

## ACKNOWLEDGEMENTS

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Our special appreciation goes to Dr. Harvey Siegal, Professor and Director of the Substance Abuse Intervention Programs at Wright State University, for his support and guidance throughout this project.



## INTRODUCTION

Approximately three decades ago clinicians began writing of their concerns about the special risks for substance abuse which are faced by people with disabilities. However, the intervening years have seen minimal progress in addressing these issues. Governmental support, community networks, professional training, and other resources necessary to address this topic have been very slow to develop. In particular, care givers in health and human services fields have lacked an understanding of the special concerns and risks for substance abuse faced by persons with disabilities.

Many of the misperceptions and stereotypes about disabilities have begun to erode in recent years, and there has been a concern that openly addressing substance abuse would only create new negative stereotypes about people with disabilities. Until recently, being identified as a substance abuser had carried its own social stigma and stereotypes which can be ill afforded by persons struggling with other forms of prejudice.

Fortunately the passage of the Americans with Disabilities Act (ADA) of 1990 has provided additional impetus for addressing all societal barriers to success for people with disabilities. At the same time, it has become less stigmatizing for an individual to identify as a substance abuser. Both of these social changes have improved the climate necessary for addressing substance abuse and disability issues. But even in this improving social climate, the provision of appropriate services may not be a certainty.

Substance abuse prevention and treatment professionals, as well as those in the disability field, have discovered that serving these needs will be difficult to effect. It is becoming very clear that multiple solutions and interdisciplinary approaches will be essential components of meaningful change. Establishing appropriate substance abuse prevention, intervention and treatment services for people with disabilities will require multiple approaches and hard line budgetary support from a number of sources.

### THE ORIGINS OF THE SARDI PROJECT

The School of Medicine at Wright State University enjoys several distinctions from other more established schools. Its mission is focused on training primary care physicians, and the clinical training is community based (without a separate teaching hospital). Also, it was one of the first programs in the country to require that all medical students receive clinical experience in substance abuse identification and intervention.

Harvey Siegal, Ph.D., is the Director of the Substance Abuse Intervention Programs (SAIP) in the Department of Community Health. His perspectives on substance abuse intervention and the need for experiential contact for learners have been a guiding influence in teaching medical students about this curriculum area. His teaching and therapeutic programs, especially the Weekend Intervention Program for convicted impaired drivers, have the distinction of being replicated throughout the United States and in at least one foreign country. Approximately 50,000 people have received clinical contact in one of Dr. Siegal's substance abuse-related programs. The Substance Abuse Resources and Disability Issues (SARDI) project began as a collaboration between Dr. Siegal and Dr. Dennis Moore, SARDI Project Director.

Dr. Siegal's perspectives on populations at risk and the special education and rehabilitation experiences of Dr. Moore served as the basis for SARDI. For several years,

Dr. Moore had been studying and counseling in the substance abuse area specifically as it applies to persons with disabilities. This included conversations with a number of professionals who serve persons with disabilities. He concluded that one of the greatest obstacles to substance abuse education, prevention, and treatment for people with disabilities resided within the attitudes and knowledge of those professionals charged with their care.

Three basic premises guided the design of the SARDI project. One assumption, based on interviews and published reports, was that individuals with disabilities were not referred for chemical dependency treatment in proportion to the estimated rates of abuse. Anecdotal evidence suggested that many active cases of substance abuse were unrecognized by the primary agency providing disability services. A second assumption was that professional awareness of this problem was minimal.

The third assumption was that professionals play an especially important role in the amelioration of substance abuse problems for persons with disabilities. Unlike other "minorities" in the U.S., people with disabilities represent diverse constituencies. Also, individuals with disabilities often do not wish to be identified as "disabled" which means that there is less opportunity for generating social changes by acting as a cohesive constituency.

Once these premises were established, Dr. Siegal and Dr. Moore searched for ways to actualize their ideas. One source of funding identified was The U.S. Office for Substance Abuse Prevention which offered prevention grants for programs targeting "high risk youth". Among the categories of youth at risk were those who experience physical pain. An application for these funds was submitted, and the grant application was successful. In February of 1990 the SARDI project was initiated as the first disability-specific OSAP program to date. The objectives of this five state regional project included the following:

1. Sensitize professionals working with youth who experience disabilities about substance abuse risks.
2. Provide training to a selected group of professionals from a variety of disciplines and evaluate the impact of this training.
3. Develop printed training and intervention materials.
4. Disseminate the materials and findings of the project regionally and nationally.

The primary age group to be addressed under the SARDI Project was youth 18-21 years of age. A variety of agencies and settings within Illinois, Indiana, Kentucky, Michigan, and Ohio were identified as potential beneficiaries of such a project.

Twenty Representative Sites were chosen, following initial contacts with representatives in each of these five states. Eventually this number expanded to thirty Representative Sites because of additional requests for assistance. Over 15,000 youth with disabilities are served by the SARDI Representative Sites. In addition to the diverse nature of agencies represented, their clients/ patients/students come from rural, urban, and minority populations. The sites and their representatives are as follows:

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Almost from its inception, the SARDI project received a number of requests for information or special services. It was very clear from this response rate that substance abuse and disability issues were of concern to professionals within a wide variety of settings. It was also clear that very few resources existed at the national level with which to address these issues. Our first task was to establish a variety of substance abuse and disability training topics, and a manual was planned based on our experiences and research. The continued contacts during the site visits and training conferences have been invaluable in guiding the evolution and development of these materials.

It has been very fortunate that since the inception of the SARDI project the U.S. Office for Substance Abuse Prevention also has funded the national Resource Center for Substance Abuse Prevention and Disability (operated by VSA Educational Services) located in Washington, D.C. This organization has been especially effective in compiling, developing, and disseminating much of what is known about this topic. The SARDI staff have worked very closely with the Resource Center over the past two years.

In the last two years, we have logged over 50,000 miles of travel in the SARDI five-state region. In the process, we were able to develop a sense of what is and is not going on at the grass roots level in the area of substance abuse services for people with disabilities. It is our hope that this manual reflects some of the practical lessons that have been learned through these experiences.

## HOW TO USE THIS MANUAL

This manual is divided into a number of distinct subject areas corresponding to the areas of interest and need determined through our evaluation data. We have attempted to discuss the most important issues in each of these areas with the overall goal of brevity. Each subject area can be read in a relatively short period of time. It is suggested that the reader focus on one subject area at a time instead of trying to absorb all of the material in only one or two sittings. If more information on any given topic is wanted, refer to the extensive bibliography in Appendix D.

Case histories, knowledge enhancing quizzes, and other resources have been added to supplement the basic text. (The names of the consumers providing stories and quotations have been changed to protect their anonymity.) These materials are designed for self-guided instruction; however, persons familiar with the subject areas can utilize this document as an outline for group training. Supplemental materials have been included in the Appendices in order to allow for a more comprehensive development of training plans.

It has not been our intention to turn disability professionals into substance abuse specialists, and this Training Manual reflects this same philosophy. Instead, we encourage professionals to identify the necessary steps and linkages to effect appropriate education, prevention and intervention activities for people with disabilities. This Training Manual is intended to assist with understanding basic concepts concerning substance abuse prevention services for persons with disabilities.

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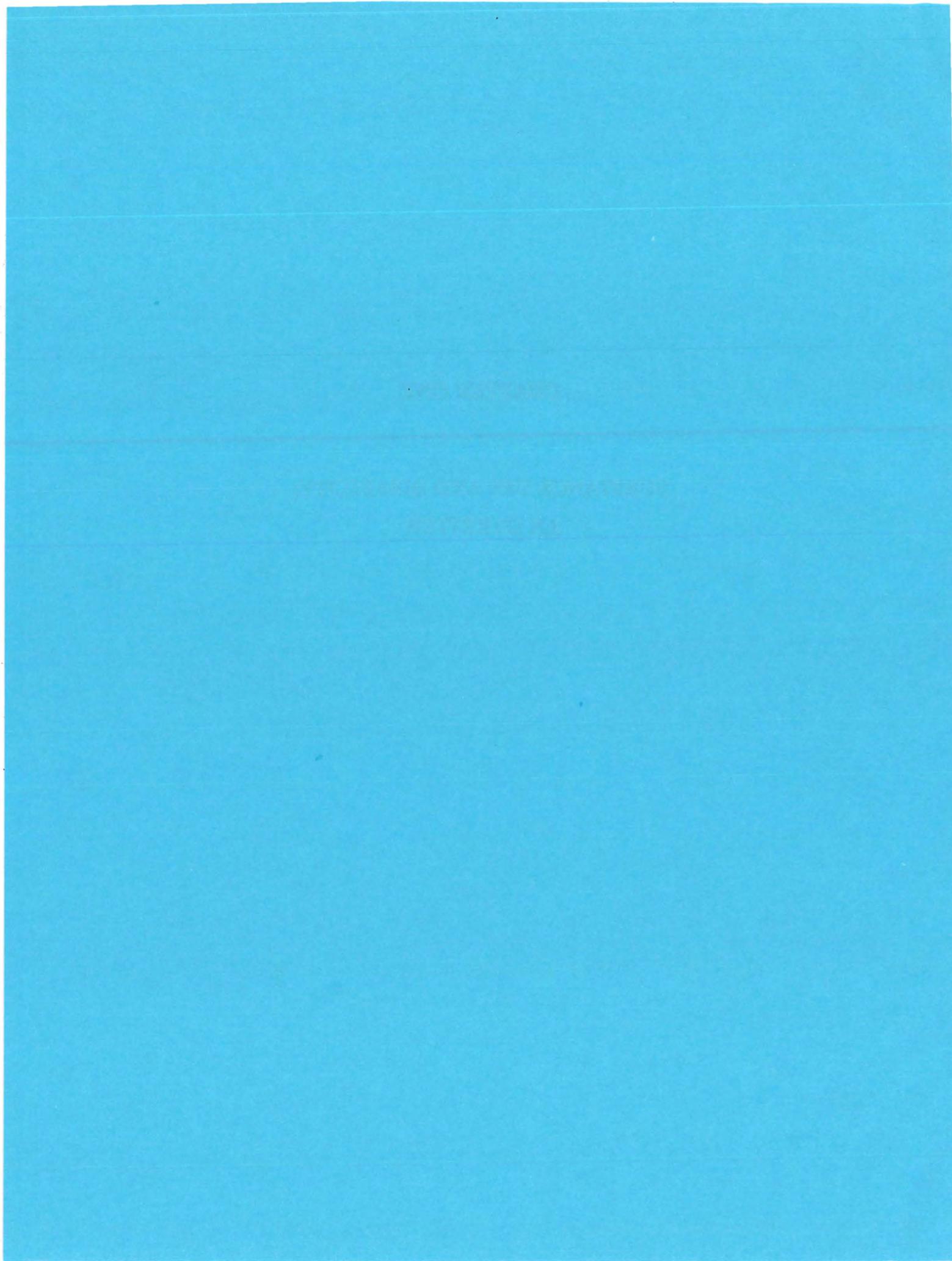
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**CHAPTER ONE**

**SUBSTANCE USE AND DISABILITY:  
AN OVERVIEW**



# SUBSTANCE USE AND DISABILITY: AN OVERVIEW

Alcohol and other drug use by young persons is of great concern in our communities today. Extensive efforts have been made to provide prevention services to all youth with an emphasis on youth described as "high risk". Although these prevention efforts have been helpful to many of our youth, one population, young persons with disabilities, has received little attention to date. Recent clinical and research findings clearly have demonstrated that the presence of a physical, mental, or psychological disability places an individual at increased risk for substance abuse problems if the individual chooses to use mind altering substances.

This chapter will describe these risks in further detail and will outline the SARDI project and the prominent place SARDI data has in the substance use and disability movement. The following topics are included in this chapter:

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## AN INTRODUCTION TO SUBSTANCE ABUSE AND DISABILITY ISSUES

The Americans with Disabilities Act (ADA) of 1990 identified over 40 million persons with disabilities in this country. The focus on societal access and integration set forth in the ADA also means that this "hidden minority" must address other related social issues. People with disabilities and their professional advocates are drawing attention to substance abuse prevention and treatment issues, in part because there is less stigma associated with substance abuse than in the past.

The fact is persons with a wide range of mental, physical and medical disabilities experience disability-specific and more common risks for substance misuse/abuse problems. Moreover, there are very few appropriate and accessible substance abuse prevention and treatment services for persons with disabilities. Further compounding this issue, societal reactions to persons with disabilities frequently include a tendency to overlook substance abuse until it becomes chronic and substantially more difficult to treat.

### INCIDENCE AND PREVALENCE INFORMATION LARGELY UNAVAILABLE

Much is known today about drug use in our society in general, but not about the substance use patterns of persons with disabilities. The limited research to date suggests that the presence of a disability may be associated with an elevated risk for substance abuse, but quantifying the scope of these risks is difficult. The study of substance abuse and disability issues is confounded by the following:

- varying or overlapping definitions of disability
- inadequate record keeping by organizations involved
- difficulty in accessing disability populations for study
- difficulties with survey methodologies relating to communication
- a lack of expertise required of researchers
- little public funding to support such study

The limited information which is available suggests that the incidence and prevalence of substance abuse is higher for many people with disabilities (Buss & Cramer, 1989; de Miranda & Cherry, 1989). In one widely-reported study, Rasmussen & DeBoer (1980-81) found that residents at a rehabilitation facility used alcohol and other drugs at a much higher rate than the general population of the same average age (26 years). Recently, the SARDI project conducted a drug use survey at this same facility 10 years after the Rasmussen and DeBoer study, and the results substantiated why the original researchers were concerned. Our study at this facility also found that it can be difficult to distinguish whether substance abuse precedes or follows disability.

Preliminary evaluation data from our SARDI project appears to corroborate that substance abuse disproportionately affects persons with a range of disabilities. In a five state drug use survey of over 1,000 consumers with disabilities (median age 26 years: range 18 - 80 years) we found that over one quarter of the respondents had experienced multiple and substantial problems from substance abuse. These consequences included family problems due to substance abuse, DWI's and other arrests, hospitalizations due to consequences of abuse, and attending school or work high or intoxicated more than 10 times. (See Appendix B for the Executive Summary of the evaluation data.)

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**DISABILITIES AND RISKS\***

*The disability categories which have been identified as at risk for alcohol and other drug abuse prevention and treatment services include:*

**Attention Deficit Disorder:** *If attention deficit disorder (ADD) persists into later adolescence, alcohol and other drug abuse and oppositional-defiant behavior occur in over 50 percent of the diagnosed persons (Hechtman, et al., 1984). Additionally, many young people with ADD are prescribed medications for behavior control, and this also may be a risk factor for some forms of subsequent alcohol and other drug abuse.*

**Blindness and Visual Impairments:** *Increased risk for alcohol and other drug abuse problems among people who are blind have been associated with isolation, excess free time, and underemployment (Nelipovich and Buss, 1989). People with visual impairments may face fewer consequences from alcohol and other drug abuse due to the enabling of others, social isolation, and constraints imposed by the disability. The treatment requirements may differ for those whose alcohol and other drug abuse has preceded, rather than followed, the onset of the visual impairment (Glass, 1980-81).*

**Deafness and Hearing Loss:** *People with severe hearing loss or deafness do not have ready access to appropriate alcohol and other drug information. When problems exist, treatment also is inaccessible (Sylvester, 1986). Alcohol and other drug abuse prevention materials frequently do not take into account the cultural, language, or communication differences indigenous to people who are deaf or have a hearing loss. There also is concern that people who are deaf attempt to avoid the additional social stigma associated with an alcohol and other drug abuse label, thereby making detection of problem use more difficult (Boros, 1981).*

**Hidden Disabilities:** *For people with hidden disabilities, there are increased risks for alcohol and other drug abuse which may not be immediately apparent. These can include decreased tolerance for mood altering drugs, atypical childhood experiences, lower resistance to peer pressure, over-protection by family members, and the use of long-term medications. These risks are increased when teachers, employers, or peers do not understand how needs or behavior are related to a disability that is not obvious.*

**Learning Disabilities:** *People with learning disabilities are more prone to misunderstanding alcohol and other drug education and prevention materials, placing these individuals at greater risk for injuries and other consequences of abuse. Unfortunately, people with learning disabilities may be in greater need of prevention information. This is because unsuccessful peer group and school experiences can hasten the use of alcohol and other drugs in order to cope with feelings of low self-esteem, perceived underachievement, and rejection.*

**Mental Illness:** *People with mental illness appear to experience recurring alcohol and other drug abuse problems at rates which are double that of the general population. Over 50 percent of young, mentally ill patients are reported to experience alcohol and other drug abuse problems (Brown et al., 1989).*

**Mental Retardation:** *Research indicates that people with mental retardation use alcohol and other drugs less than or similarly to the general population (DiNitto and Krishef 1984; Edgerton, 1986; Westermeyer et al., 1988). However, the legal, social, and work problems are more readily experienced than by non-disabled peers or family members, even when the person with mental retardation is consuming less. This is because judgment and other social skills require more concentration to begin with, and therefore are more influenced by even small amounts of alcohol consumption.*

*Mobility Limitations:* People with a variety of disabilities may have mobility limitations (e.g., spinal cord injury, arthritis, cerebral palsy). As many as 50 percent of spinal cord injuries are caused by an injury involving alcohol or other drugs. Many continue to be at risk for alcohol and other drug abuse problems after the injury (Heinemann et al., 1988; Sparadeo and Gill, 1989). Some people with mobility limitations are required to take several medications for health management. This situation greatly increases risk for complications arising from alcohol or other drug misuse (Moore and Siegal, 1989).

*Traumatic Brain Injury:* Alcohol abuse has been associated with traumatic brain injury (TBI) in over half of all occurrences. It appears to be associated in many cases with lifestyles where alcohol and other drug abuse and risk taking were common (Sparadeo, et al., 1990). Specialized alcohol and other drug abuse treatment often is necessary for people with TBI.

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## FINANCIAL IMPACT OF SUBSTANCE ABUSE ON PERSONS WITH DISABILITIES

A 1988 study of alcohol and drug abuse in the U.S. conservatively found that alcohol and drug abuse costs in America exceeded \$120 billion that year. These costs included medical care, allied health services, rehabilitation costs, and lost wages (Rice, Kelman, Miller, & Dunmeyer, 1990). We estimate that between \$50 - 80 billion of the above total is attributable to people with disabilities. This includes costs for medical and vocational rehabilitation, insurance and medical benefits (including S.S.D.I.), ancillary supports, and unemployment.

The large financial impact of substance abuse among persons with a disability is more comprehensible when considering the costs associated with medical and vocational rehabilitation. This is especially true when an individual is unsuccessful in rehabilitation because of the substance abuse and the entire process of assistance must be repeated or sustained over a long period of time. The cost of treating a bed sore for a person with spinal cord injury can be as high as \$50,000. Individuals are more likely to experience bed sores when they are immobile or inactive due to a lifestyle involving substance abuse. For persons with disabilities, every aspect of daily living can require adaptations from society, as well as the individual. These adaptations are less likely to be effective when the individual is unfocused or unmotivated due to abuse. Families, friends and professionals may have given up attempting to help because of abuse-related negative behavior. In addition, substance abuse contributes directly to unemployment and underemployment which is a particular issue for people with disabilities even without the burdens associated with the abuse of substances.

When discussing the financial impact of substance abuse and disability, it is important to keep in mind that characterizing all or even the majority of people with disabilities as substance abusers is stigmatizing and inaccurate. However, the social and financial impacts of substance abuse are often greater for people with disabilities, and these consequences must be recognized if they are to be addressed. This is especially true when persons with disabilities have so little access to alcohol and drug prevention and treatment services.

## RISK FACTORS

Just like anyone else, a person with a disability faces a number of situations which either encourage or discourage substance use and abuse. However, there are substance abuse risk factors specifically associated with disabilities. These risks include medical

concerns, chronic pain, unusual developmental experiences, low self esteem, idle time and outright enabling by others. Also, misperceptions about how and why persons with disabilities abuse substances also contribute to these problems. Some studies suggest that persons with disabilities who are most like their non-disabled peers in appearance and social behavior may be the most likely to experience negative consequences from substance abuse (Moore & Siegal, 1989; Edgerton, 1986).

### Medical Concerns

Compared with the general population, people with disabilities are more prone to medical and health problems. Substance abuse frequently will aggravate these conditions (DeLoach & Greer, 1981; O'Donnell et al., 1982). These medical problems can include inadvertent drug abuse because of compromised or unusual drug tolerance, self-medication with alcohol, and excessive medications which create problems worse than what they were originally prescribed to alleviate (Hepner et al., 1981).

*Medication Abuse.* Clinicians have documented easy access to prescribed medications as a significant risk factor for substance abuse (Hepner, Kirshbaum, & Landes, 1980-81). The problems associated with excessive or heavy medication regimens are sometimes very difficult to manage, even for the well-informed medical practitioner. Many persons with physical disabilities have chronic health maintenance concerns, and they require medications to relieve the side effects of disability. Medications often are prescribed to reduce muscle spasms, frequent infections, and other physical needs. Unfortunately, persons with physical disabilities can average two to five concurrent prescriptions, depending on age and condition (Moore & Siegal, 1989; Kirubakaran et al, 1986). Potentiation with prescribed medications and compromised drug tolerance can result in complications not generally experienced by the general population (Rasmussen & DeBoer, 1981; O'Donnell et al, 1982). Additionally, many of the medications prescribed to persons with physical disabilities contraindicate alcohol use.

*Chronic Pain.* Self-medication for pain is a significant risk factor in disabilities of traumatic origin, and it is a form of substance abuse that may be very common (Vaillant, 1983; Sullivan & Guglielmo, 1985). Several researchers have addressed the issue of persons with disabilities engaging in self-medication due to uncomfortable or painful episodes (Krupp, 1968; O'Donnell et al., 1982; Greer, 1986; Benedikt & Kolb, 1986; Rapaport, 1987). Prescribed medications that are addicting can be dangerous in themselves, especially when used over a longer period of time. These drugs also can pose a significant health and safety threat when used in combination with alcohol. Applicants to vocational rehabilitation systems, worker's compensation claimants, and patients in medical rehabilitation are a particular risk for this problem.

### Social Issues

Persons with disabilities sometimes must struggle with peer group and related social issues, especially in cases of congenital or early onset disabilities. Persons with these disabilities may be isolated from peers, with fewer opportunities to develop relationships. Special needs students may attend segregated schools or classes. These settings, in some cases, can increase risk for substance abuse by depriving students of the opportunity to learn constructive peer interaction or be made aware of peer pressure resistance skills.

Some special education students may find that peer groups which endorse drug use are the easiest to access because of these groups' acceptance of other aspects of personality that deviate from the norm (Jessor & Jessor, 1977; Sweeney & Foote, 1982). The increased desire for social acceptance may reinforce an individual with a

disability to seek settings where drug use is common, thereby making the disability less noticeable (Selan, 1979).

Later onset disabilities, including those impacting the elderly, also carry social consequences. The onset of a disability frequently means that an individual must curtail or change social activities. It may include a greater likelihood for isolation, restricted mobility, or excess idle time. Each of these factors increases risk for substance abuse.

*"Handicapism"*. An individual with a disability learns relatively quickly that people make greater allowances in their expectations for someone with a visible disability. For the most part, the general public is less demanding and more willing to assist if the individual has a disability. A disabled consumer has the choice of how to respond to this preferential, and potentially harmful, treatment. A person with a disability learns that the path of least resistance may be to take advantage of the general public's "good will" from time to time. Unfortunately, substance abuse and taking advantage of other people's feelings and generosity go hand in hand. Aside from the other negative side effects of preferential treatment, "handicapism" also leads to societal enabling of drug use among persons with disabilities.

*Social Stigma Associated with Substance Abuse*. Boros (1980/81) and others have stated that alcoholism is difficult to identify within the deaf community because of the stigma associated with the label of "chemical dependency". For a person with a disability, one potentially stigmatizing label of "handicapped" makes it even more difficult to self-identify with another label of "chemically dependent" or "alcoholic".

### **Societal Misperceptions**

A number of societal misperceptions and myths about persons with disabilities may contribute to substance abuse risks. These misperceptions are shared by many professionals who come in contact with persons with disabilities. A lack of knowledge, coupled with well-intentioned advice, actually can reinforce and encourage substance abuse among persons with disabilities. Some misperceptions include the following:

*Persons with disabilities do not have access to drugs*. In fact, persons with disabilities have very easy access to prescribed medications, and frequently these persons also have ready access to illicit substances (Moore & Siegal, 1989; Schaschl & Straw, 1989).

*Persons with disabilities are "entitled" to use drugs*. These attitudes are promulgated by a widespread misperception that a disability is some form of "illness", and therefore medication use necessarily should be part of its maintenance. In addition, a person with a disability is perceived by the uninitiated public as someone who is entitled to additional compensation for the burden that they undoubtedly must feel because of their disability. This attitude can contribute to the enabling of drug use or overlooking substance abuse problems when they occur. For example, "If I had a disability, I'd drink too!"

*The nature of disabilities creates substance abuse problems*. This misperception follows from the concept listed in the previous paragraph. People tend to believe that substance abuse may be one aspect of coping with a disability that is unfortunate, but almost unavoidable. This is not the case for most people (Schaschl & Straw, 1989). Actually, substance abuse problems frequently occur before the disability onset (Heinemann, 1989), and in fact persons with some congenital disabilities may experience lower rates of substance abuse than the general population (Moore & Siegal, 1989; Dinitto & Krishef, 1984). When a person experiences a disability, it serves to confuse a diagnosis of substance abuse and thus intervention is not provided in a timely manner.

## WHAT IS NEEDED

A great deal of education, adaptation, and resource development needs to be done in order to address the above issues. There are a growing number of organizations in the U.S. which are focusing energy on these tasks. Based on two years of experience with the SARDI demonstration project, we are suggesting that the following ideas be considered when developing services or programs to address substance abuse prevention for persons with disabilities:

1. Not surprisingly, professionals most interested in training and information about substance abuse and disability are those with the greatest contact with disability populations. For example, professionals in universities who work in disabled student services were more active in obtaining training and information than those working in other university offices. The primary responsibility for addressing substance abuse among persons with disabilities likely will fall on those working in disability fields.
2. Even an intensive, two day conference cannot "cross-train" professionals from a disability field so that the individual can conduct substance abuse prevention and intervention. The same is true for professionals coming from the alcohol and drug field regarding disability issues. A primary feature here is the degree of individualized problem solving that is required when faced with substance abuse and disability concerns. Often solutions are found on a case-by-case basis, and this type of response requires experience in addition to training. For this reason, multi-agency and interdisciplinary approaches are likely to be the most effective means for dealing with such a topic.
3. Historically, direct consumer involvement and advocacy has fueled the limited progress in substance abuse services for people with disabilities. Persons from within the disability community who are recovering from chemical dependency continue to be very important resources, whether it be for political advocacy, staff or client training, or in assisting with intervention and treatment.
4. There are at least two distinct sub-groups of persons with disabilities in regards to the use of mind altering substances. One group tends to use substances very little, but the risk for problems is significant should persons in that group change their consumption patterns. Another sub-group (perhaps 20-30% of persons with disabilities) has an extended history of substance misuse/abuse and numerous negative consequences as a result. Persons in this group generally experience few attempts from professionals to confront or intervene with the abuse. The SARDI data indicate that persons in the problem group come from all sites which participated in data collection, but tend to be most prevalent within medical and vocational rehabilitation systems.
5. Among all sampled sites, the most common areas of concern regarding substance abuse risk arise from the following areas:
  - medication use/misuse
  - medication/alcohol interactions
  - family influences which encourage or enable abuse
  - a lack of appropriate consequences for those who abuse substances
  - a lack of educational materials appropriate for special populations
  - insufficient community resources to promote and enhance healthy lifestyles
  - few professionals knowledgeable in substance abuse and disability

As stated above, the responses to these needs and risks must necessarily be tailored to an individual site, taking into account community resources, agency personnel and policy, and client profiles. Resources are beginning to emerge which also can be helpful for addressing substance abuse prevention among persons with disabilities. These include a growing awareness among federal and state vocational rehabilitation agencies, medical

rehabilitation organizations, state departments for alcohol or drug treatment services, and consumer advocacy organizations. The funding of the Resource Center for Substance Abuse Prevention and Disabilities, a component of the National Clearinghouse for Alcohol and Drug Information run by the U.S. Office for Substance Abuse Prevention, also is a pivotal service which provides library resources and much needed country-wide attention, to this issue.

In August, 1991, OSAP provided funding to the Institute on Alcohol, Drugs, and Disability (IADD) to conduct a National Policy and Leadership Development Symposium. Attendees participated in discussion groups in six categories and developed policy recommendations. Some of these recommendations are listed below:

#### *Program Design.*

- The alcohol and other drug field and the disability field should work together in assessing, planning, and implementing community-wide efforts.
- Fully accessible programs should be designed for people with disabilities who cannot participate effectively in traditional programs.
- Cultural and ethnic sensitivity should be included in all programs designed for people with disabilities.
- People with disabilities should be recruited and trained as resources, leaders, and role models for peer outreach programs.

#### *Training.*

- Cross-training and on-going relationship building should exist between independent living centers, rehabilitation agencies, and alcohol and drug programs. These organizations should train each other using positive role models of people with disabilities in recovery training.
- People with disabilities should participate in the development of all trainings.
- All levels of professional preparation should recognize the need to address alcohol and other drug issues.

#### *Collaboration.*

- Given that the current and future resources for people with disabilities are limited, it is imperative to maximize effective utilization of existing resources through the sharing of those resources across agency and organizational boundaries to improve services to people with disabilities and alcohol and other drug problems.
- Each state alcohol and drug agency should have a disability coordinator who is a person with a disability who is in recovery.

#### *Funding.*

- Funding agencies should support coordinated prevention efforts at all levels.
- Federal block grant set-asides for people with disabilities should be established. People with disabilities should be considered a special population that is unserved and underserved and is at high risk of developing alcohol and other drug problems.

*Compliance.*

- Each state should develop mandates for compliance with 504 and the Americans with Disabilities Act regulations, similar to those in Massachusetts.
- Federal funding sources such as the U.S. Office for Substance Abuse Prevention and the Office for Treatment Improvement should ensure that uniform accessibility policies exist in all of their requests for funding applications.

*Advocacy.*

- Issues related to alcohol and drug problems among people with disabilities should be insinuated into the agendas of all disability, rehabilitation, and alcohol and drug conferences and should be advanced to all relevant professional associations and advocacy groups.
- A new national organization to represent the particular concerns of people with disabilities who are also experiencing alcohol or other drug problems should be created. It should publish a multi-disciplinary journal.

Although advancements in the field of substance abuse and disability have been made, much work is still needed. Advocacy by and for persons with disabilities must continue at local, regional, state and federal levels in order to create systems capable of addressing these needs. As in other areas of social service involving persons with disabilities, better knowledge of disabilities, coupled with solutions targeted at specific problems, will be the means for accomplishing these goals.

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*One valuable resource in training professionals and families as well as junior and senior high school aged youth is a powerful film entitled **J.R.'s Story: The Disability of Chemical Dependency**. This film addresses the special challenges faced by someone with a physical disability and chemical dependency. This 26 minute film is distributed by AIMS Media in California.*

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## TEST YOUR KNOWLEDGE ABOUT SUBSTANCE USE AND DISABILITY

The following questions are based on the information contained in the Chapter you have just read. The answers are found in Appendix G.

1. It is likely that substance abuse and disability costs the U.S. approximately \_\_\_\_\_ billion dollars per year.
  - a. 75 - 90
  - b. 50 - 80
  - c. 30 - 50
  - d. 5 - 25
2. Alcohol abuse has been associated with over half of all occurrences of traumatic brain injury.  
  
TRUE      FALSE
3. Two medical risk factors for persons with disabilities are \_\_\_\_\_ and \_\_\_\_\_.
4. The presence of a disability often makes identifying substance abuse easier.  
  
TRUE      FALSE
5. The primary responsibility for identifying and addressing substance abuse in people with disabilities will likely fall on \_\_\_\_\_ professionals.
6. The most effective means for addressing substance abuse in people with disabilities will most likely be \_\_\_\_\_ - \_\_\_\_\_ and \_\_\_\_\_.
7. Some students with disabilities find more ready acceptance among peers who use alcohol and other drugs.  
  
TRUE      FALSE
8. Some consequences of substance abuse reported by people with disabilities include:
  - a. family problems
  - b. alcohol related arrests
  - c. reporting to school high
  - d. hospitalizations
  - e. none of the above
  - f. all of the above
9. As many as \_\_\_\_\_ % of spinal cord injuries occur in alcohol or drug related accidents.
10. The most valuable resource in the development of substance abuse services for people with disabilities are \_\_\_\_\_.

**CHAPTER TWO**

**WHO ARE THE AMERICANS WITH DISABILITIES?**

## CONTENTS

### CONTENTS OF THE FIRST AND SECOND EDITIONS

## WHO ARE THE AMERICANS WITH DISABILITIES?

In order to provide appropriate substance abuse prevention, education, intervention, and treatment, professionals must understand disability issues. Some of the risks for substance abuse vary by disability. Culture, communication, health, and language issues must all be taken into account by professionals working with persons with disabilities, and again, these issues may vary by disability.

A wide variety of materials about disabilities and the Americans With Disabilities Act are available to professionals. In addition, information can be obtained from consumers directly by contacting local consumer groups such as the Multiple Sclerosis Society and Easter Seals. It is important for the professional to not only gather information by reading, but also to obtain information through consumer contact.

This chapter provides a brief overview of disability issues and information about selected disabilities including the implications of alcohol and other drug abuse and suggestions to improve access and positive interactions for each. The chapter is broken out as follows:

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*We gratefully acknowledge the assistance of the Resource Center on Substance Abuse Prevention and Disability, a division of VSA Educational Services, for allowing us to reprint material in this chapter. The "Resource Center" is an affiliate of the OSAP's National Center for Alcohol and Drug Information and is funded by The U.S. Office for Substance Abuse Prevention. More complete information on these and other related topics can be obtained from the Resource Center by utilizing the order form at the end of this chapter.*  
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## AMERICANS WITH DISABILITIES

Who are the 43 million Americans with disabilities? They are the largest and most diverse minority group in the U.S. Still, two-thirds of their working age members are unemployed even though 66% of these people say they want to work. According to the President's Committee on Employment of People with Disabilities, the cost to the American taxpayer is \$300 billion annually. Worker compensation payments are over \$25 billion per year, and one dollar of every hour of wages in America now goes for a disability related expense. Disability is an equal opportunity phenomenon, affecting every racial and economic segment of our population.

To fall within the Americans with Disabilities Act's (ADA) definition of a person with a disability, a person:

- must have a physical and/or mental impairment that substantially limits one or more major life activities; or
- must have a record of such an impairment; or
- must be regarded as having such an impairment.

This definition is broad by design and is intended to address both medical and psychosocial impediments to the full integration of Americans with disabilities.

The ADA defines as disabled people who have completely recovered from a disabling condition, but who have a history or record of disability. People with a history of cancer, heart surgery, or mental illness are common examples. The ADA also defines as disabled people who once had been misclassified as disabled (e.g., a person with a medication allergy who may have been wrongly diagnosed as epileptic). People who may be regarded as having a disability include:

- a person with hypertension that is controlled by medication, but whose employer has decided he or she cannot do strenuous work;
- a person with facial disfigurement that is disabling only because of the attitudes and reactions of others;
- a person who is rumored to carry the AIDS virus, but who has no impairment and is disabled only by the perception of others.

### Architectural and Communication Barriers

The ADA recognizes that one significant barrier to the provision of alcohol and other drug abuse prevention services is the person's physical access to and within the place where such services are provided. Inaccessibility primarily affects those with mobility and sensory impairments, but it is relevant to many other disabled and even nondisabled people (e.g., pregnant women and elderly people). Title III of the ADA specifies that discrimination includes a failure to remove architectural or communication barriers in existing facilities if such removal is readily achievable (i.e., accomplishable without much difficulty or expense). Examples would include modest adjustments such as adding grab bars in restrooms, lowering public telephones, or adding braille markings on elevator control buttons.

If the removal of a barrier is not readily achievable, then one must attempt to provide services or programs through alternate methods (e.g., providing assistance to

retrieve items in an inaccessible location). The ADA mandates a much higher standard for "readily accessible to and usable by" regarding new construction and major alterations because it costs far less to design accessibility into a new construction project, typically adding 0.5% to 5% of the total budget.

### **Discrimination and Other Barriers**

The lawmakers of the ADA were quick to recognize that the serious impediments to access for people with disabilities are not problems that can be solved solely by architects. They are problems of attitude. An attitudinal barrier is defined as a way of thinking or feeling that results in behavior which limits the potential of people with disabilities to function independently. Attitudes toward people with disabilities have been explored. Three important assumptions can be noted:

- *A small percentage of people have openly negative attitudes that are associated with prejudice, fear, ignorance, intolerance, insensitivity, discrimination, dislike, condescension, and the like. They subscribe to most of the myths surrounding disabilities, even in the face of documented evidence to the contrary.*
- *The vast majority of the American public is neither positive nor negative toward people with disabilities. Their general reaction is one of massive and deliberate indifference. They just prefer not to think about disability at all.*
- *This indifference is rooted in a perfectly natural psychological phenomenon in which, when we think about or encounter disability, we must think about and deal with the fragility of our own health and ultimately our own mortality. To do so is unpleasant and uncomfortable for most people.*

Avoiding this discomfort has been too expensive. Any indifference, unpleasantness, or discomfort felt, any attitudinal barriers that may have been erected around the issue of disability must be removed. As in all areas of life, complete access to alcohol and other drug abuse prevention services must be guaranteed.

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### **Suggestions to Improve Access and Positive Interactions**

*Offer assistance if you wish, but do not insist. Always ask before you act, but do not help without permission. If you are not sure what to do, ask the person to explain what would be helpful.*

*Focus on the abilities of the person, rather than on the disability. Be mindful that alternative ways of doing things are often equally effective. Encourage people with disabilities to be their own advocates.*

*Be aware of limitations specific to a disability, but do not be overprotective. Do not exclude the person from participating in an activity just because you assume their disability would be a problem. Let them make the decision; do not lower your expectations. There is dignity in being able to take risks. Allow a person with a disability to fail just as you would allow any other person. No one succeeds all the time.*

*Make sure that parking areas, restrooms, and buildings in which you provide services or conduct meetings are architecturally and environmentally accessible to all people. This is crucial to the establishment of a comfortable and equitable relationship with people with a disability. Get expert advice before making expensive structural modifications.*

*Accessibility to the full range of services you provide is legally required. Review your programs and reading materials. Are they diverse enough to reach all levels of ability? Is the content accessible to people with hearing, visual, or learning disabilities? (e.g., audiotapes, audiovisuals, large print).*

*Conduct outreach efforts to publicize your programs to people with disabilities. Allow time for them to become fully aware of your services and develop trust in your efforts.*

*Ask a person with a disability to facilitate disability awareness training sessions with staff to promote positive attitudes. Locate material and have it available for learning more about disability related issues.*

*Involve people with disabilities on advisory boards, planning committees, in positions of authority and in the planning and presentation of all sponsored programs. Actively seek qualified persons with disabilities when hiring for staff positions.*

*Assume responsibility for understanding the issues that affect people with disabilities. Learn more. Send for information from consumer and disability related organizations, ask for their support, and invite their representatives to speak at meetings.*

*For each person with a disability, explore all possible factors contributing to alcohol and other drug involvement, not just those related to disability.*

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**The Power of Language.** It is important to monitor your use of written and spoken language regarding people with disabilities. Words are powerful tools, indicating the perceptions and attitudes of the person using them. The following general guidelines will be helpful:

1. *Focus on issues and not on a disability.* Above all, do not sensationalize a disability by using terms such as "afflicted with, suffers from, victim of, shut-in, infirmed, crippled with, or unfortunate." These expressions are very offensive, even defamatory, to people with disabilities.
2. *Emphasize people, not generic labels.* Say "people with mental retardation", not "the retarded." Put people first, not their disability.
3. *Emphasize abilities, not limitations.* Say "uses a wheelchair", not "confined to a wheelchair" or "wheelchair bound."
4. *Avoid condescending euphemisms like "handicapped, mentally different, physically inconvenienced, physically challenged."* These tend to trivialize disabilities and suggest that they cannot be dealt with in an upfront manner.
5. *Avoid disease connotations such as "patients" or "cases."*

## DISABILITY AND HEALTH IMPLICATIONS

Many persons with disabilities have health maintenance issues and are prescribed medications to relieve pain or the side effects of the disability, including muscle spasms and frequent infections. It is not unusual for some persons with physical disabilities to average between two and five concurrent prescriptions (Moore & Siegal, 1989; Kirubakaran et al, 1986). This creates a variety of risks for substance use problems including a compromised drug tolerance, addiction to prescription medications, and over-medication.

At times, persons with disabilities take prescribed medications without knowing what they are taking or the possible consequences of drinking or using other drugs in conjunction with these prescriptions. Additionally, it is not unusual for some persons with disabilities to be unsure about the specifics of their disabilities and to receive little or no information about how their physical impairments may effect the way their bodies react to the influence of alcohol and other drugs. This lack of information coupled with the continued use of alcohol and other drugs can contribute to secondary disabilities or to re-injuries.

It is a well-known fact that people with disabilities tend to experience more medical and health-related problems than the general population. However, many people with disabilities do not require greater amounts of medical care. Instead, it is the disability in combination with an unhealthy lifestyle which places a person at risk for health and medical problems (Pope and Tarlov, 1991). One lifestyle risk involves the misuse of alcohol and other drugs. Even amounts of alcohol considered "moderate" for most people can have negative effects for someone with a disability. This is due to such factors as:

- *regular use of medications;*
- *compromised circulation or metabolism; or*
- *unusual nervous system activity (e.g., spasticity, seizures, hyperactivity).*

For people with disabilities who must take special precautions about their health, alcohol and other drug misuse can increase the risk for chronic health problems, and place them at risk for secondary disabilities.

Disability-related medical care in the United States has been estimated to cost \$120 billion per year (Pope and Tarlov, 1991). The unidentified alcohol and other drug abuser within the health systems substantially raises these costs. Problems associated with alcohol and other drug abuse and disability affect many large systems including medical rehabilitation, special education, centers for independent living, vocational rehabilitation, and worker compensation. Screening and identification of alcohol and other drug abuse problems must be an integral part of these services to better serve those in need, to reduce the risk of secondary disabilities, and to maintain cost-effective services.

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*Disability management and rehabilitation success requires commitment, tenacity, energy, and endurance. These attributes become suppressed and vanish with the use of alcohol and other controlled substances. Rehabilitation requires sobriety.*

James S. Jeffers, Assistant Superintendent  
for Vocational Rehabilitation, Maryland

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Medical and other rehabilitation efforts can be severely hindered when a person with a disability is over-medicated, abusing, or using even small quantities of alcohol or other drugs (Heinemann, et al., 1989). Cognition, mobility, stamina, and interpersonal skills are all adversely affected. Rehabilitation staff do not always recognize alcohol and other drug abuse problems in their patients because some behaviors associated with disabilities are similar to the consequences of alcohol and other drug abuse, such as:

- *missed appointments,*
- *drowsiness,*
- *impaired memory,*
- *affected speech or gait.*

Moreover, health care professionals often do not perceive alcohol and other drug abuse identification as their responsibility. Unfortunately, this attitude shields the person with a disability from negative consequences, perpetuating the alcohol and other drug abuse.

One societal misperception is that people with disabilities are sick or unhealthy. This misperception tends to mask the true reasons behind some medical complications. For their part, physicians frequently have limited information regarding those patients with disabilities who are most at risk for developing alcohol and other drug abuse problems. Also, these practitioners have limited means for identifying patients who have acquired the same medication from other physicians. Sometimes, as a consequence, medications are abused because of their abundance, or they are traded for alcohol or other drugs.

Perhaps the greatest challenge to health care professionals, disability specialist, families, and society in general is to look beyond the disability and assess the underlying causes for recurring medical problems. Frequently, alcohol and other drug abuse will remain hidden behind a disability until specific questions are asked.

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*The prevalence of alcohol-related problems in persons with physical disabilities has emerged as an issue in medicine and physical rehabilitation. Physicians, rehabilitation specialists and service providers increasingly are aware that alcohol abuse not only can contribute to the onset of disability, but can undermine the rehabilitation process by impairing the learning process and increasing morbidity.*  
Allen W. Heinemann, Ph.D., Associate Professor  
Northwest University Medical School  
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## Resources

*JR's Story: The Disability of Chemical Dependency* is a video which chronicles one year in the life of a young man with quadriplegia following an arrest for drug trafficking. To order, contact Aims Media, 9710 DeSoto Ave., Chatsworth, CA 91311. Phone: (800) 367-2467.

*The Substance Abuse Assessment and Education Kit* was developed for professionals working in the field of traumatic brain injury. It contains useful clinical materials and research information intended to help identify substance abusers, develop effective plans for education and prevention, and assist in policy-making efforts. For more information, contact Rehabilitation Research and Training Center on Severe Traumatic Brain Injury, Box 434 MCV Station, Richmond, VA 23298-0434. Phone (804) 786-7290.

*The Substance Abuse Prevention Project* has developed training material for rehabilitation staff serving persons with a traumatic injury, those addicted and their families. The material is appropriate for adults and teens. To order, contact the Rehabilitation Institute of Chicago, 448 E. Ontario #650, Chicago, IL 60611. Phone. (312) 908-2802.

*Training Manual for Professionals; Substance Abuse and Disability Issues.* This manual can be used for self directed education or group training. Contact Substance Abuse Resources and Disability Issues, Department of Community Health, School of Medicine, Wright State University, Dayton, OH 45435. Phone (513) 873-3588.

### **Did You Know That.....**

- *the definition of "heavy alcohol use" is dependent, among other things, on the nature of the disability and the types of medications being used?*

For the "average" person without a disability, the body is able to process approximately one drink per hour (one shot of whiskey, one 12 oz can of beer). For this person, consuming several drinks in the course of an evening may not be considered excessive. However, a person taking medications, such as muscle relaxers (Flexeril, Soma or Robaxin) to control spasms will experience the side effects of heavy alcohol consumption after only one or two drinks. The same reactions may occur when alcohol is consumed with antidepressants, sedatives, and other drugs commonly prescribed for people with specific disabilities.

- *alcohol use can be directly implicated in some forms of arthritis?*

Of the many forms of arthritis, some are associated with alcohol abuse. Gout is one form of arthritis associated with alcohol abuse. Gout is marked by an excess of uric acid in the blood and painful inflammation of the joints. At least one form of arthritis of the hip also is strongly associated with excess alcohol consumption.

- *bedsores, or decubitus ulcers, can be caused by frequent alcohol or other drugs use?*

People who have serious mobility limitations spend much of their time sitting or lying down. If a person is frequently under the influence, it is far less likely that pressure release exercises will be conducted on time to relieve excess stress on body pressure points. Failure to follow pressure release procedures can cause ulcerations on the body. Sometimes these ulcerations extend all the way to the bone. It can take over \$50,000 and many months to heal a single bedsore.

- *the use of hallucinogens can be especially dangerous for people with spinal cord injuries?*

People with spinal cord injuries who have experimented with hallucinogens report a number of very serious side-effects. These include hyperventilation, greater spasticity and high body temperature, as well as the absence of the typical "high".

- *among some leading causes of mental retardation, Fetal Alcohol Syndrome (FAS), is the most preventable?*

FAS is currently one of the leading causes of mental retardation in the United States. This condition can be entirely prevented if women abstain from alcohol and other drugs during pregnancy. There is no known "safe" amount of alcohol which can be consumed without damaging the fetus. Common features associated with FAS include reduced growth rate, impaired cognitive functioning, abnormalities in body features, and behavioral problems.

## **ATTENTION DEFICIT DISORDER**

Attention Deficit Disorder (ADD) is marked by developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity (DSM III, R). ADD generally has an onset prior to the age of four. However, it is typical that ADD is not diagnosed until the child begins school. An estimated 3% of all children experience ADD, and it occurs approximately six times more frequently in males than in females.

A common fallacy is that ADD is a learning disability. ADD is behavioral in nature and is characterized by impulsivity and an inability to remain focused on one topic. ADD frequently is accompanied by hyperactivity. In contrast, a learning disability is associated with how a person learns. School difficulties are common to both disabilities.

It is believed that ADD has a biological basis. This disability occurs more frequently in children from families with a history of developmental disorders, conduct disorders, and alcohol and other drug abuse (DSM III, R).

### **The Implications of Alcohol and Other Drug Abuse**

Problems with alcohol and other drug abuse seem to occur more frequently in people diagnosed with ADD (Hechtman, 1986). Many youth experiencing ADD continue to show signs of the disability into adolescence and adulthood. If ADD persists into later adolescence, conduct disorder and alcohol and other drug abuse may be a problem for up to one half of these individuals.

For many people, it is difficult to distinguish between the behaviors associated with ADD and those associated with alcohol and other drug abuse especially since both are often manifested in socially unacceptable behaviors. For this reason, estrangement from family and significant adults is a possibility. These behavior issues also make alcohol and other drug abuse treatment efforts more difficult. Standard treatment modalities often do not take into consideration the special needs of people with ADD. Additionally, young people with ADD may be prescribed medications for behavior control, and this also may be a risk factor for some forms of subsequent alcohol and other drug abuse.

Alcohol and other drug abuse prevention efforts should include information specific to the person's disability. For example, the following points might be emphasized in discussions with a person who has ADD:

- Even small amounts of alcohol can be harmful in combination with prescription drugs.
- The use of alcohol and other drugs can interfere with learning and developing effective social skills, which could increase feelings of isolation and disenfranchisement.
- There is a difference between taking medication and using alcohol and other drugs to deal with emotions and difficult situations. It is important to learn effective ways to deal with stress and other problems and not use alcohol and other drugs to do so.

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### **Suggestions to Improve Access and Positive Interactions**

*Be patient when communicating with someone with ADD.* Ask clarifying questions throughout the conversation to ensure that the person is grasping the information provided. Repetition will be necessary.

*When communicating with a person with ADD, use innovative and unusual examples to catch the person's attention.* Those with ADD tend to stay more focused when the information and modalities are presented in diverse ways.

*Take frequent breaks.* When the person seems to be drifting away from the lesson, take a break before refocusing on the topic at hand.

*People with ADD seem to stay focused better when in a structured setting, receiving frequent reinforcements.* Important information may best be given in one to one situations.

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## BLINDNESS AND VISUAL IMPAIRMENTS

A person whose optimum visual acuity in the better eye is 20/200 is considered to have statutory or legal blindness. It is estimated that 11.4 million Americans have some visual impairment, even with glasses. Of this number:

- 120,000 are totally blind;
- 600,000 are legally blind with some usable vision;
- 1,400,000 are severely visually impaired (cannot read newsprint with glasses).

Visual impairments also include tunnel vision and color blindness. Two thirds of blindness is caused by cataracts, glaucoma, diabetes, vascular disease, trauma, and heredity. One third is "cause unknown."

### The Implications of Alcohol and Other Drug Use

Very little is known about the alcohol and other drug use patterns of people with visual impairments. Increased risks for alcohol and other drug problems among the blind have been associated with isolation, excess free time, and underemployment (Nelipovich and Buss, 1989). People with visual impairments may face fewer consequences from alcohol and other drug abuse due to the enabling of others, social isolation, and constraints imposed by the disability.

When alcohol and other drug dependency treatment is required, the educational modalities must be altered for this process to be effective (e.g., talking books, braille). Also, treatment requirements may differ for those whose alcohol and other drug abuse has preceded, rather than followed, the onset of the visual impairment (Glass, 1980-81).

Alcohol and other drug abuse prevention efforts should include information specific to the person's disability. For example, the following points might be emphasized in discussions with a person with blindness or other visual impairments:

- When the visual impairment is progressive, such as with glaucoma or diabetes, alcohol and other drug abuse issues are compounded. Even moderate drinking can aggravate these conditions, and the person must go through a period of psychological adjustment with each level of vision that is lost.
- When alcohol or other drugs are the means of coping with a visual impairment, psychological adjustment to disability is less complete. Successful independent functioning therefore is less likely.
- Alcohol and other drugs are ineffective means for dealing with negative self-images and feelings of isolation. Discuss other ways to develop self-esteem, social skills and independence.
- Alcohol and other drugs can effect motor coordination and cause difficulties in mobility.

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### Suggestions to Improve Positive Interactions

*To guide a person who is blind, let him or her take your arm. If you encounter steps, curbs, or other obstacles, identify them.*

*When sitting down, guide the person's hand to the back of the chair and tell him or her whether the chair has arms.*

*When giving directions, be as clear and specific as possible. Estimate the distance in steps, and point out obvious obstacles in the direct path of travel.*

*Speak directly to the person in a normal tone and speed. Do not shout or speak in a loud voice.*

*Resist the temptation to pet or play with a working guide dog. The dog is working and should not be distracted.*

*When leaving a room, say so. Anyone would feel foolish talking into thin air.*

*When the person who has a visual impairment must meet many people, introduce them individually. This helps the person to better associate names and voices for subsequent encounters.*

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## DEAFNESS AND HEARING LOSS

Deafness is the inability to hear and understand conversational speech with or without a hearing aid. Hearing loss is a condition in which the sense of hearing is defective but functional for ordinary life purposes (usually with the help of a hearing aid). There are approximately 2 million persons in the United States who are deaf. Another 20 million Americans have some degree of hearing loss. These numbers are increasing due to the aging of the population and the exposure of young people to damaging noise levels, especially from music.

It is important to understand that the major handicap is not the inability to hear, but the difficulty in communication. The way in which the person with a hearing loss will communicate depends on these factors:

- degree of hearing loss and residual hearing;
- age at which the hearing loss developed;
- language skills;
- speech abilities;
- family environment;
- educational background.

The communication problems are more complicated for the person who never heard speech than for those whose hearing loss developed at a later age. Speech develops as we imitate others and listen to the sounds we make. To improve communication, a person with a hearing loss may rely upon lip reading, manual communication, teletypewriters, or pads and pens. All methods are acceptable, if communication is achieved.

### **The Implications of Alcohol and Other Drug Use**

**Hearing Loss:** There is an assumption that all hearing losses other than profound deafness are similar in nature. People with a moderate or mild hearing loss are often perceived as being no different from those who can hear. This inaccurate perception can result in the failure of treatment and prevention service programs to respond to the needs of people with a hearing loss (Buss, 1985).

On an individual level, this insensitivity to a person's special needs can lead to a negative self-perception and a sense of social stigma. The person with a hearing loss may withdraw from the hearing world or deny the existence of a hearing loss (Kearns 1989). These behaviors lay the groundwork for isolation, and the suggestion has been made that a

high level of frustration may increase the incidence of alcohol abuse among people with a hearing loss (Harris, 1982) .

**Deafness:** There has been insufficient research to date to understand the nature and scope of alcohol and other drug abuse problems among people who are deaf. Estimates suggest that alcohol use is at least comparable to that of the general population. This in itself is a problem, because people who are deaf do not have ready access to appropriate alcohol and other drug information or treatment (Sylvester, 1986).

Alcohol and other drug prevention materials frequently do not take into account the cultural, language, or communication differences indigenous to people who are deaf. The inability of social agencies, the legal system, and school/work environments to communicate appropriately with the deaf have enabled some people with this disability to escape the normal consequences of alcohol and other drug abuse, thereby perpetuating these problems.

There also is concern that people who are deaf have a strong desire to avoid the social stigma associated with alcohol and other drug abuse because it constitutes another negative label (Boros, 1981). This reluctance to address alcohol and other drug abuse issues leads to social isolation and even more problematic consumption.

Prevention efforts should include information specific to the person's disability. For example, the following points might be emphasized in discussions with a person who is deaf or has a hearing loss:

- The use of alcohol and other drugs can interfere with learning and developing effective social skills, which could increase feelings of isolation.
- It is important to learn effective ways to deal with stress and other problems and not use alcohol and other drugs to do so.
- When the hearing loss is progressive, alcohol and other drug abuse issues are compounded. A person must go through a transitional period of psychological adjustment when hearing is lost.
- When a person with a severe hearing loss requires alcohol and other drug dependency treatment, it may necessitate specialized services established just for this disability. To be effective, a treatment program must provide much more than a sign language interpreter for some clients.

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#### **Suggestions to Improve Positive Interactions**

*Use a normal voice tone and provide a clear view of your mouth.*

*If an interpreter is involved, speak directly to the person with deafness--not the interpreter.*

*Avoid standing in front of a light source (e.g., window) which might silhouette your face making it difficult to see.*

*Use facial expressions, body language, and pantomime.*

*Explain any interruption (phone rings, knock at door) before attending to it.*

*Learn how to find an interpreter on short notice.*

*Install a Telecommunication Device for the Deaf (TDD) in your reception area.*

*Encourage and support sign language instruction for all interested employees.*

*Maximize the use of visual aids, such as flip charts.*

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## HIDDEN DISABILITIES

People with hidden disabilities appear to be physically nondisabled, healthy, and productive, leading normal lives. They have "hidden" conditions such as cancer, epilepsy, diabetes, lung disease, kidney failure, hemophilia, hypertension, early stages of AIDS, or heart disease. Therefore most people will expect them to be totally self-sufficient and competent. Yet within the disability community, they do not feel like they belong--not "disabled enough" to fit into a group of active, assertive people with disabilities. Their numbers are far greater than those of any one disability group, but they are often in a state of limbo about belonging--feeling without a place in anyone's world. People with hidden disabilities are caught between not being fully accepted as a nondisabled person, yet not being recognized as someone with a "real" disability either.

The lawmakers of the Americans with Disabilities Act of 1990 (ADA) continued in the tradition of Section 504 and includes people with hidden disabilities. This is demonstrated by the broad definition of disability which included persons with a history of impairment and those who are perceived as having a disability. This is further reinforced by ADA regulations which encourage people with hidden disabilities to disclose their impairments and seek the full protection of the new federal law.

### **The Implications of Alcohol and Other Drug Use**

For people with hidden disabilities, there are increased risks for alcohol and other drug abuse which may not be immediately apparent. These can include:

- decreased tolerance for mind altering drugs,
- atypical childhood experiences,
- lower resistance to peer pressure,
- overprotection by family members, and
- long-term use of medications

These risks are increased when teachers, employers, or peers do not understand how needs or behaviors are related to a disability that is not obvious. Misunderstandings and unrealistic expectations stifle self-esteem while promoting alcohol and other drug abuse.

Chronic pain and recurring medical relapses also place some people with hidden disabilities at risk for alcohol and other drug abuse. These conditions can lead to abuse of medication alone, or in combination with drugs such as alcohol (O'Donnell et al, 1981-82; Greer, 1986; Rapaport, 1987). Ironically, the use of drugs to alleviate long-term pain in some cases actually exacerbates the discomfort while increasing the likelihood for alcohol and other drug dependency.

Alcohol and other drug abuse prevention efforts should include information specific to the person's disability. For example, the following points might be emphasized in discussions with a person who has a hidden disability:

- If a person has diabetes, the use of alcohol and other drugs can aggravate it and lead to blindness, kidney failure and other physical problems.
- The effects of alcohol and other drugs may interfere with medications, especially those designed to prevent seizure episodes. They also may lower the seizure threshold.
- The difference between taking medication and using alcohol and other drugs to deal with negative self images and emotions.

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**Suggestions to Improve Access and Positive Interactions**

*If you think that someone has a hidden disability, ask questions that may be appropriate to the treatment process. For example, "Is there anything about you we have not discussed that might make it difficult to participate in this program? meet the program requirements? engage in these physical activities?"*

*The removal of barriers and provision of reasonable accommodation for people with hidden disabilities is highly individualized. Sometimes the evidence of your genuineness and openness to more obvious disabilities will make people with hidden disabilities more likely to discuss openly the accommodations they require.*

*Provide an environment conducive to self-disclosure. This includes hiring people with disabilities; establishing a reputation for confidentiality; formally inviting employees and clients to self-identify; and providing descriptive literature and speakers regarding your interest in serving people with disabilities.*

*Once a person is identified as having a disability, an open and honest discussion can follow regarding the need for and nature of accommodation required. For most hidden disabilities, the primary accommodation required will be acceptance by the staff and clients.*

*Hidden disabilities are not contagious. Under the ADA, the Secretary of Health and Human Services will publish a list of contagious diseases each year and the conditions under which diseases may be transmitted. There is no reason to avoid people with disabilities for fear you might catch something.*

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**LEARNING DISABILITIES**

Learning disabilities are disorders manifested by significant difficulties in listening, speaking, reading, writing, reasoning, and mathematical abilities. The primary problems do not involve collecting information (as in sensory disabilities) but in interpreting, translating, or recalling information collected. Learning disabilities are intrinsic to the person, presumed to be due to central nervous system dysfunction, and may occur across the life span.

Learning disabilities range from mild to very severe. They affect between 5 to 10% of the population. There are many types of learning disabilities. Some examples include:

- dyslexia: severe problems with reading;
- dysgraphia: severe problems with writing;
- dysphasia: severe problems with speaking;
- dyscalcula: severe problems doing math.

## The Implications of Alcohol and Other Drug Use

People with learning disabilities are more prone to misunderstand alcohol and other drug education and prevention materials, placing them at greater risk for injuries and other consequences of abuse. People with learning disabilities may begin to use alcohol and other drugs through peer pressure in an effort to gain acceptance and recognition when other avenues appear to be unavailable.

Communication difficulties experienced by people with learning disabilities often are not understood or appreciated by others. These misunderstandings compound feelings of inadequacy, frustration, and rejection. Unsuccessful peer group and school experiences can hasten the use of alcohol and other drugs in order to cope with these feelings.

Alcohol and other drug abuse prevention efforts should include information specific to the person's disability. For example, the following points might be emphasized in discussions with a person who has a learning disability:

- Even small amounts of alcohol can be harmful in combination with prescription drugs.
- There is a difference between taking medication and using alcohol and other drugs to deal with emotions and difficult situations. It is important to learn effective ways to deal with stress and other problems and not use alcohol and other drugs to do so.
- The use of alcohol and other drugs can interfere with learning and developing effective social skills, which could increase feelings of isolation and disenfranchisement.
- Using alcohol and other drugs can exacerbate difficulties which may exist in planning, concentration, and information processing speed.

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### Suggestions to Improve Access and Positive Interactions

*Processing difficulties often interfere with learning.* Extra time may be required to learn a certain skill. Once learned, however, there is no relationship between a learning disability and performance of the task.

*Occasional inattentiveness, distraction, or loss of eye contact by the person with a learning disability is not unusual.* Do not be concerned or offended, it is unintentional.

*Some information processing problems may affect social skills, such as an unconventional or complete lack of response.* Do not confuse this with rudeness.

*A person with a learning disability sometimes has difficulty interpreting social cues (e.g., facial expressions, voice tone, and gestures).* Accordingly, he or she may respond in an inappropriate manner. Again, do not confuse this with rudeness.

*If future contact with a person with a learning disability is warranted, discuss openly the preferred way to communicate.* This may be in writing or by phone.

*Have your educational and promotional materials reviewed to see that they are available in various sensory modes and accessible to people with communication problems.*

---

## MENTAL ILLNESS

Mental illness is a commonly occurring disability in the United States. Perhaps one-third of the population will experience a mental disorder at one time in their lives (Reiger et al., 1988). It is very difficult to determine the number of people with mental illness due to the nature of definitions. Mental illness often is considered a separate category from other disabilities, and this also confuses estimates of prevalence (NIDRR, 1989).

Two of the most common conditions are anxiety disorders and depression. There are different types of anxiety disorders, including:

- generalized anxiety disorder;
- panic disorder;
- post-traumatic stress disorder;
- obsessive compulsive disorder; and
- social and other phobias.

Approximately one American in twenty will suffer at least one major depressive disorder in his or her life. Depressive illnesses include:

- major depression;
- dysthymic disorder;
- atypical depression; and
- manic depression.

Among the more severe forms of mental illness is schizophrenia. It is estimated that one percent of the population is schizophrenic. Unfortunately, only one half of these people are treated for the condition (Smith, 1989). Although mental illness is not considered a physically restricting condition, it is ranked ninth out of 67 chronic health conditions for causing activity limitation (LaPlante, 1989). Mental illness is included in the definition of disability in Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA).

### **The Implications of Alcohol and Other Drug Use**

Recurring alcohol and other drug abuse problems affect perhaps 50% or more of all people with mental health disabilities (Brown, et al., 1989). When this occurs, a vicious cycle is established--the abuse degrades the person's mental health, which only increases the problems with alcohol and other drug abuse. Confounding the issue of diagnosis, the symptoms of alcohol and other drug dependency are sometimes very similar to those of depressive or anxiety disorders.

The dual problem of alcohol and other drug abuse and chronic mental illness is particularly difficult and challenging to address in treatment settings. The issues related to the mentally ill chemical abuser are a major concern for health and mental health systems for this reason. There has been more interest in this area of disability and alcohol and other drug abuse than in any other to date.

People with serious mental health problems generally do not function well in traditional alcohol and other drug dependency treatment settings. Denial of the mental illness is as common as the denial of alcohol and other drug abuse problems. Self-help support groups are one potential source of sobriety, especially if the groups are specialized for people with mental illness.

Alcohol and other drug abuse prevention efforts should include information specific to the person's disability. For example, the following points might be emphasized in discussions with a person who has a mental illness:

- Many people with mental illness receive medication on a regular basis, and these drugs can include some with habit-forming properties or potentials for abuse. Anti-anxiety medications in particular are very addictive, and they are dangerous when mixed with alcohol.
- The depressant effects of alcohol and other drugs are not helpful if proneness to major reactive episodes are common for the person with mental illness.
- There is a difference between taking medication and using alcohol and other drugs to deal with emotions and difficult situations. It is important to learn effective ways to deal with stress and other problems and not use alcohol and other drugs to do so.

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### **Suggestions to Improve Positive Interactions**

*Learn more about the nature of the person's diagnosed mental illness.* If the person is prescribed medication for his or her illness, locate information on the side effects and long-term health impact.

*Remember that people with mental health problems generally do not have lower intelligence.* Some people may have difficulties with attention span or discussion topics that produce anxiety, but other communication problems should be minimal.

*Be aware that people with more severe mental illness have difficulty dealing with emotions or expressing them.* A person may smile even when he or she is angry or afraid.

*Some people with mental health problems tend to overreact to emotionally-charged topics or conversations.* When this occurs, it is more likely that miscommunications will result. Important information should be conveyed in an objective manner, unless you know how the person is likely to react.

*Positive reinforcement and encouragement are very important tools for change for a person with mental illness.* These principles should be incorporated into conversations and activities.

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## **MENTAL RETARDATION**

Mental retardation affects approximately 1 to 2% of the population, involving slightly more males than females (DSM III R, 1988). It is defined as sub-average intellectual functioning to such a degree that it interferes with activities of daily living. A diagnosis of mental retardation only applies if the onset of the condition was before age 18. Also, the person must experience problems in daily living as a result of the condition. It has been estimated that there are over 200 causes for mental retardation ranging from genetic disorders to environmental pollution.

There are four levels of mental retardation-- mild, moderate, severe, and profound, with most diagnoses falling in the mild category. Typically, an I.Q. score of 70 or below is indicative of mental retardation.

Mental retardation is often referred to as a developmental disability. The federal definition of a developmental disability is a severe, chronic disability of a person which:

- is attributable to a mental or physical impairment or combination of physical & mental impairments;
- is manifested before the person attains age 22;
- is likely to continue indefinitely;
- results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self direction, capacity for independent living, and economic self-sufficiency; and
- reflects the person's need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated.

This definition is interpreted differently at the state level. Disabilities such as brain injury, autism, cerebral palsy, and other neurological impairments may be included.

The degree to which a person with mental retardation adapts into society depends a great deal on early identification, family support, and appropriate education. Most people with mental retardation can function in jobs and live independently if appropriate educational and support services are available.

**The Implications of Alcohol and Other Drug Use**

People with mental retardation, as a group, do not appear to use alcohol or other drugs as frequently as the general population. However, when people with mental retardation use alcohol or other drugs, problems may occur more quickly than for nondisabled peers. Limited social skills are a major reason that problems from use are likely, even with moderate levels of consumption.

One high risk group is people with mental retardation who come from a family where heavy alcohol or drug use is normal. In these situations, it is not uncommon for the family member with mental retardation to encounter serious problems from use while still a teen (Westermeyer, et al., 1988).

Living with family members who abuse alcohol or other drugs is especially risky for a person with mental retardation. In those cases, problems are more likely to result even if the person with mental retardation uses less than other members of the household (Westermeyer, et al., 1988). People transitioning into independent living, after being sheltered by family or agencies, also are at risk for alcohol abuse (Edgerton, 1986). The problems in these cases can include difficulties with employment, family, and police.

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**A FACT...**

A major health concern at the present time relates to the number of alcohol or other drug-affected babies that are born each year--many of these children will experience some level of cognitive impairment. It is estimated that as many as 375,000 babies are born each year in the United States with problems related to alcohol and other drug abuse, according to the National Association on Perinatal Addiction Research and Education. This represents a major educational and social service challenge which will face this country for many years to come.

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Another risk factor involves use of prescribed medications in combination with alcohol. Many people with mental retardation take strong medications, including anti-convulsant drugs. Many of these people are unaware of the side effects when used with alcohol (DiNitto and Krishef, 1984).

Alcohol and other drug abuse prevention efforts should include information specific to the person's disability. For example, the following points might be emphasized in discussions with a person with mental retardation:

- Alcohol and other drugs can interfere with learning and developing social skills, decreasing a person's ability to be independent.
- If a person with mental retardation is living in a supervised living situation or group home, there are probably very specific rules about use of alcohol and other drugs. Even small amounts of alcohol can be harmful in combination with prescription drugs.
- There is a difference between taking medication and using alcohol and other drugs to deal with emotions and difficult situations.

=====

#### **Suggestions to Improve Positive Interactions**

*Break down concepts into small, easy to understand components.* Use concrete terms and avoid abstract ideas. Do not be afraid to explain concepts in logical steps in sessions that may be separated by hours or days.

*Because of its social desirability, it is possible for a person with mental retardation to insist that he or she understands a concept when this is not true.* When discussing or teaching a point, be certain that the person understands the concepts involved.

*Avoid the tendency to talk around or about a person with mental retardation when that person is present.* Direct questions or comments to that person, and allow him or her to seek assistance in answering if necessary.

*If the communication deficits are significant, it may be helpful to involve an advocate in conjunction with the person with mental retardation.* The advocate, someone who is familiar with the lifestyle and communication patterns of this person, can be of assistance in facilitating conversation or planning for needed services.

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## **MOBILITY LIMITATIONS**

A broad range of disabilities have the effect of restricting independent movement or travel. Problems with mobility may result from spinal cord injury, arthritis, muscular dystrophy, cerebral palsy, amputation, polio, stroke, breathing or stamina limitations, or other conditions. Over an estimated 25 million people have mobility problems, which may take the form of paralysis, muscle weakness, nerve damage, stiffness of the joints, or lack of balance or coordination. One million of these people are wheelchair users. Orthopedic impairments and arthritis affect 9.2 million people and rank as the top causes of activity limitations.

### The Implications of Alcohol and Other Drug Use

The risk for alcohol and other drug-related problems among people with mobility limitations generally is higher than for the population at large. The specific prevalence of alcohol and other drug abuse problems varies according to the nature and origin of the disability. One subgroup of concern involves people with traumatic injuries, such as spinal cord injury. Approximately one half or more of all spinal cord injuries occur following alcohol or other drug consumption (Heinemann, et al., 1988).

Another group at high risk are those people who experience chronic pain or muscle spasms (Moore and Polsgrove, 1991). It is not unusual for people with these conditions to receive a number of simultaneous prescriptions. Even small amounts of alcohol can be harmful in combination with prescription drugs, and these dangers often are not apparent to the consumer or others. Relying on drugs as a primary means of coping with pain increases the likelihood that chemical coping will be perceived as the best way to deal with physical and emotional pain as well (Krupp, 1968).

Societal attitudes sometimes include the belief that people with mobility limitations are "entitled" to use alcohol and other drugs in order to cope with isolation, pain, or social problems (Moore and Ford, 1991). Unfortunately, once alcohol and other drug abuse becomes a problem, it is difficult to identify and treat because professionals and family focus on the disability, not the alcohol or other drug problem.

Alcohol and other drug abuse prevention efforts should include information specific to the person's disability. For example, the following points might be emphasized in discussions with a person with mobility limitations:

- For someone with serious mobility limitations, even moderate alcohol use increases risk for medical complications, accidents, and occupational difficulties.
- Alcohol and other drug use can interfere with motor coordination and muscle control, making certain tasks even more difficult to accomplish.
- Even small amounts of alcohol can be harmful in combination with prescription drugs.

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### Suggestions to Improve Positive Interactions

*If the person appears to have little grasping ability, do not be afraid to try to shake hands.* This is a traditional part of business etiquette, and signals that you are giving equal consideration. It is important to allow the person with a disability to guide you. He or she will have developed ways to handle almost all common social situations.

*Do not hold on to a person's wheelchair.* It is part of the person's body space and is both inappropriate and dangerous.

*Talk directly to the person using a wheelchair, not to an attendant or third party.* The person is not helpless or unable to talk.

*If conversation becomes protracted, consider sitting down in order to share eye level.* This not only is more respectful, but it may be more comfortable for both parties.

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## TRAUMATIC BRAIN INJURY

Traumatic brain injury refers to damage to the brain caused by external mechanical forces applied to the head. The traumatic brain injury (TBI) is acquired suddenly in the course of normal development. It typically results in brain damage which is diffuse or widespread; it is not usually confined to one area of the brain. Thus, impairments are multiple and many aspects of life are changed.

Someone receives a traumatic brain injury every 15 seconds in the United States. Over 2 million injuries occur per year with 500,000 severe enough to require hospital admission. Between 75,000--100,000 people die each year from a traumatic brain injury, which is also the leading killer and cause for disability in children and young adults. The economic costs alone approach \$25 billion per year, and astronomical medical and legal bills often leave families in financial ruin.

Among those who survive, 90,000 people will be severely and permanently disabled. They will experience deficits in physical, psychosocial, intellectual, cognitive, vocational, educational, recreational, and independent living skills. These deficits will vary in intensity over time, and will interact in ways unpredictable and unique. These interactions require extremely complex management and rehabilitation methods.

### **The Implications of Alcohol and Other Drug Use**

Alcohol abuse has been associated with TBI in over half of all occurrences. It appears to be related in many cases with lifestyles where alcohol and other drug abuse and risk taking are common (Sparadeo, et al., 1990). If the disability is a direct result of alcohol or other drug use, or if it predates the disability, the chances are greater that the problems will continue following rehabilitation. The continued abuse of alcohol and other drugs can negate attempts at physical, social, and cognitive rehabilitation.

Specialized alcohol and other drug abuse treatment often is necessary for people with traumatic brain injury. TBI's can include lasting memory and cognitive difficulties, and alcohol and other drug abuse treatment needs should be addressed by taking learning styles and capacities into consideration. Medical care for TBI is costly, and it is not uncommon to exhaust financial resources before the person can access appropriate alcohol and other drug abuse treatment.

Alcohol and other drug abuse prevention might best be approached by emphasizing the effects of alcohol and other drug use upon the damaged brain and a person's recovery from TBI. For example, the following points might be emphasized in the discussion with a person with TBI:

- The disinhibiting effects of alcohol are not helpful when disinhibition itself is a social problem for many persons with TBI.
- The depressant effects of alcohol and many other drugs are not helpful when proneness to major reactive depressive episodes are so common among person recovering from TBI.
- The effects of alcohol and other drugs may interfere with medications designed to prevent seizure episodes. They also may lower the seizure threshold.
- It is highly undesirable to exacerbate deficits in planning, verbal fluency, motor control, concentration, attention, memory, and information procession speed, which are already problems in recovering from TBI.

=====

**Suggestions to Improve Positive Interactions**

*People with TBI may digress or change course during a conversation. Redirect them using appropriate cues and reinforcers.*

*Teach prevention skills to the person with TBI in more than one setting to maximize generalization. Focus on a specific prevention goal.*

*Be redundant. Never assume understanding or memory from a previous session. Always repeat the purpose, duration, and guidelines for each meeting. Summarize previous progress and then restate where the previous meeting left off.*

*It must be understood that because the consequences of TBI are so psychologically overwhelming, most persons experience pervasive denial. This is perfectly normal. The timing and method of confrontation about deficits, including alcohol and other drug problems, should be carefully coordinated with the interdisciplinary TBI treatment team and case manager.*

*Present educational points in the most effective cognitive and sensory mode. This information is best obtained from a TBI team member known as the Cognitive Specialist.*

*All interventions should be directive in nature, short term, goal directed, and behaviorally anchored.*

*Severe brain injuries are typically so devastating to the family system that many family members "leave the field" when they come to appreciate what has occurred. Social isolation is common for people with TBI. The family system must be assessed and reassessed as it will fluctuate markedly in the first four years following TBI.*

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## TEST YOUR KNOWLEDGE ABOUT AMERICANS WITH DISABILITIES

The following questions are based on the information contained in the Chapter you have just read. The answers are found in Appendix G.

1. A person with a disability generally has at least equal access to alcohol or other drugs.

TRUE FALSE

2. The American's With Disabilities Act (ADA) states that employers will have to provide \_\_\_\_\_ on the job for persons with disabilities.

3. Alcohol and other drug use can place a person with a disability at risk for \_\_\_\_\_ disabilities.

4. Developmental disabilities manifest before the age of \_\_\_\_\_.

5. Even small amounts of alcohol when combined with prescribed medications can be harmful.

TRUE FALSE

6. Recurring alcohol and other drug problems affect approximately how many persons with mental illness?

a. 20%      b. 30%  
c. 50%      d. 60%

7. Most persons with physical impairments need medication in order to cope with the side-effects of their disability.

TRUE FALSE

8. Learning disabilities and related problems disappear as a person becomes an adult.

TRUE FALSE

9. Persons with disabilities who drink alcohol in combination with medications may experience a heightened alcohol effect after only one or two drinks.

TRUE FALSE

10. Substance abuse prevention materials for persons with deafness should take into account which of the following?

a. cultural issues      b. the stigma of substance abuse in the deaf community  
c. language differences      d. all of the above

11. Among the leading causes of mental retardation, \_\_\_\_\_ is the most preventable.

12. Some professionals have difficulty identifying substance abuse in persons with disabilities because some behaviors associated with substance abuse can also be contributed to the disability.

TRUE FALSE

# ALCOHOL AND OTHER DRUG ABUSE PREVENTION AND DISABILITY ORDERING INFORMATION

**T**hese materials were developed by the Resource Center on Substance Abuse Prevention and Disability. It was written for those working in the field of alcohol and other drug abuse services, as well as for those involved in the disability and rehabilitation fields. It reflects information available at the time of its printing, December 1991. To order, please check the box which corresponds to the fact sheet you are interested in receiving and complete the information on the back.

- An Overview of Alcohol and Other Drug Abuse Prevention and Disability**  
Provides information regarding the relationship between disabilities and the risk for alcohol and other drug problems. Includes examples of the risk factors. (8 pages)
- A Look at Alcohol and Other Drug Abuse Prevention and... Americans with Disabilities**  
Reviews the Americans with Disabilities Act of 1990 and its impact on alcohol and other drug services. Provides information on architectural and communication barriers, as well as discrimination and other barriers and suggestions to improve access and positive interactions. Resource organizations and agencies to contact for more information are provided. (8 pages)
- A Look at Alcohol and Other Drug Abuse Prevention and... Attention Deficit Disorder**  
Provides information on attention deficit disorder. Describes the implications of alcohol and other drug abuse for a person with attention deficit disorder with suggestions to improve access and positive interactions. A resource organization and a government agency to contact for more information are provided. (4 pages)
- A Look at Alcohol and Other Drug Abuse Prevention and... Blindness and Visual Impairments**  
Provides information on blindness and visual impairments. Describes the implications of alcohol and other drug abuse for a person who is blind or has a visual impairment with suggestions to improve access and positive interactions. Resource organizations and a government agency to contact for more information are provided. (4 pages)
- A Look at Alcohol and Other Drug Abuse Prevention and... Deafness and Hearing Loss**  
Provides information on deafness and hearing loss. Describes the implications of alcohol and other drug abuse for a person who is deaf or has a hearing loss with suggestions to improve access and positive interactions. Resource organizations and a government agency to contact for more information are provided. (8 pages)
- A Look at Alcohol and Other Drug Abuse Prevention and... Hidden Disabilities**  
Provides information on hidden disabilities. Describes the implications of alcohol and other drug abuse for a person with a hidden disability with suggestions to improve access and positive interactions. Resource organizations and government agencies to contact for more information are provided. (4 pages)
- A Look at Alcohol and Other Drug Abuse Prevention and... Learning Disabilities**  
Provides information on learning disabilities. Describes the implications of alcohol and other drug abuse for a person with a learning disability with suggestions to improve access and positive interactions. Resource organizations and a government agency to contact for more information are provided. (4 pages)
- A Look at Alcohol and Other Drug Abuse Prevention and... Mental Illness**  
Provides information on mental illness. Describes the implications of alcohol and other drug abuse for a person with a mental illness with suggestions to improve access and positive interactions. Resource organizations and government agencies to contact for more information are provided. (4 pages)

(Over)

# RESOURCE CENTER ON SUBSTANCE ABUSE PREVENTION AND DISABILITY

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- A Look At Alcohol and Other Drug Abuse Prevention and... Mental Retardation**  
Provides information on mental retardation. Describes the implications of alcohol and other drug abuse for a person with mental retardation with suggestions to improve access and positive interactions. Resource organizations and government agencies to contact for more information are provided. (6 pages)
- A Look At Alcohol and Other Drug Abuse Prevention and... Disability and Family**  
Addresses the impact on the family when a family member has a disability and how the issues are compounded when that person is abusing alcohol or other drugs. Provides guidelines and resources for the family. (4 pages)
- A Look At Alcohol and Other Drug Abuse Prevention and... Mobility Limitations**  
Provides information on mobility limitations. Describes the implications of alcohol and other drug abuse for a person with mobility limitations with suggestions to improve access and positive interactions. Resource organizations and government agencies to contact for more information are provided. (6 pages)
- A Look At Alcohol and Other Drug Abuse Prevention and... Disability and Health Implications**  
Discusses the health and medical implications associated with alcohol and other drug abuse and disability. Provides resources to develop knowledge and skills in addressing these issues, for those in the health, medical and rehabilitation fields. (4 pages)
- A Look At Alcohol and Other Drug Abuse Prevention and... Traumatic Brain Injury**  
Provides information on traumatic brain injury. Describes the implications of alcohol and other drug abuse for a person with a traumatic brain injury with suggestions to improve access and positive interactions. Resource organizations and a government agency to contact for more information are provided. (4 pages)
- A Look At Alcohol and Other Drug Abuse Prevention and... Service Delivery Settings**  
Discusses a component for addressing alcohol and other drug abuse within an organization or agency, the existence of a written policy regarding these issues. Includes components of an agency policy and an example of a contract used in a supported employment program. (2 pages)
- A Look At Alcohol and Other Drug Abuse Prevention and... Disability and Enabling**  
Discusses the concept of the term enabling as used in the alcohol and other drug field and in disability advocacy. Also reviews some of the reasons people will enable others, specifically people with disabilities, to continue to use alcohol and other drugs. Provides resource and reference information on addressing the issue of enabling. (4 pages)
- A Look At Alcohol and Other Drug Abuse Prevention and... Symptoms Checklist**  
Provides questions which can assist with a general screening for alcohol and other drug abuse problems among people with disabilities. (2 pages)

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**CHAPTER THREE**

**PREVENTING SUBSTANCE USE/ABUSE  
IN PERSONS WITH DISABILITIES**

## START HERE

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## **SUBSTANCE USE/ABUSE PREVENTION AMONG PERSONS WITH DISABILITIES**

Substance abuse prevention is a systematic and comprehensive approach toward reducing risks for alcohol or other drug problems. The current trend in substance abuse prevention is a multimodal approach consisting of a variety of strategies. The primary means of preventing alcohol and other drug use has been and still is through educational settings and school based programs. However, prevention efforts are becoming more sophisticated and designed more prescriptively for special populations and age groups.

Prevention is taking action beforehand to reduce the number of persons who begin to use alcohol and other drugs. For example, school systems may employ prevention specialists who provide educational activities in order to assist youth in developing healthy alternatives to using drugs. Intervention, on the other hand, reduces the severity of consequences in persons who have already begun to use and halts the progression of substance abuse problems. Both are prevention activities. If a youth has been using alcohol or other drugs on a regular basis, prevention education is not enough. This young person will need to be intervened with in order to halt the use of substances. The premise of both intervention and prevention is that a person does not need to "hit bottom" or suffer numerous consequences before the use of substances is halted. A person's use of substances and the consequences relating to substance abuse, can be interrupted at any time.

Current trends in prevention activities include community-based, multi-faceted approaches. Families, local law enforcement agencies, schools, churches, the media, and other community entities are joining forces to discourage the use of alcohol and other drugs, particularly by minors. The goals of many prevention programs include teaching abstinence by choice, increasing knowledge about alcohol and other drugs, promoting healthy lifestyles, promoting self-esteem, delaying the onset of use, and decreasing high risk use.

This chapter is not intended to be a comprehensive prevention guide for persons with disabilities, but rather a guide for discussing and formulating prevention activities individualized according to the unique aspects of the setting and the clientele. The contents of this chapter are as follows:

I. Substance Use/Abuse Prevention for Persons With Disabilities.....	2
II. What Can You Do? Prevention Approaches Which Apply to Persons with Disabilities.....	8
III. Adolescents with Disabilities: A Special Prevention Consideration.....	10
IV. Symptoms of Substance Abuse by Adolescents With Disabilities.....	13
V. Chart: Prevention Issues For Persons With Disabilities.....	15
VI. Why General Prevention Efforts Have Not Worked For Persons With Disabilities.....	17
VII. Personal Story: "Paul".....	18
VIII. Comments On Paul's Story.....	20
IX. Test Your Knowledge.....	21

## SUBSTANCE USE/ABUSE PREVENTION FOR PERSONS WITH DISABILITIES

The number of school aged children who use alcohol and other drugs is on the decline according to national statistics. However, it is unclear if this is the case for youth with disabilities. Although prevention programs for youth have made an impact on the number of persons experimenting with alcohol and other drugs, these programs are not accessible for youth with disabilities. This is in spite of recent research indicating that the alcohol and other drug use rates for some disability groups exceed those of the general population.

For some persons with disabilities the use of even small amounts of alcohol or other drugs can create a high risk situation and is considered abusive. Medications, compromised health, poor balance, or impaired judgment may mean that a person with a disability is at higher risk when that person chooses to consume alcohol or other drugs.

Substance abuse prevention is particularly important in special education settings. For these youth, the prevention focus should be on precursors of substance abuse which often accompany the disability (i.e., poor school performance, lowered self-esteem, limited social outlets, vulnerability to peer influences, and lack of knowledge about drug effects and consequences). Drug prevention approaches for youth with disabilities should be comprehensive and should begin early. Persons with some disabilities, such as Attention Deficit Disorder or Learning Disability tend to experiment with and incur consequences from drug use at an early age.

=====  
*Great gains have been made in the addiction field, but people with major life-limiting impairments continue to be undertreated and undercounted...the challenges of making treatment and prevention accessible and responsive to people with physical impairments is a challenge that faces us all.*

Alexander Boros, Ph.D., Director  
Project AID, Kent State University

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### Risk Factors

A number of risks need to be addressed in order to make prevention efforts more successful for persons with disabilities. These prevention needs create a special challenge to rehabilitation and AOD prevention professionals because they have not been trained to address these special issues. Some of these risks are listed below and addressed at greater lengths in other *Training Manual* chapters:

Adjustment to disability	Chronic pain
Peer pressure	Recurring medical problems
Work/school problems	Isolation
Excess free time	Transportation difficulties
Attention/learning difficulties	Long term medication use
Age and circumstances of disability onset	

A number of prevention approaches are needed for persons with disabilities and their families. A major prevention effort is needed in the area of improving societal attitudes. In the past, the general population has tended to believe that a person with a disability is less able to lead a productive and useful life. Because of this, persons with disabilities may be sheltered from the consequences of their behaviors--including their use of

alcohol and other drugs. It is difficult to imagine that persons with disabilities have access to environments where alcohol and other drugs are available. In fact, persons with disabilities often have ready access to some medications and equal access to other substances.

**Entitlement**

The concept of "entitlement" also allows persons with disabilities to avoid the consequences of substance abuse (Moore, 1990). It is a concept which exceeds the realm of "enabling" alcohol and other drug use. Entitlement is believing that persons with disabilities have more of a right to use because of the disability. Family members, friends, and even professional staff inadvertently may "enable" the use of alcohol and other drugs even though they may not approve of these behaviors in general. Whenever possible, family members and professionals involved directly with the consumer should be included in prevention activities. Without education and information about substance abuse and disability, significant others will continue to enable the alcohol and other drug use of consumers. In contrast to the perception of others, persons with disabilities do not tend to feel more entitled to use alcohol or other drugs because of the disability (Moore & Siegal, 1989).

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*With the onset of a disability, it's a whole new set of tools to manipulate people into enabling the chemical use. It's a way of manipulating doctors into prescribing mood altering chemicals. It's a way of manipulating families into allowing chemical use. For example, prior to the onset of my disability, my mother did not believe in anybody smoking pot. After the onset of my disability, it got to the point where she was willing to go and buy it for me. She saw it as a way for me to at least socialize. That's the kind of crazy compromises of values that people are willing to go through because of a disability.*  
"Frank", a recovering alcoholic with a physical disability  
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A related societal attitude is the mistaken perception that medication can help alleviate the consequences of a disability in the same way that illnesses are treated. This attitude focuses on the need for medications as part of the maintenance of the disability. For example, persons with disabilities may seek reassurance from their physicians, and it becomes easy for medication to be the means of support--both for the patient and for the physician. At times, physicians may prescribe unnecessary medications or over-prescribe medications in order to avoid conflict or to alleviate their guilt over not being able to "cure" the disability. Not only should the consumer receive information specific to his disability and substance abuse, but medical professionals can be targeted for additional information about the high risk nature of persons with disabilities.

**A Systems Approach Needed**

In addition to addressing societal attitudes, a multiple systems approach to prevention should be adopted. In addition to persons with disabilities, families, policy makers, community leaders, the business community, and other significant parties must be included in prevention efforts. Prevention activities can include: multi-agency trainings or staffings, providing accurate information about drug effects, training policy makers and community leaders, involving the media in information dissemination, creating positive alternatives to alcohol and other drug use within the community, and instituting policies relating to substance use and abuse within the community (i.e., school policies, workplace policies, policies relating to legal consequences for AOD related crimes, etc.).

Disability awareness activities to educate key community leaders, as well as the community in general, to the special risks for substance abuse related problems for persons with disabilities are a vital part of this systems approach. Workshops on the implica-

tions and realities of the Americans with Disabilities Act (A.D.A.)--especially on AOD prevention and treatment providers--also are important. Prevention efforts should target all youth and all persons in the community, including persons with disabilities. Some disability groups, such as persons with learning disabilities and persons with mental illnesses, have recently been targeted for prevention efforts; however, all disability groups must be included in prevention efforts in the same way that all youth must be included in prevention efforts--not just those youth considered to be at the highest risk.

### **Cultural Relevance**

The saliency of prevention information is crucial to the success of any efforts. A challenge for prevention specialists will be to find or develop materials which are both sensitive to persons with disabilities and focus on the special risks which might be experienced. Risks vary by type and degree of disability by gender and race, although the disability may be the most significant factor. In a study of college students with disabilities, those with trauma-generated disabilities were more prone to medication abuse, regular heavy drinking, and use of a greater variety of illicit drugs than students with congenital disabilities (Moore & Siegal, 1989). Due to "cultural" differences between persons with congenital disabilities and persons with trauma-generated disabilities, prevention approaches need to consider these differences.

Minorities and women with disabilities often experience different risks for substance abuse. Women with disabilities tend to experience greater social isolation and occupational impairment than do their male counterparts (LaPlante, 1985). These same persons often lack prevention materials which address their cultural and lifestyle differences.

Disabilities occur more frequently among the poor and minorities (La Plante, 1985). There presently is very little research to indicate the types of modifications appropriate for addressing disability issues among these various sub-groups. In the past, there have been few incentives in the form of increased services to warrant a disability label among persons in minority groups. As a result, the incidence and prevalence of disabilities are not as well understood. We do know that health problems such as heart disease occur more frequently among African Americans and Native Americans than Caucasians (D.H.H.S., 1985).

The distribution of disability etiologies, both genetic and traumatic, vary with race or ethnic origin. For example, disabilities related to hypothermia, pedestrian/ auto accidents, and unintentional injury appear to be elevated for Native Americans living on reservations (D.H.H.S., 1990). Disability origins relating to violent crime disproportionately occur among African Americans.

A disability may also bring with it membership in another form of "culture". This disability-related culture may in fact have a more pervasive impact on an individual's life than does one's ethnic or racial origin. Disabilities which serve to disenfranchise or isolate people from the mainstream can be a focus point in the formation of "sub-cultures". One of the disabilities most associated with a distinct sub-culture is deafness. Persons with deafness experience a culture very different from the general hearing culture. Prevention materials for this population need to be sensitive to language variables and will need to be specialized in order to avoid translation difficulties. For instance, American Sign Language (ASL) in the past has not had one sign which designated sobriety. Abstract concepts such as this are not easily translated into sign language. Prevention messages and materials may be best developed by persons with working experience and knowledge of deaf culture and sign language.

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*Many professionals insist on speaking English when "communicating" with the linguistically and culturally Deaf. When two cultures do not speak the same language, miscommunication will occur and the level of mistrust increases. The key to developing trust generally within the deaf culture and specifically when working with the Deaf substance abuser, is to familiarize oneself with the semantics and syntax of the language of the Deaf: American Sign Language, which is an ideographic language. The delivery style of ASL is very pictorial and less symbolic than English. In contrast, the message being given out by Alcoholics Anonymous or by treatment centers is often very symbolic. With this linguistic gap, it is easy to see why it is difficult to communicate symbolic messages to a culture which utilizes an ideographic language.*

Jean Modry, Project Director  
SA & AIDS Prevention Program for Hearing Impaired

### **Making Materials Accessible**

Educational materials must capture the interest of persons with disabilities, be at an appropriate reading level, utilize language which is sensitive and culturally specific, and have examples with realistic social contexts. A person with a learning disability, mental retardation, or deafness may read at a low level, but that does not mean that this person is functioning at that level. Graphics, audio-visual materials, and role play activities can be sensitive to persons with disabilities by including situations, places, and things which they are able to identify with. In addition, the prevention curriculum should take into account that persons learn differently. A variety of learning modalities could be considered. For example, educational activities can include videotape, slides, role play activities, and peer interaction to reinforce key points.

The challenge for the educator or prevention specialist is to utilize materials which are both engrossing and carefully-paced to account for various learning styles. As mentioned above, a session can be videotaped and played back in conjunction with a review of homework assignments. If the attendees exhibit impulse control issues, sitting for long periods of time or staying focused on a single source of information may be difficult. Shorter sessions that are very structured will be more successful.

### **Specific Prevention Strategies**

When thinking about prevention strategies for persons with disabilities, the focus should be on individuals, families, groups, and agencies. Professional cross-training in the areas of substance abuse and disability is crucial and needs to be a primary prevention activity. The other most common approaches to prevention for persons with disabilities are personal empowerment and health promotion. There are various means of promoting healthy lifestyles including empowering persons with disabilities to make informed decisions.

A variety of prevention strategies are appropriate to consider for persons with disabilities. These strategies may vary depending on the particular disability because, although some disability characteristics are similar, the specific substance abuse risks can be different. The following are some strategies which can be utilized with persons with disabilities:

- *disability-specific support groups*: Support groups have been shown to be particularly effective for addressing a number of issues faced by people with disabilities. Within this supportive setting, the specialized problems associated with disability management and lifestyle choices can be explored. Substance abuse issues can be addressed within a disability-oriented context, allowing for a more realistic development of coping strategies which are practical.

- *education about medications:* Consumers, pharmacists, physicians, and nurses can be valuable sources of information about how medications interact with alcohol and other drugs. The long term effects of prescribed medication management can also be discussed.
- *decision-making/self-esteem training:* Current mainstream prevention materials often focus on this area. Some of these materials can be adapted or offered in different learning modalities for persons with disabilities. Included in this component should be issues associated with accessing the community in the context of a disability.
- *substance abuse screenings for behavior problems and traumas:* When a person with a disability has experienced an injury, conduct a screening session to determine if that person has problems involving alcohol or other drugs. Be sure to ask about use of alcohol or other drugs the day of the injury since many traumatic brain injuries, spinal cord injuries, and other traumas are directly related to drug use. This same screening can be used for consumers exhibiting behavior problems. If a consumer reports late to work, misses scheduled sessions, has legal trouble, or other behavior issues, conduct a substance abuse screening immediately.
- *consequence based interventions:* It is not enough to simply identify that the use of substances is creating problems for a consumer. Behavioral consequences which can and will be consistently reinforced must be explained to the person with a disability. The consequences should be progressive in nature and may include terminating or limiting services if substance abuse continues.
- *alternatives to substance abuse/resistance skills training:* Provide training in socialization skills which do not rely on alcohol or other drug use. Persons with much idle time and limited social outlets may begin drinking at home due to a lack of alternatives.
- *include substance abuse prevention goals in rehabilitation plans:* If substance abuse is a specific concern, attending support groups or self-help groups can be required. Attendance and participation in prevention education and socialization activities can be written into the rehabilitation plan for all clientele with disabilities.
- *explore options to medication for chronic pain or muscle spasms:* Not everyone with chronic pain or muscle spasms will be helped with medications. In fact, the person may have less pain when the medications are discontinued. Contact the consumer's physician, physical therapist, or other medical professional to discuss concerns about the added risk for substance abuse and to determine if other options may work.
- *professional and family education:* The family plays an especially influential role in the life of many persons with disabilities. Often persons working with or close to persons with disabilities are unaware of the risks for substance abuse associated with disability. These persons inadvertently enable the continued use of alcohol and other drugs by persons with disabilities. Whenever possible, these persons should be actively involved in the prevention process.

### Conclusion

In the past decade, a number of advances have been made in substance abuse prevention research. In order for these efforts to result in long term success for persons with disabilities, a variety of resources and linkages need to be identified and developed. Efforts must be specific to each targeted population and the associated population risks. For example, the risks associated with Attention Deficit Disorder (ADD) and Cerebral Palsy (CP) are similar, but the relative importance of the individual risk factors can vary greatly. The individual with ADD may have greater contact with non-disabled peers, but possess less developed resistance or assertiveness skills. Whereas the person with CP may be most challenged by isolation and excess free time. This individual also may have had

fewer opportunities to learn about the social contexts of alcohol use, which increases the risk for negative consequences should that person choose to drink at all. (It would be prejudicial and inappropriate to deny someone the right to drink simply because an individual experiences a disability.) Substance abuse prevention materials also must be sensitive to real world problems and situations experienced by persons with disabilities.

Successful prevention programs should be comprised of a partnership between concerned people with disabilities and their professional advocates or service providers. Professional education is an essential component in settings providing services to persons with disabilities. Local networking of systems also is an integral part of prevention programming. Since substance abuse is multi-causal in nature, a multi-disciplinary, multi-cultural, community-based team approach is the best solution to substance abuse and disability issues.

## WHAT CAN YOU DO?

### PREVENTION APPROACHES WHICH APPLY TO PERSONS WITH DISABILITIES

**I. Procedures for all Consumers:** These approaches have the goal of reducing the number of persons developing substance abuse problems by discouraging any use. They target persons with disabilities who have not yet begun to use alcohol or other non-medical drugs.

**A. Information and Education For Consumers:** Information about alcohol and other drugs can be presented during intake and/orientation. The information should contain a description of the risks associated with the use of substances for persons with disabilities. Agency policies and procedures relating to the use of substances should be covered both verbally and in written form. Other modalities for disseminating the information should be explored as well, such as an orientation videotape made by agency staff. All persons with disabilities should be made aware of the consequences for violating substance use/abuse policies.

**B. Professional and Parental Education:** Sensitization information and drug-free work place policies should be incorporated into staff orientation training sessions (including paraprofessionals, support staff, and volunteers). Parents and significant others can be provided with written information, including the agency's substance abuse policies. When practical, parents or significant others can be involved in staffings and conferences, especially when substance misuse is a concern.

**C. Health Promotion:** Integrate education and prevention messages into the larger issue of health promotion (such as cardiovascular fitness messages for wheelchair users and the role of exercise as it relates to employment). Another health promotion activity involves AIDS education coupled with substance abuse prevention information.

Information about, and encouragement in, self-advocacy is very important in this area. Ownership of one's health is very important for this prevention perspective. Health promotion techniques involve investigating options for behavior and a sound understanding of the barriers which discourage healthy behavior. Within this context, health promotion does not involve "scare" tactics as much as an objective evaluation of behavioral options and their respective logical consequences. Specific behavioral examples, as presented by people with disabilities, can be of great assistance in the educational process.

**D. Self-Esteem/Assertiveness Training:** This is a primary component of many commercially available prevention programs. These materials can be adapted for persons with disabilities. Adjustment to disability issues need to be addressed in this component. Special support groups for the newly disabled and for persons with adjustment difficulties can address the substance abuse risks relating to disability.

**E. Alternatives To Alcohol And Other Drug Use:** Socialization alternatives which don't include alcohol or other drug use should be explored for persons with disabilities. Staff members can identify and support activities which are not centered around the use of substances. The agency itself may be in a position to sponsor socialization activities for persons with disabilities. Drug-free social clubs can be created. Recreational skills training can be included in existing curricula.

Sometimes these issues can be difficult to address. For example, what are the substance use policies of an adult residential facility going to be? Is it possible to devise policies which encourage responsible behavior but don't limit an individual's right to choose? Are there ways to encourage socialization with non-disabled peers that still acknowledge the special risks for substance abuse which may be an integral part of this normalization process?

**F. Alcohol And Drug Use Information Obtained From All Consumers:** Information about each consumer's use of substances should be obtained during initial intake sessions. Questionnaires and consumer history forms can include questions about current and past use of substances.

**II. Procedures for High-Risk Consumers:** These approaches focus on the early detection of substance use and abuse. They are restorative in nature and target persons with disabilities who are actively using alcohol or other drugs. These persons have experienced some consequences from their use of substances.

*A. Education On Medications:* Provide education about the risks associated with the use of alcohol or other drugs and medications. Information about the interactions between medications and alcohol must be accurate and presented in an understandable manner. Locate and cooperate with physicians and other medical personnel sensitive to disability issues.

*B. Selective Screening/Assessment:* Based on information received during initial intake interviews, consumers with identified risks and issues relating to substance abuse can be given additional education and therapeutic activities. Procedures for assessing consumers' substance abuse must be detailed in advance and be part of the agency's written procedures.

*C. Enforce Consequences For Substance Abuse Behaviors:* Consequences for substance abuse behaviors must be written into the agency's policies and procedures and known to agency consumers. The consequences for abuse should be related directly to the policies and be progressive in nature.

*D. Referral:* Establish referral mechanisms within the agency. Designate persons responsible for ensuring that these mechanisms are followed. Agreements between the agency and treatment centers, medical professionals, and counselors should be articulated.

**III. Procedures for Substance Abusing Consumers:** Prevention efforts involve intervention and treatment of substance abuse in its later stages. Persons in this population have experienced many consequences from their use. They've been unable or unwilling to make changes in their using patterns.

*A. Intervention:* Procedures need to be established for conducting interventions when they are necessary. One designated staff member should be responsible for ensuring that proper procedures are followed. This staff member acts as a liaison to other agencies if they are involved.

*B. Treatment:* Explore a wide variety of options. Some persons with disabilities will respond better to individual counseling or specialized programs while others may benefit from traditional services. Assist consumers in finding appropriate services. Offer to assist treatment personnel with the treatment plan--especially aftercare components.

*C. Support Groups:* Identify and/or establish local support groups which focus on substance abuse and disability. Assign a staff member to be responsible for coordinating the support groups.

*D. Establish Procedures For Limiting Services To Active Substance Abusers:* This technique may provide additional incentive for some persons with disabilities who are experiencing substance abuse issues to seek and follow through with treatment. Agency policies can include a component which states that repeated violations of policies can and will result in a reduction or suspension of services. Inform the agency consumer that repeated incidents of substance abuse are not conducive to the goals of rehabilitation programs. For example, persons with disabilities involved in vocational programs will find that the use of substances hinders their ability to obtain and maintain employment, and therefore it nullifies the services being delivered.

## **ADOLESCENTS WITH DISABILITIES: A SPECIAL PREVENTION CONSIDERATION**

One population of persons with disabilities who are at particular risk for developing substance abuse problems is adolescents. They are in particular need of specialized substance abuse prevention programs. Recent research has suggested that adolescents with disabilities are at higher risk for substance abuse problems than other populations (Prennergast, Austin, and deMiranda, 1990). The need for substance abuse prevention is substantial, as there are nearly five million children with disabilities in special education alone. This figure does not include youth who become disabled due to accidents and injuries in middle to late adolescence.

Every day, adolescents with disabilities face physical, societal, psychological, and cultural barriers that isolate them from other youth and threaten to limit their personal and educational potential. A number of adolescents with disabilities experience poor self-esteem, limited access to peer groups, chronic medical concerns, a reliance on prescriptive medications, and a high incidence of depression and related mental health problems -- all of which contribute to their risk for substance abuse problems.

Adolescents with disabilities use alcohol and other drugs not only for the same reasons as their peers, but also for reasons attributable to their disabilities. Medication to cope with chronic pain can be a precursor to alcohol and other drug use, and misuse of prescribed drugs represents a major risk factor for youth with disabilities. Low self-esteem (a pervasive problem among youth with disabilities) also correlates with a higher risk for alcohol and other drug use, and avoidance behavior may contribute to the use of alcohol and other drugs within this population (Higgins, et al., 1990). Peer pressure and social interactions create risks for drug use among the general population and particularly among youth; a disability may make AOD use more attractive as an available outlet for "fitting in." Adolescents with disabilities also face psychological problems far more frequently than their peers, an additional risk factor for alcohol and other drug use (Thurer et al., 1985).

Persons with disabilities, including adolescents, have ready access to prescribed medications, and in many cases, youth with disabilities in mainstream settings have access to illegal drugs as well. Adolescents in special education settings seeking non-disability peer group acceptance also may be offered alcohol or drugs by well-meaning, but poorly informed peers who do not appreciate the vulnerability for problems that some of these youth experience (Moore & Ford, 1991).

Medical and human services professionals can inadvertently encourage alcohol and other drug use among adolescents with disabilities. The contributors to this phenomenon can include doctors, counselors, parents, peers, and teachers (Moore, 1987; deMiranda, 1990). These individuals' feelings of sympathy, attempts to effect social mainstreaming, and overcompensating reactions to a disability all contribute to this situation. In some cases, this is further compounded by inappropriate or heavy use of prescribed medication by the person with a disability.

Environmental exposure and family history of substance abuse problems also contribute to the risks for substance abuse faced by adolescents with disabilities. According to the Children of Alcoholics Foundation, Inc., there are approximately seven million American children under the age of 18 who are children of alcoholics (COA). The problems these youth experience can be difficult to detect because their coping behaviors, such as high achievement, sensitiveness, and perfectionism often appear socially acceptable.

However, a substantial portion of the youth entering the juvenile justice system and mental health facilities are children of alcoholics. Many COA's experience learning disabilities, physical impairments, attention deficit disorder, and mental health and behavior problems (DSM-III-R, 1987; NIAAA, 1990). This subgroup of children of alcoholics often end up in special education settings. Another subgroup of COAs are those with Fetal Alcohol Syndrome or Fetal Alcohol Effects. According to Abel and Sokol (1986), maternal use of alcohol during pregnancy is one of the leading causes of Mental Retardation in the western world.

Possibly, the greatest risk factor for substance abuse problems among adolescents with disabilities is the low level of professional and public awareness of this issue. Persons with disabilities who abuse substances tend not to be identified or receive intervention services until the problems are very obvious. One contributing factor is that so few persons are familiar with both substance abuse and adolescents with disabilities. Therefore, consequences of substance abuse often are attributed to the disability, rather than the use of alcohol and other drugs.

For adolescents, some aspects of living with a disability may increase the risk for substance abuse. These may include biomedical, family, and societal factors such as the following:

- Fewer opportunities to develop and practice decision making skills
- Social isolation or unusual peer groups increases vulnerability to peer pressure
- Heavy use of alcohol or other drugs in the family
- The encouragement of use as a "normal" part of growing up
- Health problems make any use physically risky
- Medication magnifies alcohol's effect, making combinations dangerous
- Reactions to the disability may rationalize substance abuse among family members
- Lack of accessible and appropriate drug use prevention information

Appropriate prevention activities for adolescents with disabilities must take the above factors into account. Educators, counselors, family members, and medical personnel need to be aware of these issues and must be capable of addressing them. Prevention materials for adolescents with disabilities must be sensitive to learning styles and possible cognitive limitations. The materials should recognize that the usual adolescent risks must be addressed as well (e.g., media portrayals of alcohol use, ready access to drugs, peer pressure).

Prevention education for adolescents with disabilities should include sections on teaching youth with disabilities about the following: 1) peer pressure, 2) appropriate resistance skills, 3) the substance abuse risks specific to their disabilities, including the use of medications, 4) the law as it relates to the possession and use of illicit drugs, and 5) legal, social, developmental, family, and health consequences. Training models must be responsive to the areas of greatest risk for the adolescents with disabilities being served. For example, the onset of drug use by students in learning disability classes comes

from considerably different factors than does the onset by students in classes for children with mental retardation. Consequently, information must be relevant and individualized by disability if it is to be effective in preventing substance abuse.

Creating and implementing substance abuse prevention efforts for adolescents with disabilities are challenging, especially if support for such efforts is limited. Community, professional, and family education are crucial components. Although public education activities such as public service announcements, advertisements, billboards, and flyers can impact the knowledge and attitudes of communities, additional efforts will be necessary for prevention to be successful. Perhaps most importantly, each member of the community prevention team needs to be aware that experiencing a disability does not isolate an adolescent from substance abuse risk. In fact, the opposite may be the case.

## **SYMPTOMS OF SUBSTANCE ABUSE BY ADOLESCENTS WITH DISABILITIES**

Some of the symptoms included in this list may be a normal part of adolescence and developing independence; however, the number and severity of symptoms should be considered when there is a concern about substance abuse. If adolescents with disabilities are exhibiting several of these symptoms, a substance abuse assessment should be conducted by a professional trained in both substance abuse and adolescents with disabilities. Any time a parent or professional working with an adolescent with a disability suspects alcohol or other drug use, the problem areas must be explored and addressed.

### **SOCIAL**

- Changing several friends or changing peer groups
- Suddenly popular with friends who are older and unknown to family
- Becoming involved with peers when formerly isolated from peers
- More frequent phone calls
- Social activities occurring more often, sometimes at odd hours
- Engaging in thrill seeking behaviors evidenced by law breaking, promiscuity, and other dangerous physical situations

### **FAMILY**

- Using disability as a means for isolation from family members (hiding in room, locking bedroom door) and avoiding family activities
- Exhibiting negative attitude toward rules and parents
- Failing to follow through on promises
- Sneaking out of the house
- Blaming disability for negative behaviors
- Becoming manipulative
- Lying

### **SCHOOL**

- Lacking motivation and lower grades
- Sleeping in class
- Skipping class or school
- Blaming disability for poor performance in school or negative behaviors
- Dropping out of school activities
- Becoming disrespectful of teachers, administrators, and rules
- Frequently needing disciplined
- Suspended or expelled

## PHYSICAL

- Smelling of alcohol, marijuana or stale smoke
- Frequent minor illnesses (headaches, nausea, slight tremors, flu-like symptoms, vomiting, sluggishness)
- Neglects taking prescribed medications or takes more medications than usual
- Memory lapses
- Weight changes or unusual eating patterns (types of foods, amounts, time of day)
- Frequent use of eyedrops for bloodshot eyes
- Change in normal sleep patterns (more or less than usual, frequent naps)
- Injuries occurring more often
- Frequent infections or infections which don't heal
- More frequent complaints of pain or illness

## LEGAL

- Shoplifting or stealing from family members
- Unruly behaviors like skipping school and not following family rules
- Charges for Public Intoxication, DWI, Vandalism, Breaking and Entering, Underage Use (or these incidents occur but no charge is made)
- Involved in car accidents or near misses
- Selling drugs

## EMOTIONAL

- Impaired judgment (putting self in dangerous situations)
- Talking about or attempting suicide
- Violent or threatening (verbally or physically)
- Lethargic or apathetic
- Mood swings
- Blaming disability for all that goes wrong
- Burned out
- Operating at an inappropriate maturity level

## OTHER

- Poor management of money
- Spending large sums of money and asking for money
- Having drug paraphernalia in bedroom or school locker
- Reading drug oriented magazines
- Wearing drug oriented clothing and accessories
- Using drug slang, talking about drugs

It is important to remember that exploring independence, becoming self-involved, and focusing on peer groups are normal parts of adolescence. Some adolescents will exhibit one or more of these symptoms which may not be related to the use of alcohol or other drugs. However, if you suspect substance abuse in an adolescent with a disability, it is better to explore these symptoms further.

## PREVENTION ISSUES FOR PERSONS WITH DISABILITIES

Disability	Incidence/Prevalence	Specific SA Risks and Concerns	Prevention and Treatment Strategies	References
Mobility Impairment	<ul style="list-style-type: none"> <li>Over 10 million persons experience significant mobility impairment</li> <li>Prevalence of substance abuse greater than general population</li> <li>Approximately 1/2 of all spinal cord injuries occur while person has been using alcohol or other drugs</li> </ul>	<ul style="list-style-type: none"> <li>Accessibility of resources</li> <li>Continued AOD use affects outcome of rehabilitation</li> <li>Medication use</li> <li>Chronic pain</li> <li>Age of disability onset affects SA risk</li> <li>Recurring medical problems</li> <li>Adjustment to disability</li> </ul>	<ul style="list-style-type: none"> <li>Education about AOD and medications</li> <li>Help in coping with chronic pain</li> <li>SA screening for trauma related disabilities</li> <li>Professional education focusing on identification and treatment of SA</li> <li>Support groups</li> <li>Readjust definition of abuse re: medication and physical condition</li> </ul>	<ul style="list-style-type: none"> <li>Moore &amp; Siegal (1989)</li> <li>Nashel (1989)</li> <li>Heinemann et al. (1988)</li> </ul>
Attention Deficit Disorder	<ul style="list-style-type: none"> <li>ADD affects approximately 3% of children</li> <li>If ADD persists into later adolescence, conduct disorder and then SA may occur 50% of the time</li> </ul>	<ul style="list-style-type: none"> <li>Socially unaccepted behavior</li> <li>Effects of ADD may continue into adulthood</li> <li>Risk-taking behaviors</li> <li>Limited attention span</li> <li>Poor impulse control</li> <li>Use of medication</li> <li>Family of origin influences</li> </ul>	<ul style="list-style-type: none"> <li>Address and control anti-social behavior</li> <li>Screening for SA with behavior problems</li> <li>Respect and allow for attention limitations</li> <li>Adapt standard curricula with augmentations allowing for behaviors and attention problems</li> </ul>	<ul style="list-style-type: none"> <li>Loney (1988)</li> <li>Gittelman et al (1985)</li> <li>Hechtman et al. (1984)</li> <li>Kraner &amp; Loney (1982)</li> </ul>
Hidden Disability	<ul style="list-style-type: none"> <li>Variety of disabilities, including epilepsy, diabetes, cystic fibrosis, and many others</li> <li>Very little is known about substance use, which is likely to vary by condition</li> </ul>	<ul style="list-style-type: none"> <li>Unusual childhood experiences</li> <li>Over-protection</li> <li>Decreased tolerance for AOD</li> <li>Lowered self-esteem</li> <li>Medication use</li> <li>Chronic pain</li> <li>Medical relapses</li> <li>Not viewed as disabled, therefore sometimes unreasonable expectations are made</li> </ul>	<ul style="list-style-type: none"> <li>Education about medication risks</li> <li>Options for chronic pain</li> <li>Explore reasons for frequent hospitalizations</li> <li>Utilize consequence based intervention</li> <li>Support group for specific disability</li> <li>Rejust defintion of abuse re: medication and physical condition</li> </ul>	<ul style="list-style-type: none"> <li>Howell (1990)</li> <li>Simon (1988)</li> <li>Stern et al. (1987)</li> </ul>
Mental Retardation	<ul style="list-style-type: none"> <li>Affects between 1% and 2% of the population with approximately 85% of those affected being in the mild range</li> <li>Use of AOD is slightly less than the general population, but consequences occur more frequently and with greater severity for same amount consumed</li> </ul>	<ul style="list-style-type: none"> <li>Communication limitations</li> <li>Peer pressure or social isolation</li> <li>High risk when transitioning to independent living</li> <li>Limited social skills to limit consequences of use</li> <li>Medication use, including anticonvulsants</li> <li>Over protection by family</li> <li>Family of origin influences</li> </ul>	<ul style="list-style-type: none"> <li>Provide basic education about AOD risks and consequences for use</li> <li>Consequence based approach may be best</li> <li>Mainstreaming into prevention/treatment may not be appropriate for all</li> <li>Support group specific to MR</li> <li>Alternatives to use must be explored</li> <li>Family interventions</li> </ul>	<ul style="list-style-type: none"> <li>Westermeyer et al. (1988)</li> <li>Edgerton (1986)</li> <li>DiNitto &amp; Krishef (1983-84)</li> </ul>
Traumatic Brain Injury	<ul style="list-style-type: none"> <li>An estimated 2 million persons experience head injuries each year</li> <li>Alcohol abuse is believed to be related to one-half or more of traumatic brain injuries</li> </ul>	<ul style="list-style-type: none"> <li>Memory and cognitive difficulties</li> <li>Adjustment to disability</li> <li>Disability onset may be related to SA</li> <li>Continued AOD use affects outcome of rehabilitation</li> <li>Lifestyle and previous use may be large issues</li> </ul>	<ul style="list-style-type: none"> <li>SA screening for all with TBI</li> <li>SA education during rehabilitation</li> <li>SA education to family</li> <li>Respect attention limitations</li> <li>Frequent repetition of basic information will be necessary</li> <li>Utilize behavior oriented techniques</li> <li>Consequence-based interventions</li> </ul>	<ul style="list-style-type: none"> <li>Sparadeo et al. (1990)</li> <li>Kreutzer et al. (1990)</li> </ul>

**ABBREVIATIONS**

SA = Substance Abuse  
AOD = Alcohol & Other Drugs

J. A. Ford & D. Moore  
SARDI Project, Medical School  
Wright State University, 1992

## PREVENTION ISSUES FOR PERSONS WITH DISABILITIES

Disability	Incidence/Prevalence	Specific SA Risks and Concerns	Prevention and Treatment Strategies	References
Learning Disability	<ul style="list-style-type: none"> <li>• Learning disabilities affect between 5% and 10% of the population</li> <li>• Prevalence of substance abuse is suspected to be higher than average</li> </ul>	<ul style="list-style-type: none"> <li>• Disability may be "hidden"</li> <li>• Peer pressure</li> <li>• Lowered self-esteem</li> <li>• Poor school performance</li> <li>• Communication difficulties</li> <li>• Impulsivity</li> </ul>	<ul style="list-style-type: none"> <li>• Standard curricula could be adapted utilizing alternate learning modalities</li> <li>• Decrease reading requirements</li> <li>• Consequence based interventions</li> <li>• Reinforce non-use socialization</li> <li>• Resistance skills training</li> </ul>	<ul style="list-style-type: none"> <li>• Ralph &amp; Barr (1989)</li> <li>• Miksie (1987)</li> </ul>
Mental Illness	<ul style="list-style-type: none"> <li>• Approximately 10% of population experiences mental illness that impairs functioning</li> <li>• Perhaps 50% or more of persons experiencing recurring episodes of mental illness also experience recurring substance abuse problems</li> </ul>	<ul style="list-style-type: none"> <li>• Medication use/misuse</li> <li>• Self-medication with alcohol</li> <li>• Denial of MI or SA problems</li> <li>• MI symptoms similar to SA symptoms</li> <li>• Mental health relapses</li> <li>• Isolation</li> <li>• Lowered self-esteem</li> <li>• Unemployment</li> </ul>	<ul style="list-style-type: none"> <li>• Education about medications and their reactions with AOD</li> <li>• Dual diagnoses support groups</li> <li>• Include SA in MH assessment</li> <li>• Involve family members in interventions</li> <li>• Include SA goals in MH rehab plan</li> <li>• Alternative treatment models</li> </ul>	<ul style="list-style-type: none"> <li>• Brown et al. (1989)</li> <li>• Regier et al. (1988)</li> <li>• Christie et al. (1988)</li> </ul>
Visual Impairment	<ul style="list-style-type: none"> <li>• Approximately 11 million persons experience visual impairments</li> <li>• 2% of population legally blind (600,00 persons)</li> <li>• 1/5 of legally blind are totally blind</li> <li>• SA prevalence unknown</li> </ul>	<ul style="list-style-type: none"> <li>• Isolation</li> <li>• Excess free time</li> <li>• Employment issues</li> <li>• Communication barriers</li> <li>• Adjustment to disability</li> <li>• Transportation</li> <li>• Current prevention materials mostly visual in nature</li> <li>• Visual impairments can be result of SA</li> </ul>	<ul style="list-style-type: none"> <li>• Explore non-use activities</li> <li>• Alternative learning modalities</li> <li>• Visually impaired support group</li> <li>• Education focusing on role AOD plays in affective states</li> <li>• Involve vocational and social rehabilitation agencies</li> <li>• Professional and family education focusing on enabling</li> </ul>	<ul style="list-style-type: none"> <li>• Nelipovich &amp; Buss (1989)</li> <li>• Glass (1980-81)</li> </ul>
Hearing Impairment	<ul style="list-style-type: none"> <li>• Approximately 16 million persons experience hearing impairment or deafness (2 million profoundly deaf)</li> <li>• Number of persons with hearing impairments increasing due to increased life expectancy and environment</li> <li>• Substance abuse rates suspected high, but unproven</li> </ul>	<ul style="list-style-type: none"> <li>• Significant communication difficulties</li> <li>• Cultural issues re: deaf community</li> <li>• Fear of additional stigma if admit SA</li> <li>• Lack of appropriate prevention materials</li> <li>• Very wide range of learning abilities represented</li> </ul>	<ul style="list-style-type: none"> <li>• Include SA screening in services for deaf and hearing impaired</li> <li>• Support group for deaf</li> <li>• Separate and specialized treatment programs for deaf</li> <li>• Prevention activities conducted by staff knowledgeable of sign language and deaf culture</li> <li>• Consequence based interventions</li> </ul>	<ul style="list-style-type: none"> <li>• Sylvester (1986)</li> <li>• Steitler (1984)</li> <li>• Boros (1980/81)</li> </ul>

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## WHY GENERAL PREVENTION EFFORTS HAVE NOT WORKED FOR PERSONS WITH DISABILITIES

### A. *Efforts For Youth With Disabilities Begin Too Late:*

Often children with disabilities are overlooked in prevention curricula. Professionals do not always have the needed information for educating these youth. What is more, many people do not consider children with disabilities at risk for substance abuse problems.

### B. *Prevention Materials May Not Be Culturally Appropriate Or Otherwise Accessible For Some Persons With Disabilities:*

Materials often only depict non-disabled youth. Additionally, some groups of youth with disabilities are segregated or isolated due to communication, mobility, or social skill difficulties. If the youth cannot relate to the materials, learning and understanding are not likely to occur.

### C. *Frequently, Rehabilitation Drug Education is Focused on Effects of Prescription Medications Only:*

Most youth and adults need additional information such as the effects of certain drugs, including alcohol and marijuana; the legal consequences of abuse; the social ramifications of use versus non-use; how to resist peer pressure as a person with a disability; how to fill free time appropriately; how to make friends with others who do not use drugs, etc. To date, very few drug education curricula have been designed to be specific to individual differences in lifestyle.

### D. *Existing Prevention Materials Don't Explain Special Risks Associated with Disability:*

Medical, vocational, and social consequences are different for persons with disabilities. Additionally, there are risks which non-disabled youth don't experience. These special risk factors are not addressed in current prevention programs (i.e., factors such as increased medical/health risks or social isolation typically are not covered in existing curricula).

### E. *Lack of Policies and Lack of Enforcement of Consequences in Schools, Rehabilitation, and Judicial Settings:*

Prevention efforts don't work if follow up is not available. Education alone does not provide enough initiative for most youth to resist drug use onset or abuse, unless it is also followed by specific adverse consequences for abuse. Unfortunately, many youth and adults with disabilities find it relatively easy to avoid most of the negative social consequences from being identified as a drug abuser. One example of this phenomenon is the fact that persons with certain disabilities apparently are arrested less frequently than persons without disabilities for the same offenses (e.g., DWI charges for persons with cerebral palsy or deafness) (Moore & Polsgrove, 1991).

## PAUL

*I was born with cerebral palsy which significantly affects my speech and my coordination. I was born an hour and a half after my twin sister, and it is believed that my brain didn't get sufficient oxygen during that time. A physician in Baltimore diagnosed my CP as primarily athetoid, which is an abnormal amount of arrhythmic involuntary movement with some spasticity. He prescribed specific kinds of therapy several days per week which began when I was four and continued in one form or another through my high school years.*

*My social life outside of school was limited. My sisters usually went across the street or up the block to play. I always wanted to go along, but I was never able to; I know that I stopped asking early. School friends usually lived several blocks away or out of town which made it difficult to have contact after school or on weekends. In the nice weather, my mother would frequently take me to the park after school. It seemed inevitable that a group of kids would gather around where I was and begin to make fun of me; as a result of these experiences, I grew up being afraid of most able-bodied kids.*

*My high school teachers thought that I should be able to go to college. I had a sense that, even apart from my disability, going away to college could be a major breakthrough for me. I knew that if I was going to make it in this new campus environment, I had to survive both physically and academically. Although I had therapy for many years, my independent living skills were not truly tested until I went away to college. It was essential that I learn to accomplish those routine tasks in the most efficient way possible--so that I would still have enough energy to do other things. During those first years at college, the physical and academic tasks took most of my time and energy.*

*Disabled students were integrated with nondisabled students on the first floor of wheelchair accessible residence halls; initially, disabled students were assigned space so that they were evenly distributed throughout these halls. Of the forty-four or so students who lived on the floor, perhaps, eight or nine were disabled. There was a refreshing, easy-going camaraderie among most of the students on the floor which included most of the disabled as well. This general camaraderie that I experienced and observed between nondisabled and disabled students on the floor did not seem to extend readily to upper floors or other campus settings.*

*Unless you had a date, students on the floor usually grouped to do stuff together on the weekends. There seemed to be, essentially, three things to do to relax on campus--go drinking, go to a movie, or go to a movie and then go drinking. It was well into my second semester before I tried to include myself in some of those social things. I began going out occasionally on Friday or a Saturday night with others from the floor. Since I never had the opportunity to do any thing like that before, I felt very adventurous on these initial excursions.*

*When I did go out, I always went along with others who would push me in my wheelchair, so I never had to worry about getting myself back to the residence hall. At that time, the drinking age was twenty-one, no one under that age was even supposed to be in these places, and most establishments carded sporadically at best. I was twenty when I was a freshman and probably looked about fifteen, but I was never carded; moreover, they may have carded others who were with me, but they never carded the person pushing my wheelchair. So, the plan became obvious: Be sure that the person who needs the most luck getting inside is pushing the wheelchair.*

*Although I quickly learned that my drinking limit was usually three or four beers, when the band or the jukebox was blaring and rocking away, it was often difficult to stop at that point, and I can remember getting back home and puking my guts out on several occasions. At that time, it was becoming increasingly important to me to fit in, so I tried not to focus on some of the more negative consequences of drinking too much.*

*It was on one of those initial excursions that I bit into my beer glass. I knew that something had happened, but I didn't know what. [My friends] yanked my wheelchair away from the table and rolled me quickly out the door. Although no one that I was with was in that great a shape, they did manage to get me over to the campus health center fairly quickly where my mouth was cleaned out and checked over--no stitches fortunately. Although the experience scared me, it really didn't change anything; I just made certain that when I drank that I always got a thick glass mug or a couple of paper cups that could be stacked together. The other students with me didn't make a big deal out of it either, and it became one of those shared experiences that would be retold and embellished a little more each time by those around me.*

*The fall saw the beginning of my recreational drug use. In the weeks and months that followed, drugs became a new social outlet for me on an occasional Friday or Saturday night. I knew that it took some planning and maneuvering to get these drugs, but I did not think much about who made the buys, how the buys were made, or where the stuff came from; it was just nice to be invited to be a part of that scene.*

*As I look back at those times, I think that I was attracted and began using recreational drugs for several different reasons. Perhaps most importantly, similar to alcohol, drugs were simply a social outlet that became accessible to me. Second, recreational drug use was the new wave of popular culture, and I had a strong desire to want to fit in and be a part of that scene. Third, although I realized that since I had cerebral palsy these drugs may affect me differently than a person who did not have CP, I think that I was beginning to try to push the limits to some extent in my efforts to be open to new experiences--regardless of the consequences.*

*My college years were some of the more positive and growing years of my life, but I think that they could have been even more life enhancing. When I arrived on campus, if I had begun meeting with a junior or a senior, perhaps, every ten days or two weeks just to talk about how I was doing, what I was thinking, and then to begin to hear about some of the diverse interest groups, programs, and services on campus and in the community, I doubt if drugs and alcohol would have played such a significant role in my life during those years. It would not have been enough to have drug and alcohol education, resistance skills training, or some kind of life skills training. The individual with significant disability often desperately needs encouragement and assistance in finding and developing creative and meaningful avenues of expression; otherwise, he may choose to just go with the flow.*

## SUBSTANCE ABUSE PREVENTION AS IT RELATES TO PAUL

Paul, like many other young persons, began experimenting with alcohol and other drugs when he left home for the first time. Having felt isolated from his peers when growing up, Paul began drinking to fit in with his new peer group. He experienced a number of negative consequences due to his use, including several physical problems which could have been even more serious than they were.

He discussed the reasons why he began to use and several possible scenarios which may have prevented his use. Paul admits that his use could have progressed had he not made changes in his living situation and social activities. He tired of using substances, and had he not, he might have experienced even greater consequences.

Persons with congenital disabilities are at risk for developing substance abuse problems due to isolation and perceived peer pressure. Prevention efforts geared specifically toward the transitioning to independent living period are particularly needed. Paul mentioned that he had never had the opportunity to go out drinking while at home with his family, and he readily felt accepted when he went out with others from his dormitory. Paul's friends enabled his use of substances and he was never confronted with any of the consequences from his use.

In spite of his alcohol and other drug related consequences and his own recognition that his life was becoming more centered on using, Paul did not become chemically dependent. Paul's story ends when his college years were completed because he did not continue to abuse alcohol and other drugs. Unlike some persons with disabilities who abuse substances, he was able to make the necessary changes in his lifestyle in order to avoid continued problems with alcohol or other drugs. It is not entirely known how one person can reduce consumption to avoid problems while another continues to use even when consequences become quite painful.

## TEST YOUR KNOWLEDGE ABOUT SUBSTANCE ABUSE PREVENTION

The following questions are based on the information contained in the Chapter you have just read. The answers are found in Appendix G.

1. Prevention will be more successful if the following parties are included:
  - a. family members
  - b. persons with disabilities
  - c. community leaders
  - d. teachers and other educators
  - e. all of the above
  
2. All persons with disabilities who abuse alcohol or other drugs need treatment.  
TRUE      FALSE
  
3. \_\_\_\_\_ groups for persons with disabilities may be helpful in addressing substance abuse risks and issues.
  
4. Which of the following are high risk times for persons with disabilities in relation to the onset of alcohol and other drug use?
  - a. high school
  - b. first time away from home
  - c. isolation from peers
  - d. onset of disability
  - e. all of the above
  
5. Which of the following is/are **not** reasons why prevention efforts have been unsuccessful with persons with disabilities (*circle all that apply*).
  - a. efforts begin too late
  - b. special risks aren't addressed
  - c. disabled don't drink
  - d. disabled need medications
  
6. Substance abuse education by itself will keep most youth with disabilities from using substances if the education begins early.  
TRUE      FALSE
  
7. Substance abuse risks are the same for most disability groups.  
TRUE      FALSE
  
8. The current trend in substance abuse prevention is to utilize a variety of strategies and to involve the entire community.  
TRUE      FALSE
  
9. A person must "hit bottom" and suffer consequences before interventions will be successful.  
TRUE      FALSE
  
10. Two prevention approaches I can take at my agency are  

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**CHAPTER FOUR**

**IDENTIFICATION OF SUBSTANCE ABUSE  
IN PERSONS WITH DISABILITIES**

RESEARCH REPORT

THE EFFECTS OF  
TECHNOLOGY ON  
TEACHING AND LEARNING

## IDENTIFICATION OF SUBSTANCE USE/ABUSE RISKS

Persons with disabilities are not generally viewed as substance users, let alone substance abusers. However, when persons with disabilities do abuse substances, the consequences are often more rapid and severe. Early identification of substance abuse is crucial in preventing secondary disabilities or other physical, emotional, and behavioral consequences.

It is important to remember that identification of substance abuse and chemical dependency are much different than identifying the use of substances. Knowing the signs and symptoms of substance abuse and the special risks for persons with disabilities is one way to promote early identification of risk or abuse.

This chapter focuses on the identification of substance abuse for people with disabilities and includes the following:

I. Signs and Symptoms of Substance Abuse.....	2
Frequent Intoxication	
Atypical Social Settings	
Intentional Heavy Use	
Symptomatic Drinking	
Psychological Dependence	
Health Problems	
Employment Problems	
Problems With Significant Others	
Problems With the Law or Authorities	
Financial Problems	
Belligerence	
Isolation	
"Handicapism"	
II. Substance Abuse Symptoms Checklist.....	8
III. Personal Story: "Jesse".....	10
IV. Comments on Jesse's Story....	12
V. Test Your Knowledge.....	13

## IDENTIFYING SUBSTANCE ABUSE

Although substance abuse is a known risk among persons with disabilities, identification of the problem is difficult. This is due to a number of factors, including the attribution of unusual or abnormal behavior to disability because the disability is the primary presenting feature to others. Confounding the problem of identifying substance abuse is the reality that most professionals have limited experience in both disability and substance abuse.

One of the first steps in identifying substance abuse is to recognize the signs and symptoms--some of which will be specific to persons with disabilities. The following categories, adapted from Marden's (1979) major problem areas will be discussed in light of people with disabilities:

*frequent intoxication*  
*atypical social settings*  
*intentional heavy drinking*  
*symptomatic drinking*  
*psychological dependence*  
*health problems*  
*job or employment problems*

*problems with significant others*  
*problems with law or authority*  
*financial problems*  
*belligerence*  
*isolation*  
*"handicapism"*

### **Frequent intoxication.**

It is not always easy to tell if a person is under the influence, especially if there is a well developed drug tolerance created by prolonged heavy use. This may be particularly difficult in a person with a disability due to the combination of drugs the person may be taking or the unusual behaviors or body movements associated with the disability. The person simply may not act or appear intoxicated due to "cross tolerance" or "potentiation" of various drugs. Cross tolerance occurs when a person's body develops tolerance for a particular drug and this tolerance carries over to similar types of drugs. One example is diazepam (Valium), which is a sedative drug often prescribed to relieve muscle spasms. When a person develops a tolerance to this drug, the tolerance will tend to "cross over" to alcohol and other sedative drugs, and the person will have a tolerance for alcohol even if the person rarely drinks. Potentiation occurs when one drug interacts with another drug resulting in increased effects from otherwise safe doses. For example, Xanax and alcohol are both sedative drugs; however, one Xanax and one beer will not produce the same effects as two beers. The effects will be elevated. When chemicals are mixed, one plus one does not always equal two.

### **Atypical social settings.**

In unusual social settings or peer groups, heavy drinking may be the norm. For example, persons attending schools for the deaf are segregated from the general population, and there is some evidence for a higher incidence of alcohol-related problems within these types of settings (Locke & Johnson, 1981). In addition, several researchers discovered that clients at an independent living center and residents of a rehabilitation center also drank more heavily than the general population (Hepner et al. 1981; Rasmussen & DeBoer, 1981). Persons with disabilities who are living alone and are isolated from normal social settings may also drink to a greater extent than the general population (Edgerton, 1986). Unfortunately, the person using in isolation often is the most difficult to identify as a substance abuser.

### **Intentional heavy use.**

Heavy use can sometimes be masked by the consumer's claim that medication is needed to relieve pain, side effects, or other symptoms of the disability. For example, some persons who experience spasms claim that marijuana use will relieve the severity of spasms (Malec et al., 1982). Actually, there has been no substantiation of this, and some consumers have reported increased spasticity following marijuana use. It is important to remember that for someone taking medication the definition of heavy use depends on the number and types of other medications which the person with a disability is taking. For example, two drinks may be considered heavy use for a person who is taking a prescribed antispasmodic medication.

If there is a concern about medication or potentiation, it is prudent to consult informed medical sources. To gain knowledge in this area, consult the PDR (Physicians' Desk Reference, 1992) or the drug chart in this Training Manual. Remember, when discussing concerns with medical personnel, be specific about why you are concerned, listing both suspect behaviors and any knowledge about non-prescription drug and alcohol intake.

Several warning signs of heavy use are hangovers, episodes of alcohol induced amnesia (also referred to as "blackouts"). Hangovers may take the form of headaches, feeling shaky, dehydration, nausea, and/or vomiting following a period of heavy drinking. With blackouts, a person is fully conscious, appears to be functioning normally, and sometimes will not even appear intoxicated; however, the short term memory is partially or fully inoperable. The person and others will be unaware that the person is in a blackout, but later the person will have no recollection of the events happening during that time.

Other symptoms of heavy use can be disability-specific, such as hyperreflexia. Hyperreflexia, a condition unique to persons with spinal cord injuries, involves an exaggeration of reflexes. The effects are hypertension, headache, sweating, facial flushing, congestion, nausea, and vomiting in response to the distension of the bladder or other bodily stimuli. Hyperreflexia is not always drinking-related, but it can occur after or during a heavy drinking episode. This condition can be life threatening.

### **Symptomatic drinking.**

This refers to predictable and generally excessive drinking on a recurring basis as a means of handling stress or unconscious problems. Several negative consequences are likely to occur. A person may begin drinking or using to relieve stress or painful feelings, and soon the drinking becomes routine in spite of recurring negative consequences. Daily use even in moderate or small quantities may in itself be problematic for a person with a disability. One consequence of regular use is that a person never seems intoxicated but actually is under the influence. Symptomatic drinking can lead to psychological dependence, which is the most common form of substance dependence according to the Diagnostic and Statistical Manual for Mental Disorders, 1987.

### **Psychological dependence.**

There is an increased danger of dependence due to the medications which are commonly prescribed to persons with disabilities. A disability can increase risk for dependence because of the belief by the consumer, as well as the professionals working with him or her, that the pain or side effects of the disability cannot be addressed without medications. The consumer may begin to expect medications and even other drugs to relieve or cure aspects of the disability. Other signs which may begin to appear are drinking or using alone, getting high before socializing or fulfilling obligations, and hiding use

from others. Negative feelings become more common and certain defense mechanisms begin to appear. The defensive behaviors of the consumer may tend to be focused around the disability, but in fact can be related to substance abuse.

Mood swings also are a very common sign of substance abuse, and the person may begin blaming the disability for various negative emotions. Additionally, the consumer may deny that anything is wrong. Although denial is a normal response to any tenuous situation, it blocks the recognition of negative consequences and therefore blocks the motivation to make changes in one's life. The person continues to drink or use in spite of repeated negative consequences.

### **Health problems.**

Persons with disabilities can be prone to health problems, and alcohol and other drug use can exacerbate some conditions. Digestive disorders, poor circulation, and chronic infections are some conditions common to persons with disabilities, and these conditions are exacerbated by even the moderate use of alcohol or other drugs. Medications prescribed for these conditions may create unwanted side effects. Persons with disabilities may average between 2 and 5 concurrent medications (Kirubakaren et al, 1986; Hepner, Kirshbaum, and Landes, 1980-81; Moore & Siegal, 1989).

Other health-related drug abuse symptoms include tolerance change, bladder and urinary tract problems, infections, increased muscle spasms, sleeplessness, weight changes, and diarrhea. Frequent hospitalizations or medical attention may also be an indicator that the person is abusing substances.

As many as 50% of traumas involving hospitalizations among adolescents and young adults involve alcohol or other drugs (Heinemann et al., 1988; Sparadeo & Gill, 1989; O'Donnell et al., 1982). These persons are at continued risk for recurring injuries due to substance abuse in many cases. Recurring injuries can include traffic accidents, burns, falls, sprains, and medication-alcohol potentiation.

### **Job or employment problems.**

Lack of satisfying employment can be a significant barrier to adult fulfillment. In today's society, "we are what we do." Because of a disability, a person may be particularly vulnerable to substance abuse due to a lack of gainful employment. Lack of employment or under-employment can lead to low self esteem or a negative self image, both of which have been correlated with higher rates of substance misuse (Jessor & Jessor, 1979; Kandal, 1980; Sweeney & Foote, 1982; Chassin, 1984). By contrast, employed persons with disabilities are less likely to use Valium, cocaine, alcohol, or marijuana (Heinemann, 1990).

When persons with disabilities are employed, substance abuse can interfere with work in several ways. DiNitto and Krishef (1984) found that persons with mental retardation drank somewhat less than the general population, but they reported that one third of their sample had experienced alcohol-related work problems. These problems may include missing work, tardiness, absenteeism, frequent job change, difficulty holding a job, and poor relationships with supervisors and co-workers. Irresponsibility in job roles also may be a consequence of substance abuse, and it is not uncommon for persons to blame these problems on their disabilities. Unemployment problems can create a vicious cycle. Drug use decreases employability, and decreased employment raises the risk for substance abuse (Greer, 1986).

### **Problems with significant others.**

Persons in close contact with a substance abuser are often aware of a problem long before it is apparent to the person at risk. Unfortunately, significant others frequently believe that accommodations have to be made due to the disability. Family and friends may believe that a person with a disability is more entitled to use drugs because of the disability. Wishing the person with a disability would stop using may create feelings of guilt, and family and friends begin to blame themselves or other external factors for the substance abuser.

For example, one man with a physical disability explains that he lived with his parents for a five year period after incurring his disability. His mother was very concerned about him and was unsure of how to help him overcome isolation and loneliness. At first, she bought beer for him to drink but realized that alcohol was not good for him because of his catheter. She then began to buy marijuana for him although she was strongly opposed to the use of illicit drugs. Marijuana use was never condoned and was not permitted in the house at all until the disability occurred. Since then both sons were allowed to smoke marijuana in the house provided it was done with the brother with the disability. This kind of enabling, where family members change their beliefs and values, can exist in families when someone is provided special treatment because of a disability.

By contrast, sometimes an abuser will gravitate toward relationships where substance abuse is accepted. For example, persons with physical disabilities may choose an attendant and friends who use drugs in order to keep using without difficulty. Persons who abuse substances tend to spend time with others who use like they do. These peers may accept and tolerate a disability more so than the general public, especially when that person with a disability supplies drugs or promotes drug use.

### **Problems with law or authority.**

Obviously, problems in this area suggest more problematic abuse. Persons with disabilities in general are not viewed as offenders, although some populations have high rates of arrests or incidents related to alcohol or other drug use. Particular problems with criminal justice have been noted in the disabilities of mental illness, mental retardation, and traumatic head injury (Brown, 1989; DiNitto & Krishef, 1984; Locke & Johnson, 1981).

A contrasting problem is that persons with disabilities often can avoid suffering legal consequences. For example, how does the legal system incarcerate a person with a physical disability who needs attendant care? Prisons and jails often are not physically accessible. Few courts have adequate resources for dealing with a deaf defendant. and frequently persons with disabilities go unpunished or simply get probation. These dispositions can reinforce maladaptive behaviors, especially substance abuse. The legal system is very difficult for persons with certain disabilities to understand. Sometimes legal officials feel sorry for persons with disabilities and simply don't arrest them, or they may not want the extra problems associated with processing a person who has a disability.

### **Financial problems.**

People with disabilities frequently face financial problems exacerbated by under-employment and a need for specialized personnel or medical services. It also is common to be underpaid for the work they do. People with severe disabilities may not receive more than a minimal subsidized income. Often, they are uninsurable and must rely on government assistance in order to qualify for any insurance. In fact, the need for public assistance with medical problems can prevent gainful employment due to a fear of losing

benefits (Greer, 1986; Callahan, 1990). Within such a financial climate, any expenditures for alcohol or other drugs can put a serious strain on a budget. The substance abuser is far more likely to give up basic services, such as recreation or disability management costs (e.g., wheelchair maintenance) in order to purchase drugs.

One of the consequences of financial problems for someone abusing drugs is that the person with a disability may sell prescribed medications to earn money for other drugs. This is especially true with certain types of drugs, such as cocaine. Professionals may want to determine if a suspected abuser has a trust fund or other stable form of income to ascertain if this money is being used to purchase drugs.

### **Belligerence.**

Substance abuse fosters belligerent behavior which is anger turned outward. This belligerence can be seen as a "chip on the shoulder" attitude. Persons with substance abuse problems demonstrate unfocused anger even though they don't recognize why they are angry. In fact, anger is one of the most effective defenses to avoid confrontations about drug and alcohol use.

It will be beneficial for professionals to observe what affect is present once the person's anger is diminished. For example, depression commonly underlies anger in persons who have substance abuse problems. Other common underlying feelings are fear, guilt, and shame.

### **Isolation.**

Persons with disabilities are faced with greater possibilities for social isolation, and interpersonal skills correspondingly may be less developed. It sometimes is difficult to tell if social isolation is perpetuated by substance abuse or disability. As drug use becomes more important to someone, that person is even more prone to isolation and self-imposed distancing from others. This is a very dangerous symptom because it suggests chronic dependency and it is difficult to assess. When isolated, a person can more easily hide or avoid the negative consequences of substance use.

### **"Handicapism."**

It is impossible to expect persons with disabilities not to have to deal with the disability in all aspects of their lives. However, if the person focuses on the disability to the exclusion of other aspects of life, the possibility of substance abuse should be explored. The disability can become the excuse for all that goes wrong and a ready justification to use drugs. As is the case in the general population, blaming external sources for personal problems can be a symptom of substance abuse.

For example, a volunteer with the SARDI project became disabled after an automobile accident. She stated that for a number of years she allowed the disability to take precedence in her life. She did not actively participate in rehabilitation; instead she only did what she had to do in order to keep her doctors from questioning her motivation. She requested large quantities of medications and was able to convince significant persons in her life that she needed all the medications because of her disability. Friends and family never questioned her about her disability, and she was able to use it to her advantage in that respect. Whenever she was uncomfortable in a situation, she stated that she must leave because of the disability. She blamed the disability on her poor grades, lack of money, poor eating habits, drug use, isolation from family and friends, and lack of motivation. Although her disability may have contributed to all of these circumstances, she allowed the disability to rule her life and to serve as a reason for continued drug abuse.

**Summary.**

Identifying substance abuse among persons with disabilities is very important and precedes concerns about the availability of appropriate treatment services. When persons with disabilities experience substance abuse problems, these problems tend to be more severe. Professionals working with persons with disabilities need to learn the signs and symptoms of substance abuse, many of which are similar to the signs and symptoms exhibited by the general population.

It is important to remember that the substance abuser may feel trapped. This person probably can't imagine life without chemical assistance. Persons with disabilities may go to great lengths to keep their situation hidden. If you are professionally hesitant about confronting substance abuse issues, you will be less likely to identify a substance abuse problem in a consumer. If you are uncomfortable, you should seek additional assistance when substance abuse issues have been identified. Remember that colleagues, as well as family members and friends, can become involved in a caring and supportive exploration of these concerns.

## SUBSTANCE ABUSE SYMPTOMS CHECKLIST

1. *Frequent intoxication.*

- a. Does the person report or appear to be frequently high or intoxicated?
- b. Do recreational activities center around drinking or other drug use, including getting, using, and recovering from use?

2. *Atypical social settings.*

- a. Does the immediate peer group of the individual suggest that substance abuse may be encouraged?
- b. Is the person socially isolated from others and is substance abuse occurring alone?
- c. Is the person reluctant to attend social events where chemicals won't be available?

3. *Intentional heavy use.*

- a. Does the person use "social drugs" with prescribed medications?
- b. Does the person use more than is safe in light of medications or compromised tolerance?
- c. Does the person have an elevated tolerance as evidenced by the use of large quantities of alcohol or other drugs without appearing intoxicated?

4. *Symptomatic drinking.*

- a. Are there predictable patterns of use which are well known to others?
- b. Is there a reliance on chemicals to cope with stress?
- c. Has the person made lifestyle changes yet the drug use has stayed the same or increased? (eg. changed friends or moved to another area)

5. *Psychological dependence.*

- a. Does the person rely on drugs as a means of coping with negative emotions?
- b. Does the person believe that pain can't be coped with without medication?
- c. Does the person obviously feel guilty about some aspect of the person's use of alcohol or other drugs?

6. *Health problems.*

- a. Are there medical conditions which decrease tolerance or increase the risk of substance abuse problems?
- b. Are there recurring bladder infections, chronic infections, bed sores, seizures, or other medical situations which are aggravated by repeated alcohol or other drug use?
- c. Did the disability occur when the individual was under the influence, even if it is denied by the person?

7. *Job problems.*

- a. Is the person underemployed or unemployed?
- b. Has the person missed work or gone to work late due to use of alcohol or other drugs?
- c. Does the person blame the disability for work related problems?

8. *Problems with significant others.*

- a. Has a family member or friend expressed concern about the person's use?
- b. Have important relationships been lost or impaired due to chemical use?

9. *Problems with law or authority.*

- a. Has the person been in trouble with authorities or arrested for any alcohol or drug related offenses?
- b. Have there been instances when the person could have been arrested but wasn't?
- c. Does the person seem angry at "the system" and at authority figures in general?

10. *Financial problems.*

- a. Is the person's spending money easily accounted for?
- b. Does the person frequently miss making payments when they are due?

11. *Belligerence.*

- a. Does the person appear angry or defensive but doesn't know why?
- b. Is the person defensive or angry when confronted about chemical use?

12. *Isolation.*

- a. Does increasing isolation suggest heavier substance abuse?
- b. Is the person giving up or changing social and family activities in order to use?

13. *"Handicapism".*

- a. Does the person focus on disability to the exclusion of other aspects of life?
- b. Does the person blame the disability for what goes wrong?

Exhibiting one of these symptoms is not necessarily indicative of substance abuse; however, several or more of these symptoms in combination may suggest that issues related to substance abuse should be explored at greater length. If a consumer exhibits several of the above symptoms, it might be advisable to consult with a substance abuse specialist.

## JESSE

*I was born in 1956, my little brother arrived 20 months later, and my parents were divorced shortly thereafter. My brother and I lived with our mother but spent a lot of time with grandparents, babysitters, and a couple of aunts and uncles. We rarely saw our dad, even though we spent weeks at a time in the summer and every other holiday with his parents. Nobody talked about dad. When he remarried is still a mystery to me, but I knew I had a stepmother.*

*My mom married my "wicked" stepfather when I was in the 4th grade. He said he was strict. I'd call it abusive. My mom divorced him about five years later after he threatened to kill us. I remember he used to have a couple drinks every night to unwind after work, but I don't remember him ever being noticeably drunk. I believe he was crazy, not alcoholic.*

*Right after my stepfather was locked up, I started my first batch of home-brew. I was 14 at the time and had been drinking an occasional can of beer at home or a glass of stepmother's wine at her house. [It was] no big deal. But when my first batch of home-brew came out of my closet, I drank a whole fifth of it and then some, while I bottled the rest of the 5 gallons in whisky bottles I had scavenged from behind the local bars. This was the first time I ever got drunk, and it was great! I remember my bed floating around the room with me in it and the wine tasting so good. I'm still surprised that I didn't get sick. From this point on my life revolved around feeling this way again. I tried everything. I bought or traded wine for marijuana, hashish, mescaline, and any other drugs that came around.*

*When my mother moved out of state I didn't want to leave my plants (pot) and my drug dealing buddies behind (I had become quite the bootlegger). Instead, I volunteered to move up to my dad's house. My stepmother loved this idea because having kids at home would keep dad out of the bars. Wrong! About a week after I moved in (age 16) my dad and I became drinking buddies and we both left her sitting at home every night.*

*My dad finally divorced my stepmother, married a waitress he knew, and quit going to the bars so much. I started going by myself which was "ok" because I was known at the bars by then. It didn't matter that I was under age, so I became the designated 6% beer buyer for all my "friends" and they'd always buy me a 6-pack for getting theirs. I was also able to smoke a little more pot or drop some mescaline once in a while since dad wasn't around. (He seriously disapproved of other drugs.)*

*Then, one day right before I graduated from high school, I overdosed (bad trip) on mescaline, pot, beer, and a fifth of tequila. Needless to say, I swore off drugs. I had gone to the hospital when I "overdosed" but they just sent me home to come down on my own and suggested that I see a counselor. I went once, decided the counselor was an idiot, and never went back. After all I had quit on my own, hadn't I?*

*The week after my overdose, I proposed to my girlfriend, got a real job (it didn't pay as much as dealing), and found a cheap apartment. A year later we were married and after a couple of weeks I started to bring a quart of beer home after work to relax and help me get to sleep at night. My new wife didn't approve (she knew about my previous antics) so I started waiting until after she fell asleep every night to go get my quart. This went on for almost a year, and I finally decided to leave her. I confronted her once about her weight gain and sleeping habits as a way to bring up the subject of separation. She blamed it on the "pill" and said she'd try to do better. A month later she was pregnant. We didn't have a family insurance plan yet because I didn't know we were planning a family. After all I didn't want kids, I wanted a divorce. I thought long and hard and decided to stay married for the children (We quickly had our second child.) as long as I could drink whenever and whatever I wanted to.*

*I started driving around in the mornings after work and getting drunk. Over the next 5-6 years I got on a first name basis with every drive-through employee in a 50 mile radius of my house. I only went to each of them once a day because I didn't want them to think I was a drunk, but I'd hit at least four of them every day for a cheap 6-pack. I'd drive till I couldn't keep the car between the lines or I thought I was ready to black out and then I'd make a bee-line for home and go to bed, usually late in the afternoon.*

*I went into the roofing business, and I thought working with a bunch of drunk contractors would at least make my life bearable. The kids were growing up and I wanted to spend more time with them instead of coming home drunk and passing out right when school let out. Besides, the blackouts had become a daily routine and not remembering coming home was starting to scare me.*

*And then on August 21, 1991 after I realized I had lost two days in a blackout (I had been taking muscle relaxers and Tylenol with codeine at work which might have explained the extra long blackout) and had still gone to work and to a bar one night, I decided it was time to get off the merry-go-round before I had a wreck or got busted for DUI. On August 22 while on my daily cruise I decided the only way to get out was to move out on my wife so I wouldn't have to avoid her anymore by driving around till she went to sleep. On August 23 I found a place to move, got drunk, and went home. On August 24 I got up and decided to take the day off to celebrate this monumental decision and to pack (this was the only day I can remember taking off work to get drunk in my life). On August 26, I woke up in the hospital.*

*I didn't know where I was or what had happened. I couldn't see, I couldn't move, I couldn't talk, and I had no feeling anywhere. I decided I was dead. I don't remember when I found out I had lost both of my legs above the knee, that I had burned my left ear off along with severely burning my left shoulder, that I had a collapsed lung, or that they had to put my right eyeball back in it's socket. But I do remember when they told me I had broken my left hip I said, "Oh great, so I'm going to limp too"!*

*While I was in intensive care I talked with a psychiatrist about my drinking. He told me to go to A.A. when I got out of the hospital. He also suggested that as soon as I got to rehabilitation, I should mention my drinking to the resident psychologist. I had been in the physical rehab unit for four weeks before I finally convinced my [psychologist] that I was an alcoholic. He had been too busy concentrating on helping me through the grief of losing my legs. (Hey! So what if I lost my legs, I can still drink so how do I keep from getting drunk again and really killing myself?) He didn't know how to help me, so he called in a drug counselor for the last week of my rehabilitation. One of my counselors happened to attend a disability and substance abuse workshop where Dennis Moore was speaking about the SARDI project. She approached him about me doing volunteer work for SARDI. It was a way for me to get out of the house at first, but as I learned more about substance abuse and disability, I became aware of my need to get out even more. SARDI staff suggested that I attend some AA meetings.*

*I had been out of the hospital for three months before I got up the courage to go to my first AA meeting. I was still in a wheelchair and was sure somebody was going to have to carry me up and down some stairs. I finally got in touch with an ex-biker who I at least half way trusted to carry me down the stairs and went to my first meeting even though I knew I would never drink again, meetings or no meetings. I had found out staying sober pissed the old lady off as much as getting drunk, she lost her best excuse to go shopping.*

*I've been straight a year and a half, in AA a year, and separated for three months as of this writing. I quickly found out AA wasn't a bunch of old wings. In fact it's been more help to me than any "professional" has ever charged me for. I didn't really look for professional help that hard but nobody came looking for me either. AA has been the only place I've been able to go to discuss disability, substance abuse, and how they relate to each other, as one topic.*

## SUBSTANCE ABUSE IDENTIFICATION AS IT RELATES TO JESSE

Jesse falls into the category of a Type A substance abuser. He experienced substance abuse problems before becoming disabled, and in fact, his disability is due to his use of alcohol and other drugs. Some of the symptoms of substance abuse which Jesse has experienced include the following:

- Frequent intoxication
- Atypical childhood experiences
- Intentional heavy use
- Blackouts
- Family history of substance abuse
- Using alcohol with prescribed medications
- Use of alcohol and other drugs when alone

If someone had confronted Jesse about his substance use early on, he might not have become disabled. Jesse had begun to realize some of his own substance abuse issues prior to his injury, yet he had not taken any steps toward abstinence. However, he readily admitted his chemical dependency during his hospitalization following the accident. He had some difficulty finding a professional who understood both substance abuse and disability. For Jesse, the substance abuse issues were primary and dealing with his new disability secondary.

Jesse did not receive formal treatment for his substance abuse issues and received very little assistance from professionals. He was able to find support that he needed in the 12-Step program of Alcoholics Anonymous. Jesse describes how this support helps him cope with not only his chemical dependency, but also his disability.

## TEST YOUR KNOWLEDGE ABOUT THE IDENTIFICATION OF SUBSTANCE ABUSE

The following questions are based on the information contained in the Chapter you have just read. The answers are found in Appendix G.

1. The most serious deficit in substance abuse services for persons with disabilities is the lack of identification of problem use.

TRUE FALSE

2. A disability can sometimes hide substance abuse symptoms.

TRUE FALSE

3. One source of medication information is the PDR, which is the \_\_\_\_\_

4. Hyperreflexia is a condition unique to which disability group?

- a. Visually Impaired                      b. Hearing Impaired  
c. Spinal Cord Injured                  d. Mentally Ill  
e. all of the above

5. Which of the following accurately describes a "blackout"?

- a. A person smokes marijuana and becomes paranoid.  
b. A person takes more Flexeril than has been prescribed and feels ill.  
c. A person drinks and then has no recollection about a period of time.  
d. A person wakes up the day after using and feels sluggish and thirsty.

6. According to sources cited in this chapter, approximately how many injuries among young persons are related to alcohol and other drugs?

- a. 30%    b. 50%    c. 60%    d. more than 70%

7. List four health related symptoms of substance abuse.

\_\_\_\_\_  
\_\_\_\_\_

8. Approximately half of all persons with disabilities become chemically dependent.

TRUE FALSE

9. Allowing persons with disabilities to use drugs in situations where drug use is generally not condoned is an example of enabling.

TRUE FALSE

10. What are the special risks relating to cross tolerance?

\_\_\_\_\_



**CHAPTER FIVE**

**INTERVIEWING FOR SUBSTANCE ABUSE RISKS**

the user's information needs. The user's information needs are defined as the user's information requirements, which are the user's information needs that are not satisfied by the user's current information resources. The user's information needs are defined as the user's information requirements, which are the user's information needs that are not satisfied by the user's current information resources. The user's information needs are defined as the user's information requirements, which are the user's information needs that are not satisfied by the user's current information resources.

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## INTERVIEWING FOR SUBSTANCE ABUSE RISK

The previous chapter discussed the identification of substance use/abuse in persons with disabilities. This chapter takes that concept one step further. In order to interview for substance use/abuse, the interviewer needs several prerequisite skills. This chapter will provide understanding of how to develop better interviewing skills in order to obtain substance use/abuse information from clients.

One of the best ways to gather information about substance use/abuse is to utilize interviewing skills. Successful interviewing can be aided by understanding some basic counseling techniques. Counseling requires complex skills obtained through specialized training and practice, and this short chapter will not prepare anyone for conducting counseling sessions. Instead, the purpose of this chapter is to provide the reader with knowledge about and suggestions for conducting interviews. It will also provide an understanding of how basic counseling techniques and skills are important in interviewing and intervention processes.

This chapter provides a format for interviewing people with disabilities suspected of substance abuse. If the professional does not feel comfortable conducting interviews, referrals should be made to others who are experienced in substance abuse and disability issues. In addition to information about interviewing, this chapter contains a case study of a person with a hidden disability, and it illustrates how the disability can sometimes mask the substance abuse.

The following components are included in this chapter:

I. Interviewing for Substance Use/Abuse.....	2
II. Characteristics of Interviewers.....	5
III. Interviewer Self-Rating Checklist.....	8
IV. Obtaining Specific Substance Use Information.....	9
V. Points To Remember.....	11
VI. "Jane": A Case Study.....	12
VII. Comments on Jane's Story.....	14
VIII. Test Your Knowledge.....	15

## INTERVIEWING FOR SUBSTANCE ABUSE

Interviewing for substance abuse problems is the initial step in a process of interactions geared toward discovering and resolving documentable problems. The professional's attitudes toward persons with disabilities and substance abuse problems are important to consider. Biases and negative attitudes about these issues can be very subtle and difficult to recognize. The following exercise may help you identify some of your own attitudes toward persons with substance abuse issues and/or disabilities. This works best as a small group activity where it can be followed by a discussion of stereotypes and biases.

### An Attitudes Exercise

First, visualize a person who has problems with alcohol. Write down a brief description of that person. Next, visualize a person with a disability and write down a brief description of that person. Ask yourself the following questions:

- *What type of person did you visualize for each question?*
- *What was the person's sex? race? age?*
- *What background did the person come from?*
- *What was the person wearing?*
- *What activities is the person involved in?*
- *What is the person's family like?*
- *Did you picture someone you actually know?*

Although this brief exercise will not identify all of our stereotypes, it may provide some insight into your attitudes about persons with substance abuse problems and/or disabilities. It is important to be aware of your attitudes and opinions about both in order to provide the best services or to make referrals as needed.

Did you visualize an individual of the same age, gender, race, and economic status for each? People tend to view people with visible disabilities with a more charitable or empathetic eye than they do substance abusers. By the same token, we tend to view people with chemical dependency problems from more of a "moral" perspective. We more readily pass judgment that the chemical dependency is a character defect which can be corrected if the person would only take charge and act more responsibly. These moral overtones have different connotations when considering persons with disabilities, as we tend to be more condescending and sympathetic in our perspectives. These prejudices are stigmatizing and unhelpful for either group. It should be pointed out that it is possible to hold substance abusers responsible for their behavior without "blaming" the person for the chemical dependency. After all, chemical dependency is a complex biopsychosocial phenomenon with many contributing causes (Donovan, 1988).

### Strategies for Interviewing Consumers

Substance abusers generally go to great lengths to keep their use of alcohol and other drugs hidden. Fear and distrust of others frequently occurs when substance abusers lose control of their use. They may have feelings of confusion, guilt, and shame about the consequences from their use and may not share information for fear that they will be looked down upon. Family, friends, and professionals may be held at bay even when the substance abuser wants and needs empathy and assistance. Persons with disabilities may perceive negativity from others because of the disability. When substance abuse is added, feelings of guilt and shame may compound the problem even more. A person experiencing a disability may go to even greater lengths to hide substance abuse to avoid the additional stigma.

Keeping this in mind, an interviewer needs to develop specific strategies for obtaining substance use information. It is crucial for interviewers to have a general knowledge of substance abuse as well as knowledge about the consumer's particular disability. Interviewers also must be aware of how a disability can mask the symptoms of substance abuse. Successful interviewers develop a personal style of interacting which is comfortable rather than forced.

### **Establishing a Relationship**

One of the most important factors in interviewing is the development of a positive relationship with the consumer. The rapport between the interviewer and the person with a disability should be established and maintained throughout all contacts. The ability to understand, convey respect, and be "real" are all factors in establishing the relationship. An interviewer's attitudes, feelings, values, and expectations also influence this rapport.

*Self-Image.* All of an interviewer's feelings and thoughts, including personal feelings toward self, affect the professional relationship. For example, if an interviewer feels a need to be liked, it may be difficult to confront a consumer. Likewise, an interviewer who has difficulty dealing with negative emotions such as anger or depression may structure the session in such a way as to avoid evoking these feelings.

It is a good idea to role play and practice interviewing with coworkers prior to interviewing consumers. When first attempting interviews about substance abuse, it may be normal to focus all attention on the reactions of the consumer. The interviewer may feel uncomfortable and awkward when talking with the consumer. However, with experience comes a level of comfort, and the interviewer will be able to focus more on the salient issues and behavioral symptoms.

*Values.* Values also play an important role in the helping process. Values refer to peoples' attitudes about something and their preferred actions and behaviors. An interviewer needs to be aware of values that reflect personal constructs about morality, ethics, and lifestyle in order to avoid imposing them on consumers. An interviewer who believes that using alcohol or other drugs is "sinful" or "stupid" may have great difficulty working with a client with another disability who uses these substances. In cases where there are strong personal reactions to this topic, refer persons with disabilities to specialists or other staff.

*Expectations.* Interviewer expectations also play a role in the interviewing session. Some expectations, such as the ability to change, can have a positive impact on the consumer and the outcome of the interviewing process. However, if these expectations are overly optimistic or pessimistic, the effects on the consumer can be detrimental. Professionals generally have a preference about the type of person they would like to work with. Sometimes there are misconceptions about the capabilities of clients, as in the case of believing that persons with disabilities are helpless and unable to make changes in their lives without assistance. The professional might visualize a chemically dependent person as poor, uneducated, and unmotivated.

*Extending the Information Gathering Process.* Although it is possible to conduct a chemical dependency assessment in one session, many rehabilitation professionals will work with consumers over a longer period of time. In these cases, the interviewing process can be divided into a number of phases. For the purposes of this chapter, three phases of the interviewing process will be discussed: 1) rapport building, 2) goal setting, and 3) actively transferring learned skills (Cormier & Cormier, 1979).

## Phases of the Interviewing Process

*Rapport Building.* This is the first stage in building a therapeutic relationship. The interviewer needs to help the consumer feel at ease and often begins by telling the consumer about the purpose of the interviewing sessions. Then questions are asked to invite the consumer to become involved in the process. The interviewer may just nod, give small words of concern and understanding, or reflect back what the consumer is saying in order to help the consumer feel comfortable. The interviewer is working towards building rapport with the consumer during this phase.

Rogers (1961) discussed three important conditions necessary to develop rapport. These are empathy, respect for the person, and genuineness. A person with a disability needs to observe and experience these three conditions to fully gain from substance abuse interviewing. This stage may take only a short time but it can take several sessions for a consumer to feel comfortable enough to talk about the details of the problem behaviors. The consumer needs to be able to view the professional as understanding and trustworthy before truthfully exploring problem areas. Sometimes rapport will not be established. Remember that it is ultimately the consumer's choice whether or not to work with a particular interviewer. A consumer can be referred to another professional when necessary. Once rapport is established, it is time to move to the next phase.

*Goal Setting.* In this phase the client begins to understand more about the problem to be addressed. Specific behaviors are explored, as are concepts of self, attitudes, and motivational forces. Any discrepancies in the information provided will be addressed in this phase, and a client's defense mechanisms will become more apparent to the interviewer. More direct questions about the consumer's use of alcohol and other drugs can take place during this phase.

The interviewing/assessment becomes therapeutic in itself, and if done correctly some clients become ready to make constructive changes in behavior (Miller & Hester, 1988). The consumer may not be willing yet to change using patterns, but future consequences for alcohol and other drug related behaviors can be outlined. Goals are developed and agreed upon, and then the consumer is ready to begin taking action.

*Transferring Learned Skills.* During this phase the established goals are worked on to promote behavior change. Goals are prioritized, alternatives are outlined for achieving each goal, and alternatives are selected. The consumer has an active role in choosing which alternatives to try. The plans are then implemented and evaluated. If a certain action plan is not successful, alternatives will have already been agreed upon. It is not enough for the consumer to only learn more about problems or to have new awarenesses about personality. For interviewing to be effective, positive behavior changes will occur. Consequences for any infraction of rules or violations of agreed upon behaviors must be consistently reinforced.

The above stages idealize an interactive process involving some degree of mutual cooperation between the interviewer and the client with a disability. The level of cooperation may be more difficult to maintain when substance abuse related discussions threaten the individual who is an active abuser. When the interviewer encounters resistance or hostility, there are two specific strategies which may be of assistance.

1. *focus the interview on historical questions and perspectives* "Have you ever experienced problems in the past because of substance use?" More specifically,

- Have you decided to "Cut down" your drinking?
- Have you ever felt "Annoyed" because of criticism of your drinking?
- Have you ever had "Guilty" feelings about your drinking?
- Have you ever had an "Eye-opener" in the morning (morning drinking)?

The above four questions are referred to as the "CAGE", derived from the first letter of the words in quotes (Ewing & Rouse, 1970). A positive response to any of these items will allow an exploration of contexts and consequences of drinking. Slight modifications to these questions work with prescribed or illicit drugs as well.

2. *maintain a non-judgmental and positive outlook when discussing substance abuse behaviors.* Regardless of whether or not an individual experiences a disability, they will be more willing to discuss their experiences and beliefs if the interviewer does not provide inadvertent negative feedback to their answers. For example, an interviewee may acknowledge that she has been arrested for a DWI in the past. If the contexts and outcomes of that experience are openly discussed without introducing value judgments the interviewer may discover that the arrest did have an impact on her short term goals regarding drinking. However, a lack of social supports and alternative activities made drinking increasingly more attractive and frequent again. The person being interviewed is reluctant to share this information because she feels guilty about her lack of "will power", and she would have avoided this issue altogether if it had not been specifically asked. This type of information can find its way into rehabilitation goals that include identifying and accessing peer groups or other social alternatives which promote non-drinking activities. It can also include a discussion of the differences between "will power" and being able to identify suitable alternatives for drinking.

These strategies may appear to be overly simplistic for someone who is attempting to develop or improve interviewing techniques. There are a number of training materials available which focus on substance abuse interviewing and assessment, and the reader should attempt to locate such materials which are discipline-specific. Professional associations, multi-media libraries, state departments for alcohol or drug abuse, or alcohol and other drug clearinghouses can assist in locating these materials. Some of these resources are listed in the Training Manual Appendices.

## CHARACTERISTICS AND SKILLS OF INTERVIEWERS

**Self-esteem:** The interviewer needs to be psychologically healthy and able to deal with life effectively in ways that enhance self-esteem. An interviewer's personal problems and issues cannot be allowed to enter the sessions. Those issues must be put aside when dealing with consumers. Interviewers should be sure of themselves in order to be a model for consumers. This does not imply that an interviewer is perfect; instead, there is a positive regard for self and the belief that the interviewer can effectively deal with life and assist others in dealing with their lives.

**Empathy:** This skill can generally be learned through experience and practice and refers to an interviewer's ability to understand another person's experience and to accurately express that understanding. An interviewer is not expected to have firsthand knowledge of every life situation which consumers have experienced; however, it is essential that the concerns of others can be perceived. The interviewer needs to "think with" a person with a disability instead of "think about" that person. Empathy can be conveyed through direct eye contact, leaning toward the consumer, and nodding of the head. Empathy is also conveyed through attentive listening, verbal comments reflecting feelings, and a willingness to problem solve.

**Respect:** Along with a basic respect for self, an interviewer will recognize the rights of consumers to their own identities even when behaviors conflict with personal beliefs. Respect also implies caring and concern for the consumer. It is important for the professional to show respect and to accept a consumer's right to behave a certain way (unless it endangers others). Additionally, an interviewer's attitude toward disability and/or substance abuse, especially if the attitude is condescending or overprotective, can undermine respect. If an interviewer has difficulties respecting and dealing with certain consumers, the consumer should be referred to another professional.

**Genuineness:** In an interviewing setting, genuineness means that feelings and nonverbal messages match what the person with a disability is feeling. The interviewer is able to be "real" as opposed to playing a role. For example, if the interviewer does not believe what someone is saying and the disbelief shows, and yet the interviewer states a belief in the consumer, there are mixed messages going to the consumer. Mixed messages are confusing and can hinder the interviewing process. In a similar vein, an interviewer must look beyond a consumer's disability and see the consumer as a person.

**Concreteness:** The professional will need to be able to help consumers express their thoughts and ideas in enough detail to reach the real issues. The person with a disability will probably only report broad issues and vague feelings unless the interviewer is able to focus on details and gently probe into other important areas. The focus should go beyond the behavioral symptoms and focus on the real issues, including substance use/abuse. In general, the interviewer should remember that there is more unspoken than spoken and that the information left unsaid is valuable.

**Self-disclosure:** Self-disclosure refers to an interviewer sharing experiences, feelings, and values when doing so will be helpful to the consumer. It is sometimes helpful to let the consumer know that the interviewer has had similar experiences and can relate to the consumer's problems. However, self-disclosure is not always appropriate, and thought must go into deciding when to disclose certain issues and when not to. Additionally the interviewer must have already dealt with those issues and must take care not to reverse roles with the consumer. It may not be appropriate for an interviewer to mention a relative with a disability as a means of establishing rapport with someone with a disability. In fact, statements like this may have the opposite impact on some consumers. *Remember, the more time the professional spends talking, the less time the consumer will have to talk.*

**Confrontation and feedback:** Confrontation is an important tool for interviewers to utilize. It assists the consumer in making essential connections, such as between actions and consequences and between words and behaviors. Confrontation is not an attack; it is

bringing a consumer face to face with reality in a gentle yet firm way. The professional needs to confront the consumer by pointing out that the nonverbal cues and behaviors are inconsistent with verbal statements.

Feedback is describing the consumer's behavior to the consumer. Making accurate self assessments is usually difficult for most persons, and when the interviewer can provide this information to the consumer, the consumer has a better chance of facing true feelings. For example, a consumer may deny being angry with another person, yet when talking about this person, behavioral changes such as a loud voice, red face, and other non-verbal signals of anger are exhibited.

**Observation:** Observation is important to interviewers because it provides information needed to understand what is going on with a consumer. Through observation, the interviewer will be able to pick up on nonverbal cues and will be able to identify inconsistencies. Simply watching a person can provide valuable information about that person's mood and feelings. This information coupled with what the consumer says helps the interviewer decipher the issues which brings the consumer into the interviewing sessions.

**Education:** Interviewing sessions, either individual or group, are an ideal time to provide education to consumers. Facts and data about alcohol and other drugs (or other pertinent information) can be presented to the consumer in a straightforward manner. Education can assist the consumer in developing new attitudes and to help the consumer handle feelings of guilt and shame. When an individual with a disability has the appropriate information, it is more likely that the changes in lifestyle suggested by the interviewer will be supported.

Interviewers should be honest in regard to what they know and do not know about substance abuse and/or disability topics. Persons providing educational activities must teach in their own areas of expertise. It is not necessary for an interviewer to be knowledgeable about every aspect of substance abuse and disability; however, the interviewer must be comfortable accessing and utilizing referral sources. Remember that most issues as complex as substance abuse and disability require a team or cooperative approach.

### For More Information

Cormier, W. & Cormier, S. (1979). *Interviewing strategies for helpers: A guide to assessment, treatment, and evaluation*. Monterey, CA: Brooks/Cole.

Egan, G. (1975). *The skilled helper: A model for systematic helping and interpersonal relating*. Monterey, CA: Brooks/Cole.

Okun, B. F. (1976). *Effective helping: Interviewing and counseling techniques*. North Scituate, MA: Duxbury Press.

Rogers, C. R. (1961). *On becoming a person*. Boston: Houghton Mifflin.

## INTERVIEWER SELF-RATING CHECKLIST

Read the following statements carefully and *check the statements which generally describe you*. After completing the checklist, refer to the scoring section at the bottom of the page. This exercise should provide you with a better understanding of possible problem areas to be aware of when you are working with persons with disabilities and/or substance abuse issues.

- 1. I usually don't feel confident about my ability to help others.
- 2. I sometimes find myself apologizing for my behaviors.
- 3. When possible, I try to avoid conflict or giving negative feedback to persons with disabilities.
- 4. I tend to be protective of persons with disabilities.
- 5. I become impatient with others who don't see things my way.
- 6. It is difficult for me to confront someone who has a disability.
- 7. I become annoyed or angry with persons who are resistant.
- 8. I would be hesitant to work with persons with histories of violence.
- 9. I would feel uncomfortable working with a person who is a substance abuser.
- 10. I feel uncomfortable around persons with disabilities.
- 11. It would bother me if a person obviously didn't like me.

### RATING YOUR ANSWERS

It is very normal to feel many of the above statements at one time or another, but generally these feelings happen during times of situational conflict or stress. If these feelings are the norm rather than a response to crisis, professionals should carefully consider whether or not they are in a position to assist consumers. Professionals working with persons with disabilities generally chose their respective jobs to fulfill a desire to help others. This sometimes makes it difficult to confront consumers about their harmful behaviors. In order to be an effective interviewer, a professional needs to be aware of limitations and possible problem areas, including a reluctance to confront consumers. Professionals with no experience working with particular issues (such as substance abuse, incest, and domestic violence) may best serve the consumer with these issues by making a referral to an expert.

Keeping this in mind, review the responses you gave and then use the following as a general guideline. **(Remember, this rating is not intended as an absolute and does not identify professional counselors.)** *Count the number of statements checked.*

- 0 - 2      Ready to interview
- 3 - 6      May need to refer consumers with special issues to a professional counselor
- 7 or more      Probably best to address substance abuse suspicions by referrals to substance abuse counselors

## OBTAINING SPECIFIC SUBSTANCE USE INFORMATION

Interviewing is a valuable source of information about substance abuse risk. Not only is information provided verbally, but also through non-verbal means. The consumer may not tell you everything that you need to know, and indeed may lie, but the nonverbal information you receive will also tell you much about the consumer. The information you receive will indicate whether or not further exploration into possible substance abuse problems is warranted.

The easiest recognizable symptoms of substance abuse are generally behavioral. Often they can be determined in one or two short interviews with the consumer. The interview can focus on these major life areas:

*Family:* concern expressed to consumer by family; divorce; separation; consumer not spending time with family; arguments; abuse.

*Social:* change of friends to those who use drugs; change of activities; activities centering around alcohol and other drugs.

*Work:* frequent job changes; attitude problems; tardiness; underemployment; poor relationships with co-workers and supervisors.

*School:* poor attendance; poor grades; sleeping in class; lack of interest in school activities.

*Legal:* arrests for DWI, public intoxication, disorderly conduct, theft, etc.; in trouble with police but not arrested.

*Financial:* selling prescribed medications; having problems paying bills (although the person receives enough money to do so); depleted savings or trust fund.

*Values:* what is important changes for no apparent reason; compulsive behaviors appear; new habits develop; loss of control.

Other symptoms of abuse are psychological in nature and may not be as easily identified--especially in persons who are only recently beginning to experience early symptoms of substance abuse problems. You can look for signs of psychological symptoms while you are interviewing the consumer. It may be beneficial to ascertain from other sources, such as family members and friends, if they have observed any of the following symptoms:

*Denial:* unintentional lying which the person believes is true.

*Guilt:* feeling bad about something said or done while under the influence.

*Shame:* negative feelings about self.

*Depression:* some signs of depression include sleeping for longer periods of time than usual, feeling tired all the time, loss of appetite, weight change, isolation, and lack of motivation.

*Rationalizing use:* making excuses for behaviors--"Smoking pot relieves my spasms", "I was celebrating getting an A", "I only had two beers and my doctor said it was o.k. to drink a little", "Drinking helps me fit in".

*Mood swings:* mood often changes for no apparent reason and seems to fluctuate between very high and very low; others are never sure what to expect from the person.

*Impaired thought processes:* thinking may become slow and irrational; person has memory difficulties; seemingly easy thinking tasks become more difficult.

*Lowered stress tolerance:* person's reaction to stress is more pronounced; person cannot deal with small stressors and tends to rely on substances in order to cope with stress.

*Personality change:* at first the change occurs when person is using substances, later this change occurs even when person is not using alcohol or other drugs.

*Decrease in motivation:* person loses interest in activities which had been important; the person may find it difficult to work or attend school.

*Anger:* person may express annoyance and anger when questioned about substances use; may be angry more often and others may not have any idea about why the person is angry.

Often the last group of symptoms to be identified or associated with substance abuse in persons with disabilities are physical signs and symptoms. Other than overt signs of withdrawal, persons with disabilities often can hide their physical symptoms of substance abuse by blaming their disabilities for any health problems that occur. In addition, many medical professionals don't tend to look for substance abuse symptoms in persons with disabilities unless they are specifically requested to do so. The following are some of the physical signals of substance use and abuse problems in persons with disabilities:

*Tolerance:* need for more of a substance in order to achieve desired effect; body's ability to process more and more of the drug; tolerance effected by the quantity and types of medications being consumed concurrently.

*Recurring infections:* infections become slower to heal and recur on a regular basis; common infections are bed sores, bladder, urinary tract, and sinus infections.

*Appearance:* may appear older than chronological age; person may stop taking care of appearance; may sweat excessively and be unkempt.

*Blackouts:* episodes of alcohol or sedative-induced amnesia; person will not be able to remember a period of time when under the influence; blackouts increase in length and occur more frequently in later stages of abuse/dependence.

*Injuries:* frequent falls; scrapes; bruises; car accidents.

*Stomach problems:* chronic upset stomach; cramps; using antacids regularly; change in eating habits.

*Weight change:* may go up or down depending on the type of substance used and any changes in eating habits.

*Malnutrition:* may be diagnosed by physician; person eats very little or food has little nutritional value; may look gaunt, tired, pale.

*Increase in spasms:* frequency and duration of spasms may increase; person who never used medications for spasms before may request a prescription.

## **POINTS TO REMEMBER WHEN INTERVIEWING FOR POSSIBLE SUBSTANCE ABUSE**

### **Defenses**

- People tend to minimize and rationalize their alcohol and other drug consumption as well as problems which occur because of their use.
- People may feel threatened and become defensive when asked about their alcohol and other drug use.
- Denial is prevalent in persons who abuse substances. This unintentional lying is often well ingrained--these persons believe the stories they tell.
- Be careful not to let the consumer focus solely on the disability. It is common for a person with a disability and substance abuse to blame the disability for what is wrong in life.
- Observe body language for signs of discomfort with the discussion. Watch for lack of eye-contact, slouched and closed posture, nervousness, and pauses of inappropriate length (too long or too short) before responding to questions.

### **Obtaining accurate information**

- It is better to interview clients when they are sober rather than under the influence. If a person reports for services, work, or school under the influence, it is better to handle the immediate issue (i.e., suspension from work or school, canceling appointment due to the person's intoxication, etc.) and schedule another time to confront the substance abuse issue.
- Information may be more accurate if the person is asked questions about the use of substances on specific memorable days. For example, "How many drinks did you have yesterday?" or "Tell me what you drank at the party Friday."
- Have specific reasons for why you are questioning the consumer's alcohol or other drug use. Present the consumer with facts--not just a suspicion that something must be wrong. Remember that not all consumers who drink or use other drugs are substance abusers or in need of treatment.
- Ask the client with a disability for permission to interview family members or other significant persons. Even though it is common for significant others to be in denial of substance abuse problems and enable the use of substances, they often can confirm how often the person refills prescribed medications, how often or how much the person drinks, who free time is spent with, mood changes, job changes.

### **Professional ethics**

- Confidentiality is an important issue--especially when illicit substance use is acknowledged or when a person is under the legal age to use alcohol.
- Be supportive and understanding--not judgmental--when interviewing the consumer. Ask open-ended questions instead of "yes" or "no" questions.

## JANE: A CASE STUDY\*\*

*Jane describes her childhood as one of withdrawal, loneliness, emotional detachment, introspection, and unhappiness. She sees herself as an adult child of an alcoholic and an incest survivor who adjusted to her dysfunctional family situation by developing chronic depression, as well as substance abuse problems that plagued her from young adulthood to age 37. While she has been successful in recovering from the alcohol and other drug problems (she has been clean and sober for 8 years), Jane continues to experience major life difficulties stemming from her chronic depression. Today she is a 45 year old, single mother whose children are 22 and 23 years old. She has been diagnosed with the primary disability of Chronic Depression.*

*Jane's drinking began during the early years of her marriage. She states that as soon as she began drinking, she was drinking "alcoholically." She believes that she inherited this tendency from her father. He was also an alcoholic, who died several years ago due to complications arising from his drinking. Jane does not speak easily about her father, only acknowledging that on at least two occasions during her adolescence he made overt sexual advances to her. Nor does she talk much about her marriage and her life in the Midwest. Following her divorce, Jane began drinking heavily to deal with feelings of loss and loneliness. She sought counseling to deal with the divorce and to receive support during her transition to single parenthood. During this period she also discovered the effects of marijuana and began to seek out social situations at which pot was present.*

*After her relocation to the San Francisco area, Jane stopped drinking because of a romantic relationship; however, during this period her drug use continued with the addition of cocaine to her repertoire. When the relationship ended, Jane returned to drinking but found that her tolerance to that drug had decreased considerably. She began using cocaine in conjunction with alcohol to keep from getting "too drunk." During this period, Jane describes herself as intensely depressed. At times she was unable to leave her home for work because of her feelings of immobility. She was also experiencing considerable difficulty caring for her children, as well as meeting financial obligations.*

*At this time, Jane sought assistance through the county system of mental health services. She remembers being evaluated for hospitalization at a mental health crisis center where she was immediately prescribed tranquilizers without any attention to the fact that she acknowledged significant alcohol and other drug abuse. Jane describes her experiences with the mental health system in largely negative terms, but acknowledges that she was in need of psychiatric help.*

*One night Jane was listening to a radio talk show which focused on alcohol and other drug problems among women. She was able to identify some of the warning signs in her own life, especially relating to her children. Although only 13 and 14 at the time, both her daughter and son were using alcohol and other drugs regularly. Frightened and acutely motivated, she immediately took action by going to a meeting of Alcoholics Anonymous. Jane began attending meetings regularly, but her depression worsened, or at least became more evident to her. Her life was still chaotic and she and her children were living in hotels, constantly on the verge of eviction, and not eating properly or regularly.*

*Jane began receiving counseling services at a publicly funded women's chemical dependency program. Initially her experience at this agency was positive, but the program staff's inflexibility towards Jane's particular situation resulted in her leaving the program after a short time. The reason for her premature termination from the program stemmed, at least in part, from the staff's rigidity in negotiating her recovery plan. As counseling progresses, they insisted that Jane give up her children to a foster home. Their reasoning stemmed from the*

*belief that the pressures of parenting two adolescent children while on public assistance would, in their opinion, inevitably precipitate Jane's relapse. In addition, staff felt that the inner-city, economically depressed housing conditions of Jane's neighborhood were inimical to the well-being of her children. To force the issue, program staff made continuation of counseling contingent upon turning the children over to foster care. Since she was unwilling to take this step, Jane withdrew from the program. Today she acknowledges with some animosity aimed at the counseling service, "The fact is that I kept my kids, I didn't drink, and I eventually moved into a better housing situation!"*

*About a year into her recovery, Jane joined a clean and sober support group at another urban alcohol and drug agency. At this program she also began to attend an incest survivors support group. Her decision to seek help for this additional problem was propelled by the fact that early in her recovery she knew that the negative interpersonal relationships she had with men were inextricably tied to the fact that her father had attempted to sexually abuse her.*

*Jane believes that the several alcohol/drug counselors with whom she has been involved were remiss in not diagnosing this condition. At the very least, she believes they should have suspected an underlying depression and referred her for more specialized testing and treatment. She also experienced a lack of sensitivity to her mental health problems among fellow members of Alcoholics Anonymous. She feels that many members share a belief that one can overcome emotional difficulties by a simple act of willpower. They carry over the AA philosophy of "not drinking a day at a time" to fighting depression and despondency by similar methods.*

*Throughout the past 15 years, Jane has been the recipient of a variety of social, mental health, and substance abuse services. Indeed her continuing survival and recovery in the face of significant obstacles is partly the result of her savvy at understanding and utilizing these various service systems. Only recently, however, has the issue of her ongoing depression been addressed by any of her professional caregivers. Jane now considers herself a person with a mental disability and believes strongly that her difficulties in recovery might have been significantly ameliorated if this combination had been identified sooner.*

**\*\* Adapted with permission from Final Report: Case Studies Project--An Investigation of Alcohol and Drug Problems and Recovery Among Five Persons With Disabilities. John de Miranda, 1991.**

Copies of this report are available by contacting Peninsula Health Concepts listed in the Resource Section of this manual.

## SUBSTANCE ABUSE INTERVIEWING AS IT RELATES TO JANE

Jane's chronic depression is characterized by a depressed mood, loss of interest and pleasure for previously enjoyed activities, fatigue and loss of energy nearly everyday, feelings of worthlessness and guilt, diminished ability to concentrate and make decisions. Her depression is chronic because it lasted more than two years without a significant period of relief from symptoms (DSM-III-R, 1987).

An association between depression and substance abuse is common. Many persons with substance abuse problems relate episodes of depression, and in fact, many persons with depression use alcohol or other drugs as a means of coping. In Jane's case, her depression occurred prior to her drinking and was found to be endogenous, meaning that its cause came from within and was not merely a response to difficult situations. Her depression is likely biologically based and due to a chemical condition. In contrast, some people who abuse substances become depressed due to their use.

Jane sought counseling to deal with her depression on several occasions, both before her substance abuse was identified and after. At one mental health facility, Jane admitted that she frequently abused both alcohol and a variety of other drugs, yet she was given tranquilizers immediately. These professionals attempted to address the depression, yet they ignored the obvious substance abuse symptoms, thereby enabling Jane's ongoing substance abuse.

After obtaining sobriety through involvement in Alcoholics Anonymous, Jane sought counseling again for her depression through a women's chemical dependency treatment program. The staff addressed her substance abuse recovery issues, but did not identify her chronic depression as a disability requiring attention. The staff philosophy seemed similar to the philosophy of some AA members that not drinking and working the AA program will solve all problems including depression. In fact, Jane related that some AA members, herself included, did not believe that medication was a viable option for dealing with her disability.

Jane received conflicting information from several professional sources and had difficulty knowing what information to believe. Her use of substances was enabled by the mental health professionals, and her recovery issues were complicated by chemical dependency professionals not recognizing her disability of Chronic Depression. Although Jane is bitter about some of the experiences she has had with professionals, she understands their important role, and currently she is involved in support group and counseling activities.

## TEST YOUR KNOWLEDGE ABOUT SUBSTANCE ABUSE INTERVIEWING

The following questions are based on the information contained in the Chapter you have just read. The answers are found in Appendix G.

1. If a person with a disability chooses to lie about substance use, there will be no useful information derived from the interview.

TRUE FALSE

2. Which of the following will make the interviewing of a consumer difficult?

- |                                     |  |
|-------------------------------------|--|
| a. negative stereotypes             | b. the stigma of substance abuse                   |
| c. disability masks substance abuse | d. professional lack of knowledge about disability |
| e. none of the above                | f. all of the above                                |

3. One of the most important factors in interviewing is developing a \_\_\_\_\_ with the consumer.

4. The three phases of the interviewing process are:

\_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

5. In Jane's story (see Case Study), her Chronic Depression was brought about by substance abuse.

TRUE FALSE

6. Self-disclosure is always appropriate and appreciated by the consumer.

TRUE FALSE

7. \_\_\_\_\_ cues are as important as verbal information to the interview process.

8. The easiest symptoms of substance abuse to recognize are generally \_\_\_\_\_.

9. Unintentional lying is:

- |                    |                      |
|--------------------|----------------------|
| a. rationalization | b. guilt             |
| c. denial          | d. none of the above |

10. If a consumer reports to work high or intoxicated, the best plan is to confront the person's use and to gather information about the person's use on the spot.

TRUE FALSE



**CHAPTER SIX**

**FINDING SOLUTIONS TO SUBSTANCE ABUSE PROBLEMS  
FOR PERSONS WITH DISABILITIES:  
INTERVENTION, TREATMENT, AND RECOVERY**

## ABSTRACT

THE EFFECTS OF THE 3 STAGES OF POSTOPERATIVE  
WOUND HEALING WITH SPECIAL  
REFERENCE TO THE TREATMENT AND  
PREVENTION OF WOUND HEALING

# FINDING SOLUTIONS TO SUBSTANCE ABUSE PROBLEMS FOR PERSONS WITH DISABILITIES:

## INTERVENTION, TREATMENT, AND RECOVERY

Once substance abuse has been identified, professionals often are uncertain about the steps to take in order to find appropriate solutions. Some consumers with substance abuse issues will recognize their problems with limited external assistance; however, the majority of consumers may be completely unaware of the effects of substance use on their lives. Even when a consumer agrees to seek assistance for such a problem, adequate services may not be readily available.

This chapter focuses on intervention techniques, treatment considerations, and recovery issues. The following components are included:

I. Intervening With People With Disabilities Who Abuse Substances.....	2
II. Strategies For Categorizing Substance Abuse Level.....	6
III. Structuring A Successful Formal Intervention.....	7
IV. Substance Abuse Treatment Considerations For Persons With Disabilities.....	9
V. Recovery Issues.....	12
VI. Personal Story: "Maria".....	16
VII. Comments on Maria 's Story.....	19
VIII. Test Your Knowledge.....	20

## INTERVENING WITH PEOPLE WITH DISABILITIES WHO ABUSE SUBSTANCES

**The Scenario.** *Dan, a young man with cerebral palsy, is late for his job try out at the rehabilitation center for the third time this month. His performance on the job has been off during the last week, and other consumers have requested to be moved to work stations away from him because of his negative attitude toward them. His case manager called Dan's group home supervisor yesterday and discovered that Dan was staying out later than usual and that on several occasions he had returned to the group home smelling of alcohol. Dan's case manager suspects that Dan is using alcohol on a regular basis and that some of his rehabilitation problems are related to his drinking. Dan is prescribed a small dose of Valium to take on a daily basis to prevent spasms, and he may be drinking while taking his medication. Although the case manager suspects something is wrong, she is unsure of what to do.*

Variations on this scenario are played out daily in rehabilitation and educational settings. Professionals working with persons with disabilities often are not equipped with the information needed to deal with this type of situation. Historically, interventions are not attempted, consequences are not consistent, and the consumer's substance abuse behaviors have continued.

**Defining Intervention.** In relation to substance abuse, intervention is generally defined as interrupting someone's problematic involvement with mind altering substances. Without this interruption, it is assumed that the person's use will continue and probably worsen. The philosophy behind intervention is that it is possible to interrupt substance use problems before the person "bottoms out." Often, a crisis in a legal, work, school, or family life area precipitates an intervention. For example, courts, schools, student assistance programs, and medical personnel conduct interventions routinely.

**Disability Issues Confuse Intervention Attempts.** One of the difficulties in providing intervention services for persons with disabilities is that substance abuse symptoms are not recognized. Therefore, substance abuse becomes severe before it is identified. Professionals often feel ambivalent about confronting consumers because it is very difficult to separate disability from substance abuse behaviors.

=====  
*During a ten year period while I was living in nursing homes, I was hospitalized 31 times. It was generally accepted that it was because of my disability, because of the old attitude that disabled people are sick and need hospitalized all the time. Looking back on things, only one of those hospitalizations was legitimately related to my disability. All the others were a direct result of chemical use because I wasn't taking care of myself. I was drinking so much alcohol that my immune system was shot.*  
"Frank", a recovering alcoholic  
with a physical disability  
=====

Many substance abuse professionals identify a crisis such as expulsion from school, reprimands at work, or legal charges as opportune times to intervene. One type of intervention is based on the premise that concerned persons significant in a consumer's life can initiate a crisis situation from which positive changes can occur (Johnson, 1975). A formal intervention involves structuring a meeting between the substance abuser and significant people in that person's life. Generally, a formal intervention is based on the knowledge that the consumer is a substance abuser, and the goal is to make that person aware of these problems with alcohol and other drugs. A second purpose is to convince the consumer to seek assistance for these problems.

••• **Remember:** *It is not necessary, and can be detrimental, to try to label a person with a disability as chemically dependent, alcoholic, or a substance abuser. If a consumer can come to terms with the fact that alcohol and /or other drugs are creating problems, an intervention has been extremely successful. The consumer needs to explore behaviors, patterns of use, and consequences that may be related to chemicals. The intervention can be viewed as a pre-treatment effort (Donovan, 1989).•••*

### Aspects of Intervention.

1. *Education.* This is crucial to the intervention. The person with a disability needs to be made aware of how alcohol and other drugs can be especially hazardous in light of the disability. The consumer must learn the role alcohol and other drugs play on feelings and emotions, and how it effects different life areas, such as work, family, and social life. A variety of modalities can be utilized to educate consumers. Films, lectures, group discussions, workbooks, case studies, and self-help group involvement can all play important roles in the educational process. Don't overlook consumer to consumer or peer assistance possibilities. Sometimes these types of assistance are the most comprehensible.

2. *Screening tests.* It may not be easy to convince some persons with disabilities to participate in assessment activities such as seeing a psychologist or taking screening tests. During these early contacts, it may be better to downplay the substance abuse aspect and identify behavioral reasons or other educational issues which make screening tests beneficial. For example, if the person is involved in classroom activities, it may be beneficial to administer the screening tests to the entire class. Or the person may be asked to complete a screening test as a standard part of an intake procedure.

There are a number of services and screening instruments available to assist with the identification process. There may be professionals in the area who are familiar with disabilities and substance abuse as well as AOD treatment personnel who have access to instruments such as the CAGE, Michigan Alcoholism Screening Test (MAST), and the Trauma Index, all of which are commonly used to identify substance abuse problems.

3. *Gathering additional assessment information.* Additional consultations may also be helpful in the investigative stages. Get permission to contact family members, friends, dorm advisors, employers, etc. to gather additional information about possible substance related problems. Significant others most likely will be willing to share information provided they are not asked (or put in a position to make a judgment about) whether or not the person is a substance abuser. The information provided should be behaviorally specific, such as how much the person uses on a daily, weekly, or monthly basis.

It will also be important to look at the consumer's medical history, prescription drug use, and personal history as well as test results when attempting to determine if substance abuse is present. Additionally, professionals will want to make use of their own observations of the consumer and any written documentation available.

4. *Interviewing and processing information.* Repeated contacts or education about substance abuse can be conceptualized as an intervention. The consumer will need to process the information learned throughout the intervention. Following involvement in educational activities, meet with the consumer and discuss what has been learned. This will give the consumer a chance to ask questions and clarify information. This will also provide the opportunity for the information to be applied to the consumer's own situation. The professional can observe the consumer's behavior and reaction to the information. These repeated observations are often more valuable in assessing substance abuse than other more direct methods.

**Other Important Considerations.**

*Reality checking.* After information is gathered from a variety of means, a reality check needs to be completed by sharing, in a general way, the original concerns with the person with a disability. Confront the consumer in a caring, non-threatening manner. Expressing concerns to a consumer will not be as threatening as many professionals believe. Frequently, if a problem is suspected, more than one person has the same suspicion. In fact, consumers often know when they have substance abuse issues.

=====  
*During my medical rehabilitation, I had six sessions with the psychologist. He seemed afraid to confront me about my drinking. We danced around the issue before he realized that I knew I had a substance abuse problem. When we finally came to that understanding, he realized that the hospital unit was not set up for this type of counseling.*  
"Roger", a chemically dependent person  
with a physical disability  
=====

*Addressing denial.* Once substance abuse behaviors and consequences have been identified, the goal of the intervention shifts. The next step is educating the person with a disability about the fact that alcohol and/or other drugs are creating the problems being experienced and that a change is essential.

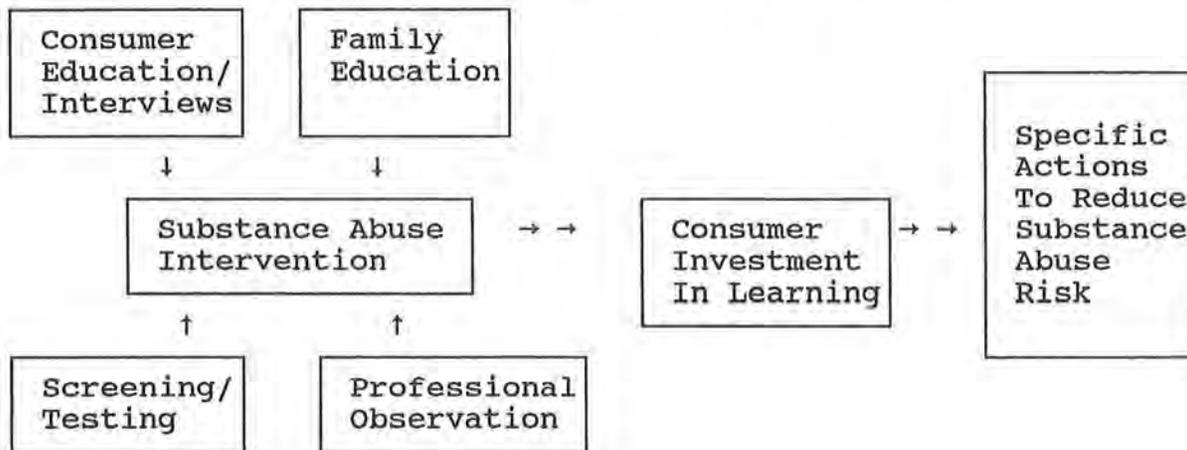
*Motivation.* Motivation refers to helping the person with a disability realize that action is needed and assisting the consumer in deciding to accept professional or group assistance. If the majority of the intervention process up to this point has been positive, the consumer will be more likely to see that participating in a structured activity, whether treatment or a support group, is valuable and reasonable.

*Exploring treatment alternatives.* Professionals need to be aware of the variety of treatment options available in their communities. A number of factors should be considered when determining which alternative is best for a certain consumer. These include drug use patterns, specific risk factors, physical health, prescribed medications, severity of life area impairment, consumer maturity, family or other support, and motivation. It is important to be sensitive to individual needs when exploring treatment or other helpful alternatives. Some consumers may benefit more from one-on-one counseling, family counseling, or support groups than traditional chemical dependency treatment.

*Matching persons with disabilities to treatment alternatives.* People with disabilities should have individualized or prescriptive treatment even when experiencing similar problems. Traditional chemical dependency treatment settings find it difficult to provide truly individualized treatment options. It will be up to the professional to try to match the consumer with appropriate services. One approach is to allow the persons with disabilities to "self-match" their needs with a treatment alternative (Miller and Hester, 1989). The consumer will probably be more motivated to follow through with additional services if given a choice from a variety of alternatives.

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*I think [any program] can be accessible physically. It's not a great deal of work to add ramps or some grab bars. More importantly, I think we need to look at attitudinal accessibility. Accessibility where someone with a disability who's coming into the program will have access to all areas of the program and will be expected to participate in all areas of the program.*  
"Jim", a recovering alcoholic and  
chemical dependency counselor  
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## COMPONENTS OF THE IDEAL INTERVENTION



### Planning A Formal Intervention

Sometimes formal interventions are the only, or best, means for addressing suspected substance abuse because of the immediate threat to physical health or the chronicity of the condition. When this is the case, special planning must take place prior to the intervention. The purpose of the formal intervention is to confront behaviors and convince the person with a disability that some sort of action must be taken.

There are three important things to remember when planning an intervention:

- If substance abuse symptoms occur, they can become progressively worse. The sooner an intervention occurs, the fewer resources are needed for arresting the problems.
- Substance abuse is an issue separate from the disability. In other words, **treating or dealing with only the disability won't extinguish any substance abuse problems.**
- Because it is often difficult to distinguish between disability and substance abuse behaviors, identifying persons significant to the consumer (parents, siblings, attendants, teachers, employers, social service case managers, residential advisors, probation officers) will be helpful to include in the intervention.

*Involving significant others.* Each person agreeing to be involved needs to make a commitment to stay involved no matter how the consumer may react. These significant persons need education about the risks of substance abuse and the defenses often associated with substance abuse. The risks of both doing and not doing the intervention should be discussed as well. The significant persons involved in the intervention can be educated about enabling behaviors and how those behaviors can be detrimental to the consumer. Predicting how the consumer may react and planning strategies to avoid enabling behaviors will also be helpful to discuss. Chances are the consumer is aware of how others can be manipulated, and team members need to be alert to such attempts and supportive of other team members.

*Behavioral observations.* Whenever substance abuse is suspected, clear behavioral observations must be documented. These observations will form the basis of any confrontations. Have specific behavioral examples for why you are questioning the consumer's

alcohol or other drug use. Present the consumer with facts--not just a suspicion that something must be wrong.

*Maintaining an historical perspective.* By the end of the intervention, the consumer must be made aware of future expectations and what behaviors will no longer be accepted. It will be important for all persons involved to realize that most interventions have some element of success although the success may not be apparent at the time. Substance abuse problems develop gradually, and recovery from substance abuse is also gradual.

### STRATEGIES FOR CATEGORIZING SUBSTANCE ABUSE LEVEL\*

Current Involvement	Symptoms/Diagnosis	Intervention Suggested	Level of Risk
No apparent problem.	Abstinence or minimal use; no evidence of problem use noted. Rehabilitation plan does not include habit-forming medications.	Some substance abuse risk education advised (e.g., medication precautions and posttrauma issues).	Low risk.
Mild problem.	Few consequences of abuse acknowledged; no persisting or recurring abuse evident.	Specific substance abuse risk education advised (e.g., medications, posttrauma issues, risk for increasing use.	Moderate risk.
Harmful involvement.	DSM-III-R substance abuse criteria met.	Concurrent substance abuse education and/or treatment advised.	Significant risk for problems, including secondary disabilities.
Moderate problem.	DSM-III-R substance dependence in "mild" or "moderate" range.	Concurrent chemical dependency treatment strongly indicated.	Considerable risk for additional problems and secondary disabilities.
Severe problem.	DSM-III-R substance dependence in "severe" range.	Requires immediate, intensive, and highly structured chemical dependency treatment.	Continued consumption is life-threatening.

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Moore, D. (1992). Substance abuse assessment and diagnosis in medical rehabilitation. *NeuroRehabilitation*, 2(1), 7-15.

## STRUCTURING A SUCCESSFUL FORMAL INTERVENTION

### 1. Prior to deciding whether or not an intervention is in order, the following should be considered:

#### A. Behavioral symptoms of substance abuse are documented in detail.

1. Descriptions of incidents.
2. Times, dates, and locations of incidents.
3. Reports from other agencies, professionals, peers, or family members.

#### B. A Substance Abuse Screening has been completed and results documented.

1. Professional reports which include substance use information.
2. Test results from screening instruments, psychometric tests, or assessments.
3. Urine screening or toxicity results for abused substances.

#### C. A reality check with the individual and other significant persons has been conducted for additional evidence that substance abuse is a problem.

1. Confirm behavioral symptoms.
2. Record or chart concerns. Discuss concerns with other staff.
3. Determine whether previous intervention attempts have been made.

### 2. Plan the intervention. Make the following decisions:

#### A. Who will participate?

It is best to involve persons of authority as well as significant others, but don't include so many persons as to overwhelm the consumer.

#### B. What is the expected outcome?

Some type of treatment or professional assistance is the usual outcome. Several types of treatment may be explored, and the consumer may be given a choice of treatment alternatives. Have treatment alternatives outlined and discussed in advance.

#### C. What will happen if the consumer refuses to acknowledge a problem?

Consequences must be planned in advance, and the participants must agree to follow through with the consequences if the consumer refuses help.

#### D. Who will be responsible for directing the intervention?

A counselor or someone experienced in substance abuse interventions would be the ideal leader. A family member probably should not be chosen to lead the intervention. The leader will be responsible for supporting all participants, explaining to the consumer why the intervention is taking place, and explaining the proposed course of action.

3. **Choose a location for the intervention.** Generally, the setting should be non-threatening. For example, chose a neutral site which does not create a negative mindset for the person with whom the intervention is being attempted. On the other hand, some very effective interventions utilize criminal justice rites, including detention homes or jails. This may work best with more youthful abusers.
4. **Meet in advance with all participants except the consumer. The following should be included in the meeting:**

*A. Education about enabling.*

Family, friends, and professionals may all have enabled the consumer's use of substances; however, many of these persons don't recognize the connections. Education is important to assist significant others to avoid further enabling.

*B. Discussion about specific behaviors of the consumer relating to substance abuse which could be used as examples during the intervention.*

It is helpful if persons involved in the intervention write detailed examples of how the consumer's use of substances has harmed them. The incidents should be described in an objective, straightforward manner.

*C. Plan a time for a rehearsal of the intervention.*

It might help to practice the intervention in advance. The participants should have their lists ready to read and should practice reading them to other participants. The leader can help participants decide what to do when the consumer becomes defensive, angry, or tearful. The group can attempt to predict what the consumer will do and plan their responses. Treatment alternatives should be discussed in advance, as well as actions if the consumer chooses not follow through.

5. **During the intervention, remember the following:**

*A. Be prepared for the consumer's fear and anxiety which may surface as anger, tearfulness, insincere compliance, or withdrawal.*

*B. Create an atmosphere of genuine concern.*

*C. Express the hope that the consumer will enter some type of treatment or program of support.*

*D. Tie specific expectations and consequences to the intervention.*

*E. The intervention will be successful, even if the consumer refuses treatment, because the situation is more in the open and future plans have been discussed.*

## SUBSTANCE ABUSE TREATMENT CONSIDERATIONS FOR PERSONS WITH DISABILITIES

Addressing substance abuse issues is difficult for any population, but especially for someone with a disability. People with disabilities must appreciate how substance abuse effects them even when other well-meaning persons may be indirectly encouraging use. Fewer social, programmatic, and recreational options exist for people with disabilities, especially when major changes in lifestyle are being attempted. For these reasons, assistance and additional resources are necessary to adequately address substance abuse problems. The assistance can take a variety of forms depending on individual circumstances and needs. For example, individual counseling, support groups specific to disability, specialized alcohol and other drug treatment, medication adjustments, and case management may be necessary for specific situations.

**Defining Treatment.** Substance abuse treatment is generally viewed as a means of ameliorating the negative consequences experienced from the use of alcohol and other drugs. Treatment can be formal, such as an inpatient or outpatient setting. Treatment, as it relates to persons with disabilities, can also take on other forms, such as rehabilitation, behavior contracting, empowerment, and resistance skills training. Self-help support groups, such as Alcoholics Anonymous, are not considered treatment, but they may be very important for someone who is seriously attempting recovery.

The treatment of substance abuse is relatively new, and because of this, treatment generally is not individualized. Formal substance abuse treatment was developed for white, middle-aged males and has enjoyed considerable success with this general population; however, its effectiveness with special populations is largely unknown. For example, treatment of those dually diagnosed with mental illness and chemical dependency is a matter of great concern today, yet research indicates that traditional treatment has been marginal for this population (Brown, 1989). Similar problems also exist when chemical dependency treatment is considered for persons with other disabilities. There is a need for specialized treatment services for persons with disabilities; however, they should not necessarily be isolated from others. Similarly, their problems should not be attributed to the disability or viewed as "less than" the problems of traditional treatment populations.

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*An area of problem for me (in treatment) was that they would have exercises in the morning and there was no adaptation for me so I just was not able to participate in that activity. Another activity I did not participate in was evening walks or other physical activities like volleyball or sports and there were no adaptations for myself, so I often felt left out, different than, not a part of, and just not included in the overall community and the activities that were going on. These issues for me were not addressed.*  
"Maria", recovering addict  
with a spinal cord injury  
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Rehabilitation professionals can be tremendous allies for chemical dependency treatment service professionals. They can assist in developing methods of programming that will make sense to the person with a disability. Multi-agency assistance is critical for successful case management and rehabilitation of an individual with a disability.

**Specialized services may be needed for persons with disabilities.** Specialized and prescriptive treatment services are crucial for some persons with disabilities, yet these services can be very costly in terms of time as well as money. Case managing a person with a disability is likely to take more time and energy throughout the treatment process. It may be easier to distribute responsibilities among several staff members and utilize a

team approach instead of placing the professional burden on one person. The team approach also is useful since many professionals tend to focus on a person's disability and its cause rather than on the substance abuse. Professionals must be careful not to view substance abuse as being a "normal" part of a disability.

Many of the treatment services offered today focus on a traditional disease model which educates consumers to chemical dependency as a disease. Although the disease model is a viable method of substance abuse treatment, it is possible that this treatment model may be less successful with persons facing multiple diagnoses. Often, persons with disabilities who already are living with one medical problem or disease have difficulty relating to substance abuse as a disease.

Substance abuse treatment objectives may need to be adjusted for some persons with disabilities. Treatment programs often use cognitive therapies throughout all program activities. Communication problems, memory difficulties, and lower functioning levels all can complicate these approaches and methods and will need to be addressed. Additionally, persons with disabilities often have some type of social isolation issues due to a communication problem or from social isolation. It is not uncommon for consumers to present to treatment with low self esteem, self hatred, depression, and/or a low level of motivation to make changes. Some of the components of treatment may need to include: learning new ways to deal with disability, social situations, loss, anger, sexuality, and independent living skills.

Another factor important to the treatment process is medical education and monitoring. Many treatment providers have policies against the use of medications--especially mind altering medications--during all phases of treatment. It is a fact that many persons with disabilities are prescribed numerous medications. They may require the ongoing use of these medications during the remainder of their lives. Abstinence versus controlled medication use will be one of the most difficult issues for treatment service providers to deal with.

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*What has become clear is that if a client is both chemically dependent and physically disabled, treatment has little chance of being successful unless both issues are addressed. Unless both issues are addressed, the disability continues to be a "ticket" to justify chemical use and the chemical use enables the person to remain "stuck" in the disability.*

Sharon Schaschl and Dennis Straw  
CD and Physical Disability Program  
Sister Kenny Institute

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*Disability issues.* Additionally, "handicapped" behaviors must be recognized and dealt with by the chemical dependency treatment staff. This implies that at least one person on the treatment staff will have to be practiced in dealing with persons with a variety of disabilities. Some manipulative behaviors are unique to persons with disabilities, and they are not known to the general population. If a consumer experiences a disability which is not readily apparent to others, additional problems may arise. For example, some persons with learning disabilities may appear to understand all of the cognitive and abstract concepts being presented, when in fact they do not understand. Situations such as this are frustrating for both consumer and treatment staff.

Almost all treatment programs have a component involving significant others. This is especially important as family involvement is crucial when working with persons who have disabilities. Some persons with disabilities rely on adult norms and parental figures more often than peers or others. Additionally, significant others may supersede enabling

of substance abuse "entitlement" at which point the family member actively supports the substance abuse.

**Aftercare.** Aftercare is the extended treatment and self-help contact after the initial treatment program is completed. It is a critical component of recovery. Aftercare is important in order to reinforce learning, provide new educational information as it becomes appropriate, provide continuing assistance in recovery by discussing problems as they occur, provide assistance when the person with a disability is making lifestyle changes, develop linkages with the sober community, and continue supportive relationships with counseling staff and fellow consumers developed during treatment. It requires planning and follow through, and it is perhaps the most important component of treatment. Substance abuse can be more chronic for persons with disabilities. For this reason, aftercare should be planned from the very beginning of treatment.

Specific components of aftercare may need to be expanded for persons with disabilities. A therapeutic relationship which has developed with a counselor may need to be extended longer than the average relationship with non-disabled peers. Educational efforts may need to continue throughout the course of aftercare. Some topics which may be more appropriate to address in greater detail during aftercare include training and employment issues, medical concerns, and social development.

Social service providers can become more involved during the aftercare component of treatment. Some possible service providers to include are medical and health care professionals, rehabilitation professionals, case workers, probation officers, residential advisors, employers, and educators. All involved parties will need to be especially concerned about monitoring behaviors during aftercare. It will be important for as many professionals as are working with an individual to be involved in the aftercare component of treatment, especially since persons with disabilities are more easily able to shield themselves from the consequences of chemical use.

**Contracting.** One particularly helpful idea is to create and implement an aftercare plan/document to be signed by the consumer and other appropriate persons. This document would serve as a contract between the consumer and all involved parties. The plan should list all persons who will be involved with the person with a disability and who will be given copies of the plan. The person with a disability should know from the beginning who will be monitoring behaviors and reporting progress to the treatment staff. The aftercare document also can include a plan for chemical use. If necessary, the medications the person is prescribed to take and who will monitor the use of prescription medications should be written down. A commitment will be obtained from the consumer to attend certain support groups and meetings, assigned programs such as rehabilitation or school, and other meetings. The locations and times may need to be documented in order for everyone involved to know the consumer's schedule. Included with this section can be a list of significant persons and phone numbers. Self help group sponsors, contacts, advocates, and other important resources for the consumer should be written down, with phone numbers.

It will be especially important to address the specific behaviors which are to be avoided for the maintenance of sobriety. These behaviors should be identified, preferably with all responsible parties including the consumer involved. The specific behaviors can be identified on the aftercare document. The consumer and all persons signing the aftercare document should have a clear understanding of the behaviors and consequences for any infractions. Consequences will need to be given for each violation of the rules and must be given consistently by all parties involved. Names of persons to be informed about violations must also be agreed upon. Monitoring and documenting progress during aftercare can also provide useful information upon which to base future decisions.

*Remember...* Many persons with disabilities are either underemployed or unemployed; therefore, it is beneficial for the aftercare plan to include a component for addressing ways to increase employability. The same need is present for development of social skills. Activities for the person to become involved in, and a social plan to occupy free time, should be included in the aftercare document.

## **SUBSTANCE ABUSE RECOVERY ISSUES FOR PERSONS WITH DISABILITIES**

Changing from a lifestyle which centers around the use of drugs to living drug free can be a stressful and difficult process for anyone, including a person with a disability. A comprehensive understanding of the problems relating to the use of alcohol and other drugs and a strong commitment to recovery are crucial for persons with disabilities who are attempting to make lifestyle changes. Recovery also must include an awareness of how a disability extends risk for abuse.

**Defining Recovery.** Recovery is a term often used in traditional substance abuse treatment settings and 12 step support groups to indicate that a chemically dependent person is no longer using alcohol or other mind altering chemicals. For a person with a disability who is a substance abuser, recovery can mean that sobriety has been obtained or that substantial changes in the use of alcohol and other drugs has occurred, thus reducing the risk for developing problems. Recovery can be a way of life, and each individual develops a style and meaning of recovery. For some persons, treatment is the first step in the recovery process. For others, another avenue of support such as self-help groups, individual counseling, family, friends, work, or church initiates the beginning of recovery.

There are a number of issues which must be dealt with in early recovery. Some of these are unique to persons with disabilities, and others are faced by everyone in recovery. These issues include the following:

- defense mechanisms
- adjustment to disability
- adjustment to a drug-free lifestyle
- medication use and chronic pain
- self-esteem
- enabling by medical professionals
- enabling by family members
- lack of peer support
- employment

**Defense Mechanisms.** During early recovery, a variety of defenses are likely to be in place. These can include denial, rationalization, minimization, compliance, and anger. These defenses may be associated with substance abuse, disability, or both. Many persons with disabilities who enter recovery may have used chemicals to cope with the disability and may not have come to terms with their disabilities. Defenses are a natural response to an uncomfortable or painful event or feeling. Denial is often one of the first defenses to appear when a person is abusing substances. Denial also is one of the stages of the grieving process and is a normal response to chronic illness, disability, or loss.

*Denial* is often thought of as unintentional lying and can be the result of telling oneself the same lie over and over again until it becomes so well ingrained that the person believes it is true. For example, "I only drink beer, and everyone knows beer can't hurt you." Denial can also be seen as a reaction to disability: from an outright belief that the

disability is not there, to the belief that there are no limitations and no adaptations needed. Others may believe that the disability makes it allowable for consumers to not take care of themselves and to become dependent on others for almost everything. Another example of denial is, "I can quit smoking anytime I want to; I just don't want to."

*Rationalizations* are excuses made for certain behaviors, feelings, and beliefs. Consumers may rationalize in order to convince others, as well as themselves, that their actions are justified. Examples of rationalizations may be, "It's O.K. for me to drink; at least I'm at home and not running around with other men." or "I only use a little cocaine to perk me up if I've had a bad day." A very common rationalization for persons with disabilities in relation to substance use is, "If you had a disability, you'd drink too!"

It is very common for persons who have recently given up the use of substances to feel very *angry*. The anger may be directed toward the disability, family members, professionals, or "the system" in general. Anger may be a response to frustration about giving up a major coping mechanism and an effort to avoid dealing with negative feelings such as depression and sadness. Substances may have been used as a way to avoid dealing with the disability. At times, the person may be angry and may not be able to identify the reasons for the anger.

*Minimizing* is making the drug use seem less than it actually is. One of the differences between minimizing and denial is that a person generally knows that statements have been minimized. For example, when confronted about drinking, a consumer may state adamantly, "I only had two beers. Two beers never hurt anyone!" In actuality, the person may very well have had four or more beers. "I only drink on special occasions." can also easily be a minimization. One person's interpretation of "special occasion" can be vastly different from another person's.

**Adjustment to Disability.** Even when a person's disability is congenital or occurs early in life, a person must adjust to the fact that there may be some limitations either as a consequence of the disability or societal responses that cause limitations. When a disability occurs later in a person's life, the adjustment may be even more difficult. If the disability happens to occur while a person is actively abusing substances, the person may not even have begun to deal with the issue of disability when entering early recovery. The ideal situation for a person like this may be an inpatient or intensive outpatient treatment program in order for the person to have a solid support system in place when strong emotions begin to surface.

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*When I was using and not at a good place with my disability, I expected other people to take care of me. Part of that taking care of me was telling me what I should and shouldn't be doing. One of the things I got out of treatment, probably the biggest thing, was choices. I have a choice now to go into something knowing I'm going to pay a price for it. When I was using, I did things compulsively. I didn't think about them; I just went ahead and did them.*

"Marvin", a recovering alcoholic  
with a physical disability

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**Adjustment to a Drug-free Lifestyle.** Once persons with disabilities have used alcohol or other drugs to cope with aspects of life, they will need a period of adjustment to life without this major coping mechanism. New coping methods and techniques must be developed. This adjustment will undoubtedly cause stress which is a normal response to change. Each person must develop additional life skills in order to remain in recovery.

**Medication Use and Chronic Pain.** For some persons with disabilities, recovery may also mean learning to live without some medications. This will not be true in all cases, and consumers should consult with a physician before taking action. In the case where the use of potentially addictive medications are necessary, careful monitoring should occur.

Some persons with disabilities experience problems with severe or chronic pain. A reliance on prescribed medications may have been developed over a period of time. When beginning recovery, a person may be ready to find ways to deal with the pain without the use of medications. This will be a very crucial component of treatment, because without alternative means of coping with pain, relapse may become inevitable.

**Self-Esteem.** It is not unusual for persons with disabilities to experience self-esteem problems, which in turn are often a precursor to substance abuse (Greer, 1986). Consumers may feel embarrassed or ashamed of the disability or may feel as if they don't fit in with peers. When substances are used to alleviate feelings of inadequacy, consumers still have not dealt with any existing self-esteem issues. During treatment and/or early recovery, persons with disabilities can take control of their lives in order to build positive self-esteem.

**Enabling by Medical Professionals.** An important issue to explore during early recovery and/or treatment is the knowledge and support of the person's health care provider. Some health care providers are not experienced in substance abuse issues--especially among persons with disabilities. If the disability is a primary focus for medical intervention, it is possible to overlook other factors influencing the patient's health.

Health care providers must be educated about substance abuse and disabilities. With this increased knowledge, they will be in a better position to assist with recovery, as well as the person's physical health. Ideally, health care providers and consumers together, can determine when medications are necessary and when other techniques should be explored for issues such as chronic pain and muscle tremors.

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*Since being in recovery, I have been in the hospital a couple of times. I thought my physicians knew about chemical dependency, and I did all kinds of education with them before I got in the hospital. After they started me on the drugs, it was every three hours. If I didn't have somebody close to me that cared enough to help me get off the stuff, I think my physicians may have sent me home with a bottle of pills. Somebody went to the doctors and they started looking at how much I was using and behaviors they had seen from me and realized I was abusing the drugs. It had nothing to do with physical pain anymore. It was just the drug doing its old thing.*

"Eddie", a recovering alcoholic  
with a physical disability

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**Enabling by Family Members.** Family members need comprehensive information about substance abuse and their role in the recovery process. It is not unusual for family members to inadvertently enable use of alcohol or other drugs. The family members may feel guilty about the disability or may have focused much of their energy on the disability to the exclusion of other important family roles and functions. This focus may also have enabled the individual to use substances without normal consequences. Additionally, family members may blame "alcohol and other drug behaviors" on the disability. For example, if a person is exhibiting mood swings, family members may automatically assume that the disability is to blame when in actuality the person may be using drugs.

**Lack of Peer Support.** Persons with disabilities sometimes face the situation where their peer groups are limited or not easily accessible. Some persons with congenital disabilities or those with early onset disabilities may have attended segregated schools or may have had to travel a distance to attend classes. Both of these situations tend to limit social contact. During treatment and/or early recovery, involvement in a support group specific to persons with disabilities would be especially helpful.

**Employment.** Meaningful employment is very important to persons with disabilities. This population faces difficulties with unemployment or underemployment on a continuing basis. Drugs can be a way to cope with boredom for persons faced with excess free time. By contrast, it has been shown that persons with disabilities who have jobs are less likely to smoke marijuana (Heinemann, 1990). Treatment and prevention efforts can include a component on employment and referrals can be made to agencies which assist in job skills training and employment for persons with disabilities. In the case where the person is not able to work due to physical health, every effort must be made to assist this person in discovering ways to fill free time. Involvement in self-help or support groups is one option.

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*Too much free time leads to feelings of uselessness. I had to do something to keep my mind off of my disability. Since drinking is no longer an option for me, volunteer work is my way of coping.*  
"Raymond", SARDI project volunteer  
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## CONCLUSION

The identification of substance abuse in persons with disabilities is not occurring at the rate that current research suggests is needed. Therefore, many persons with disabilities who could benefit from assistance with substance abuse issues are not being helped. When addressing identification, treatment, and recovery options, professionals must recognize that changes don't happen all at once. The solutions to these problems operate on a continuum where individuals become increasingly more self-aware and more capable of finding alternatives to alcohol and other drug use.

Due to the complexity and uniqueness of problems associated with a dual diagnosis such as substance abuse and disability, consumers cannot be expected to always find their own adequate solutions. Experienced professionals working with persons with disabilities are in an excellent position to assist consumers in exploring viable alternatives to the use of alcohol and other drugs by first becoming more aware of the options and resources available locally. Learning about substance abuse and disability issues and recognizing problems when they exist are valuable first steps to supporting and assisting persons with disabilities in finding unique solutions to substance abuse problems.

## MARIA

*I was born the third of three children. I have two older brothers and I would characterize my parents as being both addictive type personalities. My mother was addicted to prescription drugs, and my father always has been a workaholic. I understand that my paternal and maternal grandfathers are both alcoholics as well.*

*I began experimenting with alcohol when I was about 6 years old. I was staying at a cousin's house, and we decided to mix up some things and make a cocktail for ourselves. It was pretty horrible tasting, but I liked the effect and determined that drinking was something I wanted to do again. I don't remember using again until I was about thirteen.*

*My parents divorced, and my mother married another man and had two children by him, and I always felt like I didn't belong anywhere. I was resentful of this new family; I felt abandoned by my old family. My dad had kept my brothers, so I was a real confused kid and alcohol was a way for me to cope. I got pregnant when I was fifteen years old and gave the baby up for adoption. I did real well in school academically, but I was always with the wrong crowd. I always wanted some excitement that I couldn't find in school, and I found it in alcohol and running the streets and just getting in trouble. When I was eighteen, I left home. I snuck out and acted like I was going to school that day but didn't. I got off the bus at school and got in a car with a man I had met, a man 24 years older than me, and ran off with him and got married. Of course it was going from a bad situation to a worse situation. I drank throughout the marriage; it only lasted a couple of years.*

*At the age of 22, I decided to go for a motorcycle ride with a guy. I didn't know that he had been drinking all day and shooting junk and washing down Quaaludes. Honestly, he had no telltale signs. I got on a motorcycle with him, and we didn't get too far before we crashed. I flew off the motorcycle and someone came and turned me over and found my eyes rolled back in my head, no pulse on me anywhere, and my jaws locked shut. He thankfully gave me mouth to mouth resuscitation until the police came and took me to the hospital. I was pronounced dead on arrival because my neck was broken and I couldn't get oxygen. Well, they resuscitated me, diagnosed me as having a broken neck and a broken back, and didn't give me much chance of living, not even through the night. The only thing that I remember about that time was the terrific pain I was in when I was awake. There was just such intense burning like my body was on fire. I couldn't stand a sheet on the left side of my body. I was being given large amounts of narcotic drugs at the time and I finally began to come around a little bit at about three months after the accident. I remember thinking, "You have an accident; you go to the hospital; you get fixed up; and you go home." I had never seen a young handicapped person and it just didn't occur to me that I could be handicapped in any way. I thought I better ask the doctor why I am not going home. He watered it down a lot and he just said, "Maria, it looks like you are never going to walk again." I remember thinking right away, "I need more drugs than what they are giving me."*

*I had a nurse who I had bring me some extra Quaaludes and Talwin and I don't remember what all else. I kept those at my bedside and had friends and family dispense them as they came. I was pretty good at manipulating and conning and telling them how much horrible pain I was in and how desperately I needed these extra drugs. Of course, they felt sorry for me and gave them to me. Also, the hospital allowed at that time, I don't know if they still do, two beers a day. What I began to do was store them up, and the weekend would come and I would tell them that I want my beer. I don't know what their thinking was, perhaps they felt sorry for me, but they would give me the beer and I would drink it all on the weekend and that would be my party, my escape time.*

*When I left the hospital, I was still really depressed but I moved into an apartment on my own and was scared to death. I didn't know how I was going to manage in that wheelchair and what would happen to me if I fell out of it, and I was there alone. The fears were more than I could talk about. Of course, I only knew one way to deal with fear-- drinking alcohol and using drugs. It was real interesting, the enabling system that I had at this juncture. What I would have to do is call the doctor and put in my order: I need Quaaludes; I need Valium; I need codeine. He would let the pharmacy know what he was ordering for me and the pharmacy would deliver it to my house and the Federal Government would pick up the bill.*

*The next stop for me was a rehabilitation center where I would work for three or four months trying to learn to walk. On the weekends it was just a sight to behold. Six, eight, or ten of us differently disabled folks piling in a cab and heading for town to do a little celebrating. Here would be all of these wheelchairs and walkers and we would come into town, gather at a local bar, trade our drugs, and do our alcohol.*

*I left the center for a weekend to visit a friend's home, and at some point the car we were driving became airborne, and we landed in a sixty foot ditch. The car was lodged there and the others got up and took off because we all thought the car was going to blow up. Of course, I could walk with my crutches at that point, but I couldn't walk up a steep embankment. I just sat there and waited for the car to blow up. Twenty minutes later they came back and got me and drug me up the hill. The next night, I fell and broke my leg in four places and wound up in the hospital and right away I just put my order in. I know how to cope with this. I will need Demerol this time.*

*This was the beginning of my state mental hospital stays. I got so very depressed from this situation after having worked for three months at learning to walk, and I had learned to walk fairly well. To fall and break my leg and be back in the hospital was just more than I could bear. I wound up in the psychiatric unit with depression. The thing I remember about that is they gave me mood elevators which enhanced the effects of the other drugs. I was happy to add them to my repertoire of drugs.*

*The next four years saw me in and out of mental hospitals a great deal, struggling with depression and generally not feeling like I wanted to live but too afraid to die. I remember when I would go in, I would take the seat of my wheelchair apart and slice the foam rubber open and line the seat of the wheelchair with my drugs, and put it back together, because as soon as you get to the hospital they would frisk you and go through your things and make sure you didn't have any drugs. Of course, they load you up with antidepressants or mood elevators, but I had the added benefit of my own drugs. I had a great deal of physical problems, as well, as a result of my drinking and drugging at this time. I would land in the hospital with a urinary tract infection or upper respiratory disease. I remember thinking and feeling that I had to get a hold of my life, that I just couldn't go on like that, but I didn't know what to do.*

*I remember going for therapy and wanting to work on the constant depression that was a part of my life. [This man] finally confronted me about my drinking and drugging and suggested that I get treatment. I wasn't going to get better physically, mentally or any other way as long as I continued to drink and drug. I couldn't imagine life without drugs and I thought it was pretty horrible for him to even suggest it. Shortly after that visit, I was involved in yet another automobile accident and I happened to be driving. I couldn't walk but I had a car and I could drive. Of course, I was driving across town to pick up some drugs for myself and I was already loaded. I pulled out in front of a car and was hit broadside, sixty miles an hour. It really shook me up and I remembered what this therapist had said. I guess I was just bot-tomed out so bad. I was so alone and so lonely and so broken in every way that I decided I would try it. I thought I would get cleaned out of all the drugs, and I would just start over again.*

*I did decide to go to treatment at a hospital. I thought for sure that they would think I was unique and that there were some things that I had to have like Valium for the spasms and something for pain management. I was shocked when they told me that they were doing away with everything. I wasn't going to be permitted anything. I began to complain pretty heavily about the amount of pain that I was in without my pain medication, and the level of spasms that were going on in my body with the removal of the drugs. I requested therapy and the decision was made that I should focus only on my problem of addiction.*

*I remember that I bathed on my own. I was not offered assistance with any of my personal care stuff. Another area of problem for me was that they would have exercises in the morning and, of course, there was no adaptation for me, so I just was not able to participate in that activity. Then, some folks came in to teach us relaxation and it required us laying on the floor and deep breathing exercises, which could have been really helpful for me. Again I was not offered help to get out of the wheelchair and get on the floor and participate, so I didn't participate in that. These issues for me were not addressed. I didn't ask for help with them. I wasn't in touch with my feelings and I was just trying to look as normal as I could and not set myself apart as different in any way. I wasn't in touch with what I really needed at the time, so I didn't have the forethought to ask for what I needed and I was not asked what I needed. Issues relating specifically to my disability were not addressed.*

*My life is good today, and no one is more amazed by my recovery than I am. I'm just utterly floored that I could spend ten years without the use of drugs to cope with my life, to cope with my pain, to cope with my disability. I'm very active in the programs of A.A. and Al-Anon and Adult Children of Alcoholics.*

*I think it's important to note that people whom I was involved with when I was using, and I'm talking about right up to the very end, professors, counselors and family claimed to not know that I was using, and I think that that's important to realize how much one can really hide this disease.*

## **SUBSTANCE ABUSE IDENTIFICATION AS IT RELATES TO MARIA**

Maria had numerous alcohol and drug related consequences from her early use, and, in fact, might not have become disabled if her substance abuse had been identified much sooner. After becoming disabled, she continued to use and her use even increased due to the availability of prescription medications. She easily convinced professionals, family, and friends that she needed extra medications and drugs. Her substance abuse was enabled by virtually everyone in her life.

Maria identified a number of the common risks associated with substance abuse including the following:

- feelings of abandonment as a child
- thrill seeking behaviors
- family history of addiction
- early onset of use
- disability related to substance use
- chronic pain
- low self esteem

She also experienced signs and symptoms of substance abuse that, although seemingly obvious when reading her story, were never confronted or questioned by significant persons in her life until a Mental Health professional finally suggested treatment to her. Maria's numerous auto accidents, mental health related hospital admissions, and recurring urinary tract and respiratory infections all were overt signs pointing to substance abuse. However, Maria stated that even when she "bottomed out" and entered treatment, her family and friends did not realize that she had been abusing alcohol and other drugs.

This story also provides several examples of professional and familial enabling. Maria's nurses and other rehabilitation professionals allowed Maria to become intoxicated during her hospital stay. She also described episodes where she was able to convince family and friends that her disability entitled her to use more medications than were prescribed. Additionally, her physicians never questioned her requests for medications and made the entire process very convenient for Maria. She didn't even need to leave her home to get the drugs she wanted!

Maria is chemically dependent and could have been diagnosed as a substance abuser before becoming disabled. She was fortunate that one of the professionals who came in contact with her was experienced in substance abuse and disability. That confrontation may very well have saved Maria's life or at least have saved her from experiencing even more serious consequences. She decided to enter a formal treatment program. Although Maria did benefit from treatment, several aspects of her disability were not addressed and created some discomfort for her. These include the following:

- chronic pain
- personal care needs
- excess free time
- adaptations for activities
- adjustment to disability
- feelings of not belonging

Maria has dealt with these issues and other issues related to her disability since entering recovery. She has relied on 12-Step support groups to provide assistance when problems occur. Maria has adopted an entirely different lifestyle without alcohol or other drugs. She states that her life is full and better than she could have imagined.

## TEST YOUR KNOWLEDGE ABOUT SOLUTIONS TO SUBSTANCE ABUSE

The following questions are based on the information contained in the Chapter you have just read. The answers are found in Appendix G.

1. A person with a disability can receive an intervention and/or help for substance abuse problems before "bottoming out."

TRUE FALSE

2. One of the purposes of a formal intervention is to convince consumers with substance abuse issues that they are alcoholic.

TRUE FALSE

3. Which of the following is a component of an ideal intervention:

- a. screening tests                      b. family education  
c. consumer education                d. professional observation  
e. all of the above

4. All persons with disabilities who have substance abuse issues should receive formal substance abuse treatment.

TRUE FALSE

5. List three treatment components which are specific to persons with disabilities.

\_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

6. Why should at least one professional on the substance abuse treatment staff be familiar with disability issues?

\_\_\_\_\_

7. List three defense mechanisms likely to be used by consumers who are in early recovery.

\_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

8. Some persons with disabilities may be able to cope with their pain without using medications.

TRUE FALSE

9. At least one study shows that persons with disabilities who are employed are less likely to smoke marijuana while involved in medical rehabilitation.

TRUE FALSE

10. Two valuable first steps toward assisting persons with disabilities in finding solutions to substance abuse problems are

\_\_\_\_\_ and \_\_\_\_\_.

**CHAPTER SEVEN**

**SUPPORT GROUPS FOR PERSONS WITH DISABILITIES**

## REVISED

REVISIONS TO THE 1997 NATIONAL SURVEY ON THE STATE OF THE ECONOMY

## **SUPPORT GROUPS FOR PERSONS WITH DISABILITIES**

When individuals are seeking to change some aspect of their lives or attempting to deal with very stressful life events, few forms of assistance can match a caring and supportive group experience. Groups can be especially helpful for persons struggling with substance abuse and disability issues, as these groups can reassure the participant that other people share the same experiences and care what happens to that person. Such a group can be an invaluable source of practical information that is difficult to locate in any other educational or therapeutic setting.

Support groups can be loosely divided by "self-help" such as a 12-step group and those which are professionally run or sponsored. Each type of support group can meet the special needs of persons with disabilities and concurrent substance abuse issues. The 12-step groups, such as Alcoholics Anonymous (AA), are highly structured with no professional affiliation. There is a common bond among members who all have had problems with alcohol or other drugs. In contrast, two other types of groups discussed in this chapter have professional involvement at some level.

Agencies with preestablished consumer contacts are in an excellent position to provide support group services specific to substance abuse and disability. Although 12-step groups are the most successful type of support currently known, some persons with disabilities may need additional support or a different type of group experience to establish and maintain a drug-free lifestyle.

This chapter contains information about different types of support groups, suggestions for implementing groups, and information about AA. The following sections are included:

I. Support Groups for Substance Abuse and Disability Issues.....	2
II. Factors to Consider When Organizing a Support Group.....	4
III. Alcoholics Anonymous: Basic Information.....	7
IV. The Twelve Steps of AA.....	9
V. Twelve Ideas for My Improvement.....	10
VI. Test Your Knowledge.....	11

## SUPPORT GROUPS FOR SUBSTANCE ABUSE AND DISABILITY ISSUES

Persons with disabilities who have concurrent substance abuse problems are in need of inexpensive, ongoing support to deal with issues relating to these problems. Support groups are often an ideal option. Unlike traditional treatment programs, support groups are generally cost free and sometimes have open-entry, open-exit policies. This allows an individual to enter the group whenever ready, and to leave the program when it is warranted.

When persons with disabilities are identified as having substance abuse problems, professionals generally refer them to mainstreamed chemical dependency treatment programs or general support groups. Many professionals unfamiliar with disability issues believe that consumers should be able to have all of their substance abuse needs met in traditional support and/or 12-step groups. There is a lack of perceived need for specialized support groups by both consumers and professionals. Unfortunately, very few of these programs have the knowledge of substance abuse and disability issues necessary to properly provide adequate support. Some persons with disabilities and concurrent substance abuse problems attempt treatment and support group involvement over and over without success because their needs are not being adequately met. Once involved in a disability specific support group, these same persons often can begin to realize success at living drug free.

*What a support group accomplishes.* Support groups are a way for persons who are affected by substance abuse to learn to identify and cope with feelings, behaviors, and attitudes. Support groups provide nurturing, support, and encouragement which allow members to gain insights into their own situations. Additionally, these groups have a primary focus--a common problem--which allow a number of different persons to form a bond and assist one another. When group members can give back to others, their own problems no longer seem unique and hopeless. Support groups give persons with disabilities a safe place to learn about themselves by observing and communicating with others in similar situations. A supportive setting enables many persons with disabilities the opportunity to take risks and to take action, knowing that they have the benefit of others who will assist them and care about them.

-----  
*Support and sustenance from one's peers who have walked down a similar road seems to be an essential component of quality recovery.*

John de Miranda, President  
Peninsula Health Concepts

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Generally, support groups are formalized in some way. Twelve-Step groups such as Alcoholics Anonymous have structured guidelines and a direction which are standard at most meetings. The group runs without professional affiliation; a group member runs the meeting. The meetings follow a structured format, although members are free to come and go as they please. Other support groups, such as those through an Employee or Student Assistance Program, are structured in a different way. One or two professionals generally run the meetings which have a particular focus each time. The employees or students are assigned to a group and expected to attend each meeting for a period of time.

Although support group involvement can be therapeutic, there is a difference between a support group and therapy. It is common for persons to hear the word support and assume that traditional therapy is involved. In the groups discussed here, therapy is

NOT a component. Generally, support groups are differentiated from therapy groups based on the qualifications of the group leaders, the amount of responsibility the group leaders have, and the direction the group goals take. In general, therapy attempts to "cure" a problem, and support attempts to educate about and provide insight into a problem. The person or persons ultimately responsible for the support group meeting need to be very clear about where the boundaries between therapy and support will be drawn. For this reason, it will be beneficial for the group members to have ready access to a variety of additional resources, including the names and phone numbers of local professionals who provide counseling services to persons with disabilities and substance abuse problems.

*Professionally run support groups.* This type of support group is very structured. Group members are selected for or assigned to the group and remain until the group sessions are completed. New group members are admitted in a specific sequence once the group has been formed. Generally, the group leader (or leaders) has a specific plan for each group meeting and actively leads the group in discussing the topic at hand. Formal educational activities such as short lectures, worksheets, and films may be part of the group sessions. It is conceivable that group members are involved in other types of support groups or 12-step groups in addition to this group.

The professional group leader must be chosen very carefully. The group leader must be knowledgeable about substance abuse and disability issues because the role of the leader is to educate as well as provide support and understanding. The group leader must be at every session. The understanding is that the group does not meet if the group leader is unable to attend. The group leader should also be familiar with local resources and be able to refer group members for other assistance if it is needed.

Although the group leader does not typically recruit group members, the leader is responsible for tracking their attendance and progress during the group sessions. The professional group leader is responsible for planning each group meeting and bringing the needed materials to group. In addition, the group leader actively participates in each session and often directs the discussion. Homework assignments may be given, and the leader collects these assignments during the next session. If problems arise during the course of the group, the leader is responsible for responding in an appropriate way, possibly including the expulsion of a group member.

*Professionally sponsored support groups.* This type of support group is generally less structured and the "sponsor" is involved more with the organization than the running of the group. Members are recruited from a variety of sources and can attend the meetings at any time during its course. The format is open-entry/open-exit, and each session generally has a closure in case that topic is not brought up at the next meeting. Formal educational activities are not planned and sequenced by the "sponsor." Instead, discussion topics are decided by group members. As with members of the professionally run support groups, these group members may be involved in other types of support and 12-step groups as well.

Group "sponsors" are different than the leaders of other types of support groups. The sponsor may not be familiar with both substance abuse and disability issues, but understands the need for a special support group. The sponsor may actually lead the group when it first begins by opening the meeting and bringing up topics to discuss. The sponsor may need to assist the group in planning how they will run the group. However, once the group has several core members and is able to run on its own, the sponsor may be able to back off and not attend each meeting. How involved the sponsor stays will depend on the particular group members and what they are capable of doing. No matter how actively involved, the sponsor should remain available to assist the group and to ensure that it is running smoothly. In almost every case, it will not be possible for the professional sponsor to back off until a consumer actively takes over part of this role.

Typically, the professional group "sponsor" will need to recruit members by sharing information about the need for and benefits of support groups with other professionals who can make referrals to the group. The sponsor may develop and send out letters or flyers to professionals, disability organizations, and drug treatment agencies. Follow up contacts to identify potential support group members may be necessary. Once several members are identified, the sponsor works with them to establish the specifics (time, location, etc.). The sponsor also will attend meetings at least until the group members feel they are operating smoothly. After this, the sponsor will remain involved to ensure that the group continues to operate. The sponsor will continue to recruit members and keep other professionals informed about the group.

### **FACTORS TO CONSIDER WHEN ORGANIZING A SUBSTANCE ABUSE AND DISABILITY SUPPORT GROUP.**

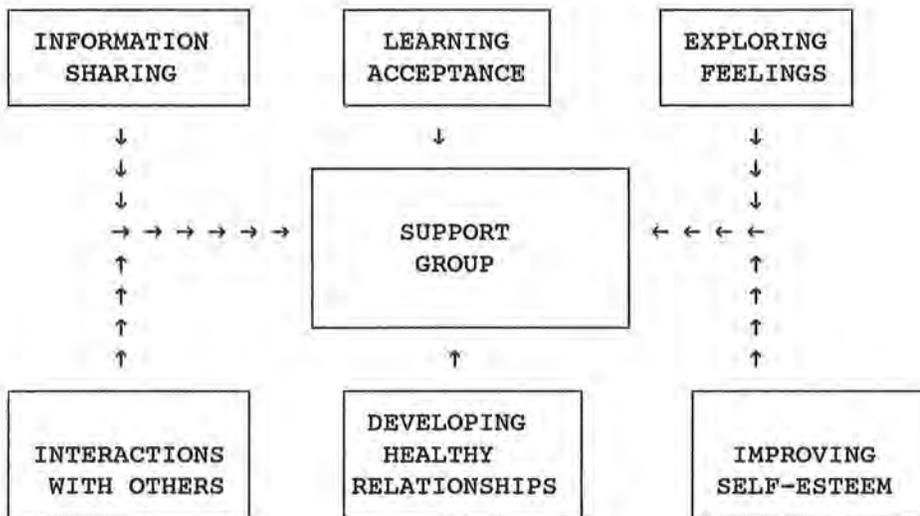
Whether a group is professionally run or professionally sponsored, a number of factors must be considered before the group is developed and members are recruited.

- *Transportation.* Many persons with disabilities, for a variety of reasons, do not have their own transportation. They must rely on others to get them to meetings. When decisions about the support group are being made, this should be taken into consideration. It may be possible to centrally locate the meeting near public transportation. Other agencies or organizations may be willing to assist with transportation, and group members with reliable transportation may be willing to transport others to and from the meetings.
- *Length of the meetings.* Keep in mind that persons with some disabilities may have difficulty either sitting or concentrating for long periods of time. The meetings can be structured in such a way that breaks are taken or that the meeting time is limited. One to one and a half hours with a short break may be a place to start. If group members are having difficulties with this time frame, adjustments can be made.
- *Location.* The location needs to be thought out carefully. If most of the anticipated group members are from one area or are involved with one particular agency, it may be best for the group to meet either at the agency or in the immediate living area. If members will be recruited from a larger area, try to centrally locate the meeting, keeping in mind transportation problems and accessibility. Other possibilities include moving the meeting to a permanent location once a core group of members has been established. In some situations it may be beneficial to investigate moving the group on a rotating basis as well.
- *Group Focus.* Although these groups focus on the combined issues of substance abuse and disability, it is critical to have a general idea of what focus the group will take. Each meeting, whether professionally led or sponsored, will have a different topic of discussion. Group leaders and sponsors should be familiar with a variety of related topics to ensure that a discussion takes place. Some possible topics include living sober, making healthy choices, improving self-esteem, dealing with chronic pain without medications, understanding the special risks for substance abuse faced by persons with disabilities etc.

- *Meeting Time.* It may be difficult to please everyone with the meeting time; however, take into consideration the group members with work, rehabilitation, or school schedules. If the group is sponsored by an agency common to all members, the meeting may be scheduled soon after the day's programming is completed. Students may appreciate having the group after their last classes but before they go back home or to their dormitory rooms. It sometimes is difficult for persons with disabilities to go back out in the evening after coming home and settling in.

*Advantages of substance abuse and disability support groups.* Alcohol and other drug related problems in general are very resistant to change, and when a disability is added, change is even more complicated. Persons with disabilities who also have concurrent substance abuse issues sometimes have difficulty finding the on-going support they need in order to make these changes in their lifestyles. For some persons with disabilities, organized 12-step groups such as Alcoholics Anonymous are enough support. However, others need more specialized support--a group which focuses on issues specific to disability and substance abuse. A variety of activities occur in well-running support groups and these are highlighted below:

### ACTIVITIES ENHANCED THROUGH SUPPORT GROUPS



### STARTING A SUPPORT GROUP

Planning and implementing support groups require a commitment of time and energy in order to succeed. The following steps may assist professionals committed to starting a support group for persons with disabilities and substance abuse issues.

1. *Make a commitment to a certain time block.* A minimum of at least six months will probably be required in order to effectively plan, market, and hold the first meeting. It may take additional time to recruit a solid core group of participants, especially if the support group is independent of agencies or organizations.

2. *Make a commitment for chosen staff sponsors or group leaders.* Professionals who will be responsible for either running or sponsoring the support group will need to make a commitment to following through with the support group at least until it is up and running smoothly. Supervisors and administrators must understand and agree to this commitment if the efforts of starting a support group are to work.
3. *Make decisions about the type of group.* Will the group be professionally run or professionally sponsored? Will the group be made up of substance abusers, persons who are chemically dependent, children of alcoholics, or persons at risk for substance abuse problems? Will the group be for persons with specific disabilities or open to all disability groups?
4. *Make decisions about the general operation of the group.* Once the type of group is determined, commit to a meeting time, length, and location. Keep in mind the issues mentioned earlier: transportation, attention span, and related health concerns.
5. *Inform appropriate sources about the group.* Depending on the type of support group to be implemented, a variety of organizations, agencies, and professionals can be informed. Some possible contacts include the following: area vocational rehabilitation personnel, area medical rehabilitation professionals, local chemical dependency treatment centers, university or college disabled student service offices, organized 12-step groups, independent professionals specializing in substance abuse and disability, disability specific support groups, and local mental health facilities. Preliminary phone contacts are critical, and these initial contacts should be followed up immediately in writing. Don't be surprised if it requires more than one call and letter to the same resources before receiving any response.
6. *Market the support group to the community.* Be sure to publicize the group as much as possible. Utilize public service announcement opportunities; list the group with area information and referral services; make use of the newspaper and radio to announce the meeting; ask rehabilitation agencies, disability specific organizations, and mental health agencies to announce the support group via newsletters and flyers. Again, it is important to remember that persistence is essential. The same steps may need to be taken several or more times.

## ALCOHOLICS ANONYMOUS: BASIC INFORMATION

Much has been written about Alcoholics Anonymous (AA), and many substance abuse treatment centers routinely refer all of their clients to this self-help group. Other popular 12-step groups such as Al-Anon, Alateen, Adult Children of Alcoholics (ACOA), Narcotics Anonymous (NA), and Emotions Anonymous (EA), are modeled after the successful AA program which has been described as the most effective treatment for alcoholism.

Alcoholics Anonymous was founded in Akron, OH in 1935, and the "Big Book," entitled Alcoholics Anonymous, was published in 1939. The AA program stresses abstinence from alcohol (and any other mind altering substance). Abstinence is the primary and basic goal for members of AA, but the individual members have their own goals as well. "Sobriety" is seen as a state of being very different from being "dry" and takes longer to achieve. Many AA members report that sobriety is a way of life in which a person not only doesn't drink, but also returns as an active participant in life. For this reason, the framework of AA is based on twelve steps and twelve traditions. AA members do not view sobriety as a passive process, but rather an active attempt to work toward a contented and productive life free from substances.

Anonymity is another key component of AA. For its members, the promise of public anonymity makes the program a safe outlet from exposure to neighbors, bosses, and others. Although sports superstars and actors have made alcoholism seem almost fashionable, there is still a stigma attached to alcoholism. Additionally, many substance abusers enter AA with feelings of guilt, low self-esteem, and shame. Confidentiality gives newcomers a chance to observe the program without fear of exposure. As a member of AA becomes comfortable with the program and begins to gain sobriety, he often recognizes other benefits from remaining anonymous including the therapeutic value of being just one of many alcoholics.

For persons with disabilities, AA or other 12-step groups are an often needed means of cost-free, ongoing support. In recent years, the AA General Service Office and area committees have taken a special interest in making AA accessible to all members, including persons with disabilities. Among the AA Conference approved literature is a new pamphlet entitled "Twelve Steps Illustrated." This pamphlet contains not only the actual AA Steps, but also applicable illustrations and simplified interpretations of each Step. It also is becoming more common for area AA committees to publish listings of local meetings that include identifiers which allow persons with disabilities to locate wheelchair accessible and sign language interpreted meetings.

Other efforts for making AA materials accessible to persons with disabilities have been very successful. The AA "Big Book" and other AA Conference-approved literature is available in large print and braille. These materials are also available on tape, and at least one chapter of the "Big Book" is available in American Sign Language on videocassette. With the ongoing success of these materials, it is likely that additional accessible materials will be developed as well.

There are many different types of AA meetings which allow for the special needs and/or interests of various individuals. Meetings can be either open (for AA members, anyone interested in finding out more about AA, family members, and friends) or closed (for persons who profess to have problems with alcohol). Additionally, the meetings can take on a variety of formats. Some meetings are called speaker meetings or "leads" where

one or more persons share their experiences with alcohol, what happened to instigate change, and what being sober has been like for them. Discussion meetings, on the other hand, allow more persons to actively participate. Generally one alcoholic facilitates the meeting and a topic about a problem with alcohol, one of the twelve steps, or another issue relating to sobriety is discussed. In addition to the types of meetings already mentioned, there are specialized meetings geared toward specific AA members. For example, there are men's, women's, young people's, gay's, deaf, and physician's meetings which still focus on recovery from alcoholism by working the twelve steps. Efforts have been made in several communities to develop disability specific AA meetings. Some of these meetings are affiliated with treatment centers specializing in substance abuse and disability. Others are independent of sponsoring agencies.

Many members of AA relate to the "program" and the twelve steps as a new way of life, and the search for sobriety as an active process. Most AA members do more than just attend meetings. They may spend time talking to other members and find a sponsor, as the program suggests. Generally a sponsor is an AA member with a longer period of sobriety who can assist the newcomer in becoming involved in the AA program. Finding the right sponsor may be very difficult for new AA members, especially if the new member has a disability. Beginners meetings and assistance from professionals can be helpful. Persons going through traditional treatment centers often can meet AA members who volunteer with the center. Persons receiving other types of assistance may need additional help in finding appropriate, accessible meetings in their communities.

There are a variety of materials published by AA which are available at meetings, treatment centers, the AA General Service office in New York, and local AA offices. For additional information about AA or their Conference approved literature, call the Alcoholics Anonymous phone number listed in the phone book or contact the General Service Office of AA, P.O. Box 459, Grand Central Station, New York, NY 10163.

## THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS\*\*

- 1: We admitted we were powerless over alcohol--that our lives had become unmanageable.
- 2: Came to believe that a Power greater than ourselves could restore us to sanity.
- 3: Made a decision to turn our will and our lives over to the care of God as we understood Him.
- 4: Made a searching and fearless moral inventory of ourselves.
- 5: Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
- 6: Were entirely ready to have God remove all these defects of character.
- 7: Humbly asked Him to remove our shortcomings.
- 8: Made a list of all persons we had harmed, and became willing to make amends to them all.
- 9: Made direct amends to such people wherever possible, except when to do so would injure them or others.
- 10: Continued to take personal inventory and when we were wrong promptly admitted it.
- 11: Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
- 12: Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

\*\* The Twelve Steps are reprinted with permission of Alcoholics Anonymous World Services, Inc. Permission to reprint the Twelve Steps does not mean that A.A. has reviewed or approved the contents of this publication, nor that A.A. agrees with the views expressed herein. A.A. is a program of recovery from alcoholism--use of the Twelve Steps in connection with programs and activities which are patterned after A.A., but which address other problems, does not imply otherwise.

## TWELVE IDEAS FOR MY IMPROVEMENT\*\*

1. Drink beat me.
2. God help me well.
3. Decide God help me life and friends.
4. Look old past good and bad -- change bad.
5. God help me talk good bad friend.
6. Me ready -- life change.
7. God change me.
8. Think sorry -- people me hurt -- me drunk.
9. People me hurt before -- me sorry -- no drink.
10. Wrong me -- admit wrong.
11. Think God help me better.
12. Me improve now -- look for people drink much -- now time -- follow 12 ideas.

These "Twelve Ideas", from the Picture-Idea Booklet, were translated into American Sign Language (ASL) by Project AID staff for persons with deafness. This particular version represents the traditional signs which are commonly understood by persons with deafness who utilize ASL. The dashes represent natural breaks in the signing.

\*\* This has been reprinted with permission from Dr. Alexander Boros, Director of Project AID. For more information contact Dr. Boros at the following address:

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## TEST YOUR KNOWLEDGE ABOUT SUPPORT GROUPS

The following questions are based on the information contained in the Chapter you have just read. The answers are found in Appendix G.

1. Which of the following are advantages of support groups for persons with disabilities and substance abuse problems?
  - a. they are cost free
  - b. formal therapy is included
  - c. disability issues can be discussed
  - d. 12-step programs discourage consumer involvement
2. Group sponsors recruit group members and keep the group in operation.  
TRUE FALSE
3. A disability can make substance abuse related problems even more resistant to change.  
TRUE FALSE
4. What activities are enhanced through support group involvement?
  - a. information sharing
  - b. developing healthy relationships
  - c. discovering feelings
  - d. improving self-esteem
  - e. all of the above
5. AA has been described as "the most effective treatment for alcoholism."  
TRUE FALSE
6. \_\_\_\_\_ is the primary goal of AA.
7. Family and friends of AA members can attend \_\_\_\_\_ AA meetings.
8. What is an AA sponsor? \_\_\_\_\_  
\_\_\_\_\_
9. A professional group leader must be knowledgeable about \_\_\_\_\_  
and \_\_\_\_\_.
10. In addition to abstinence, \_\_\_\_\_ is another key component to AA and should also be assured in any other type of support group.



**CHAPTER EIGHT**

**CONNECTING ALCOHOL AND OTHER DRUG  
AND DISABILITY AGENCIES**

## STRENGTH

STRENGTH: THE ABILITY TO EXERT OR WITHSTAND FORCE

STRENGTH: THE ABILITY TO EXERT OR WITHSTAND FORCE

## CONNECTING AOD AND DISABILITY AGENCIES

Although the alcohol and other drug field has been enjoying success in preventing, identifying, and treating substance abuse in traditional populations, additional effort needs to be focused on a variety of special populations including persons with disabilities. With the passage of the Americans With Disabilities Act, physical barriers to AOD services should become less of an issue in the future. However, attitudinal barriers constitute a significant problem for persons with disabilities.

Even with the push for equal opportunities and accessibility for persons with disabilities, a variety of myths concerning disability and substance abuse still exist. It may be difficult for traditional AOD service providers to recognize the difference in risks for substance abuse faced by persons with disabilities and the need for sometimes specialized treatment services. In the same light, disability service providers often are unable to identify substance use/abuse in their clientele and lack the resources needed to provide appropriate prevention and intervention services.

In order to begin ensuring that persons with disabilities are included in alcohol and other drug prevention, intervention, and treatment efforts, disability and substance abuse professionals must work together. This chapter discusses ways for developing working relationships between professionals and includes the following components:

I. Working with Alcohol and Drug Agencies in the Community.....	2
II. Americans with Disabilities Act Fact Sheet.....	5
III. Test Your Knowledge.....	7

## WORKING WITH ALCOHOL AND DRUG AGENCIES IN THE COMMUNITY

With Assistance From: John de Miranda, M.Ed.  
Peninsula Health Concepts

During the past 10-20 years the alcohol and other drug service infrastructure has matured to the point where we are now able to meet the needs of many communities of interest also known as special populations. Specialized service networks for ethnic minorities, pregnant addicts/alcoholics, young people, sexual preference groups, and others with particular needs, are commonplace and often well developed. Unfortunately, specialized prevention and treatment programs for people with disabilities are only in the earliest stages of development. Progress in creating effective and appropriate services for people with disabilities has been hampered by:

- a lack of dialogue between the alcohol/drug and disability communities
- the irrational fear experienced by many nondisabled people concerning disability-related issues
- resource and budget constraints
- lack of enforcement of Section 504 of the Rehabilitation Act of 1973, as well as other state, federal, and local anti-discrimination laws (The Americans With Disabilities Act of 1990 holds great promise to reverse these trends)
- a disregard, on the part of the disability community, of the seriousness and extent of alcohol and other drug problems among people with disabilities

Persons who wish to improve service accessibility must adopt an assertive posture in meeting the needs of consumers. Assume from the start that your job will be to stimulate interest in serving the consumer. Those who succeed in this process will need to act like social service "entrepreneurs," i.e. persons who both create and take advantage of opportunities for the delivery of services. Such help seekers can have a major effect on program accessibility and invigorate institutionalized treatment systems through a process of service linkage, advocacy, technical assistance, and cross-training. The need for a systems collaboration or network development approach to these issues was recognized in the early 1980s.

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*Many of these problems underlying the fragmentation in services for the physically disabled substance abuser can be addressed by developing an alternative approach to the delivery of human services based on the concept of "network development" ...the mechanism by which individuals and/or organizations may call upon each other to share resources in mutually satisfying ways.*

Lowenthal and Anderson, 1980/81  
*Alcohol Health and Research World*

The lack of appropriate services for people with disabilities requires that **client advocacy** and **creative service linkages** become the major activities for help seekers. Disability service professionals who wish to improve their response to the alcohol and other drug problems of consumers need to explore mechanisms to creatively motivate substance abuse treatment providers. Such strategies should include some or all of the activities identified below.

1. *Identify* potentially responsive alcohol and drug treatment organizations. Publicly funded programs are most likely to be receptive, as state and federal funding sources generally require that programs not discriminate on the basis of disability. (At the same time, some private programs are beginning to see people with disabilities as an untapped "market niche.")
2. *Engage* such programs by requesting a meeting to discuss the accessibility issues that might arise when persons with disabilities are referred for services. An expansion of this strategy is to host and organize an ad hoc local or regional task force of both treatment providers and disability agencies to explore opportunities to work collaboratively to improve service access.
3. *Advocate* for consumer rights by diplomatically referring to the major provisions of federal and state civil rights regulations. Programs that receive federal funds must be accessible to people with disabilities. As of February, 1992 private chemical dependency treatment programs must make reasonable accommodations to people with disabilities as do other businesses. In addition, the ADA further stipulates that health and social services for people with disabilities must be equal in quality to those in the overall program.
4. *Educate* alcohol and drug program staff about the accessibility needs of potential consumers, disability resources in the community, and legal-ethical obligations to serve the disability community. Such educational efforts may also take the form of cross-training. (Cross-training occurs when alcohol and drug staff provide inservice education and consultation to disability agencies regarding assessment, intervention, and basic substance abuse concepts. Disability staff reciprocate by training the alcohol and drug staff in basic disability issues including architectural, attitudinal, and communication considerations.)
5. *Support* the substance abuse provider who agrees to accept persons with disabilities by providing regular telephone and case consultation services to ensure that the treatment episode is a positive learning experience for both the client and the provider. Look for opportunities to publicly acknowledge those programs that accept persons with disabilities. Such recognition can create peer pressure on other programs to begin serving people with disabilities. However, also advocate for quality regional programs specialized to address particularly challenging treatment populations (i.e., people with deafness).

Your efforts will be part of a larger transition that is taking place. Significant changes are occurring that bode well for improved access. The alcohol and other drug field has recently taken steps to address historical inequities in the provision of services to people with disabilities. In addition, the 1990s promise to be a decade to rethink the status of people with disabilities within our society. The passage of the Americans with Disabilities Act of 1990 signals a societal commitment to universal access, which will, hopefully, be reflected in the alcohol and drug system of services.

6. *Network* with other organizations and individuals. A useful tactic in bridging the gap between the substance abuse and disability communities is the development of local coalitions and task forces. Most communities that have successfully tackled the issue of accessible recovery services have initially called together interested individuals for the purpose of the following:

- building personal linkages between agencies and organizations
- validating and sharing perceptions about the nature and dimensions of the problems to be addressed
- developing action plans and strategies for problem remediation

*The following example illustrates how local coalitions can work to cross educate members about complex and difficult issues.*

One of the SARDI representative sites is The Center for the Rehabilitation and Training of Persons With Disabilities (The Center) in Chicago, Illinois. The Center provides a wide range of rehabilitation services to persons with disabilities from all age groups. Some of the services offered include diagnostic, therapeutic, and consultation services for persons with communicative difficulties; specialized placement programs for persons with hearing impairments; respite care; in-home support services; work training programs; special education programs for persons with severe behavior disorders; and residential programs. Another component of The Center is comprehensive staff training and development which provides staff with the opportunity to learn about the important issues affecting their clientele. One of these issues is substance abuse and disability.

Approximately two years ago, several Center staff members were experiencing difficulty finding substance abuse treatment services which were appropriate for some of the consumers involved in their programs. Because of the importance of identifying and resolving substance abuse problems prior to independent living and employment, finding substance abuse services for these consumers became a priority. After a comprehensive search, it became apparent that there were no appropriate services available. The Center created a task force consisting partially of Center staff representatives, a state Department of Alcohol and Substance Abuse (DASA) representative, a representative from the Mayor's office, a number of consumer representatives, and representatives from the disability service community and the alcohol and other drug treatment community.

After meetings, research, and networking with other communities, the task force determined that it was more practical to bring alcohol and other drug professionals to The Center than to mainstream consumers into local treatment centers. It was also determined that the best chance for successful treatment was to create a program in conjunction with the residential programs already in place. A decision was made to focus on substance abuse treatment specific to persons with deafness and hearing impairments.

Within a short period of time after these decisions were made, seed monies were obtained through DASA in Illinois, and within a year a substance abuse in-patient and out-patient treatment component was in place for persons with deafness and hearing impairments. The program has been very successful and maintains a full census of clients. Currently the Advisory Board and The Center staff are pursuing treatment services for persons with developmental disabilities.

This case sample shows how utilizing local expertise and resources can assist with problem resolution. The Center has a staff of disability professionals who were cross trained in the issues of substance abuse. They in turn were able to identify consumers with substance abuse problems. When treatment opportunities were not readily available, community leaders became involved in the process of researching solutions. The implementation of this disability specific treatment program is a source of pride for the entire community, and it is a cost effective innovation for The Center.

## **AMERICANS WITH DISABILITIES ACT**

### **FACT SHEET\*\***

The Americans With Disabilities Act of 1990 (ADA) (P.L. 101-336), which was originated and developed by the *National Council on Disability* in 1986 and 1988, gives civil rights protections to individuals with disabilities that are like those provided to individuals on the basis of race, sex, national origin, and religion. It guarantees equal opportunity for individuals with disabilities in employment, public accommodations, transportation, state and local government services, and telecommunications. The ADA was signed into law on July 26, 1990.

#### **EMPLOYMENT**

- \* Employers may not discriminate against an individual with a disability in hiring or promotion if the person is otherwise qualified for the job.
- \* Employers can ask about one's ability to perform a job, but cannot inquire if someone has a disability or subject a person to tests that tend to screen out people with disabilities.
- \* Employers will need to provide "reasonable accommodation" to individuals with disabilities. This includes steps such as job restructuring and modification of equipment.
- \* Employers do not need to provide accommodations that impose an "undue hardship" on business operations.

#### **WHO NEEDS TO COMPLY**

- \* All employers with 25 or more employees must comply, effective July 26, 1992.
- \* All employers with 15-24 employees must comply, effective July 26, 1994.

#### **TRANSPORTATION**

- \* New public transit buses ordered after August 26, 1990, must be accessible to individuals with disabilities.
- \* Transit authorities must provide comparable paratransit or other special transportation services to individuals with disabilities who cannot use fixed route bus service, unless an undue burden would result.
- \* Existing rail systems must have one accessible car per train by July 26, 1995.
- \* New rail cars ordered after August 26, 1990, must be accessible.
- \* New bus and train stations must be accessible.

## TRAINING MANUAL FOR PROFESSIONALS

- \* Key stations in rapid, light, and commuter rail systems must be made accessible by July 26, 1993, with extensions up to 20 years for commuter rail (30 years for rapid and light rail).
- \* All existing Amtrak stations must be accessible by July 26, 2010.

## PUBLIC ACCOMMODATIONS

- \* Private entities such as restaurants, hotels, retail stores, and **chemical dependency treatment programs** may not discriminate against individuals with disabilities, effective January 26, 1992.
- \* Auxiliary aids and services must be provided to individuals with vision or hearing impairments or other individuals with disabilities, unless an undue burden would result.
- \* Physical barriers in existing facilities must be removed, if removal is readily achievable. If not, alternative methods of providing the services must be offered, if they are readily achievable.
- \* All new construction and alterations of facilities must be accessible.

## STATE AND LOCAL GOVERNMENTS

- \* State and local governments may not discriminate against qualified individuals with disabilities.
- \* All government facilities, services, and communications must be accessible consistent with the requirements of Section 504 of the Rehabilitation Act of 1973.

## TELECOMMUNICATIONS

- \* Companies offering telephone service to the general public must offer telephone relay services to individuals who use telecommunications devices for the deaf (TDD's) or similar devices, effective July 26, 1993.

\*\* For further information, contact:

**National Council on Disability**  
800 Independence Avenue, SW, Suite 814  
Washington, D.C. 20591  
Voice (202) 267-3846  
TDD (202) 267-3232  
FAX (202) 453-4240

Special Thanks to Ms. Ethel Briggs, Director  
National Council on Disability

## TEST YOUR KNOWLEDGE ABOUT CONNECTING AGENCIES

The following questions are based on the information contained in the Chapter you have just read. The answers are found in Appendix G.

1. In many cases, physical accessibility is less of a problem than attitudinal accessibility.

TRUE    FALSE

2. What are the two major activities for "help-seekers" wanting to find adequate services persons with disabilities?

\_\_\_\_\_ and \_\_\_\_\_.

3. Describe "cross-training" as it refers to the AOD and Disability fields.

\_\_\_\_\_  
\_\_\_\_\_

4. The ADA guarantees equal opportunity for persons with disabilities in the following areas:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**APPENDIX A**

**RESOURCES**



## RESOURCES FOR SUBSTANCE ABUSE AND DISABILITY

### 1. SARDI (Substance Abuse Resources and Disability Issues)

School of Medicine  
Wright State University  
Dayton, OH 45435  
(513) 259-1384 (Voice/TDD)  
(513) 259-1310 (Fax)

*This training and consultation project receives funding from the U.S. Office for Substance Abuse Prevention (OSAP) and Drug Free Schools, the Department of Education. The project staff have developed a number of printed materials including this professional Training Manual, other training materials, and screening protocols and instruments. A six state comprehensive drug use survey was conducted and the results are available through the SARDI office. SARDI conducts training conferences for teachers and school personnel, rehabilitation professionals, administrators, alcohol and drug professionals, and parents. SARDI staff also provide technical assistance in substance abuse prevention and treatment for persons with disabilities. The project publishes a quarterly newsletter available at no cost.*

### 2. Project Aid (Addiction Intervention with the Disabled)

Sociology Department  
Kent State University  
Kent, Ohio 44242  
(216) 672-2440 (Voice)  
(216) 672-2451 (TTY)

*This program provides assistance to agencies and consultations including prevention, education, referrals, follow up services, advocacy and staff training. a number of publications are available through their office including a prevention curriculum for special education students. A prevention picture book has recently been published and is ideal for non- or low-level readers.*

### 3. IADD (Institute on Alcohol, Drugs and Disability)

P.O. Box 7044  
San Mateo, CA 94403  
(707) 664-2677 (Voice)  
(707) 664-2958 (TDD)

*The focus of IADD is improving the accessibility of alcohol and other drug programs for persons with disabilities and advocating for prevention specific to persons with disabilities. They conducted the California Alcohol, Drug and Disability Study (CALADDS) whose purpose was to assess the degree to which services are not being met for persons with disabilities who also have substance abuse problems. A summary of this study, as well as several other publications, and a quarterly newsletter entitled The Seed are available.*

4. **NCADI (OSAP's National Clearinghouse for Alcohol and Drug Information)**  
P.O. Box 2345  
Rockville, MD 20852  
(301) 468-2600 (Voice)  
(301) 230-2867 (TDD)

*NCADI is a federal resource for alcohol and other drug information sponsored by the Office for Substance Abuse Prevention. A large variety of articles and publications are available, most at no charge. NCADI also has a free Audiovisual Loan Program, and personalized database searches can be conducted on many alcohol and other drug related topics. NCADI also disseminates grant announcements and application kits and offers technical support in a variety of ways. Several excellent publications available through NCADI are Turning Awareness into Action: What Your Community can do About Drug Use in America; Preventing Adolescent Drug Use: From Theory to Practice; Parent Training is Prevention; and The Fact Is...Resources Are Available for Disabled Persons with Alcohol and Other Drug Problems. To receive a current publications catalog, contact the NCADI office.*

5. **CCDD (The Congress on Chemical Dependency and Disability)**  
15519 Crenshaw Boulevard, Suite 209  
Gardena, CA 90249  
(213) 679-9126 (Voice)  
(213) 679-6523 (TDD)

*CCDC is a group of concerned persons whose goal is to ensure that persons with disabilities have appropriate substance abuse and other services. They provide community education, consultation, referrals, training, and outreach services. They specialize in providing education to chemical dependency treatment providers to assist in making treatment services physically and attitudinally accessible.*

6. **Resource Center on Substance Abuse Prevention and Disability**  
1331 F Street NW, Suite 800  
Washington, DC, 20004  
(202) 783-2900 (Voice)  
(202) 737-0645 (TDD)

*The Resource Center for Substance Abuse Prevention and Disability is one of the communications projects funded by the O.S.A.P. The "Resource Center" is part of Very Special Arts' Educational Services and is the first, comprehensive clearinghouse for research, curricula, media, and other programmatic materials related to alcohol and other drug use and individuals with disabilities. VSA's Resource Center develops publications for national dissemination and maintains a well qualified staff to answer questions on substance abuse and disability.*

7. *NCYD* (National Center for Youth with Disabilities)  
University of MN Hospital and Clinic, Box 721  
Harvard Street at East River Road  
Minneapolis, MN 55455  
(800) 333-6293  
(612) 626-2825

*NCYD is a collaborative project of the Society for Adolescent Medicine and the Adolescent Health Program at the University of Minnesota. Their mission is to raise the awareness of the needs of adolescents and young adults with chronic illnesses and disabilities. NCYD has a comprehensive Resource Library which covers a wide range of biopsychosocial issues relating to youth with disabilities. An annotated bibliography on substance use by youth with disabilities is available. This publication also includes a listing of training materials and a Treatment Selection Checklist.*

8. *UCCD* (The University of California Center on Deafness)  
Deaf Services Network - North  
3333 California Street, Suite 10  
San Francisco, CA 94143-1208  
(415) 476-4980 (Voice)  
(415) 476-7600 (TDD)

*UCCD is the only federally designated research and training center in the nation focusing on deafness and mental health. The mission of UCCD is to improve the mental health of persons with deafness and to increase professional knowledge about deafness. One component of the UCCD is the Deaf Services Network. A variety of materials are available through UCCD including a training video entitled "Meeting the Challenge: Working With Deaf People in Recovery" for alcohol and drug service providers.*

9. *Peninsula Health Concepts*  
2165 Bunker Hill Drive  
San Mateo, CA 94402  
(415) 578-8047 Voice/TDD

*Peninsula Health Concepts (PHC) is a consulting firm specializing in program development, research, evaluation, and management consultation. Its President is John de Miranda who is a leader in the field of substance abuse and disability. A number of publications are available through PHC.*

10. *RIC* (Rehabilitation Institute of Chicago)  
448 East Ontario Street, Suite 650  
Chicago, IL 60611  
(312) 908-2802

*The RIC has been actively conducting research related to substance abuse and disabilities, particularly spinal cord injury and traumatic brain injury, for a number of years. A resource manual entitled Alcohol and Other Drug Abuse Prevention for People with Traumatic Brain Injury and Spinal Cord Injuries will be available soon. The manual is designed for rehabilitation professionals, persons experiencing traumatic injuries, and their families. The four parts of the manual are challenges and risks, prevention strategies, resources for staff, and resources for consumers. Dr. Allen Heinemann, Director of the Rehabilitation Evaluation Unit at RIC, is the author of a number of professional journal articles.*

11. *CEDAR* (Center for Empowerment of Deaf Alcoholics in Recovery)  
3041 University Avenue  
San Diego, CA 92104  
(619) 293-3820 (Voice)  
(619) 293-3746 (TTY)

*CEDAR is a program developed by persons with deafness and hearing impairments with the goal of supporting each other in recovering from substance abuse. All persons with deafness or hearing impairments interested in recovery are invited to participate. A variety of activities and services are available including the following: prevention workshops, advocacy, interpreter/consultation services, inservice trainings, and a drop in center where recovery meetings, peer support, and recreational activities are available.*

12. *Minnesota Chemical Dependency Program for the Hearing Impaired*  
Riverside Medical Center  
2450 Riverside Avenue  
Minneapolis, MN 55454  
(612) 337-4402 (Voice)  
(612) 337-4114 (TDD)

*This program provides chemical dependency services to persons with deafness or hearing impairments age 16 and older. The program offers the following services: evaluation and assessment, inpatient treatment, transition back to the community, family programs, and community outreach.*

*The professional staff provide national technical assistance, professional training, and materials development. Some materials and articles are available through the program, including a periodic newsletter.*

13. *Sister Kenny Institute*  
Abbott-Northwestern Hospital  
800 East 28th Street at Chicago Avenue  
Minneapolis, MN 55407  
(612) 863-4457 (Voice)  
(612) 863-5163 (TDD)

*The innovative Chemical Dependency/Physical Disability Program was implemented in 1983 and is designed to meet the specialized treatment needs of persons with physical disabilities. The program's premise is that a person's disability is a significant component of the person's life and needs to be addressed in order to facilitate recovery.*

14. *The Chicago Hearing Society*  
332 S. Michigan Avenue, Suite 714  
Chicago, IL 60604  
(312) 939-6888 (Voice)  
(312) 427-2166 (TDD)

*The Chicago Hearing Society works to affirm the rights of people with deafness or hearing impairments. They provide services in the areas of education, communication, health, rehabilitation, social advocacy, and prevention.*

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**APPENDIX B**

**EXECUTIVE SUMMARY:  
CONSUMER EVALUATION DATABASE  
ALCOHOL AND OTHER DRUG USE SURVEY**

APPENDIX B

STATEMENT OF WORK

FOR THE DEVELOPMENT OF A

COMPREHENSIVE AND INTEGRATED

## EXECUTIVE SUMMARY

### A Regional Survey of Substance Use Among Persons With Disabilities: Patterns, Consequences, and Implications for Prevention Activities

Dennis Moore, Ed.D., Project Director

July, 1992

*The SARDI staff would like to thank the Site Representatives and other persons who assisted with the data collection and respondent solicitation. This survey would not have been possible without the unselfish efforts of many professionals and consumers.*

The first two years of the SARDI project were designed as a feasibility and pilot phase which included professional sensitization to substance abuse and disability issues, the development of training protocols and materials, and a survey of substance use patterns by older youth with disabilities. The third component was especially important considering the number of prevention areas which must be considered when looking at substance abuse risk and the characteristics of specific disabilities.

The substance use survey was conducted to assist with the evaluation of SARDI training activities. In an area where little information is available for making decisions about substance abuse prevention activities, this survey was intended to assist with focusing prevention efforts. These data also will serve as a baseline for evaluating the efficacy of future SARDI prevention activities.

#### Methodology

Representative Sites for the SARDI project and a limited number of other locations were contacted regarding a proposed survey of alcohol, other drug, and medication use among persons with disabilities. Subsequent letters and meetings developed site specific survey procedures and addressed human subjects approval requirements. Approvals for data collection were sought from all Institutional Review Boards (I.R.B.'s) where applicable, or from other entities acting on behalf of the agencies.

A total of 19 agencies or organizations within Illinois, Indiana, Kentucky, Michigan, and Ohio, and one agency in Tennessee eventually participated by permitting access to client populations. Because several participating agencies were multi-site, data was collected at 40 separate geographic sites. Tables listing participating sites and listing the nature of client services are provided in the following report.

*Survey questionnaire.* The time and resources available for data collection made a self-report questionnaire the most effective means for sampling geographically distributed respondents. Self-report questionnaires are the most widely utilized method for conducting alcohol and other drug epidemiology studies, as evidenced by the National Household Survey and the National Survey of High School Drug Use (N.I.D.A.). This methodology permits sampling of larger numbers of respondents on a cost effective basis. When properly structured, self-report data on variables such as illicit drug use provide acceptable reliability (Johnston, O'Malley, Bachman, 1985).

The primary form of the survey instrument consisted of 60 items which were classified into 119 variables. Questions regarding substance use and their consequences were chosen in some cases to parallel information from existing national alcohol and drug use epidemiology studies (e.g., National High School and College Senior Substance Use Questionnaire; National Household Drug Survey by N.I.D.A.). The substance abuse/disability questionnaire was generated in two forms: a general disability agency and a worker's compensation form. The worker's compensation form was slightly shorter to encourage completion of questions, and the disability categories were changed to include conditions such as carpal tunnel syndrome and low back pain.

Due to the nature of the services at Representative Sites, some individuals could qualify as disabled because of a diagnosis of chemical dependency. In order to clarify disability information, respondents with a primary disability of chemical dependency and no other disability were deleted from the subsequent data analysis. A total of 25 persons out of 941 respondents were deleted for this reason. The bulk of these respondents entered the survey through their application for services to a state vocational rehabilitation program.

The questionnaire was originally intended to be computer administered at the Representative Sites; however, a lack of available computers at these sites made a paper/pencil form of this instrument more accessible. Persons who could not complete a paper/pencil form, such as in cases of low reading ability, visual or physical limitations, could place a collect phone call to the SARDI program and answer the survey in this manner. Site specific special arrangements were made for deaf respondents who could not fill out the written questionnaire without assistance. This assistance generally was in the form of an interpreter provided from the agency serving as the survey site.

*Survey respondents.* Potential respondents for this study were persons who were accessing disability services at a variety of settings. A database consisting of 300 youth, 18 - 21 years of age was sought. Other sources of funds allowed for including another 700 adults over the age of 21 years. Oversampling for gender, race, and cultural differences was planned in order to represent all persons with disabilities within the region. Participating data collection sites and respondent demographics are provided in accompanying tables.

In addition to a \$5.00 remuneration for respondents, participating sites which contributed 30 or more respondents were compensated by being provided with a customized data analysis which compared their client profiles with the entire SARDI data base. All information was provided in group form, and no individual descriptions or data were made available. Demographic information which could individually identify a respondent (such as being the only blind respondent at a site) was reviewed to make certain that no specific alcohol or drug information could be traced to that individual.

*Procedure for soliciting respondents.* Each site had a specific protocol for soliciting respondents which was devised in meetings with SARDI staff. The drug use survey was not intended to be a random sample due to problems with generating a sufficient number of respondents. Instead, all clients utilizing certain agency services were asked if they wished to participate in the study. (For example, all patients undergoing intake interviews over a period of six weeks in a rehabilitation unit or all students contacting a disabled student services office for any assistance were solicited for their participation in this study.) The persons soliciting survey respondents were chosen by the host site and briefed by SARDI staff in the protocols for recruiting respondents. In no case could the recruiter choose the specific individuals to be solicited. Several sites utilized student interns, clerical or paraprofessional staff for the task of recruiting respondents.

The questionnaire solicitor asked prospective respondents if they would like to participate in a study of medication and other drug use and receive compensation for their time. If the consumer was interested, that person was provided with a number coded informed consent form and a questionnaire wrapped in a clear plastic envelope. The respondent could read the informed consent without disturbing the number coded materials. If that person agreed to participate, he or she removed the informed consent and signed it. A stamped envelope was provided to mail back the informed consent. The respondent was then directed to a private area to complete the survey. Once completed, this was mailed by the respondent in another stamped envelope provided for that purpose. Once the two code matched envelopes arrived at the SARDI office containing the informed consent and the questionnaire, a check was mailed to the respondent.

A total of seven respondents chose to answer the questionnaire by phone. The disabilities represented in this sub-sample included developmental disability, blindness, and severe physical involvement. The phone responses appeared similar in profile to paper/pencil profiles and were included in the database.

**Youth Survey Results**

A total of 295 individuals, aged 18 - 21 years, and without a primary disability of chemical dependency, provided completed questionnaires for analysis. Twenty-one year olds were included in this analysis because it substantially increased the size of the youth sample. Preliminary analysis did not indicate that response patterns of 21 year olds differed substantially from those aged 18 - 20 years.

This sample consisted of 58.4% males. The racial distribution is provided by the accompanying table. A total of 7.4% of the youth sample were African Americans. A better opportunity to oversample sub-groups existed in the adult survey where 14% were African American.

Over one-third of the sample (34.5%) was living with a parent, and one-half reported living with a roommate. Of interest for developing substance abuse prevention curricula, nearly 12% of the older youth sample lived alone.

=====

**TABLE ONE**

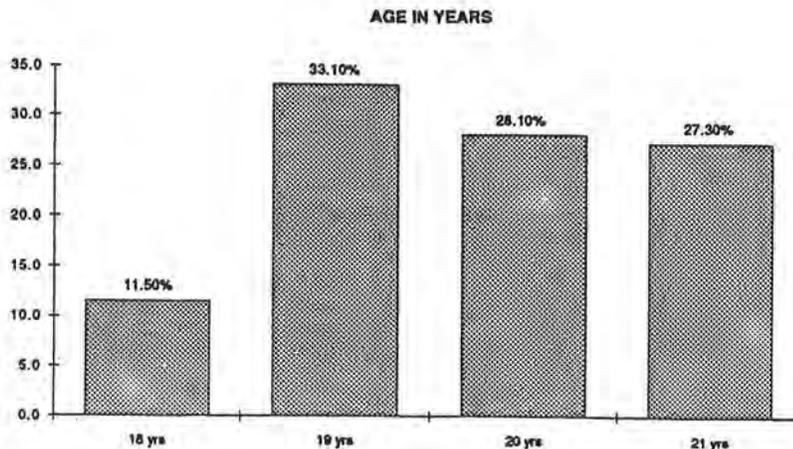
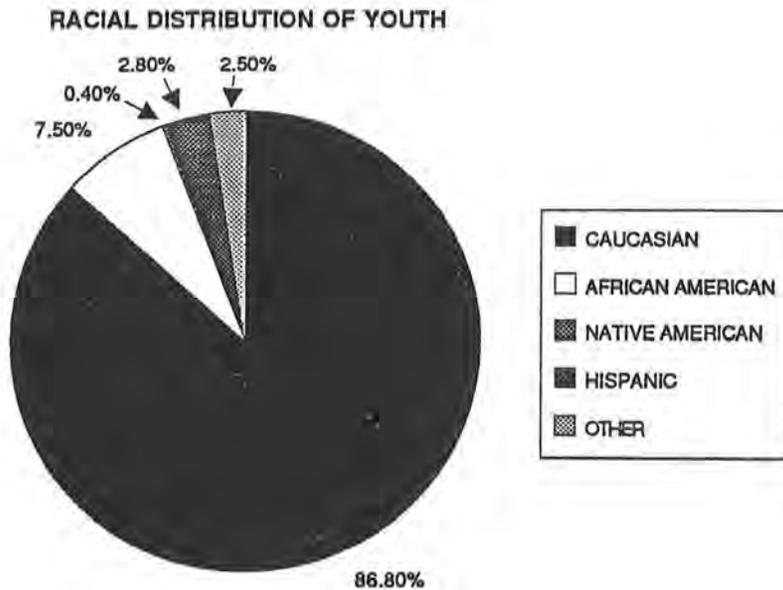


TABLE TWO



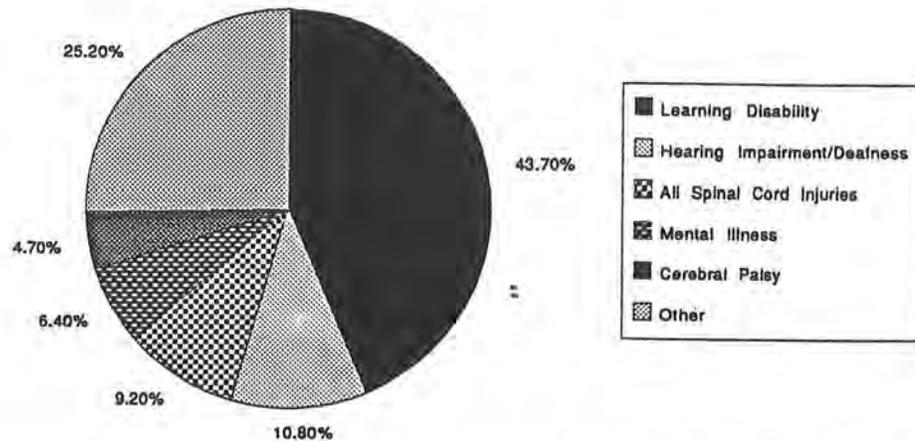
*Disability distribution.* Table three provides a listing of the disabilities reported by respondents. The percentage of persons who were unable to classify their disability, and a tendency to minimize disability condition (self-identifying as "learning disabled" rather than "mentally retarded" from a facility that only serves persons with the latter condition) indicates some inaccuracies in self-diagnoses. A total of 11.9% of the respondents considered themselves to be multi-disabled.

Nearly 10 percent (9.8%) reported problems with chronic pain, with over one half of this group rating their pain as "moderately" to "very" painful. Of respondents reporting chronic pain, approximately four percent reported using alcohol to deal with pain. A total of 18% of all respondents experience tremors or spasticity, one-third of that group requiring medication for the condition.

*Medication use.* In spite of the median age and diversity of disabilities in this sample, the group as a whole frequently required prescription medication. A total of 34.7% of the group reported current use of prescription medication. Of the individuals taking medication, 49.5% take more than one simultaneous prescription (8% take four or more simultaneous prescriptions). Multiple medication use is a strong risk factor for substance abuse, even without use of alcohol or illicit drugs. Also of concern, 42.7% of those receiving medications obtained their prescriptions from more than one physician. It is not uncommon for physicians with patients who do not fully understand their medications to be unaware of drugs which have been prescribed by another specialist.

TABLE THREE

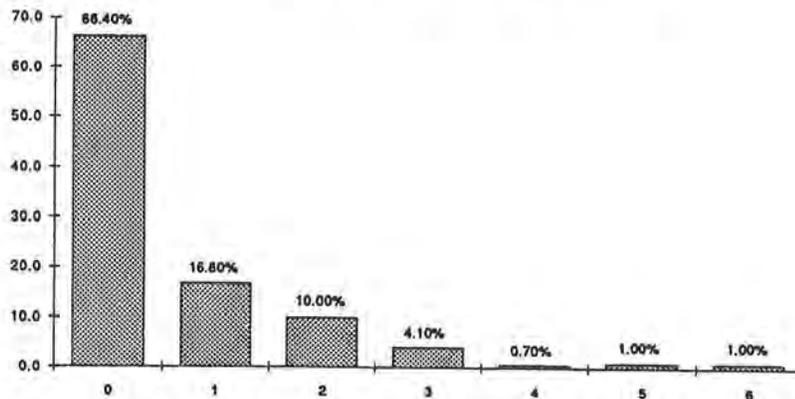
PRIMARY DISABILITIES OF YOUTH



43.5% of respondents report that their disabilities occurred at or before the time of birth (all disability categories including learning disability)

TABLE FOUR

TOTAL NUMBERS OF MEDICATIONS TAKEN BY YOUTH



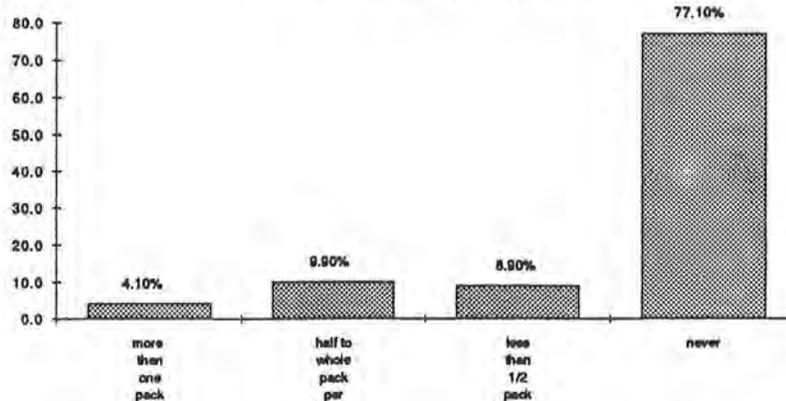
*Tobacco use.* The smoking frequency for tobacco appears to parallel the latest figures for all youth of comparable age. A total of 22.9% of this sample reported smoking currently, with 4.1% of all respondents smoking more than one pack per day. The national average for daily smoking for high school seniors currently is listed as 18.5%, with little change in these figures over the past ten years (Johnston, et al., 1992). The smoking frequency for youth with disabilities is distressingly high, especially considering the health

and medical issues facing a number of these youth. Morbidity from smoking very likely is much higher for youth with disabilities than the general population due to these other risk factors.

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**TABLE FIVE**

**CURRENT SMOKING FREQUENCY FOR YOUTH**



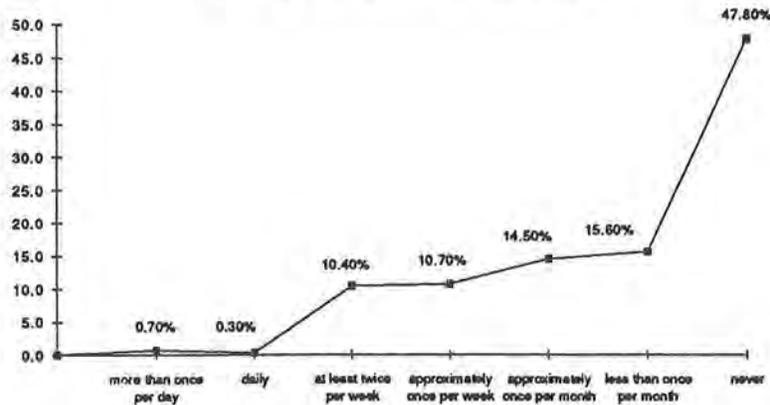
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*Alcohol use.* A total of 52.2% of the respondents currently drink alcoholic beverages. The median age of onset of intoxication is 15 years of age. This figure may be delayed slightly from the national average. Of the youth who drink, one-fourth consume a 12 pack or more on the weekend, with the median weekend consumption for those who drink falling approximately at a six pack per weekend. These figures are comparable with national statistics on the general population of youth. For example, 29.8% of high school seniors in the 1991 national study reported "binge drinking" five or more drinks at some time in the last two weeks (Johnston et al., 1992).

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**TABLE SIX**

**CURRENT ALCOHOL CONSUMPTION FOR YOUTH**

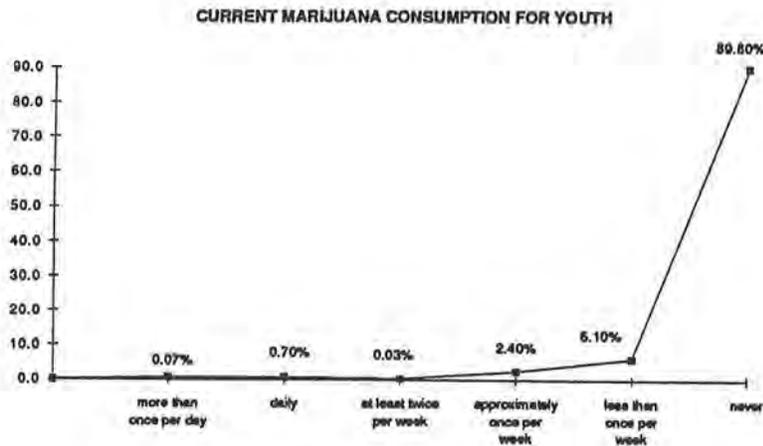


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*Marijuana use.* The self-reports of youth in this study indicated that 10.2% currently use marijuana. The median age of onset of use was 15 years of age. Of those who use marijuana, the majority claim use is less than once per week. By contrast, the national high school survey reports that 24% of all seniors in 1991 had tried marijuana, and 13.8% had used this drug at least once in the last 30 days (Johnston et al., 1992).

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TABLE SEVEN



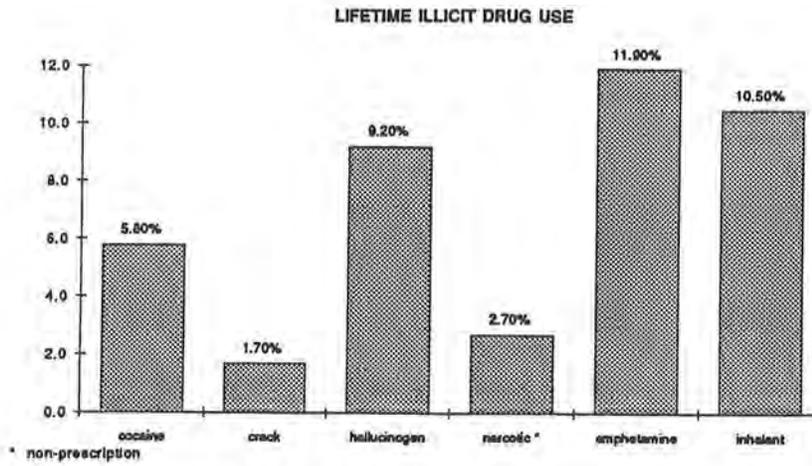
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It is important to note that self-report of current marijuana use may have been one of the least reliable aspects of the survey among youth with disabilities. It was the only question which requested "current" information about the use of an illicit drug. Compared to the national high school senior survey, the respondents in the disability study were probably less certain about how and why the information was being sought. This may have been especially true since agency personnel upon whom these respondents depended for services were perceived as administering the survey.

*Other illicit drug use.* The information about lifetime use of other illicit drugs suggests that youth with disabilities have access to the same variety of illicit substances as any other member of this peer group. Lifetime use of cocaine was admitted by 5.8% of the respondents, and 1.7% had tried crack cocaine. The national estimates for lifetime use of these drugs by all high school seniors in 1991 were 7.8% and 3.1%, respectively (Johnston et al., 1992).

A concern among all youth is the apparent rise in popularity of hallucinogens, and youth with disabilities are no exception -- 9.2% of the disability survey respondents had used hallucinogens in their lifetime (9.6% estimate for all high school seniors, Johnston et al., 1992). Also of concern, "speed" (amphetamines) lifetime use was 11.9% (compared with 15.4% for all high school seniors). Just as with the national study of high school seniors, the youth with disabilities were asked to provide information about the use of amphetamines which had not been prescribed for them.

TABLE EIGHT



*Parents and family.* Respondents were asked if "one or both of my parents have had a drinking or drug use problem". A total of 24.4% indicated in the affirmative. This figure appears to be 50 - 100% higher than estimates of the national average. The family-related concerns have immediacy, in that 24.5% of youth with disabilities acknowledged that they have current concerns about a family member's use. In addition, 13.9% felt that their own drinking had contributed to family problems.

**Negative consequences of use**

- 7.1% have "gone for help" due to their drinking
- 25.5% have been sick 2 or more times due to substance abuse
- 3.6% have been hospitalized due to their drinking
- 5.7% have been arrested due to drunkenness
- 3.2% have been charged with a DWI
- 2.9% have experienced work or school "trouble" due to use
- 9.4% have gone to work or school high or intoxicated "a few times" or more
- 5.4% have gone to work or school high or intoxicated more than 10 times
- 20.3% have felt badly about their drinking
- 11.5% scored "4" or higher on modified short MAST
- 10.0% have used 2 or more illicit drugs

*Disability differences.* Consequences and risks relating to the use of alcohol and other drugs differed by disability category. Not surprisingly, youth experiencing spinal cord injuries were most problematic especially compared to youth with congenital disabilities. The following chart provides substance abuse correlates and survey results from several disability groups.

TABLE NINE

**SUBSTANCE ABUSE RISK FACTORS BY DISABILITY  
YOUTH SURVEY: AGES 18-21  
(all numbers represent percentages)**

	SCI	HI	MI	LD	CP	MEDICAL
chronic pain	24.0	6.5	10.5	6.3	0.0	10.5
currently takes medications	63.0	12.9	50.0	18.9	50.0	57.9
currently smokes cigarettes	29.6	9.4	21.1	30.5	7.7	11.1
currently uses alcohol	73.1	61.3	38.9	48.8	28.6	42.1
currently uses marijuana	23.1	6.3	15.8	12.5	0.0	5.3
lifetime use of cocaine	18.5	3.1	0.0	0.7	0.0	0.0
lifetime use of crack	0.0	3.1	0.0	2.3	0.0	0.0
lifetime use of hallucinogens	25.9	6.3	5.3	8.5	0.0	5.3
lifetime use of amphetamines	33.3	6.3	5.3	13.2	7.1	0.0
lifetime use of inhalants	22.2	6.3	21.1	10.9	0.0	0.0
history of intoxication	44.4	18.8	37.5	24.6	0.0	5.3
parental alcoholism	29.6	34.4	37.5	22.5	8.3	10.5
alcohol/drug related arrest	18.5	0.0	0.0	6.6	0.0	0.0
reporting to work/school under the influence	42.3	12.5	16.7	17.5	0.0	0.0
feels bad about drinking	36	22.2	12.5	19.2	0.0	5.9

SCI= Spinal Cord Injury  
N=27

LD= Learning Disability  
N=129

HI= Hearing Impairment/Deaf  
N=32

CP= Cerebral Palsy  
N=14

MI= Mental Illness  
N=19

Medical= Medical Related Disabilities  
N=19

### Entire Survey Results

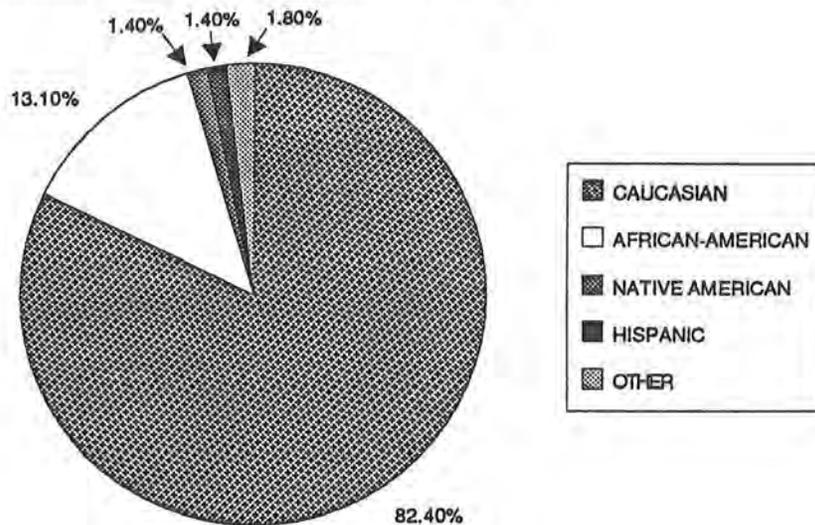
A total of 916 individuals, aged 18 - 80, without a primary disability of chemical dependency, responded to the survey. These individuals represented 20 agencies and 40 distinct sites in the SARDI region (plus one cohort of 40 former university students from

Tennessee). A total of 56.5% of the respondents were male, and the sample's median age was 27 years.

Although the majority of respondents lived in an apartment or house (69.6%), only 19.2% lived with a spouse or girl/boy friend. One third of the sample (33.7%) reported sharing living space with a roommate. One fifth (20.5%) lived alone, which constitutes a particular risk relative to substance abuse opportunity and identification.

TABLE TEN

RACIAL DISTRIBUTION OF ALL RESPONDENTS



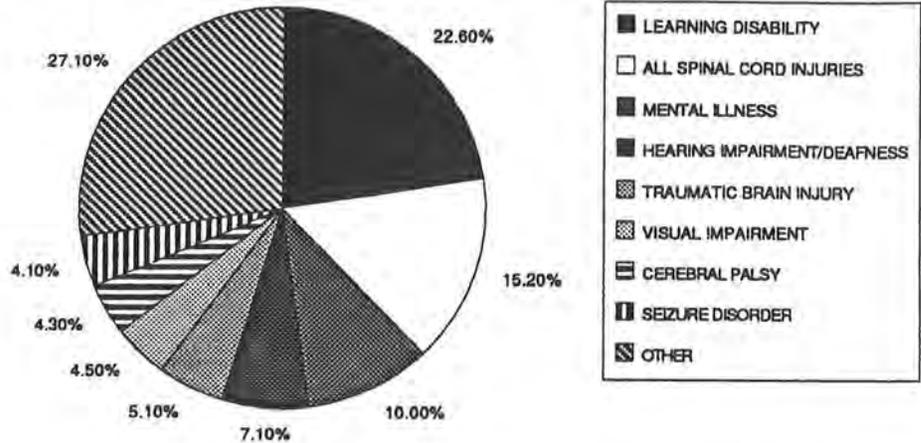
*Disability distribution.* TABLE 11 lists the primary disabilities reported by respondents. Recent changes in eligibility and services for persons with learning disabilities obviously have contributed to the larger percentage of individuals in this category. As in the youth survey, the disabilities have been determined by respondent self report.

*Other disability information.* A total of 19.8% of respondents reported experiencing a multiple disability. For 15.5%, the disability severity requires use of attendant care. Over one quarter (26.8%) reported problems with chronic pain, with 53.7% of these individuals reporting moderate to "very painful" episodes. Many persons in the sample experienced tremors or spasticity (31.6%), and slightly less than half of these persons received medication for the condition.

The self-report information indicated that 23.8% of all disabilities were injury-related, rather than disease or congenital in origin. Of the injury-related disabilities, 30% were acknowledged by the respondent as being alcohol or drug-related. Our previous study in this area suggests that this figure very likely is under-reported.

TABLE ELEVEN

PRIMARY DISABILITIES OF ALL RESPONDENTS

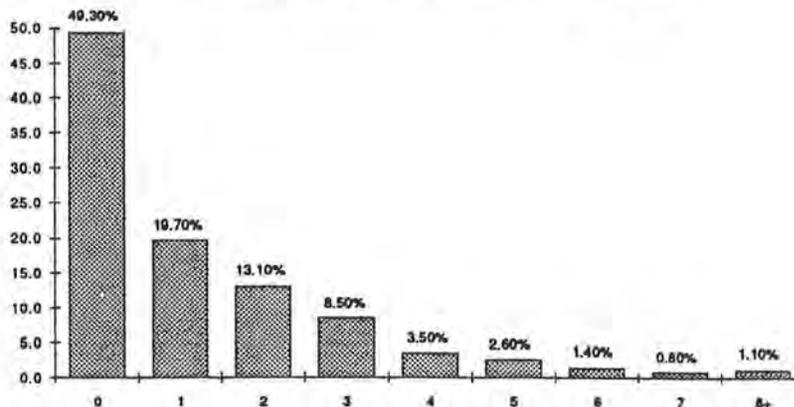


29.6% of respondents report disability of congenital origin, with median age of disability onset = 14.5 years of age.

*Medication use.* Over one half of the survey respondents (50.8%) currently take prescribed medication. One third of persons taking medication (34.6%) take three or more prescriptions. A total of 43.5% of those on medication received their prescriptions from more than one physician. Importantly, 15.1% of all respondents acknowledged using alcoholic beverages for pain. Of these, 24.5% used alcohol at least weekly for pain.

TABLE TWELVE

TOTAL NUMBER OF MEDICATIONS TAKEN BY RESPONDENTS



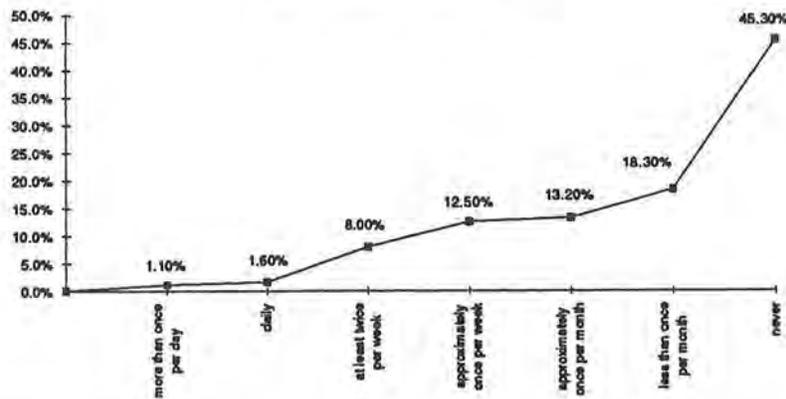
*Tobacco use.* Approximately one-third of the sample currently smoked (33.6%). The majority of the smokers consumed a pack or more of cigarettes per day. Those who smoked had consumed tobacco products for a median of 13 years.

*Alcohol use.* The majority of respondents (54.7%) reported that they currently consume alcoholic beverages. The median age of onset of alcohol use to intoxication was 15 years. Of the respondents who reported weekend use of alcohol, one-quarter (24.1%) consumed the equivalent of a twelve pack or more of beer over this period of time. On the other hand, only 2.7% of the respondents reported daily use of alcoholic beverages.

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**TABLE THIRTEEN**

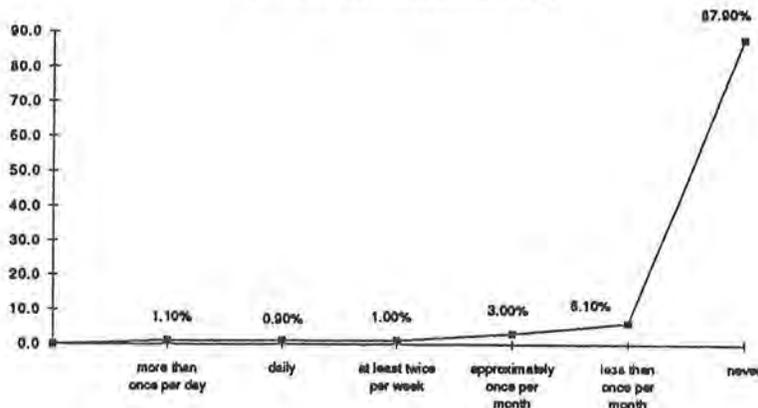
**CURRENT ALCOHOL CONSUMPTION**



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**TABLE FOURTEEN**

**CURRENT MARIJUANA CONSUMPTION**



*Marijuana use.* Current use of marijuana was reported by 12.1% of the sample, and the median age of onset of use was 16 years. These figures appear comparable to national averages, although differences in age group reporting make direct comparison difficult (nationally, 12.7% of 18 - 25 year olds have used marijuana in the last month, NIDA, 1991). As with alcohol use, the presence of a disability does not appear to delay the onset age for marijuana use when all disabilities are considered as one group.

*Other illicit drug use.* Use of other illicit drugs also appeared to parallel, and in some cases exceed, patterns established for the general population. When asked if they had ever used cocaine, 19.3% of the respondents with disabilities answered affirmatively. This figure is the same as the National Household Survey on Drug Abuse statistics for lifetime cocaine use for the 18 - 25 year old group, but lower than the 25.6% prevalence for the 25 - 34 year old group (NIDA, 1991).

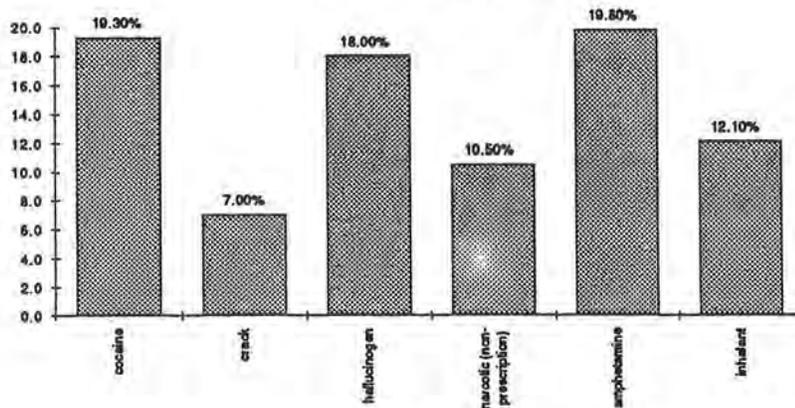
The use of crack cocaine by persons with disabilities is more problematic, as the obtained frequencies nearly double the national averages. Seven percent of the disability sample acknowledged use of crack at least once in their lifetime. No clear hypothesis addressing this phenomenon can be provided at this time.

Lifetime use of hallucinogens also was slightly elevated from figures available on the general population. A total of 18% of the respondents had used hallucinogens compared with 12% of 18 - 25 year olds and 15.7% of 26 - 34 year olds nationally (NIDA, 1991). Similarly, lifetime use of "speed" in non-medical ways (to get "high" or intoxicated) was acknowledged by 19.8% of the disability sample compared with 9% to 13.4% of the general population aged 18 - 34 years.

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**TABLE FIFTEEN**

**LIFETIME ILLICIT DRUG USE**



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*Consequences of substance abuse.* The respondents as a group reported encountering numerous problems associated with substance abuse. Among the respondents without a primary disability of chemical dependency, 15.9% reporting going for help for a drinking related problem. Self-reports indicated that nearly ten percent had been hospitalized due to drinking (including disabilities which occurred following use).

Drinking related arrests were reported by 13.1% of the respondents, and 8.9% had received a DWI. It was not established in the survey how many respondents did not hold a driver's license. A surprising 11.6% had gone to work or school high or intoxicated more than ten times, and an additional 7.9% had done this "a few times".

Items from a short Michigan Alcoholism Screening Test (M.A.S.T.) were embedded in the survey. These items were combined additively, not by assigning a weighted numerical score for some items such as when scoring a M.A.S.T. (e.g., "I have attended an Alcoholics Anonymous meeting" scores a "5" on the M.A.S.T.). Therefore the problem scale on the SARDI survey required more symptoms of substance abuse to achieve the same score as on the M.A.S.T.

Many authorities consider a M.A.S.T. score of "5" or over to be indicative of substance abuse or possible alcoholism. Respondents in our survey had a mean problem score of "2.5" with a standard deviation of "3.0". One quarter of the females scored a "3" or more, and the same percentage of males scored a "4" or higher. Although direct comparisons between M.A.S.T. scores and the SARDI problem scale are not possible, it appears likely that 25% or more of the survey respondents had experienced significant problems with substance abuse.

Family problems with substance abuse also were prevalent among the total disability sample. When asked if one or both parents had a drinking or drug problem, 29.4% of the respondents answered "yes". Nearly the same percentage of respondents reported current concerns about the use of a family member.

*Gender differences.* Distinct differences by gender existed in the nature of disabilities and in the patterns of substance use/abuse. Among both genders, the three most prevalent disabilities were learning disability, mental illness, and "other" disabilities not listed. The fourth and fifth most common disabilities for females were hearing impairment (8.9%), and cerebral palsy (5.8%), whereas males experienced spinal cord injury (7.4%) and quadriplegia (7.0%). Only 2.6% of females acknowledged that their disability was alcohol or drug related, compared with 10.6% of all males in the survey.

Females reported a multi-disability in 25.6% of the surveys compared with 15.2% of the males. Chronic pain was reported by 31.2% of the females and 23.4% of the males. Prescribed medication was taken by 60.3% of the females and 46.6% of the males. Females were more likely than males to use alcohol for pain management, and they also reported greater frequencies of medication abuse for the same reason.

Not surprisingly, males experienced more serious consequences of substance abuse than did females in the study. Females reported alcohol related hospitalizations in 5.0% of the sample, whereas it was 13.1% for males. Females reported alcohol related arrests in 2.9% of cases, whereas 24.5% of the males reported these arrests. Similarly, DWI's were incurred by 1.3% of the females and 14.8% of the males. A total of 12.9% of the females had gone to work or school high or intoxicated "a few times" or more, compared with 24.8% of the males.

Females reported that a parent had a drinking or drug problem in 31.8% of the cases, compared with 27.7% of the males. Females reported current concerns about substance abuse by a family member in 35.1% of the cases.

TABLE SIXTEEN

## PATTERNS OF SUBSTANCE USE BY GENDER

	females	males
currently use alcohol	47.8%	59.9%
currently use marijuana	7.5%	15.6%
cocaine use (lifetime)	15.2%	22.7%
crack use (lifetime)	3.8%	9.6%
hallucinogen use (lifetime)	13.7%	21.5%
"speed" use (lifetime)	18.3%	21.3%
inhalant use (lifetime)	9.6%	13.9%
narcotic use (non-prescription)	7.4%	13.1%

*African American respondents.* Oversampling of the adult population permitted the creation of a sample of African American respondents which was large enough for analysis. A total of 115 persons were included in this sub-population. They were comprised of 58.4% males, and the median age was 30. Both of these figures are comparable to the entire adult population.

The most prevalent disabilities represented among African American respondents were similar to the larger group. Learning disability constituted 20% of the sub-group, followed by mental illness (15.7%), hearing impairment (12.2%), and combined spinal cord or neurologic injuries (7.8%). Twenty percent of the African American respondents considered themselves multidisabled.

Chronic pain was a problem for 27.2% of the African American respondents, nearly identical to the whole adult group. Daily use of alcohol to deal with pain was admitted by 16.1% of the respondents with chronic pain. African American respondents received prescription medications at the same rate as the entire sample. However, daily overuse of medication to deal with pain was 20.7%, nearly double the rate of the general disability population. Nearly a fifth (19.5%, compared with 15.7% of entire sample) acknowledged combining medication and alcohol to get high. These figures, in concert with the disability distributions, most likely reflect that health care and pain management assistance are less available to African Americans.

The self-reports on substance use/abuse did not tend to differ from the general disability population. Of the African Americans, 43.9% currently smoked cigarettes. Alcohol was consumed by 51.8% of the respondents, and 12.5% currently were using marijuana. The most marked increase in admitted lifetime use were for cocaine (27%) and crack cocaine (18.3%). The crack cocaine figure is over twice the rate for the entire disability sample, and the discrepancy is similar to racially based differences in national data (NIDA, 1991). One thing that this may suggest is that people with disabilities, irrespective of race, use illicit drugs for reasons similar to non-disabled peers.

Nearly a same percentage of African American respondents reported that they had gone for help for their drinking or drug use (18%) as in the entire sample. The alcohol related arrest rates were comparable to the general sample, with 11% reporting some kind of alcohol or drug related arrest and 6.5% with a prior DWI. A total of 10.7% of the respondents acknowledged going to work or school high or intoxicated more than 10 times.

### Summary and recommendations

The youth with disabilities in this sample generally consumed alcohol and other drugs in patterns similar to non-disabled peers. Consumption patterns were influenced by the specific disability of respondents. The spinal cord injury sub-group reported the most frequent and problematic use, especially related to the use of illicit drugs. Respondents with medical-related disabilities and those with cerebral palsy reported the least use of alcohol or other drugs.

The survey results indicated that youth with disabilities in most cases have ready access alcohol and other drugs, and the presence of a disability does not appear to delay the onset of tobacco, alcohol, or marijuana use. Prescription medication use was common, and many youth on medication acknowledged prescription drug abuse either by taking more than the prescribed dosage, mixing medications with alcohol, or using medications prescribed for someone else.

Of particular concern was the number of respondents who reported a parent with an alcohol or drug related problem. Youth with mental illness and those with hearing impairment reported a parent with a problem in over one-third of the cases. This was followed by youth with spinal cord injuries, nearly 30% of whom reported parental problem use. The nature of the survey did not permit an exploration of whether parental substance abuse preceded or followed the onset of disability.

The adult survey information pointed out more problems with substance abuse than the youth survey indicated. It is clear that the progression to more serious problems, such as dependency, hospitalizations, secondary disabilities, incarceration, and loss of family are very present within the disability community. These problems frequently manifest after the individual has left the traditional school system, when that person is called upon to function as an independent adult.

The heavy substance use patterns and numerous consequences of abuse acknowledged by these respondents indicate that youth with disabilities are not receiving the types of services which could reduce vulnerability to substance abuse. It also is obvious from the data that ongoing problems with substance abuse undermine attempts at rehabilitation and meaningful employment for many persons with disabilities long into their adult years.

Although it has been suspected for some time, this survey demonstrated a link between disability and parental substance abuse. The survey did not attempt to investigate correlates of parental substance abuse, nor was it possible to determine if the presence of a disability is likely to cause or be the result of parental substance abuse.

There are at least two distinct sub-groups of persons with disabilities relative to use of mild altering substances. One group tends to use substances very little, but the risk for problems appears to be elevated for these persons if they change consumption patterns. Another group (perhaps 20-30%) has an extended history of substance misuse, and quite possibly a positive family history of abuse as well. Persons in the latter group tend not to identify themselves as abusers, nor do they appear to see the connection between their abusive consumption and difficulties in adapting successfully to an independent lifestyle. The most problematic abusers, and the individuals at highest risk for abuse, tend to come from medical and vocational rehabilitation settings.

*Recommendations for prevention activities.* Subsequent analysis of the SARDI evaluation data base will provide more insight into disability-specific prevention strategies which are necessary, but some recommendations for program development can be made at this time. The following areas should be considered when developing prevention programs and curricula for persons with disabilities:

1. Medication use and misuse is a significant problem which requires specific, and repeated, health education. Persons need to become more familiar with their medications, the actions of these drugs, and the problems when these drugs are combined. Particular attention needs to be placed on the alcohol/medication interactions that might result. Advocates, parents, and partners of persons with disabilities should be included in the education process.
2. Successful prevention must include family members, and information about COA issues to persons with disabilities. Family members require prevention activities which will address their own use. They also need to realize that persons with disabilities have access to the same drugs as non-disabled peers, plus access to a range of medications which often are supplied by more than one physician.
3. A wide variety of consumption patterns for alcohol and other drugs exist among persons with disabilities. Disability-specific strategies need to be developed in some cases. The rates of abuse of illicit drugs in the survey indicate that specific strategies to address this problem be developed.
4. Patterns of abuse in this survey suggest that persons with disabilities continue at risk for health complications and secondary disabilities. Injury prevention activities targeted to high school students should be refocused to serve youth with disabilities. It must be recognized that injury prevention and health promotion are in a continuum which by their definition should include persons with disabilities.
5. The incidence and prevalence of substance abuse demonstrated by the disability sample is largely a hidden issue, even to professionals working in disability fields. Additional efforts to upgrade knowledge and skills must be continued in this area.



**APPENDIX C**

**SUBSTANCE ABUSE AND DISABILITY  
TREATMENT CENTER DIRECTORY**

the user's information needs. The user's information needs are defined as the user's information requirements, which are the user's information needs, and the user's information requirements are the user's information needs. The user's information needs are defined as the user's information requirements, which are the user's information needs, and the user's information requirements are the user's information needs. The user's information needs are defined as the user's information requirements, which are the user's information needs, and the user's information requirements are the user's information needs.

## REFERENCES

1. *Journal of Documentation*, vol. 57, no. 2, 2002, pp. 108-111.
2. *Journal of Documentation*, vol. 57, no. 2, 2002, pp. 108-111.
3. *Journal of Documentation*, vol. 57, no. 2, 2002, pp. 108-111.
4. *Journal of Documentation*, vol. 57, no. 2, 2002, pp. 108-111.
5. *Journal of Documentation*, vol. 57, no. 2, 2002, pp. 108-111.

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ARIZONA

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**TriCity Behavioral Services, Inc.**  
1255 W. Baseline St., Suite 296  
Mesa, AZ 85202

**Phone:** (602)730-1103  
**Contact Person:** Kate Olson  
**Disabilities Served:** Physical Impairment  
**Services:** Separate program for the disabled to begin in the fall  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicare, Sliding fee scale

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**Psychological Services for the Hearing Impaired**  
St. Joseph's Medical Center  
350 West Thomas Road  
P.O. Box 2071  
Phoenix, AZ 85001-2071

**Phone:** (602)285-3939 (V)  
(602)285-3936 (TDD)  
**Contact Person:** Kay M. Seward  
**Disabilities Served:** Hearing Impairment  
**Services:** Detox program; Outpatient; Captioned videos  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicare, Sliding fee scale

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ARKANSAS

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**New Medico Rehabilitation Center At Timber Ridge Ranch**  
P.O. Box 90  
Benton, AR 72015

**Phone:** 1-800-CARE-TBI ext 3053  
**Contact Person:** Admissions  
**Disabilities Served:** Head Injury  
**Services:** Day treatment; Outpatient; Assessment; Behavioral rehabilitation  
**Staff trained in Disability:** Yes

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CALIFORNIA

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**New Bridge Foundation**  
1820 Scenic Avenue  
Berkeley, CA 94709

**Phone:** (415)548-7270 (V)  
(415)548-7273 (TDD)  
**Contact Person:** Peter Budlong  
**Disabilities Served:** Hearing Impairment  
**Services:** Long-term residential treatment; Weekly recovery group for deaf and hearing impaired  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** County contract to serve the indigent

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**Awakenings Substance Abuse Recovery Programs for Deaf and Hard of Hearing Persons**  
8515 Florence Avenue  
Downey, CA 90240

**Phone:** (213)923-0969  
**Contact Person:** Bobbie Beth Scoggins  
**Disabilities Served:** Hearing Impairment  
**Services:** Residential programs; Outpatient  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Fees based on ability to pay

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**Center for Empowerment of Deaf Alcoholics in Recovery**  
3041 University Avenue  
San Diego, CA 92104

**Phone:** (619)293-3746 (TTY)  
(619)293-3820 (V)  
**Contact Person:** Michael Eisele  
**Disabilities Served:** Hearing Impairment  
**Services:** Social model designed for deaf and hard-of-hearing alcoholics  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Services are free of charge

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DISABILITIES: HI

STATES: CA

**Benny McKeown Center**  
1281 Fleming Avenue  
San Jose, CA 95127

**Phone:** (408)259-6565 (V)  
(408)259-1983 (TTY)  
**Contact Person:** Walter Quintero  
**Disabilities Served:** Hearing Impairment  
**Services:** Closed captioned films  
**Financial Arrangements:** S.S.I., S.D.I.

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**Horizon Community Center**  
1403 164th Avenue  
San Leandro, CA 94578

**Phone:** (415)278-8654 (V)  
(415)278-5676 (TDD)  
**Contact Person:** Lee Gibbs  
**Disabilities Served:** Hearing Impairment  
**Services:** Support groups; Interpreter services; Outpatient  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Sliding fee scale

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**East Region Alcohol Services**  
1725 W. 17th Street  
Santa Ana, CA 92706

**Phone:** (714) 834-8648  
**Contact Person:** Judith Mackenzie  
**Disabilities Served:** Hearing Impairment  
**Services:** Outpatient  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Sliding fee scale

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**Signs of Recovery**  
1871 Ninth Street  
Santa Monica, CA 90405

**Phone:** (213)575-1566 (TDD)  
(213)575-4112 (V)  
**Contact Person:** Linda McCalister  
**Disabilities Served:** Hearing Impairment  
**Services:** Residential recovery home (six to nine months average stay); Videos in ASL  
**Staff Trained In Disability:** Yes

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**Addictions Program for the Hearing Impaired**  
3755 Porter Creek Road  
Santa Rosa, CA 95404

**Phone:** (707)545-7707  
**Contact Person:** James L. McCalister  
**Disabilities Served:** Hearing Impairment  
**Services:** Socio-educational based program; Residential aftercare; Outpatient; Information and referral  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicare (if arranged for in advance), insurance, personal resources

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**Valley Womens' Center, Inc. Recovery Center**  
20969 Ventura Blvd., Suite 18-19  
Woodland Hills, CA 91364

**Phone:** (818)716-7188 (V/TDD)  
**Contact Person:** Phyllis Gillian  
**Disabilities Served:** Hearing Impairment  
**Services:** Outpatient; Separate groups for deaf women  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Sliding fee scale

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CONNECTICUT

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**Commission on the Deaf & Hearing Impaired**  
**141 North Main Street**  
**West Hartford, CT 06107-1239**

**Phone:** (203)566-7414  
**Contact Person:** Diane M. Wixted  
**Disabilities Served:** Hearing Impairment  
**Services:** Outpatient; Information and referral  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Free to Connecticut residents only

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FLORIDA

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**Mental Health/Hearing Impaired Program**  
**Florida Hospital of St. Petersburg**  
**401 15th Street North**  
**St. Petersburg, FL 33705**

**Phone:** (813)821-2021 (V/TDD)  
**Contact Person:** James Tresh  
**Disabilities Served:** Dual diagnosis;  
Hearing impairment; Visual impairment;  
Multiple impairment  
**Services:** Inpatient  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicaid, Medicare, private insurance, state agency contracts

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**Transitions in Human Development**  
**5005 West Laurel Street, Suite 114**  
**Tampa, FL 33607**

**Phone:** (813)289-6167  
**Contact Person:** Patricia Purpura-Kelly  
**Disabilities Served:** Hearing Impairment  
**Services:** Outpatient; Grief counseling for persons who are newly disabled; Information and referral  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Third party insurance, sliding fee scale

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IDAHO

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**Gemhaven**  
**P.O. Box 5795**  
**Boise, ID 83705**

**Phone:** (208)344-6338  
**Contact Person:** Colleen Bird  
**Disabilities Served:** Dual Diagnosis  
**Services:** Residential; Day treatment & Outpatient; Relapse groups  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicaid, Medicare, sliding fee scale

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ILLINOIS

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**Addictions Recovery of the Deaf**  
**118 N. Sangamon**  
**Chicago, IL 60607**

**Phone:** (312)243-7696 (V)  
**Contact Person:** Addy Whitehouse  
**Disabilities Served:** Hearing Impairment  
**Services:** In-patient; Length of stay is 90 days  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Services are free

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**Nia Comprehensive Center for Developmental Disabilities, Inc.**  
**151-153 West 75th Street**  
**Chicago, IL 60620**

**Phone:** (312)873-2300  
**Contact Person:** Allen Bradley  
**Disabilities Served:** Developmental Disability  
**Services:** Individual, Group, and family counseling; Case/management  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Services are free after \$10.00 annual registration fee

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INDIANA

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**Volunteers in Prevention**  
7212 N. Shadeland Avenue  
Indianapolis, IN 46250-0856

**Phone:** (317)849-8221 (V/TDD)  
**Contact Person:** Patrick Cassidy  
**Disabilities Served:** Hearing Impairment  
**Services:** Prevention programs; Information and referral  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** No charge

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KANSAS

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**Johnson County Substance Abuse Services, Inc.**  
6221 Richards Drive  
Shawnee, KS 66216

**Phone:** (913)268-7220 (V/TDD)  
**Contact Person:** Lori Colwell  
**Disabilities Served:** Hearing Impairment  
**Services:** Captioned videos; Specialized printed materials; Case management; Support services  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicaid, Medicare, sliding fee scale, insurance

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KENTUCKY

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**Jefferson Alcohol and Drug Abuse Center**  
600 South Preston Street  
Louisville, KY 40202

**Phone:** (502)583-3951 (V/TDD)  
**Contact Person:** Evaluation Unit  
**Disabilities Served:** Hearing Impairment  
**Services:** Inpatient detox; Intensive outpatient; Daycare  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Insurance, cash, indigents

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MARYLAND

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**Family Service Foundation, Inc.**  
4806 Seton Drive  
Baltimore, MD 21215

**Phone:** (301)764-0663 (V)  
(301)764-0664 (TDD)  
**Contact Person:** Anthony Clements  
**Disabilities Served:** Hearing Impairment  
**Services:** Residential intermediate care; Psychiatric evaluation and treatment  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicaid, Medicare, sliding fee scale

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MASSACHUSETTS

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**Womanplace**  
11 Russell Street  
Cambridge, MA 02140

**Phone:** (617)661-6020 (V/TDD)  
**Contact Person:** Lorna Connelly  
**Disabilities Served:** Hearing Impairment  
**Services:** Residential program for women; Outpatient services; Information and referral  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicaid for outpatient, arrangements made individually

**New Medico Rehabilitation and Skilled Nursing Center**  
89 Lewis Bay Road  
Hyannis, MA 02601

**Phone:** 1-800-CARE TBI x3053  
**Contact Person:** Admissions  
**Disabilities Served:** Head Injury  
**Services:** Assessment; Behavioral rehabilitation  
**Staff Trained In Disability:** Yes

**The Steven Miller House**  
**P.O. Box 719, RTE. 28A**  
**West Falmouth, MA 02574**

**Phone:** (508)540-5052 (V/TDD)  
**Contact Person:** Admissions  
**Disabilities Served:** Hearing Impairment  
**Services:** Residential treatment for males;  
 Closed captioned films; Literature and films  
 translated into ASL  
**Staff Trained In Disability:** Yes

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MICHIGAN

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**Beacon Center for Behavioral Medicine**  
**7733 E. Jefferson**  
**Detroit, MI 48214**

**Phone:** (313)499-4042  
**Contact Person:** Nora Gessert  
**Disabilities Served:** Dual Diagnosis;  
TBI  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicaid,  
 Medicare, third party insurance, no fault auto  
 insurance, private pay

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**Kingswood Hospital**  
**10300 West Eight Mile Road**  
**Ferndale, MI 48220**

**Phone:** (313)398-3200  
**Contact Person:** William L. Harshman  
**Disabilities Served:** Dual Diagnosis for  
adolescents  
**Services:** Inpatient; Daycare; Intensive  
 outpatient; Outpatient  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicaid,  
 Medicare, arranged individually

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**National Counsel on Alcoholism**  
**202 E. Boulevard Drive, Suite 310**  
**Flint, MI 48503**

**Phone:** (313)767-0350 (V)  
 (313)767-4031 (TDD)  
**Contact Person:** Joanne Walker  
**Disabilities Served:** Hearing Impairment  
**Services:** Intensive outpatient; Lecture  
 series; Individual counseling  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicaid,  
 Medicare, sliding fee scale

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**Hope Network**  
**6850 S. Division Ave.**  
**P.O. Box 890**  
**Grand Rapids, MI 49518**

**Phone:** (616)455-5900  
**Contact Person:** Intake and Referral  
**Disabilities Served:** Developmental  
Disability; TBI; Dual Diagnosis  
**Services:** Residential; Outpatient  
**Staff Trained in Disability:** Yes

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**Ardmore Center**  
**19810 Farmington**  
**Livonia, MI 48152**

**Phone:** (313)474-3500  
**Contact Person:** Angie Mudd  
**Disabilities Served:** Dual Diagnosis  
**Services:** Intensive outpatient; Inpatient;  
 Daycare  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Monthly  
 payments

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**New Start Inc**  
**5839 W. Maple #112**  
**W. Bloomfield, MI 48322**

**Phone:** (313)855-3919  
**Contact Person:** Roman Frankel  
**Disabilities Served:** Head Injury;  
Spinal Cord injury  
**Services:** Outpatient; Special needs self help groups  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Arranged on individual basis

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MINNESOTA

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**Health One, Mercy Hospital**  
**4050 Coon Rapids Boulevard**  
**Coon Rapids, MN 55433**

**Phone:** (612)421-8888  
**Contact Person:** Carol Kilcullen  
**Disabilities Served:** Dual Diagnosis  
**Services:** Outpatient; Inpatient; Chemical Awareness and Assessment program (CAAP) for adolescents  
**Staff Trained in Disability:** Yes

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**Abbott Northwestern Hospital**  
**1800 First Avenue South**  
**Minneapolis, MN 55403**

**Phone:** (612)863-1500  
**Contact Person:** Sharon Schaschl  
**Disabilities Served:** Physical Impairment  
**Services:** Pre-admission assessment; Inpatient; Daycare; Peer counseling; Weekly support group meetings  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicare, Minnesota medical assistance, general assistance, HMOs and other insurance companies

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**Minnesota Chemical Dependency Program for the Hearing Impaired**  
**Riverside Medical Center**  
**2450 Riverside Avenue**  
**Minneapolis, MN 55454**

**Phone:** (612)337-4402  
 (800)282-DEAF  
**Contact Person:** Deb Guthman  
**Disabilities Served:** Hearing Impairment  
**Services:** Inpatient; Grief groups; Men's/women's groups; Deaf AA/NA meetings; Materials adapted for various language levels; Hearing impaired staff  
**Financial Arrangements:** Medicaid, Medicare, arrangements made individually

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**St. Paul Ramsey Medical Center**  
**640 Jackson Street**  
**St. Paul, MN 55101**

**Phone:** (612)221-2735  
**Contact Person:** Joel Hoffman  
**Disabilities Served:** Hearing Impairment;  
Dual Diagnosis  
**Services:** Inpatient; Outpatient; Psychiatric evaluation; Medication monitoring  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicare, Medicaid, insurance, consolidated treatment fund, personal payment plans

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NEBRASKA

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**Independence Center**  
**Lincoln General Hospital**  
**1650 Lake Street**  
**Lincoln, NE**

**Phone:** (402)473-5268 (TDD)  
**Contact Person:** Duke Engel  
**Disabilities Served:** Hearing Impairment  
**Services:** Inpatient; Outpatient; Family intervention; Aftercare; Evaluations  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicaid, Medicare, private pay, insurance

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NEW JERSEY

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**Reality House, Inc.**  
1030 N. Kings Hwy.  
Cherry Hill, N.J.

**Phone** (609)667-8422 (V)  
(609)667-3662 (TDD)

**Contact Person:** Rose Marie Wade

**Disabilities Served:** Hearing Impairment

**Services:** Outpatient; Family therapy; Peer leadership training

**Staff Trained In Disability:** Yes

**Financial Arrangements:** Sliding fee scale

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**Burlington Comprehensive Counseling**  
75 Washington Street  
Mt. Holly, N.J. 08060

**Phone:** (609)267-3610 (V)

**Contact Person:** Joan M. Rittenhouse

**Disabilities Served:** Hearing Impairment

**Services:** Methadone maintenance;  
Methadone detoxification; Outpatient;  
Evaluation

**Staff Trained In Disability:** Yes

**Financial Arrangements:** Medicaid, if on SSI or have documentation of financial need discount rate is available

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**Addiction Recovery Services**  
Recovery for Deaf & Hard of Hearing  
667 Hoes Lane  
Piscataway, N.J. 08855-1392

**Phone:** (201)463-4929

**Contact person:** Julie Droustas

**Disabilities Served:** Hearing Impairment

**Services:** Crisis intervention; Information and referral; Assessments; Support groups

**Staff Trained In Disability:** Yes

**Financial Arrangements:** Insurance, Medicaid, Medicare, sliding fee scale

**New Jersey Division of Alcoholism,  
Drug Abuse & Addictions Services**  
129 E. Hanover St., CN 362  
Trenton, NJ 08625

**Phone:** (609)-292-8947 (V)  
(609)-984-3311 (V/TDD)

**Contact Person:** Janet Dick

**Disabilities Served:** Hearing Impairment;  
Developmental Disability

**Services:** Provides funds to CD treatment and prevention programs for persons with disabilities

**Financial Arrangements:** Dependent on agency referred to

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NEW YORK

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**New York Society for the Deaf**  
817 Broadway, 7th Floor  
New York, NY 10036

**Phone:** (212)777-3900

**Contact Person:** Cathleen Rooney

**Disabilities Served:** Hearing Impairment

**Services:** Outpatient; Referrals if needed

**Staff Trained In Disability:** Yes

**Financial Arrangements:** Medicaid, Medicare

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**John L. Norris Clinic for Alcoholism**  
1600 South Avenue  
Rochester, NY 14620

**Phone:** (716)461-0410 (V)  
(716)461-4253 (TTY)

**Contact Person:** Intake Coordinator

**Disabilities Served:** Hearing Impairment

**Services:** Residential; Written material for the hearing impaired has been modified to ensure understanding of treatment vocabulary

**Staff Trained In Disability:** Yes

**Rochester Institute of Technology  
Intervention Services for the Deaf  
50 West Main Street  
Rochester, NY 14614**

**Phone:** (716)475-4978  
**Contact person:** Karen Steitler  
**Disabilities Served:** Hearing Impairment  
**Services:** Information and referral;  
Prevention education; Screening; Interpreted  
AA meetings  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Services are  
free

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OHIO

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**Center for Comprehensive  
Alcoholism Treatment  
830 Ezzard Charles Drive  
Cincinnati, OH 45214**

**Phone:** (513)381-6660  
**Contact Person:** Georgann M. Smith  
**Disabilities Served:** Hearing Impairment  
**Services:** Medical detox; Inpatient; Day  
treatment; Aftercare  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicaid,  
sliding fee scale, liberal payment plan

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**Brookshire at Harding Hospital  
445 East Granville Road  
Worthington, OH 43085**

**Phone:** (614)885-5381  
**Contact Person:** Cyndy Schmohe  
**Disabilities Served:** Adolescent Dual  
Diagnosis  
**Services:** Inpatient; Intensive outpatient;  
Outpatient; Relapse prevention  
**Staff Trained in Disability:** Yes

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PENNSYLVANIA

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**Philadelphia Psychiatric Center  
Ford Road & Monument Avenue  
Philadelphia, PA 19131**

**Phone:** (215)581-3764 (V/TDD)  
**Contact Person:** Debbie Ezersky  
**Disabilities Served:** Hearing Impairment;  
Mental Illness  
**Services:** Inpatient; Outpatient; Family  
therapy; Interpreted self help meetings; Deaf  
sponsors; Closed captioned videos  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicaid,  
Medicare, insurance

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RHODE ISLAND

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**Northern Rhode Island Community  
Mental Health Center  
58 Hamlet Avenue  
Woonsocket, RI 02895**

**Phone:** (401)765-8585  
**Contact Person:** Christian L. Stephens  
**Disabilities Served:** Dual Diagnosis  
**Services:** Residential; Educational  
programming; Twenty-four hour crisis  
intervention  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Medicaid,  
Medicare, no one turned away for financial  
reasons

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TENNESSEE

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**New Medico Rehabilitation Center  
of Tennessee  
205 Westgate Drive  
Springfield, TN 37172**

**Phone:** 1-800-CARE TBI x 3053  
**Contact Persons:** Admissions  
**Disabilities Served:** Head Injury  
**Services:** Day treatment; Outpatient  
**Staff Trained In Disability:** Yes

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TEXAS

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**CPC Millwood Hospital**  
1011 N. Cooper Street  
Arlington, TX 76011

**Phone:** (817)261-3121 (V/Relay)  
(817)461-3917 (TDD)

**Contact Person:** Jay Scirratt

**Disabilities Served:** Hearing Impairment

**Services:** Written materials adapted for language needs; One-on-one work with deaf counselor; Deaf issues support group; Videos in ASL and captioned

**Staff Trained In Disability:** Yes

**Financial Arrangements:** Most insurance and Medicare, occasionally free beds or discounted rate may be offered

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**VGS, Inc.**  
2525 San Jacinto  
Houston, TX 77002

**Phone:** (713)659-1800

**Contact Person:** Betty Crosset

**Disabilities Served:** Hearing Impairment

**Services:** Prevention; Intervention; Treatment; Outreach

**Staff Trained In Disability:** Yes

**Financial Arrangements:** Sliding fee scale

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**New Medico Rehabilitation Center of Texas**  
15862 Highway 110 North  
Lindale, TX 75771

**Phone:** 1-800-CARE TBI x3053

**Contact Person:** Admissions

**Disabilities Served:** Head Injury

**Services:** Day treatment; Outpatient services; Assessment; Behavioral rehabilitation

**Staff Trained In Disability:** Yes

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WASHINGTON

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**New Medico Community Re-Entry Services of Washington**  
6911 226th Place SW  
Mountlake Terrace, WA 98043

**Phone:** 1-800-CARE TBI x 3053

**Contact Person:** Admissions

**Disabilities Served:** Head Injury

**Services:** Day treatment; Outpatient; Assessment; Behavioral rehabilitation

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WISCONSIN

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**Keystone Residential Services**  
4734 N. 39th Street  
Milwaukee, WI 53209

**Phone:** (414)463-4257

**Contact Person:** Sarah Petrie

**Disabilities Served:** Hearing Impairment

**Services:** Residential treatment; ASL adapted; Captioning

**Staff Trained In Disability:** Yes

**Financial Arrangements:** Private pay, grant from state of WI for residents

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**Milwaukee County Mental Health Complex**  
9455 Watertown Plank Road  
Milwaukee, WI 53226

**Phone:** (414)257-6995

**Contact Person:** Dual disability program coordinator

**Disabilities Served:** Dual Diagnosis

**Services:** Inpatient

**Staff Trained In Disability:** Yes

**Financial Arrangements:** Medicare, insurance, self pay, sliding fee scale

**DISABILITIES:** HI, TBI

**STATES:** WI

**Koinonia**  
1670 N. Stephens Street  
P.O. Box 416  
Rhine Lander, WI 54501

(program moving in January 1992)

**Phone:** (715)362-5745  
**Contact Person:** Mark Strosahl  
**Disabilities Served:** Hearing Impairment  
**Services:** Residential program;  
Interpreters; Materials translated  
**Staff Trained In Disability:** Yes  
**Financial Arrangements:** Public funded facility

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**New Medico Rehabilitation**  
**Center of Wisconsin**  
1701 Sharp Road  
Waterford, WI 53185

**Phone:** 1-800-CARE TBI x3053  
**Contact Person:** Admissions  
**Disabilities Served:** Head Injury  
**Services:** Day treatment; Outpatient  
services; Assessment; Behavioral  
rehabilitation  
**Staff Trained In Disability:** Yes

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THIS NATIONAL TREATMENT DIRECTORY FOR PERSONS WITH DISABILITIES WAS DEVELOPED BY THE SARDI PROJECT: WRIGHT STATE UNIVERSITY.

The treatment centers listed in this directory provided the information about their programs and the specialized services they offer for persons with disabilities. There are undoubtedly other substance abuse treatment programs in the United States which offer specialized services, but efforts to locate these programs were exhausted.

Treatment Center Questionnaires were sent to programs listed in the U.S. Journal of Drug and Alcohol Dependence 1991 Treatment Directory as providing services for persons experiencing a dual diagnosis. Letters were also sent to State Departments of Alcohol and Drug Abuse Services in each state requesting a list of all substance abuse treatment facilities in the state which provide specialized services for persons with disabilities. Additional questionnaires were sent to treatment centers based on the information we received from state departments, other disability professionals, and SARDI site representatives. Additionally, SARDI staff and volunteers attempted to contact many programs by telephone to explain our directory and to request information about their programs.

If additional information is needed about any of the programs listed in this directory, please contact the program directly at the phone numbers provided.

At the top of each page in the directory is a listing of the disabilities mentioned on that page and the states covered. The following is a key to the disability groups mentioned in the directory.

PI = Physical Impairment/Spinal Cord Injury  
MI = Mental Illness/Dual Diagnosis  
TBI = Traumatic Brain Injury/Head Injury  
DD = Developmental Disability  
HI = Hearing Impairment  
VI = Visual Impairment

**APPENDIX D**

**BIBLIOGRAPHY**

the 1990s, the number of people in the world who are under 15 years of age is expected to increase from 1.1 billion to 1.5 billion. This increase is due to the fact that the number of children under 15 years of age is expected to increase from 1.1 billion in 1990 to 1.5 billion in 2010. This increase is due to the fact that the number of children under 15 years of age is expected to increase from 1.1 billion in 1990 to 1.5 billion in 2010. This increase is due to the fact that the number of children under 15 years of age is expected to increase from 1.1 billion in 1990 to 1.5 billion in 2010.

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**APPENDIX E**

**PREVENTION OF SUBSTANCE ABUSE AMONG PERSONS WITH  
DISABILITIES: A DEMONSTRATION MODEL**

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## PREVENTION OF SUBSTANCE ABUSE AMONG PERSONS WITH DISABILITIES: A DEMONSTRATION MODEL

by Dennis Moore, Ed.D. & Jo Ann Ford, M.R.C.

*This is a condensed version of an article which has been printed in various publications including The Illinois Prevention Forum and The AID Bulletin.*

### SARDI, A REGIONAL DEMONSTRATION PROJECT

The SARDI Project was based on the premise that unlike some other drug prevention/ intervention models, empowerment of consumers with disabilities can be accomplished most efficiently through professional education. The reason for this is that persons with disabilities constitute not one, but many constituencies, and the most effective means for educating consumers is to disburse this information to the human service agencies that have contact with consumers.

Our preliminary investigations indicated that professionals who serve persons with disabilities in most cases do not fully appreciate the scope of risk factors and complications that are present. This conclusion has been supported from other sources as well (Thurer, Pelletier, & Rogers, 1985; de Miranda & Cherry, 1989). From this frame of reference, it was clear that professionals, as well as consumers and their families, must be appraised of the potential problems and provided with the information and resources necessary for addressing substance abuse issues as they arise.

The Office of Substance Abuse Prevention released grant funds for substance abuse prevention activities for high risk youth. Included in their list of qualifying high risk categories were youth with chronic pain or disabilities. Funding from OSAP was awarded to Wright State University to develop a regional demonstration project. This project was the first QSAP High Risk Youth demonstration project to focus on the special risks associated with disabilities. The SARDI Project focuses primarily on developing models and materials for sensitizing professionals and consumers about issues in this topic area.

*Wright State University, a logical home.* Wright State University is an appropriate location from which to provide services for persons who are physically disabled, as it is nationally recognized as a leader in services to persons with disabilities. The Office of Handicapped Student Services employs a full time staff of eight persons, and the university enrolls more students with disabilities per capita than almost any other institution of higher education in the country. Wright State also has served as one of the seminal institutions in biomedical research for persons with disabilities, including such subjects as exercise physiology and electrical stimulation of paralyzed limbs for purposes of increased cardiovascular fitness.

The Medical School at Wright State focuses on training primary care physicians. Because of this orientation, the School has a commitment to training students in the problems associated with substance abuse. All medical students participate in experiential training in substance abuse identification as a requirement for graduation. The benefits from this approach to medical education will include a proactive stance on the part of these physicians when treating persons who are at risk for substance abuse problems.

*SARDI Goals.* The SARDI Project primarily serves the five states of Ohio, Indiana, Illinois, Michigan, and Kentucky. The project is striving to reduce the prevalence of alcohol and other drug abuse problems in persons with disabilities and to increase the number of interventions with this population. This integrated systems model impacts a

variety of community sites in contact with young persons with disabilities. The specific goals of SARDI are as follows:

1. Sensitize human service professionals to the risk factors for substance abuse among young persons with physical disabilities by developing training and intervention materials and fostering the establishment of coalitions for drug education, intervention and treatment services.
2. Develop an educational/screening instrument for the identification of alcohol and other drug abuse risk among persons with disabilities.
3. Compile a regional data base on the incidence and prevalence of alcohol and drug use and abuse among persons with disabilities.

*Representative Sites.* Within the five state region, a total of 30 sites were chosen as test sites. These programs include medical rehabilitation facilities, vocational rehabilitation sites, mental health centers, universities and community colleges, and other disability-specific agencies. These representative sites report a total of 8600 clientele with disabilities, 2,000 of whom fall within the 18-20 year age range. Disability conditions considered under "physical disability" include orthopedic impairments, sensory impairments (e.g., hearing impairment), learning impairments (e.g., learning disability and attention deficit disorder), and multi-handicapped (including the primary diagnosis of mild mental retardation).

We polled our 30 representative sites for information regarding substance abuse education and intervention. Site Representatives responded that substance abuse problems were common among their clientele, and they estimated that from 10 - 60% of their charges experience recurring problems with substance abuse. Although 18 sites stated that they had accomplished some form of substance abuse education in the past year, most programs have not yet included substance abuse education and intervention protocols in staff training or agency policy manuals. Site Representatives also acknowledged that they sometimes have difficulty identifying those behaviors or situations that are created through substance abuse.

The representative sites were chosen to ensure diversity. The size of the facility, demographical information about the populations served, location, and types of services provided by the facility were all factors considered when deciding whether or not to include a particular site as representative. Each site has at least one staff person who is interested in learning more about substance abuse risks and appropriate prevention and intervention techniques for their special populations. All of our sites have been able to provide valuable information to the project. Several of our sites are discussed below.

*The Hook Rehabilitation Center*, at Community Hospital in Indianapolis, is the largest post-acute rehabilitation program in that state for head trauma patients. Similar to research findings, medical personnel at the Hook Rehabilitation Center frequently assess patients as being drug or alcohol abusers. Patients frequently were involved in an alcohol or drug related head injury, and these patients tend to remain at risk for reinjury unless the drug problem is addressed in treatment.

The staff efforts at Hook to locate substance abuse services have resulted in contact with a clinical psychologist who is willing to work individually with head injured substance abusers. Patients from Hook who are referred to this psychologist are mainstreamed as much as possible into an out-patient substance abuse clinic in another hospital, and their treatment is individualized with the assistance of this psychologist. The SARDI Site Representative at Hook is Dr. Greg Correll, a psychologist with the Rehabilitation Department.

Culturally-sensitive issues also are very important to consider when offering services to a person with a disability. The service delivery needs of rural Americans are quite different from those individuals who live in or near cities. In order to address this issue, the *Carl D. Perkins Comprehensive Rehabilitation Center*, in Thelma, Kentucky, was recruited as one of our rural Representative Sites. This agency provides a wide range of rehabilitation and vocational training services to persons with disabilities. Ms. Linda Bell, the Training Supervisor, is serving as SARDI Site Representative at this location.

Issues of both disability and substance abuse impact native Americans at an alarmingly high rate. The *Hannahville Indian Reservation* in the upper peninsula of Michigan was recruited as another Representative Site. Ms. Connie Davidson, Special Education Coordinator and Site Representative, has attempted to initiate substance abuse prevention projects in the past. She is particularly concerned about the number of reservation members who qualify as disabled with the primary problem of alcoholism.

Another issue which indirectly connects with an individual's relationship with drugs is employment. For this reason, several work or job training sites participate with the SARDI Project. One of these is the *Center for Rehabilitation and Training for Persons with Disabilities* in Chicago, where Dr. Cathy Lorber serves as Site Representative.

At "The Center," staff have been aware of the problems associated with substance abuse in several of their programs. They approach substance abuse education and intervention as an issue that effects all staff. In order to better serve the needs of adolescents with hearing impairment, they are in the process of starting a chemical dependency treatment program specialized for this disability area.

The *State of Ohio, Bureau of Worker's Compensation* provides vocational training for injured workers. These services include residential training programs for chronic pain and medication reduction. The topics of medication and pain have been identified as very important in regard to substance abuse issues. Administrators in this system have been concerned about the extra time, finances and health care that are expended when substance abuse is the "hidden" second disability for claimants. For this reason, the J. Leonard Camera Center in Columbus and the W.O. Walker Center in Cleveland are included as Representative Sites in the project.

*Training and Information Dissemination.* The major thrust of the project is training and information dissemination. This provides some benefits to our Representative Sites including opportunities to receive information about substance abuse and disability and training in how to identify, intervene with, and educate clientele/students who are suspected of having substance abuse problems.

Approximately 600 professionals have received training or presentations by SARDI staff, not counting the impact of printed materials to date. SARDI staff have participated in a total of twelve training conferences including two national conferences and three regional SARDI conferences.

*Training conferences.* Several regional conferences were held in order to facilitate the sensitization of professionals to the special substance abuse risk factors of persons with disabilities. These conferences were designed and conducted by SARDI staff with the needs of our Site Representatives in mind. A total of 60 invitees attended the conferences which were held in Sandusky, OH; Chesterton, IN; and Florence, KY. At least one additional conference is being planned for 1991.

The conferences covered a variety of topics beginning with a review of what is known about this topic and the incidence and prevalence of substance abuse in persons

with disabilities. Attendees were given information about the factors heightening substance abuse risk in special populations, techniques for identifying substance abuse risk, and intervention techniques. Methods for accessing treatment and finding appropriate resources were broached. This portion of the conferences covered designing and implementing support groups within agencies and programs working with consumers. Attendees also had the opportunity to explore specific policies and procedures for dealing with substance abuse within their agencies. The conference attendees expressed appreciation for exposure to topics which were new to them.

*Written materials.* A variety of written materials are being developed in an effort to sensitize professionals to the issues of substance abuse among clients, patients, and students with disabilities. Among these materials are journal articles, chapters for inclusion in prevention training books, and a self-directed instructional manual for professionals working with persons with disabilities.

The educational/training manual will be field tested at various conferences and forums. It is anticipated that the final product will be completed and distributed to our Site Representatives by December, 1991. A limited number of copies of this manual will be available through the SARDI office at that time.

*Screening Instrument.* A screening instrument which will be utilized as both an educational tool and an early intervention guide is being developed. Counselors and other professionals working with persons with disabilities will be able to use this instrument to assess substance abuse risk and to provide educational information to consumers about the aspect(s) of their lives which might be the most risky. It is anticipated that the screening instrument will be in two formats. One would be a traditional paper/pencil instrument and the other a computerized version which would enable persons with more severe disabilities to answer the questions independently.

The screening instrument will be short and easy to administer and score. Professionals would make the decision to utilize the instrument on a client to client basis and provide drug education relative to disability. Professionals would also be able to identify existing behaviors which indicate the need for substance abuse intervention. It is anticipated that this instrument will be field tested and necessary revisions made by the end of the project period.

*Video training tapes.* For those with little substance abuse training, signs and symptoms can be easily overlooked or identified incorrectly. For these reasons, SARDI pursued a variety of ways to demonstrate the symptomology. One such training tool is a videotape for professionals that is in the process of development. The Ohio Department of Alcohol and Drug Addiction Services and Very Special Arts, Washington D.C. are supporting the SARDI project in the completion of a thirty minute video training tape on the substance abuse experiences of one person with quadriplegia who was arrested for cocaine trafficking. Sections of this tape were previewed by attendees at the regional conferences, and many persons expressed that the tape was a valuable part of their training experience.

*Future efforts.* Recently, the Office Of Substance Abuse Prevention, through a contract agency, COSMOS Corporation, convened the National Task Force On Substance Abuse and Disability. This entity has been charged with ensuring that the special needs of persons with disabilities are met in the area of substance abuse education, prevention, and treatment. A variety of professionals who specialize in this field were invited to participate in this endeavor. It was determined that several fundamental issues need to be addressed.

Among the most pressing issues identified by this Task Force is the fact that substance abuse is not readily identified when experienced by persons with disabilities. In order to address this problem, it will be necessary for professionals and consumers to better understand aspects of both substance abuse and disability. The Task Force also identified the need for better representation of persons with disabilities in substance abuse training (both as training recipients and trainers). Strategies for addressing some aspects these issues are yet to be fully drafted.

Much more is needed in prevention specific to identified disability areas, coordination of treatment availability, medical and rehabilitation education. The SARDI Project is but one approach for addressing some of these issues, and the findings of this project will lead to other ideas and approaches.

Persons wanting more information about the SARDI Project or to be added to the mailing list should contact Dr. Dennis Moore, Project Director, Wright State University School of Medicine, Dayton, OH 45435. The SARDI staff can be reached at (513) 873-3588.

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**APPENDIX F**

**SUBSTANCE ABUSE ASSESSMENT AND DIAGNOSIS  
IN THE CONTEXT OF MEDICAL REHABILITATION**

## CONTENTS

CONTENTS OF VOLUME 17 NUMBER 1, SPRING 2005  
ARTS AND REVIEWS: JOURNAL OF THE HISTORY OF MATHEMATICS SOCIETY

# SUBSTANCE ABUSE ASSESSMENT AND DIAGNOSIS IN THE CONTEXT OF MEDICAL REHABILITATION

by Dennis Moore, Ed.D.

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## Introduction

It is abundantly clear that substance abuse creates or contributes to an alarming number of medical problems, and it adversely impacts medical rehabilitation in particular (Ward et al., 1982)<sup>1</sup>. Estimates on the scope of this problem vary by medical condition, but some findings stand out. Among patients with traumatic brain injury it has been found that 56% or more of admissions involve alcohol use immediately prior to injury (Sparadeo and Gill, 1989)<sup>2</sup>. In a sample of spinal cord injured patients, 62% had significant levels of blood alcohol, or a positive urine sample for substances of abuse at the time of injury (Heinemann, 1990)<sup>3</sup>. Even among elderly rehabilitation patients, etiologies which include alcohol abuse may be common. Perhaps one half or more of elderly patients experiencing spinal cord injury are drinking immediately prior to the injury (Weingarden and Graham, 1989)<sup>4</sup>.

Although drinking or drug use contributes to a number of disabilities requiring medical care, patients with a history of substance abuse are likely to continue at risk through abusive consumption after rehabilitation. For example, alcoholic symptomology was found in approximately one half of patients with recent spinal cord injury, yet 70% of this problematic group resumed alcohol consumption within six months of discharge (Heinemann, et al., 1988)<sup>5</sup>. Even among patients with no previous history of substance abuse, the chances for abuse to occur appear to increase following rehabilitation (DeLoach & Greer, 1981)<sup>6</sup>. Experiencing a disability condition often means that an individual is at higher risk for substance abuse for numerous reasons, even including the mistaken belief by others than someone with a disability is "entitled" to use psychoactive drugs in order to cope (Moore, 1990)<sup>7</sup>.

Alcohol and other drug use following an injury also increases risk for secondary disabilities arising from improper self-care, poor treatment compliance, and lifestyles that include frequent risk taking. Compounding this increase in risk, the acquisition of a disability label makes subsequent diagnosis and treatment for substance abuse more difficult. This is because the focus of concern for the patient, family, and medical personnel is on the disability rather than other causes for difficulty (Moore & Polsgrove, 1991)<sup>8</sup>.

Considering the adverse effects of substance abuse on the rehabilitation process, it is imperative that assessment for these conditions be a matter of routine. The importance of substance abuse assessment is such that accreditation organizations and insurance providers may require this component within all medical rehabilitation settings in the future.

Faced with the already difficult and labor-intensive tasks of medical rehabilitation, it is essential that substance abuse assessments be time efficient and relate directly to the rehabilitation plan. Adherence to three principles of assessment can fulfill these requirements. 1.) Assessments should focus on substance use within the larger context of lifestyle and risk to rehabilitation. 2.) The process of assessment should constitute a form of dialogue with the patient. 3.) This should be an incremental process requiring only the health care resources which appear to be warranted.

*Identification of lifestyle risk.* As the interrelationships among lifestyle, wellness, and health education are better understood, the concept of substance abuse awareness and prevention expands accordingly. In keeping with the increased focus on lifestyle, wellness, and risk, assessments of alcohol and other drug use should be more than litmus tests for alcoholism or chemical dependency. Predisposing conditions can exist which place a patient at high risk for substance abuse problems even when there are no symptoms of chemical dependency. These conditions can range from health impairments such as diabetes to maladaptive family environments where substance abuse is normative.

Even when a patient is diagnosed with chemical dependency, that person's condition can vary widely in its manifestation, natural history, and outcome. Women, adolescents, minorities, and persons with disabilities are likely to display different symptomology or require other treatment approaches from the 40 year old, male Jellinek "gamma" alcoholic who is represented in traditional chemical dependency treatment literature. Current research in chemical dependency supports the idea that it is a complex biopsychosocial phenomena which cannot be represented through a single model or explanation. (Vaillant, 1985<sup>9</sup>; Donovan, 1988<sup>10</sup>).

In light of the multiple causes and wide range of behaviors which comprise chemical dependency and substance abuse, it is critical that assessments take into account psychological, physiological, and sociocultural perspectives. Assessments for substance abuse are most effective when they are individualized and prescriptive, sensitive both to the conditions that reinforce abusive behavior and the resources available for meaningful change.

*Assessment is interactive and therapeutic.* Assessment should be an interactive process which in itself is a therapeutic tool for change (Donovan, 1988)<sup>10</sup>. It is important to view assessment as the beginning process in educating or counseling a patient in areas which are important for the maintenance of health. Within this frame of reference, a proficient assessment enlists the patient as an active participant in this process, thereby encouraging self-evaluation and health behavior change. In some cases, the degree of post-injury cognitive impairment, anxiety, agitation, pain, or other conditions are such that a meaningful assessment is not possible. However, it is important to collect whatever information is obtainable. Interventions that utilize the recency of a trauma and the resulting focus on rehabilitation as leverage for change are more likely to be successful. Sometimes substance abuse assessment only can be undertaken by enlisting the participation of the family. Also, when a patient is not cognitively or physically stable enough to undergo substance abuse intervention or treatment, the family still can receive education about enabling, treatment alternatives, and community programs assisting with co-dependency issues.

*Progression of the assessment.* The above considerations describe important theoretical perspectives from which to conduct substance abuse assessment. When these principles are applied within the medical rehabilitation setting, there are discrete tasks which make this process manageable. The following steps are more likely to assure that substance abuse problems will not be overlooked, yet staffing resources are allocated based on positive findings at one or more of the lower levels.

1. Brief substance abuse screening at intake.
2. Assess role of substance abuse in current medical condition.
3. Interactive review (with patient) of alcohol and other drug use history.
4. Identify conditions and reinforcers associated with use.
5. Diagnose and chart substance-related disorder when applicable.
6. Assess potential for medication abuse or medical non-compliance.
7. Develop individualized education/intervention/treatment plan.

## Structuring Substance Abuse Assessment Within Rehabilitation

Medical rehabilitation settings tend to be fast-paced (sometimes frenetic) work environments by the nature of the schedules and services that are required. Rehabilitation units often are characterized by daily changes in work load or duties, especially in social work, psychology, and nursing. These departments often are responsible for collecting substance abuse data. Multiple duties and scheduling conflicts make it difficult to conduct thorough intake procedures on all patients, let alone share the obtained information with other members of the team. Addressing these obstacles requires site-specific design, but there are strategies which can assist in the standardization of substance abuse assessment on a rehabilitation unit.

The first strategy involves implementing a multidisciplinary, progressive screening "funnel", where positive findings in the initial substance abuse review places the patient in the queue for additional levels of assessment (Donovan, 1988)<sup>10</sup>. In this way, staff time is allocated for subsequent assessment activities only in cases where it is warranted. This initial substance abuse screening can rely on a brief review of available information taken from intake procedures, blood alcohol levels at admission, toxicology results, medical records, and family interviews. These sources of information are reviewed by one professional who is responsible for this specific task. The cursory screening result is presented in a staff meeting where other team members may provide other findings which were not available for initial review.

*Substance abuse assessment must be appreciated, but not everyone can perform this role.* The experiences of this author have shown that even in the current social climate which is much less accepting of substance abuse, there remain personnel in rehabilitation who condone or even promote dangerous practices among patients. This is particularly true for support staff and volunteers in such units. For this reason, it is important that all members of the rehabilitation team have a solid grounding in the concepts of substance abuse, especially as they relate to rehabilitation. When staff education includes such information, an added benefit is that more personnel can assist with collecting data on a patient's relationship with substances.

Current trends in rehabilitation suggest that within a few years virtually all rehabilitation units will require the services of a staff member who is versed in substance abuse assessment. This responsibility either will be filled by a specialist assigned from another unit, or existing staff will assume this role. If the latter is the case, it is important to consider that not everyone can perform this function to a satisfactory level. It requires specialized knowledge and skills to conduct a thorough substance abuse assessment, and these may have to be learned through a combination of academic and experiential activities.

When considering the potential assignment of staff to the role of substance abuse assessment, it is important to recognize that some professionals are more fluid and comfortable than others with the interviewing techniques and postures required for this role. Among other factors, it is important that a professional responsible for substance abuse assessment be at peace with his or her own relationship with alcohol and other mood altering drugs. Perhaps the best strategy is to be flexible in assigning staffing responsibilities for substance abuse screening and assessment tasks in order to utilize those personnel most suited to the task.

*Utilizing a substance abuse diagnosis.* Another important strategy to assist in the standardization of substance abuse assessment on a rehabilitation unit is to utilize psychiatric diagnostic categories (DSM III-R, 1987)<sup>11</sup> to document substance abuse disorders. These diagnosed conditions then can be included in the rehabilitation plan and billed for separately. Working in cooperation with other units, such as a chemical dependency

program, cost-effective services can be provided which include group activities, individual sessions, and family education. This approach to substance abuse services facilitates another desirable outcome. It is more likely that substance abuse interventions will be provided to patients before their medical benefits are depleted.

The criteria in the DSM III-R for Psychoactive Substance Dependence represent a combination of theoretical perspectives on addiction and dependency, and these standards apply to any drug capable of producing dependency symptoms. The general diagnostic strategy is to attempt to fit "Dependency" first. If the patient does not meet the minimum criteria, then "Abuse" is reviewed as an alternative diagnosis. Informed clinical judgment is important in assigning a diagnosis, as many concepts are open to interpretation. Constructs such as symptoms of life area impairment, the degree of addiction/compulsivity displayed, and physical symptoms of dependency all are considered in assigning a diagnosis. Substance Dependence can be rated as "mild", "moderate", or "severe", and it also can be noted whether the patient is in full or partial remission from this condition. The reader is referred to the DSM III-R for protocols in assigning a diagnosis.

## COMPONENTS OF SCREENING AND ASSESSMENT

### Physiological Indices Of Substance Abuse

Although substance abuse related etiologies are common in medical rehabilitation, corresponding physiologic symptoms of abuse can be difficult or impossible to detect. This is particularly true for patients who are younger, have enjoyed average health, or have not used drugs or engaged in practices that are repeatedly very dangerous. Psychological dependency is much more prevalent than physical addiction, although the former can be nearly as maladaptive and debilitating. Even when physical symptoms of abuse are found, the age, gender, and social standing of the patient can influence manifestation and interpretation of these symptoms. Aside from more obvious conditions such as cirrhosis or pancreatitis, it can be difficult to diagnose alcohol or drug related disorders, especially when to do so may result in denial, resentment, anger, or loss of trust on the part of the patient (Weingarden & Graham, 1989)<sup>12</sup>.

*Medical history.* In spite of the difficulties in quantifying the role of alcohol or other drugs in creating or perpetuating a medical condition, there are aspects of a patient's medical history which provide clues about these problems. This information can include records from previous hospitalizations, a recurring history of accidents, gastrointestinal problems, heavy or prolonged medication use, depression, sleep disorders, or a history of mental health treatment. When alcohol abuse is chronic, prolonged consumption leads to other diseases including peripheral neuropathy, alcoholic cardiomyopathy, esophageal varices, and organic brain disorders.

A patient with an extensive medication use history may indicate a lifestyle oriented toward excessive drug use to cope with physical or mental stress. A history of prescriptions for psychiatric, hypnotic, or anxiolytic drugs, or heavier than usual histories of over-the-counter drug use, may suggest a substance abuse problem created or perpetuated through iatrogenic causes. Also, patients who quickly habituate to psychoactive medications and request higher dosages or stronger drugs may do so because of psychological or physiological tolerances established through repeated abuse.

*Toxicology screening.* A number of biochemical markers for alcohol dependence have been studied, but to date the predictive power for such screens to positively identify alcoholism is modest at best. Toxicology screens will tend to be least helpful for patients who are younger or who have not experienced morbidity associated with late stage alcoholism (Leigh & Skinner, 1988)<sup>13</sup>. The most promising markers for alcoholic pathology include gamma-glutamyl transferase (GGT), mean corpuscular volume (MCV), glutamate dehydrogenase (GDH), alkaline phosphatase (AP), and beta-hexosaminidase (beta-HEX). However, several disadvantages exist when attempting to diagnose alcohol abuse based solely on toxicology screens.

Even when used in combination, these tests tend to have less predictive value than self-report or behavioral measures. For example, a combination of MCV, GGT and AP were found to be less discriminatory in predicting alcoholism than scores on the Michigan Alcoholism Screening Test (Chalmers, et al., 1981)<sup>14</sup>. The use of phenobarbital and other medications will result in abnormally high values for GGT, and smoking can invalidate MCV values relative to alcohol pathology. These and other complications can make interpretation of toxicology results ambiguous (Leigh & Skinner, 1988)<sup>13</sup>.

Detection of illicit drug use, via toxicology, can be indicative of a lifestyle more accepting of social deviance, greater thrill seeking needs, and relative insensitivity to harmful consequences of abuse. In most cases, illicit drug abusers tend to be polyabusers. Therefore, markers and tests established to measure alcohol abuse often can discriminate those persons who are substance dependent, even when the primary drug of abuse is illicit.

*Serum ethanol levels.* Many patients admitted for rehabilitation are recorded with a positive serum ethanol level at the time of injury (Anda et al, 1988)<sup>15</sup>. As little as 40mg/100ml serum ethanol has been shown to impair judgment and increase risk for injury. However, higher levels frequently are obtained during emergency room intake. One study found levels of 149-78mg/100ml in one third of all trauma admissions reviewed (Ward et al., 1982)<sup>1</sup>. Positive blood alcohol findings at the time of emergency room admission are even more frequent when considering conditions such as head or spinal cord injury (Heinemann et al., 1988<sup>3</sup>; Sparadeo and Gill, 1989<sup>2</sup>).

An elevated serum ethanol level is one indicator of a problematic relationship with this drug, and repeated consumption at higher levels suggests alcohol dependence. However, a single measurement of serum ethanol provides too little information upon which to base a diagnosis. Even among inexperienced drinkers without an established tolerance for alcohol, metabolism rates and maximum blood alcohol concentrations vary widely when controlled for amount consumed, gender, age, and body weight (O'Neill et al., 1983)<sup>16</sup>. It is most appropriate to consider a positive blood alcohol at intake as one indicator of lifestyle risk suggesting that further assessment be conducted.

### **Self-report And Psychometric Data**

*Intake information.* Rehabilitation units generally utilize standardized intake interviews. It is this information, in combination with existing medical records, which can serve as the foundation for the screening "funnel". Intake interviews are an excellent opportunity to obtain substance use/abuse information either from the patient or family members. These structured interviews should include specific questions about alcohol and other drug use, particularly information about patterns of abuse.

Several areas pertaining to substance abuse should be investigated, especially if there are indications that the patient has experienced any problems from abuse in the past. These areas include:

- frequency/quantity of use  
over lifetime and more recently
- consumption on day of disability onset  
including medication use patterns
- previous substance-related impairments to major life functions  
e.g., family, work, mobility, friendships, spirituality, sexual  
functioning, finances
- previous history of substance abuse intervention attempts or  
treatment
- substance-related legal offenses  
e.g., DWI, domestic violence, public intoxication- recurring hangovers, blackouts,  
injuries
- previous medical advice to cut down or abstain  
any history of overdoses

Social and cultural information is very important for understanding the scope and implications for substance abuse. This includes documenting family constellation, history of family substance abuse, the patient's perceived roles within his or her family, social support mechanisms, and peer influences (even among elderly patients). Sensitivity to cultural contexts is particularly important when providing substance abuse interventions.

Questions about school experiences and attitudes toward learning may indicate a potential history of Attention Deficit Disorder (ADD). This condition frequently persists into adulthood, and research suggests that it frequently is accompanied by conduct and substance abuse disorders (Gittelman et al., 1985)<sup>17</sup>. There is some evidence that suggests persons with ADD have a greater probability for being thrill seekers who may then sustain injuries through impulsive, or drug-affected, actions. Although unaddressed in the literature, the clinical experience of this author suggests that a sub-group of rehabilitation patients are multi-disabled, with ADD or Learning Disability being the first of these conditions to appear.

*Substance abuse screening instruments.* It can be beneficial to utilize screening instruments or tests which are specific to substance abuse; however, it is important to respect the limitations of such instruments. Patient reading ability, a desire to appear in a positive light, cognitive functioning, medication effects, state of mind, and previous exposure to substance abuse education or treatment can alter response patterns. Clinical confirmation of symptomology always should follow findings that suggest pathology. A number of these instruments also are insensitive to time, in that episodes of abuse at a previous point in a person's life are scored no differently than abuse that is current. Test results should be only one component of assessment if substance abuse pathology is suspected.

Because of the limitations involved with self-report substance abuse tests, only the two most widely used instruments will be reviewed below. If additional instruments are of interest, clinicians can find alternatives in reference texts (N.I.A.A.A., 1985)<sup>18</sup>.

At present, there are limited choices of instruments to measure the severity of problems for drugs other than alcohol. However, in the experience of this author, the abuse of illicit drugs, even cannabis, rarely occurs without the concomitant use and abuse of alcohol. Therefore, a test score on an alcohol use instrument may be of value even though alcohol may not be the primary drug of choice. Also, problems from abuse of illicit substances generally are more readily detectable and apparent than for comparable consumption of alcohol due to the increased social restrictions placed on illegal drug use.

*CAGE questions.* A widely utilized, quick screening for alcohol-related problems is called the "CAGE" (Ewing & Rouse, 1970)<sup>19</sup>. These four letters representing questions are reported to positively identify many patients with alcohol abuse problems. The CAGE acronym stands for:

- C - "Have you ever felt the need to **CUT** down drinking?"
- A - "Have you felt **ANNOYED** by criticism of your drinking?"
- G - "Have you ever had **GUILTY** feelings about drinking?"
- E - "Have you ever had an **EYE-OPENER** in the morning?"

Affirmative patient responses to two or more of these questions is reported to positively identify a problematic relationship with alcohol (Ewing, 1984)<sup>20</sup>, and affirmative responses should be followed up with a request for elaboration. The CAGE is least sensitive to persons who do not view themselves, or do not wish others to view them, as problem drinkers. The inclusion of this quick screening during intake can provide a reference point regarding substance abuse issues and patient self-awareness.

*Michigan Alcoholism Screening Test.* The screening instrument with perhaps the most widespread use is the Michigan Alcoholism Screening Test (MAST). This 25 item true/false test asks specific questions about alcohol use and its impact on life situations. Content validity appears quite high, but it requires that the respondent be honest about some very pointed questions concerning the consequences of alcohol abuse. The higher the score the more problematic is the relationship with alcohol. Depending on the selectivity and specificity desired, scores from "5" to "8" generally are considered significantly problematic to warrant additional assessment for a substance abuse disorder.

In a study of spinal cord injured patients admitted to rehabilitation, Heinemann, Donohue, and Schnoll (1988)<sup>21</sup> documented a mean of 6.8 on MAST scores. One half of the sample had scores equal to, or exceeding this figure. Of note, only 13% of those patients felt that they needed any help regarding their use of alcohol.

A substance abuse screening instrument for persons with disabilities recently has been developed through the S.A.R.D.I. Project, in the Medical School at Wright State University in Dayton, Ohio (Moore & Ford, 1991)<sup>22</sup>. This instrument is intended to be used as a screening and educational tool to identify areas of substance abuse risk among persons with disabilities. Findings are then discussed between the patient and the professional staff who utilized the instrument. Substance abuse risk areas assessed include those covered by shorter, standardized screenings, such as in the MAST and the Zuckerman Sensation Seeking Scales. It also includes assessment for disability specific factors like medication use patterns, health problems, substance use prior to disability onset, feelings of isolation, and perceptions of excess free time. The instrument will be available in the public domain through the Resource Center for Substance Abuse Prevention and Disabilities, V.S.A. Educational Services, Washington, D.C., which is funded by the Office of Substance Abuse Prevention. The instrument is being published in research form, without any validity or reliability information available.

## UTILIZING ASSESSMENT INFORMATION

Information regarding substance abuse history and risk is of little value unless it can be brought to bear in the patient's behalf. This is why the substance abuse assessment process is not completed until specific education/ intervention/ treatment plans are formulated which address patient health risks, lifestyle issues, and substance abuse prevention needs. Practitioners in medical fields prefer to deal in facts and hard evidence, but the nature of substance abuse assessment is such that conclusions about patients should be viewed as working hypotheses which

have been synthesized from several sources of data. These hypotheses require periodic reappraisal and updating, based on continued interactions with the patient and progress in other areas of the rehabilitation process.

A practical approach for utilizing assessment data is to view substance abuse as a continuum of harmful involvement and risk, where more severe categories of abuse require increasingly intensive and immediate interventions. One such classification system of harmful involvement has been successfully employed in a regional impaired driver program (Siegal & Moore, 1985)<sup>23</sup>. A modification of that method for classifying degree of harmful involvement, along with the implications for medical rehabilitation, are listed on Table One.

Table One  
STRATEGIES FOR CATEGORIZING  
SUBSTANCE ABUSE LEVEL

Current Involvement	Symptoms/Diagnosis	Intervention Suggested	Level of Risk
1. No apparent problem	Abstinence or minimal use; no evidence of problem use noted. Rehabilitation plan does not include habit forming medications	Some substance abuse risk education advised (e.g., medication precautions and post-trauma issues)	Low risk
2. Mild problem	Few consequences of abuse acknowledged no persisting or recurring abuse evident	Specific substance abuse risk education advised (e.g., medications, post-trauma issues, risk for increasing use due to boredom, pain, stress)	Moderate risk
3. Harmful involvement	DSM III-R Substance Abuse criteria met	Concurrent substance abuse education and/or treatment advised	Significant risk for problems, including secondary disabilities
4. Moderate problem	DSM III-R Substance Dependence in Mild or Moderate range	Concurrent chemical dependency treatment strongly indicated	Considerable risk for additional problems, and secondary disabilities
Severe problem	DSM III-R Substance Dependence in Severe range	Requires immediate, intensive, and highly structured chemical dependency treatment	Continued consumption is life-threatening

Modified from Siegal & Moore (1985)

It is the responsibility of the entire rehabilitation team to collect information relative to substance abuse; however, one team member should compile and synthesize this information. The salient aspects of the assessment, along with the initial substance abuse diagnosis should be presented in staffing by the assigned professional. The potential impact of the patient's consumption patterns on the course of rehabilitation should be discussed, along with specific

recommendations for addressing the problem. The staffing is the best time to discuss any education or treatment required considering the patient's cognitive functioning level, medication regimen, interpersonal supports, and health care resources available.

The interventions available for addressing substance abuse problems within medical rehabilitation can represent a variety of options, including group education, counseling, support groups, individual psychotherapy, outpatient or inpatient chemical dependency treatment. To this end, it is important to articulate agreements in advance with chemical dependency treatment units which are willing to accommodate to the needs of rehabilitation patients. Some patients, such as those with closed head injuries, may require treatment alternatives that are flexible in the type and degree of group therapy that is offered. Sometimes the best or only option for the patient is for the rest of the family to become involved in counseling or support groups. Family involvement in treatment is highly recommended in any case.

Due to the unique needs presented by each rehabilitation patient, education and treatment options need to be individualized as much as possible. However, some standardized group education is appropriate to all patients. This education can address the specific substance abuse risks encountered following medical rehabilitation (e.g., medication management, adjustment to sexuality, societal enabling of use).

### **Conclusions**

Misuse of alcohol and other drugs negatively impacts medical rehabilitation in several ways. These effects include increased severity of injury, degradation of medical prognosis, and generation of secondary disabilities. Screening and assessment for substance abuse are necessary and fundamental tools for addressing these disorders. Conducting substance abuse assessments in the rehabilitation setting is based on the assumption that prescriptive intervention for substance abuse is available and effective in addressing these problems. Patients will change for the better when they are provided with alternative, healthy choices, and the skills to accomplish those behaviors. Assessment also can be viewed as a management tool within rehabilitation in that it facilitates integrated or sequential treatment for at least two debilitating and interactive conditions -- the physical condition requiring rehabilitation and substance abuse.

Standardizing substance abuse assessment within a medical rehabilitation setting requires department-wide involvement with input from many staff. This cannot be accomplished without an organizational commitment which recognizes and values the importance of this component in rehabilitation. It may also necessitate the inclusion of a substance abuse specialist on staff.

Although the ramifications of this issue can be difficult to address, it may be advantageous to some patients if the nature and scope of rehabilitation services are limited until they are able to gain greater control over their chemical dependency. Considerable human and financial resources are expended unproductively when this all too common issue is not addressed.

As in all areas of health care, the field of medical rehabilitation is evolving and undergoing continuing change. There is little doubt that the role of substance abuse assessment and treatment will be integrated into medical rehabilitation in the future, if for no other reason than to assist with the distribution of diminishing health care resources.

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**APPENDIX G**

**ANSWERS TO TEST YOUR KNOWLEDGE**

## SOLUTIONS OF THE PROBLEMS OF THE THEORY

Let us first consider the problem of the theory of the motion of a particle in a magnetic field.

Let us assume that the particle is moving in a magnetic field of constant strength  $H$ .

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## ANSWERS TO THE TEST YOUR KNOWLEDGE ACTIVITIES

### CHAPTER 1: SUBSTANCE ABUSE AND DISABILITY: AN OVERVIEW

1. It is likely that substance abuse and disability costs the U.S. approximately \_\_\_\_\_ billion dollars per year.  
*b. 50 - 80*
2. Alcohol abuse has been associated with over half of all occurrences of traumatic brain injury.  
*TRUE*
3. Two medical risk factors for persons with disabilities are *medication abuse* and *chronic pain*.
4. The presence of a disability often makes identifying substance abuse easier.  
*FALSE*
5. The primary responsibility for identifying and addressing substance abuse in people with disabilities will likely fall on *disability* professionals.
6. The most effective means for addressing substance abuse in people with disabilities will most likely be *multi-agency* and *interdisciplinary*.
7. Some students with disabilities find more ready acceptance among peers who use alcohol and other drugs.  
*TRUE*
8. Some consequences of substance abuse reported by people with disabilities include:  
*f. all of the above*
9. As many as *50%* of spinal cord injuries occur in alcohol or drug related accidents.
10. The most valuable resource in the development of substance abuse services for people with disabilities are *people with disabilities*.

## CHAPTER 2: AMERICANS WITH DISABILITIES

1. A person with a disability generally has at least equal access to alcohol or other drugs.

*TRUE*

2. The American's With Disabilities Act (ADA) states that employers will have to provide *reasonable accomodations* on the job for persons with disabilities.
3. Alcohol and other drug use can place a person with a disability at risk for *secondary* disabilities.
4. Developmental disabilities manifest before the age of 21.
5. Even small amounts of alcohol when combined with prescribed medications can be harmful.

*TRUE*

6. Recurring alcohol and other drug problems affect approximately how many persons with mental illness?

*c. 50%*

7. Most persons with physical impairments need medication in order to cope with the side-effects of their disability.

*FALSE*

8. Learning disabilities and related problems disappear as a person becomes an adult.

*FALSE*

9. Persons with disabilities who drink alcohol in combination with medications may experience a heightened alcohol effect after only one or two drinks.

*TRUE*

10. Substance abuse prevention materials for persons with deafness should take into account which of the following?

*d. all of the above*

11. Among the leading causes of mental retardation, *Fetal Alcohol Syndrome* is the most preventable.

12. Some professionals have difficulty identifying substance abuse in persons with disabilities because some behaviors associated with substance abuse can also be contributed to the disability.

*TRUE*

**CHAPTER 3: SUBSTANCE ABUSE PREVENTION**

1. Prevention will be more successful if the following parties are included  
*e. all of the above*
2. All persons with disabilities who abuse alcohol or other drugs need treatment.  
*FALSE*
3. *Support* groups for persons with disabilities may be helpful in addressing substance abuse risks and issues.
4. Which of the following are high risk times for persons with disabilities in relation to the onset of alcohol and other drug use?  
*e. all of the above*
5. Which of the following is/are not reasons why prevention efforts have been unsuccessful with persons with disabilities (circle all that apply).  
*c. disabled don't drink*  
*d. disabled need medications*
6. Substance abuse education by itself will keep most youth with disabilities from using substances if the education begins early.  
*FALSE*
7. Substance abuse risks are the same for most disability groups.  
*FALSE*
8. The current trend in substance abuse prevention is to utilize a variety of strategies and to involve the entire community.  
*TRUE*
9. A person must "hit bottom" and suffer consequences before interventions will be successful.  
*FALSE*

**CHAPTER 4: IDENTIFICATION OF SUBSTANCE ABUSE**

1. The most serious deficit in substance abuse services for persons with disabilities is the lack of identification of problem use.

*TRUE*

2. A disability can sometimes hide substance abuse symptoms.

*TRUE*

3. One source of medication information is the PDR which is the *Physicians Desk Reference*.

4. Hyperreflexia is a condition unique to which disability group?

*c. Spinal Cord Injured*

5. Which of the following accurately describes a "blackout"?

*c. a person drinks and then has no recollection about a period of time*

6. According to sources cited in this chapter, approximately how many injuries among young persons are related to alcohol and other drugs?

*b. 50%*

7. List four health related symptoms of substance abuse.

*tolerance change, bladder and urinary tract problems, infections, increased muscle spasms, sleeplessness, weight changes, diarrhea, digestive disorders, poor circulation, and frequent hospitalizations*

8. Approximately half of all persons with disabilities become chemically dependent.

*FALSE*

9. Allowing persons with disabilities to use drugs in situations where drug use is generally not condoned is an example of enabling.

*TRUE*

10. What are the special risks relating to cross tolerance?

*person will have tolerance to drugs rarely used resulting in potential over-dosing. There is the potential for increased drug effects from amounts thought to be safe.*

## CHAPTER 5: SUBSTANCE ABUSE INTERVIEWING

1. If a person with a disability chooses to lie about substance use, there will be no useful information derived from the interview.  
*FALSE*
2. Which of the following will make interviewing a consumer difficult?  
*f. all of the above*
3. One of the most important factors in interviewing is developing a *positive relationship* with the consumer.
4. The three phases of the interviewing process are:  
*rapport building, goal setting, and transferring learned skills.*
5. In Jane's story (see Case Study), her Chronic Depression was brought about by substance abuse.  
*FALSE*
6. Self-disclosure is always appropriate and appreciated by the consumer.  
*FALSE*
7. *Non-verbal* cues are as important as verbal information to the interview process.
8. The easiest symptoms of substance abuse to recognize are generally *behavioral*.
9. Unintentional lying is:  
*c. denial*
10. If a consumer reports to work high or intoxicated, the best plan is to confront the person's use and to gather information about the person's use on the spot.  
*FALSE*

## CHAPTER 6: SOLUTIONS TO SUBSTANCE ABUSE

1. A person with a disability can receive an intervention and/or help for substance abuse problems before "bottoming out."

*TRUE*

2. One of the purposes of a formal intervention is to convince consumers with substance abuse issues that they are alcoholic.

*FALSE*

3. Which of the following is a component of an ideal intervention:

*e. all of the above*

4. All persons with disabilities who have substance abuse issues should receive formal substance abuse treatment.

*FALSE*

5. List three treatment components which are specific to persons with disabilities.

*new ways of dealing with disability, social adjustment, dealing with anger, sexuality, independent living skills, medication education and monitoring, and family involvement*

6. Why should at least one professional on the substance abuse treatment staff be familiar with disability issues?

*to identify special risks and disability issues requiring special attention. "handicapped" behaviors can also be more readily identified and dealt with.*

7. List three defense mechanisms likely to be used by consumers who are in early recovery.

*denial, rationalization, anger, compliance, and minimization.*

8. Some persons with disabilities may be able to cope with their pain without using medications.

*TRUE*

9. At least one study shows that persons with disabilities who are employed are less likely to smoke marijuana while involved in medical rehabilitation.

*TRUE*

10. Two valuable first steps toward assisting persons with disabilities in finding solutions to substance abuse problems are

*learning about substance abuse and disability and identifying problems when they occur*

## CHAPTER 7: SUPPORT GROUPS

1. Which of the following are advantages of support groups for persons with disabilities and substance abuse problems?
  - a. *they are cost free*
  - c. *disability issues can be discussed*
  
2. Group sponsors recruit group members and keep the group in operation.  
*TRUE*
  
3. A disability can make substance abuse related problems even more resistant to change.  
*TRUE*
  
4. What activities are enhanced through support group involvement?
  - e. *all of the above*
  
5. AA has been described as "the most effective treatment for alcoholism."  
*TRUE*
  
6. *Abstinence* is the primary goal of AA.
  
7. Family and friends of AA members can attend *open* AA meetings.
  
8. What is an AA sponsor? *A sponsor is an AA member with a longer period of sobriety who works with the new member and assists the new member in becoming involved in the AA program. Most AA members have a sponsor throughout their involvement in AA--not just when they are new to the program.*
  
9. A professional group leader must be knowledgeable about *substance abuse* and *disability*.
  
10. In addition to abstinence, *anonymity* is another key component to AA and should also be assured in any other type of support group.

## CHAPTER 8: CONNECTING AGENCIES

1. In many cases, physical accessibility is less of a problem than attitudinal accessibility.

*TRUE*

2. What are the two major activities for "help-seekers" wanting to find adequate services persons with disabilities?

*Client advocacy and creative service linkages.*

3. Describe "cross-training" as it refers to the AOD and Disability fields.

*AOD service professionals provide education to disability professionals in the area of substance abuse and the disability professionals train AOD professionals in the area of disability. Training and consultation are two way activities.*

4. The ADA guarantees equal opportunity for persons with disabilities in the following areas:

*employment*

*public accommodations*

*transportation*

*state and local government services*

*telecommunications*

**APPENDIX H**

**DISABILITY RELATED MEDICATIONS:  
SIDE EFFECTS AND INTERACTIONS**



**DISABILITY RELATE' MEDICATIONS:  
SIDE EFFECTS AND INTERACTIONS**

<b>DRUG GROUP</b>	<b>USE</b>	<b>PRECAUTIONS/ POSSIBLE SIDE EFFECTS</b>	<b>INTERACTIONS WITH ALCOHOL</b>	<b>INTERACTIONS WITH OTHER DRUGS</b>
<p><b>ANALGESICS</b></p> <ul style="list-style-type: none"> <li>• <b>OPIOIDS</b></li> <li>Morphine</li> <li>codeine</li> <li>Demerol</li> <li>Percocet</li> <li>methadone</li> <li>Darvon</li> <li>Talwin</li> <li>• <b>OVER THE COUNTER</b></li> <li>acetaminophen</li> <li>aspirin</li> <li>ibuprophen</li> </ul>	<ul style="list-style-type: none"> <li>• raises the threshold of pain and helps suppress anxiety about the pain</li> <li>• decreases inflammations that cause pain</li> </ul>	<ul style="list-style-type: none"> <li>• dizziness</li> <li>• drowsiness</li> <li>• euphoria</li> <li>• nausea/vomiting</li> <li>• addiction potential</li> <li>• decreased respirations</li> <li>• dizziness</li> <li>• headache</li> <li>• gastrointestinal disturbance</li> </ul>	<ul style="list-style-type: none"> <li>• respiratory depression</li> <li>• dizziness</li> <li>• increased drowsiness</li> <li><i>aspirin</i></li> <li>• induces gastric bleeding</li> </ul>	<ul style="list-style-type: none"> <li>• stimulants: convulsions</li> <li>• MAO inhibitors: must reduce opioid dose and must avoid Demerol can be lethal</li> <li>• anticoagulants: increases bleeding</li> <li>• arthritis medications: decreases drug's effects</li> <li>• oral antidiabetic drugs: increases effect of antidiabetic drugs</li> </ul>
<p><b>ANTIDIABETICS</b></p> <p>Insulin Glucotrol</p>	<ul style="list-style-type: none"> <li>• management of diabetes</li> </ul>	<ul style="list-style-type: none"> <li>• lightheadedness</li> <li>• nervousness</li> </ul>	<ul style="list-style-type: none"> <li>• can be lethal</li> <li>• symptoms of low blood sugar</li> <li>• drowsiness</li> <li>• severe nausea/vomiting</li> </ul>	<ul style="list-style-type: none"> <li>• birth control pills: decreases the effects of antidiabetic drugs</li> </ul>
<p><b>ANTIARRHYTHMICS</b></p> <p>Biquin Procain quinidine Isoptin Calan</p>	<ul style="list-style-type: none"> <li>• prevent or eliminate abnormal contraction or rhythm in the heart</li> </ul>	<ul style="list-style-type: none"> <li>• dizziness</li> <li>• fatigue</li> <li>• nausea/vomiting</li> <li>• skin rash</li> <li>• overdoses can depress the strength of the heart muscle</li> </ul>	<ul style="list-style-type: none"> <li>• can slow the rate of absorption of the drug</li> </ul>	<ul style="list-style-type: none"> <li>• lithium: decreases serum levels of lithium</li> <li>• nitrates: increases antianginal effect</li> <li>• beta blockers: increases antianginal and antihypertensive effects</li> </ul>
<p><b>ANTIHISTAMINES</b></p> <p>Bromarest Chlor-Trimeton Benadryl Seldane Marzine</p>	<ul style="list-style-type: none"> <li>• relief of the sign and symptoms of seasonal allergies</li> <li>• over the counter sleep aids</li> </ul>	<ul style="list-style-type: none"> <li>• drowsiness</li> <li>• dizziness</li> <li>• muscle weakness</li> <li>• gastric disturbances</li> </ul>	<ul style="list-style-type: none"> <li>• increases depressant action</li> <li>• increases drowsiness</li> <li>• possible respiratory depression</li> </ul>	<ul style="list-style-type: none"> <li>• sedatives: exaggerates sedative effect</li> </ul>

**DISABILITY RELATED MEDICATIONS:  
SIDE EFFECTS AND INTERACTIONS**

DRUG GROUP	USE	PRECAUTIONS/ POSSIBLE SIDE EFFECTS	INTERACTIONS WITH ALCOHOL	INTERACTIONS WITH OTHER DRUGS
<b>SEDATIVE HYPNOTICS</b>  Dalmane Seconal Luminal Restoril Halcion Nembutal	<ul style="list-style-type: none"> <li>• produce a relaxed calming effect</li> <li>• induce sleep</li> </ul>	<ul style="list-style-type: none"> <li>• psychological dependence</li> <li>• dizziness</li> <li>• slurred speech</li> <li>• impaired judgement</li> <li>• sleep disturbance when discontinued</li> <li>• irritability</li> </ul>	<ul style="list-style-type: none"> <li>• potentiates drugs effects</li> <li>• toxic interactions</li> <li>• impairment of coordination</li> <li>• easily leads to overdose</li> <li>• can be lethal</li> </ul>	<ul style="list-style-type: none"> <li>• antidepressants: exaggerates sedative effect</li> <li>• antihistamines: exaggerates sedative effect</li> </ul>
<b>H2 RECEPTOR BLOCKERS</b>  Tagamet Pepcid Axid Zantac	<ul style="list-style-type: none"> <li>• treatment of ulcers</li> <li>• regulation of gastric secretions</li> </ul>	<ul style="list-style-type: none"> <li>• drowsiness</li> <li>• dizziness</li> <li>• constipation</li> <li>• serious side effects are rare</li> </ul>	<ul style="list-style-type: none"> <li>• increases stomach acid</li> </ul>	<ul style="list-style-type: none"> <li>• many: Tagamet slows inactivation of many drugs including diazepam, lidocaine, tricyclic antidepressants, propranolol, theophylline, chlordiazepoxide</li> <li>• oral anticoagulants: increases risk of bleeding with Tagamet</li> <li>• cigarettes: reverses effects of tagamet and zantac</li> </ul>
<b>ANTIANGINA</b> <ul style="list-style-type: none"> <li>• <b>BETA-ADRENERGIC BLOCKERS</b>                              Lopressor                              Inderal                              Tenormin</li> <li>• <b>NITRATES</b>                              Nitro-Bid                              Nitro-dur</li> <li>• <b>CALCIUM CHANNEL BLOCKERS</b>                               Cardizem                              Procardia                              Calan                              Isoptin</li> </ul>	<ul style="list-style-type: none"> <li>• treatment of chest pain resulting from myocardial ischemia</li> <li>• increases oxygen supply to myocardia</li> <li>• decreases heart rate and force of contraction</li> </ul>	<p><i>Beta Blockers</i></p> <ul style="list-style-type: none"> <li>• bronchoconstriction</li> <li>• excessive cardiac depression</li> </ul> <p><i>Nitrates</i></p> <ul style="list-style-type: none"> <li>• headache</li> <li>• dizziness</li> <li>• nausea</li> </ul> <p><i>Calcium Blockers</i></p> <ul style="list-style-type: none"> <li>• headache</li> <li>• flushing</li> <li>• dizziness</li> <li>• muscle fatigue and weakness</li> </ul>	<ul style="list-style-type: none"> <li>• makes drug action inactive</li> <li>• severe hypotension</li> <li>• cardiovascular collapse</li> </ul>	<p><i>Beta Blockers</i></p> <ul style="list-style-type: none"> <li>• other hypertensives: increases hypertensive effects</li> <li>• tagamet: increases plasma levels</li> </ul> <p><i>Nitrates</i></p> <ul style="list-style-type: none"> <li>• antihypertensives: increases hypotensive effects</li> </ul> <p><i>Calcium Blockers</i></p> <ul style="list-style-type: none"> <li>• beta blockers: increases risk of hypotension and heart failure</li> <li>• oral anticoagulants: increases anticoagulant effects</li> </ul>

**DISABILITY RELATED MEDICATIONS:  
SIDE EFFECTS AND INTERACTIONS**

<b>DRUG GROUP</b>	<b>USE</b>	<b>PRECAUTIONS/ POSSIBLE SIDE EFFECTS</b>	<b>INTERACTIONS WITH ALCOHOL</b>	<b>INTERACTIONS WITH OTHER DRUGS</b>
<p><b>ANTIBIOTICS</b></p> <p>Penicillin Ampicillin Bactrim Cipro Duricef Macroclantin</p>	<ul style="list-style-type: none"> <li>• treatment of infections</li> </ul>	<ul style="list-style-type: none"> <li>• rash</li> <li>• hives</li> <li>• nausea/vomiting</li> <li>• gastric upset</li> <li>• avoid milk products within two hours of taking medications</li> </ul>	<ul style="list-style-type: none"> <li>• potentiates effects of alcohol</li> </ul>	<ul style="list-style-type: none"> <li>• barbiturates: decreases effects of antibiotics</li> </ul>
<p><b>ANTIDEPRESSANTS</b></p> <p>• <b>TRICYCLIC</b></p> <p>Elavil Sinequan Prozac Desyrel Pamelor</p> <p>• <b>MONOAMINE OXIDASE INHIBITORS</b></p> <p>Marplan Parnate Nardil</p>	<ul style="list-style-type: none"> <li>• treatment of depressive illness</li> <li>• some special uses for chronic pain</li> <li>• some uses for panic attacks and eating disorders</li> <li>• treatment of depressive illness</li> <li>• some uses for panic attacks</li> </ul>	<ul style="list-style-type: none"> <li>• blurred vision</li> <li>• nausea/vomiting</li> <li>• tremors</li> <li>• difficulty urinating</li> <li>• check with physician before taking any other medications</li> <li>• dizziness when standing up</li> <li>• drowsiness</li> <li>• overdose very dangerous</li> <li>• dizziness when standing up</li> <li>• check with physician before taking any other meds including OTC</li> </ul>	<ul style="list-style-type: none"> <li>• antagonizes antidepressant effects</li> <li>• increases central nervous system depression</li> <li>• can be lethal</li> <li>• antagonizes antidepressant effects</li> </ul>	<ul style="list-style-type: none"> <li>• some blood pressure meds: hyperexcitability, fever, blood pressure fluctuations</li> <li>• anticoagulants: internal bleeding</li> <li>• minor tranquilizers: severe sedation</li> <li>• Tagamet: increases drug levels</li> <li>• opioids: increases opioid effect</li> <li>• Demerol: produces lethal fever</li> <li>• some foods: initiate hypertension and stroke</li> <li>• other antidepressants: can be lethal</li> </ul>
<p><b>MINOR TRANQUILIZERS (ANTI-ANXIETY DRUGS)</b></p> <p>Librium Valium Serax Xanax Ativan Tranxene Miltown lithium</p>	<ul style="list-style-type: none"> <li>• treatment of anxiety</li> <li>• some used for treatment of muscle spasms</li> </ul>	<ul style="list-style-type: none"> <li>• drowsiness</li> <li>• nervousness</li> <li>• mental confusion</li> <li>• depression</li> <li>• slurred speech</li> <li>• gastric upset</li> <li>• could precipitate suicidal behaviors</li> <li>• physical dependence</li> <li>• psychological dependence</li> </ul>	<ul style="list-style-type: none"> <li>• severe effects on central nervous system</li> <li>• excessive amount may cause death</li> <li>• severe hypotension</li> <li>• deep sedation</li> </ul>	<ul style="list-style-type: none"> <li>• antidepressants: exaggerates sedative effect</li> <li>• antihistamines: exaggerates sedative effects</li> </ul>

**DISABILITY RELATED MEDICATIONS:  
SIDE EFFECTS AND INTERACTIONS**

<b>DRUG GROUP</b>	<b>USE</b>	<b>PRECAUTIONS/ POSSIBLE SIDE EFFECTS</b>	<b>INTERACTIONS WITH ALCOHOL</b>	<b>INTERACTIONS WITH OTHER DRUGS</b>
<b>NEUROSPASMATICS</b>  baclofen Lioresal Flexeril Parafon Soma	<ul style="list-style-type: none"> <li>• controls muscle spasms</li> </ul>	<ul style="list-style-type: none"> <li>• gastric distress</li> <li>• lightheadedness</li> <li>• blurred vision</li> <li>• take with food</li> <li>• drowsiness</li> </ul>	<ul style="list-style-type: none"> <li>• increases depressant action</li> <li>• decreases judgement</li> <li>• decreases alertness</li> <li>• respiratory arrest</li> </ul>	<ul style="list-style-type: none"> <li>• sedatives and hypnotics: increase depressant action</li> </ul>
<b>ANTICONVULSANTS</b>  Dilantin Tegretol Tunal Depakene phenobarbital Clonopin	<ul style="list-style-type: none"> <li>• prevention and control of seizures</li> </ul>	<ul style="list-style-type: none"> <li>• mental confusion</li> <li>• slurred speech</li> <li>• nervousness</li> <li>• blood abnormalities</li> <li>• liver damage</li> <li>• decreased blood clotting</li> <li>• bone problems with longterm use</li> </ul>	<ul style="list-style-type: none"> <li>• chronic alcohol use diminishes drug effect</li> <li>• concurrent alcohol use enhances drug effect</li> </ul>	<ul style="list-style-type: none"> <li>• antidepressants: high doses may worsen seizures</li> <li>• Diazepam: potentiates effects of Diazepam</li> <li>• Haldol: potentiates effect of Tegretol</li> </ul>
<b>ANTICOAGULANTS</b>  warfarin Coumadin Heparin Persantine	<ul style="list-style-type: none"> <li>• prevention of the formation of blood clots</li> </ul>	<ul style="list-style-type: none"> <li>• hemorrhage</li> <li>• nose bleeds</li> <li>• discolored urine</li> <li>• bruises</li> <li>• excessive menstrual bleeding</li> </ul>	<ul style="list-style-type: none"> <li>• increases or decreases blood thinning effect</li> </ul>	<ul style="list-style-type: none"> <li>• birth control pills: decreases blood thinning effect</li> <li>• aspirin: increases bleeding</li> <li>• antiarrhythmics: increases possibility of hemorrhage</li> <li>• barbiturates: decreases drug effect</li> </ul>
<b>MAJOR TRANQUILIZERS</b>  Neuroleptics Thorazine Trilafon Mellaril Haldol Navane Prolixin	<ul style="list-style-type: none"> <li>• short-term management of mania</li> <li>• schizophrenia</li> </ul>	<ul style="list-style-type: none"> <li>• drowsiness</li> <li>• fatigue</li> <li>• tremors</li> <li>• weight gain</li> <li>• increases appetite</li> <li>• photo sensitivity (sunburn)</li> <li>• dizziness when standing up</li> <li>• difficulty maintaining body temperature under extreme conditions</li> </ul>	<ul style="list-style-type: none"> <li>• severe effects on central nervous system</li> <li>• may cause death</li> </ul>	<ul style="list-style-type: none"> <li>• antidepressants: exaggerate sedative effects</li> </ul>

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