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ABSTRACT

This literature review discusses cultural influences on individuals with disabilities and describes three historical models of disability--the moral model, medical model, and sociological/environmental/civil rights/minority group model. The use of alcohol and drugs by disabled persons is explored, focusing on individuals with orthopedic and sensory disabilities, developmental disabilities, and dual diagnosis (psychiatric disability concurrent with an alcohol and/or drug problem). The contents of the volume 13, number 2 issue of "Alcohol Health and Research World," described as the definitive document on disability and alcohol problems, are summarized. A bibliography of over 500 items is included, listing journal articles, monographs, sections of monographs, conference papers, and government reports. (CDD)

California Alcohol, Drug and Disability Study (CALADDS)

Literature Review and Bibliography

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California Alcohol, Drug, and Disability Study Literature Review excerpted from *CALADDS Final Report* © Institute on Alcohol, Drugs and Disability, 2165 Bunker Hill Drive, San Mateo, CA 94402 (415) 5789-8047 John de Miranda, Study Director (NOTE: The Coalition on Disability and Chemical Dependency mentioned below has changed its name to the Institute on Alcohol, Drugs, and Disability)

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Disability In Our Culture: An Overview

> *Whatever the physically impaired person may think of himself, he is attributed a negative identify by society, and much of his social life is a struggle against this imposed image. It is for this reason that we can say that stigmatization is less a by-product of disability than its substance. The greatest impediments to a person's taking full part in his society are not his physical flaws, but rather the tissue of myths, fears and misunderstandings that society attaches to them.* (Murphy, 1987, p. 113)

Who are these people so aptly described by Murphy? According to Bowe (1978) one in six Americans has some sort of physical, mental or emotional disability, creating one of the largest minorities in the country. Only one-sixth of these Americans were born with a disability; most were once able-bodied and acquired their disabilities from injury or illness. Indeed, as medical science has progressed, the number of people saved from death but left with a disability has grown. Bowe predicted that by the year 2000, there will be one physically disabled, chronically ill, or over-65-year-old with diminishing sight, hearing or physical abilities for every able-bodied individual in the country. Seventy percent of all individuals will experience a permanent disability (defined as a condition of at least six months duration that interferes with a person's ability to perform certain major life activities) at some point in their lives (Johns, 1987).

Bowe also drew a disturbing and dramatic relationship between disability rates and poverty. He reported that well over half of all children with disabilities come from families at or below the poverty level, and that rate is increasing. In a later study (1984), he calculated that only 38.7 percent of the disabled persons aged 16-64 in California participate in the labor force.
Murphy asserted that the median income for people with disabilities is only 62 percent of that of the nondisabled, and that one in four people with disabilities live below the poverty level. This compares with one in 10 in the general population.

Unlike members of other minority groups who share specific racial or gender traits, people with disabilities generally share only the experience of living in a society devoted to the body beautiful. People with congenital disabilities are usually born to nondisabled parents. Disability identify is not obtained through genes or cultural heritage. Even among those with similar disabilities, the limitations vary significantly. The *disabled minority* is composed of individuals with conditions that are often distinctly unique. But Murphy defined the commonality:

> *The similarity of our conditions is, however, social, for no matter who we are or how we got into our unenviable situation, the able-bodied treat the physically handicapped in much the same way. Disability is defined by society and given meaning by culture; it is a social malady....Disablement is at one and the same time a condition of the body and an aspect of social identity — a process set in motion by somatic causes but given definition and meaning by society. It is preeminently a social state.* p. 195

The interpretation of that social state has varied through history. Longmore (1987) described three models of how disability has been viewed over the years.

Moral model — This model asserts that people with disabilities deserve their states; that they are being punished for some wrongdoing or evil. Few people currently subscribe to this theory, at least not consciously or overtly.

Medical model — This model is still quite prevalent. Historically, it suggested that people with disabilities needed to be fixed and assimilated into *normal* society. When they could not be normalized, society needed to be protected from them by having them institutionalized. Sterilization laws to prevent people with disabilities from reproducing themselves grew from this desire to protect society. Not until after World War II did it dawn on society that it simply could not afford to institutionalize all people with disabilities. From that realization emerged the independent living movement aimed at mainstreaming people with disabilities into the community to the fullest extent possible.

According to Johns (1987), when people with disabilities are seen as sick, they are treated as patients. Their job as patients is to follow orders, be cheerful, spend time and energy getting well, and accept loss of control over their lives. Getting well (ie. becoming whole) is the goal of the medical model. Time that could best be spent becoming functional and educated is spent on getting whole, on not being or looking disabled. Those who resist the role of patient — of being sick — are often labeled hostile or *uppity*.

Again the words of Murphy:

> *To make matters worse, as the price for normal relations, they must comfort others about their condition. They cannot show fear, sorrow, depression, sexuality or anger, for this disturbs the able-bodied. The unsound of limb are permitted only to laugh. The rest of the emotions, including anger and the expression of hostility, must be bottled up, repressed, and allowed to simmer or be released in the backstage area of the home... As for the rest of the world, I must sustain their faith in their own immunity by looking resolutely cheery.* p. 107

People with disabilities are assumed to have a different *essence* from those who are *normal* (Johns, 1987). Reacting to a phenomenon called "spread" by Wright (1983), the able-bodied tend to view all behaviors by those with impairments as related to their disability. They further generalize one limitation to the entire person and his or her whole body; hence the common reaction of shouting at someone in a wheelchair, as if a mobility impairment must also mean a hearing impairment!

Sociological / environmental / disability rights / civil rights / minority group model — The genesis of this model can be attributed to work begun in the 1940s by the blind movement to ensure access and non-discrimination for those with visual impairments. An underlying premise of this model is that while disabilities are personal phenomena that interfere with the ability to perform certain major life activities, handicapping is a social phenomenon. An individual with a disability is handicapped by a specific set of environmental conditions that renders them unable to perform certain activities (Bowe, 1978). The difficulties, then, are caused by external and environmental factors, not internal or individual conditions. Problems stem from disabling environments, not from personal defects. Thus the differences between people with disabilities and the nondisabled could be obliterated through adapted environments (Johns, 1987).

However, such obliteration will occur only through acknowledging and redressing three truisms.

1. The public attitude of the non-disabled majority is based on aversion, avoidance and segregation. Being in the presence of a person with a disability stirs the non-disabled's sense of vulnerability and fragility. *If it happened to them, it could happen to me.* The best way to reduce those fears, reasons the non-disabled, is to avoid contact with the people who evoke them (Zirpolo, 1988).

2. The environment is shaped by public policies that allowed or required it to be so shaped; thus inaccessibility is not accidental.

3. Public policies that so shape the environment reflect the attitudes and values of the dominant, non-disabled population.

Changing those attitudes and values to ensure changes in public policy will require looking at certain psychosocial aspects of disability as described by Wright (1983). As mentioned above, the non-disabled all too often subscribe to the notion of "spread". That is, a specific limitation in one area is generalized to mean the individual is limited in all areas. *If s/he can't walk, s/he can't hear, so I should talk to the companion, not this completely limited person.* The surest way to overcome the attitude of "spread" is through consistent and meaningful interaction with people with disabilities and learning to focus on abilities rather than limitations.

Wright (1987) also describes two frameworks through which people with disabilities are often viewed: succumbing and coping.

> *The succumbing framework highlights the negative impact of disablement, giving scant attention to the challenge for change and meaningful adaptation. Prevention and cure are seen as the only valid answers. Satisfactions and assets are minimized or ignored. The emphasis is on the heartache, the loss, on what the person cannot do. Such a state is viewed as pitiful and tragic. The person as an individual with a highly differentiated and unique personality is lost.*
>
> *The coping framework, on the other hand, orients the perceiver to appreciate the abilities of the person in terms of their intrinsic or asset value. People with disabilities are regarded as having an active role in their own lives and in the community, not as being passively devastated by difficulties. The problem of managing difficulties has a double focus. One is geared toward environmental change; that is, changing those alterable conditions that add to the person's handicap such as architectural barriers, discriminatory practices, lack of employment opportunities, family problems and inadequate education, housing and transportation. The second focus concentrates on change in the person through medical procedures that reduce the disability, education and training that lead to new skills, and value restructuring that allows the person to accept the physical condition as nondevaluating. As for the suffering associated with disability, the coping framework is oriented toward seeking solutions and discovering satisfactions in living. Moreover, it recognizes the disability as only one aspect of a multifaceted life that includes gratifications as well as grievances, abilities as well as disabilities.* p. 194

One sign that disability is viewed from the coping framework is evidenced in the language used to discuss people with disabilities. Unless the emphasis is on the person rather than the disability, the coping framework is probably not at work. Unless the distinction between having a disability and being handicapped is understood, the coping framework is probably not in place.

If for no reason other than economic, coping should be the framework of choice. According to Bowe (1978), every one dollar spent on rehabilitation of people with disabilities that leads to productive living results in nine dollars returned to the government through taxes paid by employed or upgraded individuals.

Unfortunately, the alcohol and drug field has made little contribution to this rehabilitation in spite of the

understanding of the issue exhibited in the following quote from John Nobl., deputy director of NIAAA's division of special treatment and rehabilitation, reported by Hindman and Widen in the Winter 1980/81 Alcohol Health and Research World:

> *Disabled persons, particularly the deaf and visually impaired, often believe that established agencies are unable to communicate with them; disabled persons may use alcohol to ease chronic pain and may be reluctant to give up this established coping mechanism; the prospect of participating in a separate alcoholism treatment program, at the same time they are involved in vocational rehabilitation, may be seen as too taxing; the dual stigma of alcoholism and physical or mental disability may deter the multidisabled person from admitting to an alcoholism problem; previous rejection by community service agencies may prevent the multidisabled alcoholic from seeking treatment; the limited income available to most disabled people may cause feelings that they cannot afford the cost of alcoholism treatment; a negative self-concept reinforced by the fact of a physical or mental disability, may contribute to lack of self-motivation to seek treatment; disabled persons may be unable to face guilt feelings relating to their alcoholism's role in causing the disability (in the case of accidents); and physical disability often creates dependence on others, contributing to the maintenance of alcoholism.* p. 6

Despite a special NIAAA initiative announced at that time to support public and private service agencies and the development of model programs to advance understanding of how to reach and treat people with both alcohol or other drug problems and disabilities, little has been accomplished. According to Paul Widen, special assistant to Nobel, *The NIAAA is committed to providing Federal leadership and advocacy to assure that the disabled alcoholic person is given every opportunity to become an independent and productive citizen.* (Hindman, 1980/81, p. 6)

Unfortunately, there has been little evidence of that national leadership or advocacy. The majority of efforts devoted to improving accessibility to alcohol and drug services has grown from community level advocacy initiatives. These, often spontaneous, ad hoc task groups usually arise out of a perceived need for changing the status quo, and consist of members from both the disability service and alcohol/drug fields (de Miranda and Cherry, 1989; Coalition on Disability and Chemical Dependency, 1986; Cherry, 1989; McDonough, 1989).

ORTHOPEDIC AND SENSORY DISABILITY

In developing this literature review, addressing alcohol and other drug problems among people with orthopedic or sensory disabilities as a subset was based on the assumption that, if accessible to people with mobility, visual or hearing impairments, the program modalities of existing alcohol and drug service providers would be appropriate. Although that assumption is somewhat questionable with regards to members of the deaf community, program modifications for that population would be more in line with those developed in response to ethnic or gender differences than in response to cognitive or psychiatric differences (de Miranda, 1988). In general, however, alcohol and drug recovery and treatment programs as they currently exist could accommodate most potential clients with mobility, visual or hearing impairments. Why those services have been scarce is revealed through a search of pertinent literature and presentations by those few people who have attended to this issue. Indeed, inattention to the issue and a chronic lack of funding appear to be the roots of why people with disabilities do not receive services for their alcohol and drug problems.

In an unpublished paper prepared for the forerunner of the Coalition on Disability and Chemical Dependency, Knig... (1986) quotes Isaacs, et al. (1979):

A survey of the research literature...found no research studies on the use of alcohol among the deaf (nor any other handicapped group, for that matter).... It is a sobering fact that we know more about the alcohol use of a few thousand Lepcha of the Himalayas than we do about the estimated 13 million hearing-impaired persons in our country.

Indeed, Isaacs' lament may have been the catalyst for what attention the issue has received during the 1980's. Other than Hopkins' analysis in 1971 that twenty years of sporadic research indicated a high rate of suicide and other destructive behaviors (often involving alcohol, illicit drugs or medications) among people with disabilities, literature citations do not begin to appear until the definitive Winter 1980-81 issue of Alcohol Health and Research World. Devoted entirely to alcohol and drug concerns among people with orthopedic, sensory, emotional and intellectual impairments, that publication included the following:

• Prow's description in an interview of the connections she came to make between her quadraplegia and addiction and a plea to rehabilitation counselors to recognize the need for sobriety for their clients.

• A report by Hepner, et al. that as many as 25 percent of their clients at the Center for Independent Living in Berkeley experienced problems with alcohol and other drugs. Such problems included using chemicals to avoid the difficult and painful work of developing social skills and overcoming social isolation. They pointed out how alcohol and drug program policies of total abstinence create barriers for those people who require medications to manage certain aspects of their disabilities. On the other hand, they reported over-prescribing by physicians frustrated at being unable to *cure* their patients with disabilities as often opening the door to addiction for those patients.

• Lowenthal and Anderson pointed out that while there could be as many as 2.1 million disabled adult alcoholics, "people who are constantly reminded of their disabilities, as opposed to their abilities, find the admission of an alcohol or drug abuse problem an additional burden."

• In a separate article, Anderson offered the treatment consideration that from his experience a paralyzed person may try to use the disability to manipulate treatment service providers or even as an excuse to escape responsibility for his or her actions.

• Through a section of "Perspective" interviews, leaders from the deaf community attributed alcohol and drug use among their constituents to feelings of uselessness, being allowed to do little that is creative and constructive during a normal day, social rejection and coping with the disability. Attempts at providing alcohol or drug services had been ineffective due to staff fear of working with the deaf and avoidance tendencies, staff wanting to "take care of" the deaf, inflexible requirements to participate in program activities without providing the accommodations to make participation meaningful, and failure to understand the culture shock experienced by a member of the deaf community going into a mainstream program.

Much of the literature following that 1980-81 issue of Alcohol Health and Research World simply reviewed and summarized its contents for publications directed at other kinds of professionals such as Rehab Brief newsletter in 1982, Greer in Journal of Rehabilitation in 1986 and Orzolek in The Almacan in 1987. Comprehensive reviews of that publication plus additional writings have appeared more recently including Sylvester in Alcoholism Treatment Quarterly in 1986 and Lane in ADARA in 1989. Original, though isolated, works did began to surface occasionally in the mid-'80s, particularly in relation to spinal cord injured patients and the hearing impaired. Even to date, very little has been written about alcohol or other drug problems among those with visual impairments.

Two regular periodicals that focus on the issue of disability and alcohol and other drug-related problems are:

AID Bulletin (Addiction Intervention with the Disabled) Alex Boros, Editor
Department of Sociology
Kent State University
Kent, Ohio 44242
Price: $6.75/year

The Seed Jim Bouquin, Editor
Coalition on Disability and Chemical Dependency
P. O. Box 7044
San Mateo, CA 94403
No charge

AOD Problems among People with Mobility Impairments

A report from Baltimore's Montebello Center Spinal Cord Unit the following year (O'Donnell, et al, 1981) indicated that of the 47 traumatic spinal cord injured patients seen in the unit during one six-month period, 29 or 62 percent of the injuries were alcohol or other drug related. As members of both the treatment and research teams, the author warned against the continued abuse of alcohol or other drugs by spinal cord injured patients for a variety of reasons: contra-indicated depressant effect on central nervous system struggling to re-learn motor activities, chemical exacerbation of emotional depression over results of injury, hangovers interferring with participation in rehabilitation program, interference with and potentiation of effects of prescription medications, and the compounding effect on potential skin, pulmonary, urinary and joint problems.

By 1983, Boros at Kent State had broadened the focus of his Addiction Intervention for the Deaf (AID) program to include all disabilities and was urging networking between rehabilitation agencies and alcoholism programs to meet the needs of mutual clients. No further documented attempts to build service coalitions or to create systems changes were discovered until the work of the Coalition on Disability and Chemical Dependency (CDCD) in the late 1980s. CDCD's The Seed has published information on disabled adult children of alcoholics, access to publicly-funded alcohol and drug programs, prevalence of alcohol and drug problems among the disabled, recovery by people with disabilities, alcohol and drug problems among the developmentally disabled, special education, prevention, and an on-going literature review.

However, research on the issue of alcohol and other drug problems among people with disabilities continued to be sporadic at best. Frisbie, et al reported again in 1984 on the connection between consumption and the acquisition of spinal cord injuries. Of the 101 SPI patients studied, 94 were drinkers prior to their injury, and 39 of them were drinking the day they were injured in motor vehicle and diving accidents and from gunshot wounds and falls. Consumption patterns varied after the injuries: seven became drinkers, eight significantly increased consumption, 12 significantly reduced consumption, and 33 became abstainers. Greenwood (1984) reiterated alcohol's role as a complicating factor in rehabilitation as well.

The first reports from Heinemann, et al, out of the Rehabilitation Institute of Chicago appeared in 1985. Over the next several years and leading to a national conference on the issue planned for the fall of 1989, Heinemann concluded that alcohol or drug use among spinal cord injured patients was cause for concern because: 1) use may have been the cause of the disability, 2) use adversely affects the rehabilitation process, and 3) use adversely affects the rehabilitation outcome (1985). He showed that few alcohol or drug problems were identified and diagnosed by physicians treating the SPI patients even though the patients were more likely to use to a greater extent that the general population (1985,1987). He also discovered that those patients who were more accepting of the disabilities that resulted from their injuries spent more time out of their homes performing activities independently. Those who were less accepting spent more time at home

in quiet recreation including drinking. He urged asses ing alcohol and drug use among people with disabilities early on to determine if a dual disability exists (1987).

Also by 1985 the prevalence of alcohol or drug problems among people with disabilities began to be investigated, albeit with mixed results. Dean, et al, (1985) and Kirubakaran, et al, (1986) concluded that use among people with disabilities is about as prevalent as among people without disabilities while preliminary data from Buss's study (1985) suggested that people with disabilities have a 50 percent higher use of alcohol than the general population. There was no disagreement, however, on the conclusion that people with disabilities were not receiving services for their alcohol an drug problems. Rohe and DePompolo (1985) highlighted the incongruity of rehabilitation medicine departments' expressed concern for the alcohol and drug use of their patients and the obvious failure to take steps to address that use. They suggested that ambivalence about the ability of alcohol and drug programs to serve people with disabilities fueled that reluctance to take action. Cherry (1988) found reason for and no significant difference in that attitude three years later. Schuckit (1986) discovered that the need for alcohol, drug and psychiatric counseling for people with disabilities, their families, and caregivers is greater than for the non-disabled.

One of the early programs to respond to this need for alcohol and drug services by people with disabilities was Abbott Northwestern Hospital in Minneapolis. At an international conference in 1986, Schaschl (1986) warned that for 25-60 percent of people with disabilities who are in the work force, chemical dependency imposes far greater limitation than their physical impairments. The significance of the imprecision of Schaschl's estimate was validated by the Bay Area Project on Disabilities and Chemical Dependency's (Cherry, 1988) discovery that disability service agencies did not know the extent to which their clients were involved with alcohol or other drugs and not all of them were interested in addressing the issue.

An admittedly limited study by Meyers, et al, reported in 1988 stresses that even if alcohol and drug problems are no greater among people with disabilities than among the general population, services to those who do develop such problems are essential to avoid the costly complications that could results from lack of attention. Gentilello, et al, (1988) suggested that trauma units conduct interventions with patients known to have been under the influence at the time of the traumatic incident and determined to be alcoholic. Moving them directly from trauma rehabilitation into treatment and recovery could significantly reduce the prospect of future, disabling traumas. Glow (1989) recommended looking at the individual needs of each person with a disability when developing treatment plans, treating the individual and not just the disability, and integrating people with disabilities into the general population during treatment.

As part of the CALADDS project Davis (1989) reported on the experience of people with disabilities who are also homeless. This is the only attempt to investigate the relationship between homelessness, disability, and alcohol/drug problems in the literature. While this article was largely experiential and anecdotal, more detailed data is available about this population from the data tables in the appendix.

AOD Problems among People with Hearing Impairments

Much more has been written in the past decade about deafness and chemical problems among people who are deaf than about those with mobility and visual impairments combined. The emphasis has been on the necessity of understanding that the deaf community encompasses a unique culture. As a pioneer and on-going leader in advocating for services for alcoholics and addicts who are deaf or disabled, Alexander Boros speaking at the National Capitol Drug Abuse Conference in Seattle explained in 1978:

> *Deaf people...share a common identify. Hence, they fear being labeled by what a few deviant members might do. They have already shared the burden of the stigma deaf and dumb; now they shrink from any imposition of the added label of deaf and drunk. For self protection, the deaf community tends to deny that alcoholism has existed among them.*

Isaacs (1979) even reported that efforts at creating alcoholism services for people with hearing impairments *have met with massive denial by the organized deaf community of the existence of the problem as well as occasional active hostility to its being raised as a possibility.*

Although a majority of students in a high school for the hearing impaired reported drinking alcoholic beverages (Locke, 1981) McCrone (1982) began explaining in 1982 why the potential 206,000 deaf people with alcohol or other drug problems are reluctant to seek treatment for those problems. He contended that:

- Little or no alcohol and drug education was provided to students in schools for the deaf. Overdoses were not uncommon among students who were unaware of the concepts of drug tolerance, impurity or interactions.

- Deaf youngsters were often initiated into drug use by their hearing siblings. The youth then continued the behaviors in attempts to be accepted by the sibling.

- Deaf children were likely to be labeled hyperactive and given psychoactive medications for that condition. They then began to associate their impairments with being sick and later turn to self-medication.

- Deaf drug dealers were unlikely to be prosecuted so there was little reason to seek rehabilitation.

- There was no tradition within the deaf community of seeking the services of a counselors to assist with difficulties.

As soon as the need for such services was recognized, however, the debate began as to whether they should be offered through mainstream or specialized programs (Doherty, et al, 1982; Rothfeld, 1982; Jorgensen, 1982; Fulton, 1983; Alcoholism and Addiction, 1986). Wentzer and Dhir (1986) were among the early authors to provide recommendations for conventional treatment programs interested in working with client with hearing impairments:

In conclusion, the recommendations these authors make:

1) To understand the deaf as a culturally different group.

2) To respect that difference and via respect potentiate better treatment success.

3) To use a paid, qualified sign language interpreter to facilitate communication for the length of the treatment.

4) To check references, arrange payment, and schedule interpreter services for both patient and family prior to admission.

5) To use the minimum number of interpreter personnel possible, preferably one interpreter for the duration of the inpatient stay.

7) To get the deaf patient in contact with any and all recovering deaf or sign language using persons prior to discharge.

8) To expect to teach more basic language concepts to deaf patients.

9) To watch for signs of isolation and discharge early if necessary.

Treating a deaf patient in most other respects is the same as non-deaf. p. 15

Prevention of alcohol and other drug problems among people with hearing impairments began to receive attention in the mid-'80s. A program in Spartanburg, SC was developed to teach both information on alcohol and drugs and skills in decision-making, values clarification, self-esteem building, relationship building and coping to youngster who were deaf (Glenn, 1986). Thanepohn (1986) discussed how isolation and limited communication opportunities have resulted in a lack of understanding of the disease concept of alcoholism and addiction among the deaf. Such issues are taboo and seen as great stigmas. Mainstreaming through prevention, twelve-step and after-care programs is recommended to break through that lack of understanding.

The most recent writing about alcohol and drug problems among people with hearing impairments continued to stress measures needed to successfully accommodate such clients in existing programs. Dixon (1987) suggests:

- Train interpreters in treatment terminology and procedures.
- Teach hearing counselors sign language.
- Educate recovering deaf alcoholics and addicts to be substance abuse counselors.
- Initiate courses in deaf culture and deaf awareness in schools where substance abuse programs are offered.
- Introduce deaf awareness programs in the hearing community.
- Alert funding agencies to the need for financial resources for deaf awareness programs.

Finally, a moving first-person account of his experiences with treatment programs, self-help groups, and recovery appeared in 1989 (Fortney).

AOD Problems among People with Visual Impairments

Without doubt the group of people whose alcohol or other drug problems have been the most ignored in the past several years are those who are blind or visually impaired. In that definitive 1980/81 issue of Alcohol Health and Research World, Glass defined two kinds of visually impaired drinkers. Type A problem drinking begins, he said, before the loss of vision occurs. Type B drinking begins after the onset of disability. He reported that both types share the common assumption that alcohol use is an acceptable tool for coping with the stress of loss of sight and adjustment. He predicted better chances for recovery among Type B's, however, due to their having to learn new skills to live with visual limitations.

Since Glass's article, only two citations appear in numerous computerized bibliographies on alcohol and other drug problems among people with disabilities. Evans, et al., (1982) found that alcohol or drug use was the least problematic variable in social isolation and loneliness for visually impaired elderly people. A 1983 citation on *Alcoholism and the Visually Impaired Client* by Peterson and Nelipovich has yet to be located. Anecdotes reported by Cherry (1988) suggested a lack of recovering blind people to serve as peers and role models and cases in which drinking was the preferred method of dealing with isolation.

No conclusions can be reached for this dearth of information. It can be reported that among those agencies contacted for the documentation aspect of this project, those who serve the visually impaired were the least responsive to the issue.

DEVELOPMENTAL DISABILITY

While almost all authors addressing the topic of drug and alcohol use/abuse among people with developmental disabilities complained of the lack of relevant research, the existing literature does consistently indicate the need for prompt attention to this issue. Early discussion, in the 1960's, tended to suggest that mentally retarded individuals might be especially susceptible to the inebriating effects of alcohol (Tregold and Soddy, 1963; Davies, 1964). A strong relationship between mental retardation and alcohol abuse is not supported in the literature. However, substance abuse is demonstrated to occur, specific psychological, social and medical factors are identified, and implications for specialized educational and treatment approaches are described (Ludwig,1989; de Miranda, 1989).

A 1981 study by Huang found that among 190 "educable" mentally retarded and 187 non-retarded high school students, retarded students were less likely to use alcohol, but patterns of drinking among teens from both groups who drank were very similar. At about the same time, Krishef and DiNitto (1981) received completed questionnaires from 54 offices of the Association for Retarded Citizens, and 50 alcohol treatment programs, located in major metropolitan areas. Both types of agencies had been asked to identify the numbers of clients they saw who were both mentally retarded and alcohol abusers. In addition, the respondents provided comprehensive demographic data. While the ARC's identified 139 persons with alcohol problems, the ATP's identified 275 clients who were mentally retarded. While these numbers did not suggest a rate of alcohol abuse which was greater than the rate among the non-retarded population, the existence of a significant occurrence of the problem was demonstrated. The large difference in numbers between the two types of agencies suggests that interagency communication and cooperation, in working with a population which is generally highly dependent upon bureaucratized social support is inadequate.

Recent studies continue to assert that people with developmental disabilities (most studies focus on the disabilities of mild to moderate retardation) who drink and/or use drugs approximate the patterns of people in the general population (DiNitto & Krishef, 1983; Krishef, 1986; Westermeyer et. al, 1988). Beginning with DiNitto & Krishef's 1981 work, psychosocial variables are described which begin to suggest reasons why people with mental retardation who do drink will, in some cases, become substance abusers. Complicating the directionality of the main body of current research is a 1986 study by Edgerton, a Los Angeles area ethnographer who found that of 181 community-living retarded adults, the subjects, with few exceptions, used alcohol or drugs less often than their non-retarded relatives, spouses and friends; and less often than the deinstitutionalized mentally ill population. Even with a quarter of the subjects being ghetto-dwelling Blacks, where street use and availability of drugs and alcohol is high, use and abuse by subjects was not greatly increased. Family histories of alcohol and drug use/abuse patterns were also gathered, and no particular family influence effects were found. Subjects did frequently report that they had general knowledge about the harmfulness of drug and alcohol abuse. Any lingering controversy around how significant a problem alcohol and other drug abuse is for the developmentally disabled population should not stand in the way of addressing the needs which do exist.

As discussed by Sengstock, et. al (1975), mentally retarded people have the same needs for acceptance and love as their non-retarded peers. Current attention to "quality of life" issues for people with developmental disabilities includes such needs as accessibility to all community services, meaningful work for pay, decent housing without being forced to live in a large group or institutional setting, and the opportunity to participate in creatively bettering one's community for present and future generations (Allen, 1989). When basic human needs are not met, and among many disabled populations they may not be, conditions such as low self-esteem, feelings of social inadequacy and alienation, depression, confusion around sexuality, and gravitation toward deviant means of seeking acknowledgement and gratification are likely to appear (Sengstock, et. al, 1975; Krishef & DiNitto, 1981; DiNitto & Krishef, 1983; Krishef, 1986; Moore, 1987).

As commonly described in the alcohol and drug problems literature the above-described psycosocial conditions are related to patterns of substance abuse in the general population. Moore suggests, (1987) that these conditions affect people with disabilities much more frequently than is found in the non-disabled population.

While many people with developmental disabilities who engage in alcohol and other drug abuse may eventually be identified, especially through the professional intervention of caseworkers, law enforcement agents, employers and health care workers, it will probably not be through a presenting problem of substance abuse, but through a person's experiencing breakdowns in social or personal relationships and functions (The Maine Approach, 1984). Just as there have traditionally been few attempts to provide adapted educational materials regarding drugs and alcohol to special education students (Sengstock, etc. al, 1975; Boros, 1988), there have also been few attempts to adapt drug and alcohol treatment programs to successfully serve people with developmental disabilities. People with mental retardation may learn differently or more slowly than the general population. Learning may occur best when prompt positive reinforcement practices are used. Teaching through role modeling and repetition, and the use of interesting films and audio tapes for those who read poorly, is beneficial. It is warned by Moore (1987) that people who have grown up in special education environments may have learned certain behaviors which increase susceptibility to abuse through exposure to the inherent acceptance of deviance and socially immature behaviors in the special education classroom.

The pioneering effort of the Mental Retardation Alcoholism Project, described in the 120-page monograph called: The Maine Approach brought together state agencies for the mentally retarded, mentally ill, and drug abusers to devise a workable method for the identification and treatment of mentally retarded persons with alcohol and drug problems. The project, now defunct due to loss of funding, created replicable processes to assure effective provision of services: 1. Prototypic interagency contracts, screening and evaluative instruments, and documents which address and assure the protection of clients' rights were developed. 2. Accessibility to Alcoholics Anonymous, the only free, broadly available, cultural, active recovery program extant, was facilitated through linking disabled clients with a specially trained A.A. sponsor, early in the intervention process. 3. Agency liaisons were created so that each discipline (typically not knowledgeable about other disciplines), had ongoing programming input, training and follow-along support from the others. A great deal of additional useful information is included in the monograph which describes the project and defines types of developmental disabilities as well as behavioral learning methodologies.

An additional complicating factor in substance abuse by people with developmental disabilities is the typically high rate of use of other prescription medications for seizure control and for mental illness or behavior control. Drug interaction effects may exacerbate or create health problems. Treatment for disabled substance abusers may be refused by "social-model" programs, when the abuser is taking other prescription drugs.

Ethical concerns about the use of psychopharmacology with developmentally disabled persons are quite widely reported in the psychiatric, psychological and mental retardation literatures. Major issues include whether or not psychotropic drugs are used as convenient means to control behavior; how being under the influence of psychotropics may further impair learning and abilities to participate in everyday living activities; risks of side effects including tardive dyskinesia; and the diagnostic difficulties which are presented when developmentally disabled persons are also mentally ill. Many citations which address these problems are included in the bibliography.

Psychopharmacology was developed for institutional use in the 1950's. A period of time followed in which the number of institutionalized persons receiving such drugs was large, and the average drug dosage level was quite high. As the movement to deinstitutionalize gained momentum, and as advances were made in the practical applications of behavioral analysis and modification, more people with disabilities made transitions into supported community living. Pressure was applied to institutions, to reduce the use of psychotropic drugs, by patient-advocates, researchers, clinicians and legislators. Research was conducted to demonstrate that behavioral teaching and adequate social support could reduce the need for high dosage, frequently prescribed drug regimes (Lipman, et al., 1978; Inoue, 1982; La Mendola et al., 1980; Fielding et al. 1980; Sovnere 1984; Aman, 1985; Aman and Singh, 1986; Gualtieri et al., 1986; Sovner and Hurley, 1987; Boshes, 1987; Sovner, 1987).

Although abuse of psychotropic drugs has certainly decreased over the years, the continuing reliance on these drugs for treatment of widely varying symptoms and behaviors, in both institutional and community settings must be assessed. In community settings, for example, disabled people are often seen by community mental health psychiatrists or by general practitioners who have little experience with prescribing psychotropic drugs for people with a primary developmental disability. Follow-along in community settings may range from very poor to very good. While administrative regulatory measures are beginning to address the use of psychotropic drugs in community settings, such regulations are in general, quite new; and often only help people who live in relatively well funded, highly structured, richly staffed programs.

It is not surprising that the literature regarding the potential for abusive use of drugs perpetrated by caretakers on developmentally disabled persons is quite rich, while the literature regarding disabled persons who independently abuse drugs or alcohol is relatively scant. People with developmental disabilities are just beginning to lead more independent lives in all types of community settings. The numbers of disabled people living and working in the community has never been greater, and continues to increase. It would seem prudent for communities to seriously prepare to serve developmentally disabled people who have substance abuse problems.

DUAL DIAGNOSIS (psychiatric disability concurrent with an alcohol and/or drug problem)

The issue of dual diagnosis - mental health problem(s) existing concurrently with alcohol and other drug related problems - has long challenged and frustrated treatment providers. In recent years, especially since the de-institutionalization movement of the 70's, a focus on young adults with chronic mental illness has revealed a substantial rate of concurrent substance abuse problems. Clinicians in the fields of both addictionology and psychiatry are increasingly aware of the very special and complex problems presented by the dually diagnosed client. One of the central problems confronted by the dual diagnosis issue is having two, traditional, parallel systems which provide services to the mental health or addicted client. This dual track delivery system forms a context for many of the issues addressed in the past 25-30 years in the professional, literature and continues to be reinforced through the current system of delivering mental health and alcohol or other drug related problems. Some other major issues include:

1. Assessment - How can each distinct problem be adequately assessed in a setting that specializes in only one of the presenting problems? Similarly, the typical professional providing the assessment has usually been trained in only one problem area. This limited area of focus makes truly global assessment difficult.

2. Split setting - Treatment facilities are traditionally oriented to deal with either alcohol and other drug related problems or mental illness. This often forces the dual diagnosis client to be enrolled in and receiving treatment services from two separate sources. Such a scenario is often confusing, can lead to frustration, and may contribute to a high client dropout rate. Only a handful of programs are equipped to provide appropriate services in a single location.

status within the realm of psychiatric treatment, and in recent years has broken away to gain credibility as a separate specialty. Twelve step, self help groups--the bedrock of addiction treatment--have often been misunderstood, and sometimes rejected by mental health professionals. Confusion also exists regarding the medical/professional model of mental health service versus the social/community model of addiction recovery service.

4. Lack of experience - Inadequate experience with integrated treatment, and resultant paucity of an effective treatment literature remains a significant issue. In recent years, more interest has been expressed about the dual diagnosis client, but effective programs are scarce.

Despite the complexity of this problem and the plethora of questions posed by the dual diagnosed client, the relevant literature, as mentioned above, is scanty and inadequate. Published materials specific to this issue have been slow to appear into the mid-1980's and the majority of materials prior to 1980 dealt with dual diagnosis only obliquely. As recently as 10/88, the bibliography list from a San Francisco Bay Area conference on dual diagnosis contained only a small number of citations specific to the issue of concurrent major psychopathology co-existing with chemical dependency (Double Trouble VI, 1988). The larger share of readings consider related topics such as alcohol and/or drug use in psychiatric hospitals, training needs of health professionals, rehabilitation, and evaluation methods.

It has often been observed that the professional literature lags several years behind clinical practice. For example, conferences have addressed the problem of dual diagnosis for several years, discussing anecdotal and experiential developments as well as current research, program development, and staff training. Much of this information becomes "oral history" as funding for the majority of conferences is inadequate for the publication of proceedings. When proceedings are published, the dissemination may not go beyond the sponsoring university's library and the conference attendees. Without inclusion into one or more of the growing numbers of computer accessible data bases, the materials do not become available to the professional community at large. Additionally, the gathering of formal research data, analysis and interpretation of information, submission and publication of outcome is a lengthy, time-consuming process. All of these factors contribute to the inadequate pool of available published materials specific to dual diagnosis.

Prior to the 1960's, there were rare articles addressing co-existing psychopathology and addiction. Those citations that might loosely be regarded as pertinent include several attempts to classify personality types who develop addiction (Hewitt, 1943; Felix, 1944) . This topic was first addressed in 1925 (Kolb, 1925).

In 1957, a new theme was suggested in an attempt to make clinical connections between manic-depressive disease and substance abuse (Cassidy et al, 1957). Looking for such connections or suggesting that alcoholism or drug addiction was a manifestation or form of an underlying psychiatric problem continued to be a popular topic of investigation through the late 60's and into the 70's (Freed,1970; Flemenbaum, 1974; Tyndel, 1974; Skinner et al., 1974; Mayfield & Coleman, 1968). One interpretation of this movement is that the psychiatric profession was attempting to incorporate addiction problems into the province of psychiatric treatment. Studies of both psychiatrically hospitalized alcohol abusers/ narcotics addicts, and studies utilizing the Minnesota Multiphasis Personality Inventory to compare and contrast alcoholic/addicts to psychiatric patients were published in the 1960's and 1970's. (Parker et al., 1960; Robbins,1974; MacAndrew, 1965). Literature of the late 1960's and 1970's broadened this theme to include reports of specific drugs that caused psychotic manifestations when abused, such as amphetamines and PCP (Janowski & Risch, 1971; Rockwell & Ostwald, 1968; Robinson & Wolkind, 1970). One study attempted to relate addicts' drugs of choice to specific psychopathology or personality disorders (McLellan & Druley 1977).

Through the 70's the examination of inpatient psychiatric populations for illicit drug and alcohol use attracted the interest of investigators (Blumberg et al, 1971; Butzer and Cline, 1974; Fischer et al, 1975). Attempts were also made during these years to asses which problem, addiction or psychopathology, was primary. As psychiatric treatment was viewed as distinct from drug or alcohol treatment, it seemed important to determine which problem required treatment first (Sobel, 1978; McCellan et al, 1978). Relative to this issue were concerns regarding assessment issues and the appropriate use of various assessment tools (DeGroot and Adamsom, 1973).

Writings beginning in the mid 1970's discuss the relationship of psychopathology to drug or alcohol abuse (Dunner, 1979; Westmeyer and Walzer, 1975). The need for psychiatric care providers to be competent to discern alcohol or other drug problems was recognized. Additionally, concerns were raised that unrecognized alcohol or drug abuse disturbs psychiatric treatment and outcome (Dichter and Eusamio, 1978; Hall et al, 1977; Jones, 1979).

The early 80's witnessed the development of some of the subtle trends of the previous decades. Authors were increasingly specific when discussing co-existing psychopathology and substance abuse. A variety of articles demonstrated particular focus on co-existing psychiatric conditions including schizophrenia, affective disorders, anxiety disorders, borderline personality and their interface with alcohol and other drug problems (Abbott and Peake,1982; Fine,1980; Hellman,1981; Hudson and Perkins, 1984; Hesselbrock et al, 1986; Dackis & Gold,1984; Cadoret et al ,1985; Bowen et al , 1984).

This era also saw the recognition of the problem of chronic mentally ill young adults who are homeless (Harris & Bergman, 1984; Glass, 1982; Stein & Test,1982; Unger & Williams, 1984; Sheets, et al, 1982; Caton, 1981). Estimates were proposed that up to 50% of this population were drug and/or alcohol dependent. The literature reflects the challenges this difficult group presents to health care providers, especially as drug or alcohol services are offered through a system parallel to mental health care. These clients invariably bounce back and forth between the two systems, receiving fragmented and often contradictory treatment. Recognition of this system dysfunction engendered the appearance in the mid 80s of recommendations for the conjoint treatment of such clients (Harrison et al, 1985). The mid-80s also offered a developmental perspective for alcoholism treatment which merged psychological perspectives with traditional 12-step models of Alcoholics Anonymous and other anonymous self-help groups(Brown, 1985). While this author did not comment directly on the dual diagnosis issue, her work provided an integration of traditional addiction treatment methods with a psychological/developmental model. Perhaps Brown's major contributions are an understanding and appreciation of the addiction recovery process as seen through the eyes of the mental health professional.

During the 1980's the literature continued to examine the phenomena of illicit drug use among psychiatrically hospitalized patients, but broke patient populations into smaller homogenous groups by diagnostic categories (Alterman et al..1982; Hasin et al., 1985; Knudsen & Velmar, 1984). The use of alcohol or drugs by psychiatric patients to suppress or treat emotional pain and psychiatric symptoms was explored (Khantzian, 1985).

As this decade progressed, articles that focused on the chronic mentally ill young adult evolved from observation of the problem to literature reviews designed to identify research needs, treatment and program design issues, and staff training for effective intervention (Bachrach, 1980,1982a, 1982b, 1983, 1984, 1984a, 1984b, 1986; Schrader and Goldberg, 1982; Ridley et al, 1986).

In the past few years, the amount of literature on dual diagnosis has increased markedly in both volume and scope. Authors are critical of the traditional system of separate treatment; describing programs designed specifically for this population ; discussing the training professional's need to effectively treat the dual diagnosis client (Bauer, 1987; Sciacca, 1987; Brown, 1987; Brown and Backer 1988; Lehenan, 1986; Ridgeley et al 1987). Articles also explore the phenomena of homelessness among chronic mentally ill and/or substance abusing young adults (Koegel & Burnam,1988a, 1988b). Other citations discuss various treatment modes or settings (Kofoed et al., 1986; Intagliata and Baker,

York, and Oregon. A similar study is in progress in California. Perhaps a further indication of the magnitude of this problem is the recent conference whose theme was integration of AA and professional addiction treatment. Within this context there was discussion of the use of psychotropics in recovery, the growth of "double trouble" AA meetings and the need for AA members to accept the problems and treatment of co-existing mental illness (Zimmerman, 1989).

The most recent literature reveals articles aimed at some of the specific problems presented to clinicians by the dual diagnosis client such as: inpatient treatment of these patients in a chemical dependency program for adults or adolescents (Wallen and Weiner, 1988; Schif and Cavaiola, 1989); providing psychotherapy to this population (Kaufman, 1989); and differential diagnosis (Kosten and Kleber, 1988; Rivincus, 1988).

A major contribution to the field is the forthcoming "white paper" commissioned by the California Department of Alcohol and Drug Programs, which is expected to focus on the chronic mentally ill young adult substance user/abuser, ages 18-40 years (Cooper, et al. 1989).

ALCOHOL HEALTH AND RESEARCH WORLD **VOL. 13, NO. 2.**

For its Winter 1980/81 issue, Alcohol Health and Research World published what has become the definitive document on disability and alcohol problems. For nearly a decade, virtually every writer on the topic of alcohol or other drug problems among people with disabilities referred to at least one article from that publication.

In response to the growing attention granted this topic, AHRW devoted its Volume 13, Number 2 issue of 1989 to an update on alcohol and the physically impaired. Because of its potential significance to the field, and its recent publication the entire issue will be reviewed below.

In introductory notes, the editors hail the progress made since 1980, and the issue does contain informative discussions from a variety of perspectives. Unfortunately, hard data on incidence and prevalence of alcohol and other drug problems among people with disabilities continues to be elusive.

Alexander Boros, founder of the Addiction Intervention with the Disabled (AID) Project at Kent State University, served as guest editor for this special issue of AHRW. He points out that while significant advances have been made in the field of addiction treatment, people with disabilities have not fully benefited (Boros, 1989). Boros lists several stressors that may contribute to the development of alcohol or other drug (AOD) problems among those with disabilities, especially among those who acquire physical impairments through injury or illness:

- adjustment to a world designed for nondisabled
- boredom and lack of challenging activities
- frustrations and pain associated with the impairment
- inadequate income to purchase needed services
- easy access to addictive prescription medications
- societal rejection and deprivation of jobs, recreation and services
- admitting to an AOD problem would be another blow to diminished self esteem
- physical impairment presents strong rationale for drinking to cope and/or escape

- no standardized models for providing the services have been created
- treatment activities must be paced at slower rates for those who require more time for mobility or communication
- facilities are often inaccessible for wheelchair or other walking-aids users
- misplaced sympathies inhibit AOD counselors from confronting people with disabilities about their denial
- the criminal justice system generally sends people with disabilities arrested for AOD-related instances home rather than for treatment
- treatment and recovery facilities are unable to transport orthopedically impaired clients
- families of physically impaired may be less demanding of AOD services than they would be for an able-bodied family member
- the unemployed disabled lack job-related incentives to seek AOD services
- AOD service providers are often perceived as disjointed, inaccessible, and bureaucratic
- literature fails to adequately address unique treatment problems facing those addicts with physical impairments

Jones (1989) reports a 50 % incidence of intoxication at the time of injuries that result in traumatic brain damage and a two-to-four times higher incidence of head injury among alcoholics than among the general population. In spite of these large numbers, the limitations that result from such injuries are uniquely specific from individual to individual. However, Jones urges AOD service providers to be aware of several common consequences and to take them into account when dealing with clients with traumatic brain injury (TBI):

- impairment of memory
- decreased self-awareness and insight
- impairment of abstract reasoning
- deficits of attention and concentration
- inappropriate social behavior
- changes in mood and affect
- language and communication deficits
- sensory deficits
- goal-formulation and problem-solving difficulties
- vocational/educational problems
- impact on family and community

- Subjective reports of AOD use and of past head injuries may be inaccurate due to memory deficits and impaired insight. Ask specific questions such as "Have you every been knocked unconscious?"

- Long or complicated assessment tools may be inappropriate for those who have difficulty with abstract thought and complex concepts. Use the simplest tool available.

- Changes in functional ability are often most reliable indicators of AOD problems when all other medical considerations can be eliminated.

- Cognitive deficits may make psychodynamic approaches such as group sessions questionable. Behavioral models with short-term goals may be preferable.

- Interdisciplinary teams will be more effective with TBI clients than isolated therapists.

- Attention should also be given to the stresses on families of TBI clients.

TBI clients are quite likely to need AOD services following their injuries. Jones reports that in one study 54 % of patients returned to alcohol use after rehabilitation even though the majority of them had been under the influence at the time of injury. The remaining 46 % were abstinent due to seizure disorders or placement in long-term, supervised living situations.

As with traumatic brain injuries, AOD use contributes significantly to the acquisition of spinal cord injuries (SCI). According to a study reported by Heinemann, et al, 68 % of 54 patients were under the influence of alcohol or another drug at the time of their disabling spinal cord injuries. Sixty-eight % of the study group also resumed drinking while they were hospitalized.

Heinemann describes two types of drinkers in relation to SCI. Type A's are those with prior drinking problems, and Type B's are those whose problems develop after their injuries. Type A's were more likely to have been intoxicated at the time of injury.

Reporting on another study, he indicates that while the overall proportion of drinkers among the 103 patients studied declined after injury, two-thirds of them were drinking 18 months after their injuries. Seventy-one % of them reported alcohol related problems, 15 % felt they needed treatment for those problems, and 11 % received such treatment. Although most SCI patients with alcohol related problems do not seem to view their injuries as major enough life disruptions to seek AOD treatment, Heinemann insists the incidents present opportunities for intervention. He encourages rehabilitation professionals to assess all patients for AOD problems, to obtain training in recognizing abuse among their patients, to establish AOD referral networks, and to examine their agencies' policies that may actually allow or encourage patients to consume alcohol or other drugs.

Heinemann warns that failure to intervene with patients who have obvious or suspected AOD problems at the time of injury can lead to:

- neglect of self-care and increased morbidity

- poor psychological and social adjustment

- interference with productive physical rehabilitation

In reporting on a study conducted among college students who were orthopedically impaired, Moore and Siegal (1989) indicate that eight out of nine of the students who were impaired as a result of trauma were using alcohol or other drugs at the time of their disabling injuries. They also found that disabled college students use AODs for the

same thrill-seeking/social reasons as nondisabled students. Although the vast majority of survey participants reported no use of marijuana, barbiturates, amphetamines, cocaine, hallucinogens or narcotics, only 10% claimed not to use alcohol. Nearly 45% reported drinking at least weekly. Better than 61% reported use of at least one prescribed medication, and 30% of the sample indicated using at least three prescription drugs concurrently. Nearly 44% reported receiving no medical information on how aspects of their disability might influence alcohol or other drug tolerance.

While the connection between arthritic gout and consumption of alcohol has long been acknowledged, the contribution of such consumption to the acquisition of avacular necrosis can also be asserted, according to Nashal (1989). This condition leads to the destruction of body joints, particularly hip joints. Dupuytren's contracture, which involves tissue development that causes the hand to be drawn into a closed position, is also strongly associated with relatively high levels of alcohol consumption. Nashal suggests that alcohol abuse always be investigated as a possible cause or contributor to arthritis and that consumption be eliminated in the treatment and management of arthritis cases.

In working with AOD clients who are blind or visually impaired, Nelipovich and Buss (1989) recommend determining the level of acceptance of the disability before deciding whether to deal with the disability or the addiction first. They warn that the most difficult cases to work with will be those people who have accepted neither their impairments nor their AOD problems. They urge AOD programs to assess clients adjustment regarding mobility, communications and personal management. Although accommodations may be necessary, they should not be accomplished in ways that detract from already lowered self-image. In working with AOD clients with visual impairments, Nelipovich and Buss offer suggestions for reducing barriers:

- ensure transportation to the program site
- orient clients thoroughly to the facility's environment
- facilitate introductions and early interpersonal communications
- prepare materials on audio tape using 15/16 rpm instead of the standard 1-7/8 rpm.

In discussing visually impaired children of alcoholics, Saulnier (1989) reminds AOD service providers that 90% of those with visual impairments have some degree of sight. Clients should be asked what their needs are relative to their visual capabilities. She encourages AOD program staff to maintain the same expectations of visually impaired clients as of other clients relative to homework, participation, activities, etc. She does suggest that newly impaired clients may need more supportive than confrontive therapy in breaking through their denial.

Stoil (1989) reports that 20-25% of newly diagnosed adult cases of epilepsy have no risk factors other than histories of alcohol abuse. According to developing and still controversial research, withdrawal from — rather than actual consumption of — alcohol may be the contributing factor in alcohol related seizures. It has been determined, however that drinking can contribute indirectly to seizures by creating sleep disruptions, causing individuals to forget to take their medications, interacting negatively with medications, and leading to accidents that trigger seizures.

Although much of the information in the Vol. 13 No. 2 AHRW is directed to alcohol and other drug service providers, Greer (1989) speaks to rehabilitation counselors about their roles. He counsels:

- clients should be notified that use of alcohol or other drugs may interfere with their rehabilitation
- interventions should be part of rehabilitation plans, with client consent
- clients have the right to refuse intervention

- counselors have the right to terminate services if AOD problems impair the potential for rehabilitation

- against setting lower expectations for AOD abusing rehab clients

- against accepting AOD abuse as a normal part of the mourning process many people with disabilities experience

- against being manipulated by abusing clients who use their disabilities as ploys for sympathy

- counselors to be aware of how their own histories with and use of AODs influence their attitudes toward clients' use

Greer encourages rehab counselors to consult with their agencies' medical directors when there is suspected misuse of prescription medications. Confronting the client on issues involving their physicians may not be appropriate. He also acknowledges the need to begin addressing AOD issues in rehabilitation counselor education curriculum.

A program in Minneapolis which draws clients from both rehabilitation and chemical dependency treatment units has found that peer support is a significant contributor in maintaining sobriety for people with both AOD problems and physical impairments. In describing that model program, Schaschl and Straw (1989) warn that failure to address AOD problems among rehab patients can prevent successful rehabilitation and adjustment to disability, lead to increased medical complications and interfere with progress toward independent living. They cite negative attitudes toward people with disabilities and with AOD problems, plus beliefs among caregivers and families that consumption helps with "normalization," socialization, and exerting choices as factors that contribute to their patients failure to maintain sobriety.

Grassroots efforts supported by government agencies are leading to changes in the accessibility of alcohol and other drug services in California. De Miranda and Cherry (1989) report on activities in Los Angeles, Orange County, the San Francisco Bay Area, and across the state that are bringing professionals from both the disability service and AOD fields together to create better services for their mutual clients. Using documentation from regional and statewide surveys, advocates are pressing for systems changes that will both educate the disability service field about AOD issues and make AOD programs more accessible for those with a variety of impairments. This report provides background material for the California Alcohol, Drug and Disability Study (CALADDS).

A model for achieving such change is presented which suggests:

- a few concerned individuals perceived a social injustice and became organized with the goal of effecting system change

- this organization and collaboration resulted in a greater network of advocates for change within the two (AOD and disability) service systems

- resources external to those systems were generated to document the scope of the problem and potential need for services

- resources from within the AOD system were allocated for further documentation

- a consensus among advocates and policymakers will be sought to determine the nature of changes that will improve access

- systems changes to ensure continued accessibility would then occur

An examination of hospital discharge records reported by Dufour, et al,(1989) suggests that alcohol related diagnoses for the physically impaired were double that of the general population. They conclude that a

significant amount of alcohol related morbidity exists in the disabled community, probably more so than suggested by this particular study.

An estimated 600,000 men and women in the United States experience the double burden of having an alcohol or other drug problem plus a hearing impairment. Most, according to Kearns (1989), cannot take advantage of state of the art AOD treatment services that depend upon communication among individuals, communication between an individual and a group, or simply listening to a film or talking on the phone. This exclusion is often based on the lack of understanding of the variety of hearing impairments and the gradations of hearing loss that result. While some people with hearing impairments may benefit from amplification devises in one-to-one situations, hearing aids may actually compound difficulties in group situations by indiscriminately picking up background noises. Hearing people should not assume that hearing aids completely restore hearing for their users. Other people with hearing impairments may use alternate forms of communication such as sign language, interpreters or lip reading. Ignorance or denial by AOD programs of these differences — like denial of AOD problems — decrease the likelihood of identifying problems, minimize the client's acceptance of special needs and reduce the probability of a positive treatment outcome.

Both the AOD system and the deaf services system contribute to the gap in services experienced by these potential clients by failing to understand each other's fields and issues. To correct this dilemma will require, according to Kearns:

- hearing impaired activists promoting the issue
- caring and concerned responses from society
- cross training between the alcohol and drug field and the deaf service field

Cramer (1989) suggests that consumption of alcohol may contribute to bullous changes in the lungs resulting in irreparable damage to the bronchials.

Given the all-to-frequent connection between traumatic injuries and disability, this issue of AHRW also included a report on NIAAA's symposium on "Post-Injury Treatment of Patients with Alcohol Related Trauma" held in Washington, D.C. in June of 1988. Participants were encouraged to take advantage of the crises presented in trauma units and emergency rooms to intervene with those who have alcohol or other drug problems.

As reported by Bradley (1989), 20-37% of admissions to acute care facilities involve excessive alcohol use. Trauma and ER staff need to develop and use measurements to determine whether dependence or abuse is the case, if for no other reason than to determine the amount of anesthesia to be used if surgery is necessary. A currently intoxicated, non-addict would need less anesthesia while even a sober alcoholic would require more. Medical staff should also be prepared for the occurrence of DTs during treatment of addicts forced into withdrawal by their injuries. Trauma and ER staff need to understand AOD intervention techniques since opportunities may present at any time.

Challenge

The issue of alcohol and other drug problems both for those who have disabilities and those who work in the field may be best summarized by a quote from Greer (1986). Speaking to the progress made by people with disabilities in leading independent lives, he warned that mainstreaming *is now being undermined by the presence of another more tragic disability, and this threat to their status must be met now. Failure to face the problems...would negate many of the advances achieved in the last two decades.* p. 37

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Appendix 16

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March 29, 1991