



SUBSTANCE ABUSE AND COEXISTING DISABILITIES

INTRODUCTION

A person is considered to have a disability if she/he has a chronic physical or mental health problem (a disease, disorder, or after-effect of an injury that has lasted at least 3 months or an impairment that restricts the ability to perform one or more activities. Activities can range in importance from eating to working at a job to riding a bicycle. The restriction can be total, rendering the person unable to perform the activity, or partial, proscribing the amount or kind of activity that can be performed (Disability Statistics Center, 1997). According to the Census 2000, 6.8% of the population ages 5-20 years have a disability with this statistic increasing to 13.8% for ages 21-64 years. Approximately 26 million Americans have a disability, of which 52% are unemployed (United States Census Bureau, 2000).

According to the 2000 National Household Survey on Drug Abuse (NHSDA), approximately 15.9 million Americans aged 12 or older have used illicit drugs during the month prior to the survey. This estimate reveals an increase in the percentage of the population using illicit drugs (6.3% in 1999 and 2000 to 7.1% in 2002). Employment status is also affected by the use of illicit drugs. For example, the NHSDA posits that

17.1% of unemployed adults aged 18 or older were current illicit drug users compared to 6.9% of adults who were employed full-time and 9.1% of those employed part-time (NHSDA, 2001).

The Rehabilitation Research and Training Center (RRTC) on Drugs and Disability survey of 1,876 clients within the state VR program in Ohio, Michigan and Illinois found that approximately 33% of individuals with disabilities in the state vocational rehabilitation system also have a co-existing addictive disorder. Similarly, 22.4% of clients served by licensed substance abuse facilities were reported to have a coexisting physical and mental disability (RRTC, 1996).

The overlapping of disability, substance abuse and unemployment as well as other related topics will be addressed in this issue of Resource Links. The contents include a review of the latest statistics on substance abuse and coexisting disabilities, outcomes from the 2nd National Conference on Drugs and Disabilities, sample client profiles, a program response to disability, recommendations for change regarding addressing and providing needed resources, frequently occurring coexisting disabilities, a New Jersey accomplishment, and a resource section including online links to the most current research, publications, and programs.

WHAT ARE THE RISKS FOR SUBSTANCE ABUSE AND FOR DISABILITY?

*The following two sections were derived from
Substance Abuse, Disability and Vocational Rehabilitation (1998).*

Risks for substance abuse for individuals with disabilities:

- Misusing prescription medication (abuse, overuse)
- Self-medicating to reduce symptoms (hallucinations)
- Using substances for socialization purposes, fitting in (social acceptance; lack of peer group; abusers are easy fit)
- Masking and reducing feelings of isolation, desperation, stigmatization (rejection)
- Responding to enabling by family and friends (“at least he/she has friends”)

Risks for acquiring a disability among substance abusers:

- Engaging in risk taking behavior while high (drunk driving)
- Acquiring disabilities as a consequence drugs and alcohol (amphetamine/cocaine abuse can result in stroke and heart attacks)
- Becoming a target or victim related to sale and distribution of drugs (drive-by shootings)
- Abusing physical and mental health while addicted

DISABILITIES AND PREVALENCE OF CO-EXISTING WITH SUBSTANCE ABUSE

*The following disabilities have the highest prevalence for coexistence with substance abuse.
The different groups have different prevalence because of associated risk factors,
individual self-reporting, and the issue of stigma.*

Spinal Cord Injuries and Traumatic Brain Injury (TBI): Both may result from accidents that occur while the person is high, intoxicated, or hung-over. Some of these accidents may include automobile accidents or on-the-job accidents. Not heeding barriers and warnings and taking great risks that threaten life and compromise safety can result in these disabilities. Alcohol and drug use are thought to be related to spinal cord injury from 39 to 66 percent of the time (Bricort, Polgar, Howard, et.al ,2002), while a review of the literature suggests that between 1/3 and 1/2 of persons with brain injury were intoxicated at the time of injury (Corrigan,1995). Post-injury, 28% of patients in

one of the few studies focusing on post-injury alcohol and drug use rates remained moderate or heavy drinkers (Kreutzer, et. al., 1991). This high level of use is of concern, “given persistent reports of increased sensitivity to alcohol after brain injury” (Cope & Hall, 1982, Dahmer, et. al., 1993, as cited in Kreutzer, et. al., 1996).

Blindness and Visual Impairments: Isolation, inaccessibility, and stigma are critical factors, which may lead to substance abuse. Substance abuse may compound visual impairments and contribute to the acceleration of their symptoms through neglect of deteriorating health (Koch, Nelipovich & Sneed, 2002).

Deafness and Hardness of Hearing: Isolation is a significant contribution to substance abuse for this population. Within the deaf community, substance abuse is viewed as a major sign of moral weakness. The associated stigma impedes people from seeking treatment. The inability of the staff to communicate is a further barrier to treatment for those who use sign language (Guthmann & Blozis, 2001).

Severe Mental Illness: It is now generally recognized that as many as 50% of persons with mental illness also have a substance abuse problem (NAMI, 2002). Many mental illness conditions are compounded by the use of substances (e.g. depression). Individuals frequently seek out illegal drugs for symptom management. This is referred to as self-medication. Psychiatric disorders, where substance abuse is most common, include mood disorders, anxiety disorders, and schizophrenia (NHSDA, 2002).

Learning Disabilities: There appears to be a strong correlation between substance abuse and early, undiagnosed learning disabilities. A sense of failure and early rejection by peers may lead an individual to turn to drugs or alcohol for a social life and feelings of acceptance or for withdrawal from the challenges of life (NIDA, 2000). Studies have revealed that 40-60% of people in substance abuse treatment have a learning disability (NIDA, 2000) Additionally, adolescents with learning disabilities have been identified as being at high risk for incurring traumatic brain injury (Haas, Cope, & Hall, 1987).

Attention-Deficit Hyperactive Disorder (ADHD): The use of substances to control behavior and mitigate poor impulse control may contribute to chronic substance abuse. Seventy-five percent of males with ADHD who were not on medication were reported as having a substance abuse problem. It is also estimated that 33% of adults with ADHD abuse alcohol and 20% abuse other substances (Wood, 2002).

Diabetes: Individuals with diabetes are particularly susceptible to loss of vision. Drinking can exacerbate declining vision or can damage vision. Drinking can also increase the pain, numbness and other symptoms found with nerve damage, another serious side effect of diabetes. Even light drinking can bring on nerve damage. Liver damage caused by alcohol use makes diabetes much more difficult to control (American Diabetes Assoc., 2002)

Seizure Disorders: Alcohol interferes with the effects of anti-convulsant drugs and lowers seizure thresholds. In some cases, overindulgence may actually trigger seizures (Epilepsy Foundation, 2002)

IMPORTANCE OF WORK IN RECOVERY

Work provides the person in recovery the ability to enhance self-esteem and to build confidence and self-worth. Clients in treatment see work as equated with normalcy, being part of society. Employment is a vehicle for reintegration into the community. For individuals with coexisting disabilities the challenges are more acute but no less significant. Employment services should begin early in treatment and involve a careful analysis of strengths. The rehabilitation community of agencies (State Vocational Rehabilitation Agency, federal and state-funded One-Stop Centers where vocational services are provided under one umbrella, and other vocationally oriented community organizations) can help to bring the person to meaningful, gainful employment.

CASE STUDIES

The following case studies portray the intersection of substance abuse and disability.

SUSAN IS 23 YEARS OLD and has been severely hearing impaired since birth. She communicates through sign language and reading lips. Her family, with whom she lives, resisted learning sign language and denied that she had any special needs because of her disability. She attended a special education program at a local public school, but felt that she "just didn't fit in". Susan started sniffing inhalants and smoking marijuana at age 12 and began using crack and hallucinogens at age 16. Her peer group consisted of others in her special education classes, who, like herself, felt isolated and different from other kids. She needed an outlet for her feelings of isolation and low self-esteem.

Once in treatment she gained more self-awareness and the support that she craved. With the help of the treatment team, Susan attained a GED and began doing volunteer work as a step toward developing skills and positive work behavior.

LUCY IS A 31 YEAR OLD single female. She grew up living with her parents and one sibling. Her father was an alcoholic, but was able to maintain his career as an educational administrator.

When Lucy was 7, she was diagnosed with Macular Degeneration, and was considered legally blind. Throughout her childhood, she was able to read and function in school, and was active in swimming and gymnastics. However, during the 7th grade, her visual impairment began to have an effect on her academic performance and social confidence. No

one else in her school had an apparent disability, and when she requested that her parents send her to a specialized school, they replied that there "was no such place."

Lucy felt "tortured" in high school, seeing no hope for improvement of her visual impairment and feeling totally unlike the students "who mattered." Lucy began to socialize with a "partying" crowd, where the focus was off academics and sports. By the 11th grade, she was drinking heavily and gained a lot of weight. She displayed promiscuous behavior and suffered temporary lapses of memory.

Post graduation, Lucy worked as a clothes saleswoman, and often went to work drunk and high on marijuana. After a year, her job was terminated. Job loss, as result of her alcohol and drug use, continued for two more years.

Lucy felt fed up with the consequences of her drinking and drugging. Lucy, however, did not know where to go to get the help she needed. When Lucy reached out to friends for help, one mentioned contacting the Commission for the Blind. The Commission referred Lucy to a substance abuse agency that was willing to accept an individual with vision impairment.

Lucy's treatment was successful and she has been in recovery for 4 years. She attends AA meetings regularly, preferring those led by persons with disabilities. She is working in a public utility company's department of customer service and feels as though she is on the path to a rewarding life. She began in this job through a supported work effort provided by the Commission for the Blind.

THE TREATMENT APPROACH

The following scenario reflects common experiences consumers and counselors face in treatment that is not inclusive of persons with disabilities.

PETER, A 38-YEAR-OLD man with a coexisting disability (traumatic brain injury and substance abuse) entered outpatient treatment for group and individual therapy. The staff felt Peter was non-compliant with treatment since he rarely participated in groups and often missed scheduled appointments with his counselor. Peter was discharged from the program and referred to more intensive treatment.

Examination and Recommendations

Possible responses by staff to Peter:

- "I don't know what is wrong with Peter. He's odd."
- "Peter holds up the groups."
- "I think we should discharge Peter. He misses appointments, is always late, and can't remember simple things I tell him to do."
- "I think Peter is just being resistant."

What is really going on?

- Peter's traumatic brain injury (TBI) interferes with his ability to focus, remember, concentrate and organize.

What treatment programs could have done for Peter? (Derived from Treatment Improvement Protocol 29, 1999)

- Ask basic questions to determine the problem.
- Based on his answers, refer him for a more in-depth assessment.
- Based on assessment, develop a more individualized treatment plan.

What treatment accommodations could help Peter?

- Provide more one-to-one counseling.
- Provide Peter with a notebook and help him use it to write down tasks, appointment dates, assignments and directions.
- When in groups, slow down the process, modify material and repeat directions. Use visuals whenever possible and provide Peter with a 15 minute post-group session to review material and answer questions.
- Refer Peter to a local TBI Network to provide for additional cognitive support.

- Break down tasks and goals into smaller and more specific steps. Practice and rehearse desired behaviors.
- Learn more about TBI to better understand Peter's difficulties, limitations and to recognize his strengths.

What will happen as a result of this team effort?

Peter will be able to participate more fully in treatment. Peter's counselor will be less frustrated as will other clients. Peter's recovery prospects will improve!

What treatment programs can do for all individuals with disabilities? (Derived from TIP 29, 1999)

- Support ongoing and comprehensive staff training on physical, sensory and cognitive disabilities.
- Assure each new client be screened for disabilities before individualizing treatment plans.
- Encourage staff to find creative ways to adapt treatment procedures for persons with coexisting disabilities.
- Promote use of "disability etiquette."
- Contact experts on TBI or other disabilities with questions and/or concerns.
- Use treatment models appropriate for persons with coexisting disabilities. Contact professional organizations such as the Commission evidence-based practices.
- Work with Peter to define and achieve work related goals.

Alcoholism, Addiction and Disability

Commentary by John de Miranda
National Association on Alcohol,
Drugs and Disability

Ask a dozen recovering alcoholics and addicts if they have a disease and 10 or more will likely answer, "yes." Ask again if they have a disability and you will get a dozen blank looks.

I have repeated this experiment many times, always with the same results. However, if disease is the primary identifying label of alcoholism and addiction, disability is certainly the flip side of the same coin.

Unlike disease, which is defined in terms of individual pathology, disability is described in terms of functional limitation. A person is disabled if they are unable to perform one or more of the activities of daily living such as working or self-care. During the active stage of their disease, alcoholics and addicts easily fall into this categorization. Congress and the courts have recognized this reality, and wisely included alcoholics and addicts within the provisions of disability rights legislation such as the Americans with Disabilities Act of 1990 and the Rehabilitation Act, which is up for reauthorization.

The need for legal disability protections continues into a person's recovery, because of the often-virulent discrimination that recovering individuals face.

In addition to understanding the disability component of alcoholism and addiction, the treatment and recovery community would do well to increase its sensitivity to the more than 5 million Americans with a physical, sensory or cognitive disability who are also suffering from drug and alcohol problems. Many of these individuals are unable to access care despite federal and state requirements that people with disabilities be accommodated.

Steve Towle, a quadriplegic, veteran, and recovering addict/alcoholic, recently recounted

the difficulties he encountered in his efforts to seek treatment. His contacts with dozens of treatment programs, National 12- Step organizations, federal agencies and two Governor's offices resulted in 100% failure to find an accessible program.

"At this point, I gave up. I wasn't sure I wanted to work so hard to get sober anyway," he remembers. "Ultimately, it was not the "system" that helped me get and stay sober; I had no help from the treatment community. No one helped me but my friends and luck and desperation and my higher power." (Read Steve's full account at (www.naadd.org "Advocacy"))

If you are interested in learning more about the alcoholism, addiction and disability connection contact NAADD at: National Association on Alcohol, Drugs and Disability, Inc. 2165 Bunker Hill Drive, San Mateo, CA 94402-3801; 650-578-8047; fax: 650-286-9205; E-mail: solanda@sbc-global.net

New Jersey Rules!

Great strides have been made in the past decade to improve alcohol and drug treatment and prevention services for people with disabilities in the United States.

There are many stories to be told about the individuals and organizations working for the goal of accessible services. One of the most exciting and powerful stories is taking place in The Garden State, where committed advocates convinced the New Jersey legislature to "set aside" funds earmarked for improving substance abuse services for people with disabilities. The story of how Public Law 1995 came to be is a terrific example of grass roots organizing and how people with passion and commitment can make a difference.

You can read about this story on the National Association of Alcohol, Drugs and Disability web site at:

www.naadd.org/NJCasestudy

2nd National Conference on Substance Abuse and Coexisting Disabilities:

“Facilitating Employment for a Hidden Population”

STATEMENT OF NEED:

- Substance abuse treatment programs frequently do not provide equal access to individuals with coexisting disabilities.
- Very little attention is paid to employment outcomes.

These two factors create significant barriers to meaningful recovery for persons with coexisting disabilities. The conference was charged with addressing this issue.

This conference brought together a national group of 150 multi-disciplinary professionals committed to improving research and practice related to substance abuse and coexisting disabilities. Through a series of plenary sessions and work groups, the participants were tasked to develop an agenda for change to improve recovery and employment services for individuals with multiple disabilities including substance abuse that could be implemented at the local, state and national levels. The conference proceedings were prepared and are available at www.sardi.wright.edu/conference. The Change Book, produced by the National ATTC, was used to develop the conference agenda and the tasks undertaken by the work groups.

Key components of the recommendation for change were:

- Provide the disability community with equal access to all substance abuse treatment services
- Establish a shared vision of employment as an integral part of recovery and as an outcome goal
- Reduce stigma against individuals with substance abuse and coexisting disability
- Provide adequate resources for research, staff development and program services
- Increase the availability of evidence-based practice
- Facilitate collaboration across disciplines within agencies and between community based agencies, including the business community

The conference was supported by a Knowledge Improvement Conference Grant from CSAT, the RRTC on Drugs and Disabilities, National Association on Alcohol, Drugs and Disability, the National, Prairielands, Mid-Atlantic and DC/Delaware ATTCs and the National Counsel of Rehabilitation Education. For access to the proceedings please visit www.sardi.wright.edu or www.danya.com/rrtc

NATIONAL ORGANIZATIONS

National Association on Alcohol, Drugs and Disability (NAADD). Promotes awareness and education about substance abuse among people with co-existing disabilities. Address: 2165 Bunker Hill Drive, San Mateo, CA 94402-3801 / Phone/TTY: (650)-578-8047 Executive Director: John de Miranda, Ed.M. Email: jdem@aimnet.com Web site: www.naadd.org

RRTC on Drugs and Disability. Designed to improve vocational rehabilitation outcomes for individuals who abuse substances. Address: P.O. Box 927, Dayton, OH 45401-0927 / Phone/TTY: (937)-775-1484 Director: Dennis Moore, Ed.D. Email: dennis.moore@wright.edu / Web site: www.med.wright.edu/citar/sardi/rrtc.html

Proceedings from Second National Conference on Drugs and Disabilities. Included at the site are links to state and national agencies focused on substance abuse and disabilities as well as those that are disability-specific. Please visit the conference website at: www.med.wright.edu/cital/sardi/prodAndPub.html. Scroll to Second National Conference Proceedings. This PDF and can be downloaded. The resources are in Appendix E.

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