additional challenges to developing the most effective and efficient VR plan. This should not be presented as a threat or manipulation, but as an informed sharing of information. Let the consumer know that there may be future opportunity to revisit screening and/or assessment.

2. What should a counselor do if a consumer tests positive in a drug screen such as a urine test?

Schedule an immediate meeting with the consumer and discuss the consequences of this positive test and behavior. Explain your agency's rules concerning this result as it pertains to services. Explain that positive drug tests result in inability to obtain, or retain, employment, and such a result is incompatible with employment. As such, it is a critical issue in the provision of VR services. Adjust the consumer's VR plan to address the behavior, using input from the consumer. This plan may include substance abuse assessment, consultation with a substance abuse specialist, substance abuse or mental health treatment, attendance at self-help support groups (e.g., AA), planning for future random drug tests, and the creation of a "recovery plan".

3. Is failing one drug test enough reason to close a case?

No. Relapse is an integral component of recovery for most persons with a SUD, as consumers attempt various strategies to cope with their dependency. A relapse can be an important time for learning from the experience to strengthen the recovery plan. An immediate meeting with the consumer is important, at which time a clear direction for sustaining and strengthening recovery should be addressed, following your agency's specific guidelines.

Q&A VI: Substance Use Disorders Among Consumers

1. Can I require a period of abstinence for someone with SUD?

Requiring a period of abstinence prior to the provision of VR services is not consistent with the Rehabilitation Act Amendments, and is not therapeutic for the consumer in many cases. It is best to negotiate a recovery plan with the consumer that is appropriate for that person, and mutually agree upon steps to sustain that recovery. Above all, the consumer needs to understand the critical importance of recovery as an underpinning for sustained employment.

2. When does a counselor have grounds to deny services because of substance abuse issues?

This issue may be specifically addressed by your agency: you should consult with your supervisor concerning your specific regulations. If a consumer is unwilling to discuss or

consider specific steps to address substance abuse recovery as a component of their employment plan, then the probabilities for success are not good. In some instances, VR resources are wasted when assisting the individual with employment until the consumer is willing to address these behaviors.

3. What recourse do I have if my consumer will not agree to random drug testing as part of the IPE and I suspect continuing drug use?

There are two distinct lines of thought on drug testing as a component of rehabilitation programs. Some programs and professionals feel that drug testing is an important "reality test" of how well the consumer if progressing. Others feel that recovery is only under the control of the consumer any way, and they will learn from negative experiences with or without this requirement. Required drug testing may "artificially" enforce abstinence, and the consumer may still relapse as soon as the requirement is lifted. The counselor may be able to detect on-going substance abuse, with or without drug testing, because of other behaviors The more important issues are whether the consumer is willing to address substance abuse in a meaningful and effective way, and whether the consumer continues to demonstrate gains in their recovery. Alternatives to drug testing as a component of the recovery plan can include attending substance abuse treatment or aftercare, attending self-help support meetings, or periodic meetings with a counselor or case manager versed in substance abuse recovery. It also is possible to create a written contract with the consumer, so that if additional problem behaviors are encountered then the consumer agrees to a specific course of action.

Appendix D

Counselor Satisfaction Survey Results (N=389)

What state are you from?

Illinois = 9%
Ohio = 41%
West Virginia = 20%
Kentucky = 21%
Utah = 9%

1. Did you attend an in-person training session? 82% yes

2. To what extent was the in-person training helpful? 62% somewhat/very helpful

3. Are you aware of on-line training modules at "www.myVRtraining.com"? 26% yes
   If yes, have you used the online training modules? 14%
   If yes, how helpful are they? 23% somewhat/very helpful
   Have you received CEUs for completing any of the on-line training modules? 1%

4. Have you administered the SAVR-S? 85%

5. How easy, or difficult, is it to:
   (a) use 64% somewhat/very easy
   (b) download 74% somewhat/very easy
   (c) print 86% somewhat/very easy
   (d) fax 78% somewhat/very easy

6. If you could go to the internet and have the SAVR-S appear so consumers could answer the questions, how likely would you be to use it? 22% somewhat/very likely

7. Does your office have computers with internet access available for consumers to complete a web-based SAVR-S? 35% yes

8. Do you screen every consumer? 59% yes

9. Please rate your typical consumers' level of cooperation with the screening process:
   70% most/always cooperative

10. How easy is it to read the screening reports on consumers' SAVR-S results?
    72% somewhat/very easy

11. Are the reports timely? 86% somewhat/very timely

12. Are the results easy to understand? 54% somewhat/very easy

13. Are the results helpful? 35% somewhat/very helpful

14. Have you had a positive screening report on a consumer 78% yes
    If yes, what action is taken when a SAVR-S screening report is positive?
    (a) referral for further alcohol and drug evaluation 30%
    (b) referral to treatment (various levels) 30%
    (c) talk to the consumer about their drinking or use of drug 72%
    (d) close the case 2%
    (e) nothing 14%
    (f) other, please explain 30%

15. Please rate consumers' cooperation with attending follow-up substance use evaluations, if any: 29% most/always cooperative

16. How easy is it to find a substance use treatment provider or program for consumers who need one? 54% somewhat/very easy

17. Are the substance use treatment resources listed on the SAVR-S reports helpful? 23% somewhat/very easy

18. How helpful do you think screening for substance use problems is in reducing barriers to employment? 40% somewhat/very helpful

19. How likely do you think the SAVR-S screening and referrals will be to increase successful case closures? 18% somewhat/very likely

20. How useful are the monthly summary reports on your SAVR-S administrations? 8% somewhat/very useful

21. How useful are the reports showing cumulative results on all your SAVR-S administrations? 9% somewhat/very useful

Table 3. Responses to the follow-up survey (N=329): Comparison between early adopters (OH, IL, W) and late adopters (KY, UT)

	Item Means on 5-point Likert Scale		
	Early Adopting States *x* (NIDRR)	Later Adopting States *x* (RUA-funded)	*t* values
To what extent was the in-person training helpful?	3.5	4.06	3.8*
How easy it to use? (somewhat/very easy)	3.65	3.98	13.6**
Likelihood of using web-based SAVR-S?	2.06	2.60	4.4*
Does your office have computers with internet access available for consumers to complete a web-based SAVR-S?	1.81	2.81	18.4**
How easy is it to read the screening reports on consumers' SAVR-S results?	4.23	4.48	4.4*
Are the results easy to understand?	4.1	4.4	6.2**
Are the results helpful?	2.6	3.2	4.9*
How helpful is screening in reducing employment barriers?	3.0	3.4	4.1*
How likely do you think the SAVR-S screening and referrals will be to increase successful case closures?	2.2	2.5	5.2*
How useful are the monthly summary reports on your SAVR-S administrations?	2.09	3.09	7.4**
How useful are the reports showing cumulative results on all your SAVR-S administrations?	2.03	3.07	8.1**

Note: * $p < .05$, ** $p < .01$, and the scale ranged from 1 ("strongly disagree") to 5 ("strongly agree").