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ABSTRACT

This 1-year project identified several goals to increase the awareness of chemical abuse among older women, older adults, and disabled people. The goals included: develop an assessment instrument; identify chemical health service providers; develop a process to coordinate outreach and case-finding; develop a guide for chemical health service providers; provide a training conference; and convene an advisory committee. Project activities carried out to achieve these goals are described. Recommendations are offered concerning the development of a screening tool, training needs, and distribution of the project's products. Appendixes, which make up the bulk of the report, contain: (1) a literature review titled "Screening for Chemical Abuse in Three Populations: Older Adults, People with Severe and Persistent Mental Illness, People with Physical Disabilities" and descriptions of 10 screening and assessment instruments; (2) a report titled "Hazelden Screening Study: Report of Instrument Analysis" which examines the item analysis, reliability, validity, and selection of cut score for instruments designed by project staff to screen for chemical problems; (3) training materials on behavioral symptoms of chemical dependency, impact of chemical dependency on special populations, interviewing techniques, participant consent, and coordinated service delivery; and (4) copies of the project-designed screening tools and questionnaires to gather demographic information on participants. (JDD)

FINAL GRANT REPORT: CHEMICAL ABUSE AMONG OLDER WOMEN, OLDER ADULTS AND DISABLED PEOPLE

Prepared for the Chemical Dependency Program Division, Department of Human Services, State of Minnesota. Grant #93335. Prepared by Hazelden Foundation, Box 11, Center City, Minnesota, 55413. June 30, 1989.

GRANT ADVISORY COMMITTEE

JOHN CLAWSON
Minnesota Community Action Program

KATHLEEN ERHARDT, BA, CCDP
Lead Chemical Dependency Councelor
D.A.R.T.S.

HAL FRESHLEY, PhD
Sr Planner Region Eleven, Area Agency on Aging

MARY HOLMES, BSW
Admissions Director, Sage Crossing

NANCY HOULTON, ACSW
Mental Health Resources, Inc.

SHARON JOHNSON, MA
State of MN, Chemical Dependency Program Division

KURT KOEHLER, BA, CCDR
Planning Specialist, Ramsey County
Chemical Dependency Administrative Services

LORRAINE KOLLING
Social Service Worker, In-Home Supportive
Services
Catholic Charities

PAT PARCHEM, MA
Program Director, Kelly Institute

PEG REILLY, BA, CCDP
Program Director, Bridgeway

SHARON SCHASCHL, RN, CCDP
Program Coordinator, Abbott-Northwestern,
Chemical Dependency/Physical Disability Program

BARB SCHOMMER, RN
Supervisor, Ramsey County Public Health Nursing Service

DENNIS STRAW, CCDP
Consultant for Chemical Dependency/Physical Disability, Abbott-Northwestern, Chemical Dependency/Physical Disability Program

LOU TOWNER, ACSW
Supervisor, Ramsey County Pre-Admission Screening/Alternative Care Grants

SANDY VOGT, CCDP
Senior Counselor/Coordinator, Senior Chemical Dependency Program,
HealthEast

MARK WILLENBRING, MD, Veteran's Administration

CHEMICAL ABUSE AMONG OLDER WOMEN, OLDER ADULTS AND DISABLED PEOPLE

PROJECT STAFF

KATHLEEN M. GILMORE, MSW
Project Director

DONALD JONES, MA
Project Facilitator

DEBRA HOLE, BA
Researcher

JEAN SCHROEDER, MA
Training Coordinator

RENEE LEVEILLE
Video Producer/Director

MAUREEN CABLE
Project Secretary

PEGGY FISHER
Project Secretary

SHIRLEY CHRISTENSEN
Typist

PROJECT CONSULTANTS

KEN WINTERS, PhD
Research Consultant

RANDY STINCHFIELD, PhD
Research and Statistical Consultant

JAYNE FULKERSON, MA
Research Consultant

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INTRODUCTION

July 1, 1988 the State of Minnesota, Chemical Dependency Program Division awarded a grant to Hazelden entitled, "Increase Awareness of Chemical Abuse Among Older Women, Older Adults and Disabled People" This report summarizes the results of the one year grant project. The grant contract identified 7 goals. This report will highlight each goal, the tasks undertaken to accomplish the goals and the extent to which each goal was achieved.

GOAL ONE: Develop an Assessment Instrument

Goal one of the grant is aimed at developing a screening instrument for use with older adults and people with disabilities. Early in the project it was apparent that one screening tool would not meet the needs of older adults and people with physical and mental disabilities. Consequently, it was necessary to create three screening tools, one for each population group. Five tasks were completed to accomplish this goal.

Task #1 - Three literature reviews, one for each population group (older adults, people with mental illness, people with physical disability), were conducted to identify assessment factors relevant to screening for alcohol and drug problems within each special population. Search services included Drug Information Service, Index Medicus, Mini-Medline, Sociological Abstracts, Psychological Abstracts, Social Work Abstracts and numerous specialty national and university abstracting services.

Key findings from the Older Adult literature review revealed that housing problems, falls or accidents, poor nutrition, self-care, level of exercise, level of activity, losses, chemical related health problems are specific content areas and behaviors to be assessed by instruments screening older adults.

With the Mentally Ill population, the following factors were recommended for consideration in developing a screening process: vulnerability factors including self-medication issues and level of social skills; potential for drug interactions; use of a collaborative model; attention to differential diagnosis; items related not only to quantity/frequency of use but consequences of use; use of collateral sources.

Factors influencing screening for alcohol and drug problems in people with physical disabilities include assessors attitudes toward people with disability and their knowledge of various disabilities. In addition, interpersonal beliefs of the disabled person can prevent the screening process from occurring. The literature suggests the screening issues for a person with disability has less to do with the actual screening process and more to do with barriers preventing screening from occurring. Program barriers, architectural impediments, and language as a cultural barrier, are factors inhibiting the screening process.

The results of the literature reviews were taken into account in the development phase of the screening tool. In addition, the literature reviews were distributed to 400 participants of the grant workshops conducted in May, 1989. The literature reviews are located in Appendix 1.

Task #2 - Another method of identifying assessment factors relative to screening was utilized. Questionnaires were sent to 200 chemical dependency programs throughout Minnesota. Programs were asked to identify chemical dependency assessment issues specific to older adults and people with disabilities, as well as issues pertinent to women. The summary of program comments are located in Appendix 2.

Task #3 - To design and create an assessment tool, an expert consultant was hired. The consultant provided feedback on sample size, methodology, interview protocol, validity and reliability issues and attention to issues of elderly and disabled women. Three screening tools were developed for use with the following groups: older adults, people with mental illness and persons with physical disabilities. The tools were designed to be sensitive to women and men in each group. The tools were designed to be administered in an interview setting, with a professional asking the client the screening questions. Appendix 3 contains examples of the screening tools used in field testing.

Task #4 - A field testing process was developed and implemented to answer an initial set of research questions. Appendix 3 and 4 describe the field testing

results. Each field test site received training in use of the screening tool. Other training materials are found in Appendix 5.

The research questions addressed in the field testing are as follows:

Do experts familiar with the subject area of alcohol and drug problems perceive screening items to be appropriate to the domain of alcohol and drug problems?

This question was answered by forming an advisory committee of experts in chemical dependency and each population group. A set of screening factors/test items were identified through the literature reviews, through meeting with community representatives in each population group, and through the survey of CD programs. Nu-merous revisions were made to the set of screening questions for each population groups. Some items in the screen are adapted from CAGE and MAST items, while others are new. The expert advisory committee was asked to qualitatively judge the appropriateness of each item in the screening tool prior to field testing by reviewing, editing and giving feedback to grant staff. The final screening tools prior to field testing were deemed by the expert committee to be appropriate to the domain of alcohol and drug problems. The tools were considered to have content validity.

Are test scores related to criterion groups: in other words, does the screening tool differentiate between a known CD group and a control group?

To test concurrent validity, the extent to which the screen can differentiate between a CD group(experimental) and a non-CD group (control), group comparisons were examined by t-tests. The experimental and control groups were significantly different on the scale score of each of the three special populations. Further validity studies are recommended to look at comparisons of screening results with independent clinical ratings as to the need for a chemical dependency evaluation.

Is the screening tool useful to potential users? Is the screening tool feasible to use in an applied setting?

Utility is basically a test to assure the screen will be used. It refers to the extent to which the instrument looks like it measures what it is intended to measure. It is meant to assure it is acceptable to potential users. Utility concerns judgements about a test after it has been constructed. Feasibility, on the other hand, refers to the extent to which a test can be practically applied in a practice setting. To evaluate these issues, each screener completed a Feasibility/Utility questionnaire. The results, only highlighted below, can be found in Appendix 4.

In terms of usefulness, the majority of screeners believed it was important to ask a set of alcohol and drug screening questions during the assessment process. In addition, the majority of screeners
considered the screening questions to identify potential problems. A few screeners were not sure if the screening questions identified potential problems because their clients did not have obvious alcohol and drug problems. A number of screeners were not sure if their clients were responding truthfully. Overall the screening tool demonstrated feasibility. On the average, the tool was administered between 9 and 13 minutes. It took slightly longer, on the average, to administer the test to older adults. The older adult screening tool was slightly longer compared to the mentally ill or physically disabled tools. The majority of the screeners perceived the screening questions to be asked at the appropriate time during the assessment process. Overall the screeners did not report difficulty in asking the screening questions of their clients/patients.

Field testing of the instruments was conducted from November 14, 1988 to January 31, 1989 in urban and rural settings. Factors taken into consideration in field test settings included: urban versus rural location, type of client(public assistance, third party and private pay), representation of women. Each field test site received training on how to conduct the field test. Details of the field testing results can be found in Appendix 3.

Task #5 - The following adjustments were made to the screening tool after review of the test results and feedback from participating screeners:

a. Preliminary items were dropped from the older adult and physically disabled tools.
b. Items related to misuse of prescription medication were identified in the research results as not relating to the content of the other items. In light of the small sample sizes, it was determined more data needs to be collected before the decision is made to delete items from the screen.
c. A cut score of 4+ is recommended.

Revised screening tools can be found in Appendix 6.

GOAL TWO: Identify Chemical Health Service Providers

To accomplish this goal two tasks were completed. First, a telephone survey of treatment programs in the State of Minnesota was conducted. The purpose of the survey was to identify the extent to which programs met the individualized needs of the specific population group. The survey was drafted with input and critical feedback from the advisory committee. Examples of the data collection forms can be found in Appendix 7.

Secondly, the 104 completed surveys were compiled into a resource manual. The resource manual is a supplementary guide to CD programs in Minnesota. The audience or users of such a manual are intended to be human service professionals working with older adults, people with mental illness and people with physical disability. This manual was distributed to the 400 participants of the grant workshops. An example of the manual can be found in Appendix 8.

GOAL THREE: Process to Coordinate Outreach and Case-finding

To accomplish this task grant staff met with the advisory commitee on two occasions and identified steps to be taken by CDPD to work toward a coordinated service delivery system for the older adult population. Recommendations fell into 6 areas: Identification of Services, Raise Awareness of Older Adult Service Providers, Raise Awareness of Chemical Dependency Service Providers, Find Solutions to Identified Referral Problems, Factors to Maintain Dignity and Respect of the Older Adult Client. Specific recommendations to CDPD are highlighted in Appendix 9.

GOAL FOUR: Develop Guide for Chemical Health Service Providers
Under the recommendation of the advisory committee and Sharon Johnson, this task was redefined. Rather than create a schematic chart of a single county's available resources, a listing of CD program types and definitions was developed. In this way, the product would have more value to professionals across the state, rather than in one county only. This document was distributed at the 3 workshops. Participants informally identified this as a very useful tool, as the CD service delivery system was unknown to them. This document can be found in Appendix 10.

GOAL FIVE: Provide a Training Conference
One-day training workshops were conducted in St. Paul, Mankato and Grand Rapids. Over 400 individuals participated in the three workshops. Two-hundred and twenty-six individuals completed evaluation forms. Ninety-six percent of the respondents perceived the workshop helped them list the signs and symptoms of chemical dependency.Ninety-eight percent of the respondents indicated the workshop helped them identify chemical dependency in special populations.Ninety-seven percent of the respondents said the workshop helped them define the obstacles in the identification of CD in special populations. Ninety percent indicated the workshop helped them observe and practice the use of a population specific screening tool. The training materials can be found in Appendix 11.

Open-ended comments suggested the trainers were perceived as knowledgeable and articulate. Content of the workshop received positive feedback. Many participants would have preferred attending each of the three tracks rather than choosing only one track. Older adult participants were from clinical and non-clinical backgrounds: social workers, preadmission screeners, home health aides, housing professionals and gerontology workers. The training was geared toward clinical professionals. Dissatisfaction was expressed in the use of a screening tool with older adults by some of the groups representing older adults. Some thought it was intrusive, some thought the questions were illegal to ask in a HUD project. Further training on use of a screening tool should be targeted to specific clinical audiences.

Other training on recognition of alcohol and drug problems should be targeted to many of the other diverse older adult professional groups. Evaluation Results of the Grant Training can be found in Appendix 12.

Three videotapes were developed to accompany the training workshops. The videotapes include an introduction to the grant project, overview of population specific screening information, a role play and a wrap-up. The advisory committee evaluated the three videotapes and revisions were made based on the committee recommendations. The videotapes were well received during the workshops with the exception of the older adult tape. The role play on the tape used a housing example. One participant indicated that HUD would not allow the screening questions to be asked. It is recommended CDPD examine HUD rulings. After review of HUD law, the specific audience for use of the older adult videotape should be determined. The videotapes are enclosed in this package.

GOAL SIX AND SEVEN: Convene an Advisory Committee and Complete Required Reports

The advisory committee met on 6 occasions throughout the grant period to evaluate the extent to which grant staff were meeting grant objectives. Each session lasted two hours. Advisory committee members made themselves available beyond the 6 meetings. A large part of the success of the project can be attributed to the strong support of each advisory committee member. At each meeting, members kept the grant targeted on grant objectives, critiqued grant work and made recommendations for changes or modifications.

Summary progress reports and budget reports were submitted to the CDPD on a monthly basis.

RECOMMENDATIONS

The recommendation section of the report is divided into three parts: Research on Screening Tool, Training Needs, Distribution Plan.

Research on Screening Tool

The development of screening tools has been a focus of this grant. While field testing revealed adequate levels of credibility and usefulness, the small sample sizes and research issues raised in the pilot testing, dictate further study. After additional field testing, the State of Minnesota will be in a better position to recommend the use of the screening tools. Factors to incorporate in further screening tool development are identified below:

1. Sample size - It is recommended that a larger sample be collected for each population group. Samples approaching 100 in size would lend more credibility to the results. This can be accomplished by increasing the length of the data collection period.

2. Use of collateral sources - The issues of denial in older adults and lack of historicity in people with mental illness argue for the need to collect collateral information from a client's significant other. Further study should incorporate obtaining corraborating information from a client's significant other as well as from the identified client. Reliability of self-report data can then be examined.

3. Validity testing - While a form of concurrent validity was established in this study, the next step, with a largersample, would be to look at comparisonc of screening results with independent clinical ratings as to the need for a chemical dependency evaluation.

4. Inclusion of Physicians - Helping professionals from the social service delivery system (social workers, public health nurses) participated in the study. Other professionals involved in working with older adults, specifically physicians, should be considered for involvement in further validity and reliability testing/instrument development. Physicians are key actors in the delivery of health care to older adults, for example. With a trusting relationship already

established between the older adult patient and the physician, the issue of denial may not be as problematic in a screening process. Physicians also play a major role in the treatment of people with mental or physical disability, and are in excellent positions to ask screening questions.

Training

The grant project received a strong response for the training workshops held in May, 1989. Responses on the evaluations suggest a strong continuing need for training. It is recommended that the State of Minnesota continue providing training workshops on screening for alcohol and drug problems throughout Minnesota. The following factors should be incorporated into the workshop model demonstrated in Appendix 11.

Audiences - Future training should consider two audiences. The first audience consists of helping professionals with a clinical background. (The older adult workshops in May attracted clinical and non-clinical people, while the training content was directed towards providers with a clinical background.) These individuals are in a position to receive information on signs and symptoms of chemical dependency, screening methods, drugs and drug interactions, methods for intervening with family/significant others, the how to's of making a referral. Recommended areas of training for the second audience, a non-clinical audience, include: prevention model, medication management, medical complications/commonly prescribed medications, alcohol/drug interactions and effects, how to raise level of awareness in each population group, how to intervene.

Training Manual - It is recommended a training manual be developed specifically for the latter audience featuring didactic information and prevention techniques. This approach is also recommended for training the first audience. See section below outlining the Distribution Plan.

Addressing Needs of Rural Providers - The Chemical Dependency Program Division, no doubt, is already familar with facets of training in rural versus urban areas. Many of the rural providers work with each population group addressed in the grant, rather than with one group. Future trainings should attempt to accomodate the diverse needs of this audience. It was not uncommon to hear during our training in May that rural service providers would have appreciated attending all of the afternoon tracks rather than just one. Perhaps a conference model, over 2-3 days, could better meet the needs of the rural community of service providers.

Training for Providers working with Developmentally Disabled Consideration should be given to the development of training professionals working with this population. A number of programs, including the Minnesota Association of Retarded Citizens, perceive a strong need for assistance in recognizing and treating alcohol and drug problems.

Audience Development - In the development of this grant project it became apparent that the chemical dependency field is in its infancy in addressing the needs of some specific special populations. Professional groups representing special populations, on the other hand, may experience a lack of understanding and awareness of the problems of chemical dependency. One explanation of this dynamic is that the CD field does not know the special population groups and vice versa. For the chemical dependency field to impact the older adult, the mentally ill or physically disabled communities, it is necessary for the CD delivery system to know the delivery system of each of the special population groups. It is recommended, prior to further training, that the State further identify the specific audiences it is attempting to reach and then gear training specifically to meet those needs. Identifying audiences can be facilitated by working closely with departments across the Department of Human Services, outside of the Chemical Dependency Program Division.

Distribution Plan

This grant developed the following major products: population specific literature reviews, Minnesota resource directory, model for coordinated service delivery system, screening videotapes. It is recommended these products be nested in a training package as described below. In addition to a training package, each product, with instructions on use, can be distributed individually to human service providers throughout the state.

A training package would ideally be made available to each county human service department within the state. Each county would typically have more than one audience for whom the training package would be most appropriate, eg/ public health nurses, social workers, older adult services, etc. The CDPD, or its contracted agent, could offer technical assistance to county training staff in unfolding the training throughout the human service department.

The training package would be self explanatory with information on training the trainer as well as the training content. A sample of the sections to be included in a training package are highlighted below. Each section of the training package would be complete with the following pieces:

- Didactic information to be communicated to audience
- Pointers for Trainers
- Issues to Raise in Training
- Recommended method for training (lecture, role-play, dyad, question/answer, panel, small group interaction, videotape, etc)
- Training tools: handouts, overheads, videotape, etc.

The actual sections of the training package, to be distributed throughout the state, would include the following: (not necessarily in order of importance)

Section One:	Need and Demand for Chemical Dependency Services
Section Two:	Manifestation of Chemical Abuse and Dependency in the special population: Signs and Symptoms
Section Three:	Outreach and Casefinding Methods
Section Three:	Medication Management

Section Four:	Drugs and Interaction Effects
Section Five:	Prevention Model
Section Six:	How to Screen for Potential Alcohol and Drug Problems
Section Seven:	Intervention Options for Service Providers
Section Eight:	Working with Families and Significant Others

In terms of the actual screening tools, it is recommended that after further validity and reliability testing, a brief instruction guide be developed. Distribution of this product would follow further testing.

SCREENING FOR CHEMICAL ABUSE IN THREE POPULATIONS: OLDER ADULTS, PEOPLE WITH SEVERE AND PERSISTENT MENTAL ILLNESS, PEOPLE WITH PHYSICAL DISABILITIES

Hazelden Foundation

Planning & Evaluation Division

August 28, 1988

Prepared for: Minnesota Department of Human Services, Chemical Dependency Program Division, Grant #93335 -- Increase Awareness of Sevice Providers of the Chemical Abuse Among Older Women, Older Adults and Disabled People.

CONTENTS

INTRODUCTION

The State of Minnesota, Chemical Dependency Program Division, funded a grant to raise the awareness of alcohol and other drug problems among special populations. The three populations addressed in the grant include the older adult, people with mental illness and people with physical disabilities. Part of the grant was devoted to identifying or developing chemical abuse screening tools to be used by professionals who do not have a background in chemical dependency. In a search for appropriate screening tools for use in Minnesota, the following criteria were defined as important:

- The screening tools were to address women's issues.
- The screening tools were to be easily incorporated into the assessment process of human service or health care professionals.
- The screening tools were to be capable of producing credible and useful information.

The literature regarding chemical dependency and each special population group was reviewed to help tease out salient factors in the screening of chemical abuse. Grant project staff also reviewed the literature to learn about current assessment instruments being used for alcohol and other drug problems.

The following writing is divided into four sections. The first three sections highlight finding related to chemical dependency and each population group. The fourth section briefly describes current screening and assessment instruments identified in the research literature. As a caveat, you will notice in the literature review

that alcohol is described as a drug, or in other words, one of the number of mood-altering chemicals. Chemical dependency is a term used to describe a dependency to alcohol or other drugs.

On a final note, this literature review is intended for audiences across disciplines, that is, for professionals in the chemical dependency service delivery system as well as professional service providers in each population group. The authors are aware that each professional discipline may know very little about the other discipline. With this in mind, some of the readers may find this a time for different disciplines to come together and learn more about each other's approaches and fields of practice. Since the audience for this document is quite varied, concepts presented in the literature review may range from appearing simple to being perceived as complex. The authors encourage you to take in the information most useful to your practice setting.

Kathleen M. Gilmore, MSW
Project Director

SCREENING FOR CHEMICAL ABUSE IN OLDER ADULTS

Ken C. Winters, Ph.D. and Randy D. Stinchfield, Ph.D.

Introduction

Although it often goes unnoticed, chemical abuse does exist among older adults. In Minnesota, it is estimated that there are approximately 8,000 older adult men and 3,000 older adult women who experience significant problems with alcohol and other drug abuse. In light of the growing population of older adults, it may be expected that this problem will continue to increase. Alcohol abuse (and chemical abuse in general) has been referred to as the greatest "untreated treatable" disease of our time (Vaillant 1978).

The first step toward treatment of alcohol and other drug abuse is the detection of the problem. Early detection and treatment of chemical abuse is likely to decrease chemical-related morbidity and mortality (Cyr and Wartman 1988).

Lack of Detection

Chemical abuse in older adults often goes undetected (Gomberg 1982; Williams 1984). This lack of detection occurs for a variety of reasons. First, some older adults with chemical abuse problems are less involved in the mainstream of life, and this lack of contact with people and social systems decreases the chances of their problem being detected. Older adult chemical abusers tend not to exhibit the more conspicuous problems that clinicians and the community have come to recognize as indicators of chemical abuse. For example, older adult chemical abusers are less likely than other chemical abusers to be

arrested for a DWI (Driving While Intoxicated), to have contact with the police or criminal justice system, or to have job or school-related chemical problems. Second, the symptoms of chemical abuse in older adults often mimic or resemble other conditions that afflict older adults such as dementia. Third, some health care providers may not know how to assess someone for the presence of alcohol or other drug abuse. Fourth, it is thought that the attitudes of some health care providers hinder the detection of chemical abuse among older adults. These attitudes include the beliefs that older adults would not benefit from treatment, that drinking is one of their last pleasures and should not be taken away from them, and that it would be too embarrassing for an older adult to be asked about their chemical use.

The Use of Instruments to Screen for Chemical Abuse

The detection of alcohol and other drug abuse often relies on the use of screening instruments. There are a number of studies which indicate that screening for chemical abuse with brief assessment instruments can be an efficient and effective procedure for identifying people with chemical abuse problems (Beresford et al. 1984; Cyr and Wartman 1988; Leckman, Umland and Blay 1984; Sherin et al. 1982). These studies indicate that asking simple questions about chemical abuse can be useful in determining whether further assessment of a person's chemical use is warranted.

There is widespread interest in the detection and assessment of chemical abuse and a number of instruments have been developed for this purpose. These instruments include: (1) Addiction Severity

Index (McLellan et al. 1980); (2) Alcohol Clinical Index (Skinner and Holt 1987); (3) Alcohol Use Inventory (Wanberg, Horn and Foster 1977); (4) CAGE Questionnaire (Mayfield, McLeod and Hall 1974); (5) Drinking Behavior Interview (Shelton, Holister and Gocka 1969); (6) Drug Abuse Screening Test (Skinner 1982); (7) Michigan Alcohol Screening Test (Selzer 1971); (8) Minnesota Assessment of Chemical Health (Kincannon 1984); (9) Stages Index (Mulford 1977); and (10) Unitary Alcoholism Factor (Overall and Patrick 1972).

Some of these instruments were designed only to detect the presence of chemical abuse, while others provide a more detailed description of the extent and nature of a respondent's chemical use. Please see the appendix for a detailed description of each of these instruments. A careful review of these instruments indicates that most of them assess alcohol abuse alone and most have been standardized on nonolder adult males.

Although there is a growing interest in screening for chemical abuse among older adults there are no screening instruments available that are designed specifically for the identification of alcohol and other drug abuse in older adults. One review of current instruments, as they apply to identifying alcohol abuse in older adults, concluded that these instruments are inappropriate for use with older adults because they were standardized on nonolder adult men and because the content of these instruments does not always apply to older adult populations (Graham 1986). There is a need to improve the detection of chemical abuse among older adults.

Challenges in Screening Older Adults

The detection of alcohol and other drug problems in older adults poses several challenges to the assessor. Some of these challenges have already been discussed above such as older adults not often exhibiting conspicuous signs of alcohol and other drug abuse. Additional challenges include problems of self-report and appropriate detection criteria.

Self-Report Method

In evaluating for chemical abuse, use of the self-report method, while a desirable assessment strategy, may not always yield valid information. This is particularly true when respondents employ defense mechanisms of denial and minimization. Some experts contend that denial of chemical abuse is greater among older adults than among other age groups because many older adults were raised during a period in which drinking and other drug use was stigmatized (Graham 1986). They may be reluctant to admit to even limited consumption.

Some older adults may also give inaccurate information on their level of use and any problems associated with that use for fear that a significant source of pleasure and/or relief, their use of chemicals, will be taken away from them.

In addition, some older adults may experience serious problems with memory and cognitive functioning. Memory/cognitive problems can interfere with the respondent's ability to provide accurate information. Some assessment instruments require fairly complex cognitive processing such as the ability to calculate an average

consumption or to recall detailed information. Some older adults may have problems recalling recent alcohol or other drug consumption because they have few regular events, such as a job, to help structure their recent memory. These memory/cognitive problems may prevent the use of self-report questionnaires, thus forcing the assessor to rely on information from others or on direct observation of substance abuse problems.

Appropriate Detection Criteria

While there is some research to support the view that there is continuity between adult and older adult chemical dependency (Christopherson, Escher and Bainton 1984; Janik and Dunham 1983), important differences may be present. The social and economic lifestyle of older adults may represent important differences from the nonolder adult world. Thus, nonolder adult norms and criteria for chemical dependency, both in terms of consumption levels and clinical signs and symptoms, may not apply to an older group. Many formal diagnostic criteria are related to work, social, legal, personal and family problems stemming from chemical use. Since older adults may no longer have the same responsibilities and obligations of nonolder adults (they may be retired, or live alone or may not own a car), standard nonolder adult criteria for abuse/dependence may be less relevant.

There is also the issue of different types of chemical dependency in the older adults. Three subtypes of alcoholism in the older adults have been hypothesized and described (NIAAA 1982): (1) lifetime (current or in remission); (2) intermittent; and (3) late onset. If

assessment is not sensitive to onset and course variables, some older adults might be assumed to have a current problem when they may be recovered, or some might be assumed to not have a problem when, in fact, they may have an intermittent problem.

Because older adults as a group consume large amounts of prescribed medications they are at a greater risk of misusing these medications. Screening for chemical abuse among older adults needs to include the abuse of prescribed medications, as well as alcohol and illicit drugs.

An additional problem is that the symptoms of some disease processes in older adults may resemble symptoms of chemical abuse. Although it would be useful if a screening instrument could distinguish these two processes, it is neither likely that a self-report screening instrument would be able to distinguish these two phenomena, nor should it be expected of a screening instrument to make such a fine-tuned differential diagnosis. This process of differential diagnosis would best be conducted with further assessment procedures after the question of chemical abuse has been raised by the screening instrument.

In a study of alcohol and other drug abuse among older adults, Brown and Chiang (1983) found that a higher percentage of abusers than nonabusers were separated or divorced and that abusers not in treatment were more likely to be living alone than their nonabusing cohorts. The implication of this study is that marital status and living situation (alone vs. not alone) is associated with substance abuse.

A number of authors have suggested specific content areas and behaviors in an older adult's life which should be addressed when screening for chemical abuse (Caroselli-Karinja 1985; Graham 1986; Williams 1984). These specific behaviors have been highlighted because they are often associated with alcohol and other drug abuse and thus raise a question of the presence of chemical abuse.

These suggested areas include: (1) housing problems (evictions); (2) falls or accidents; (3) poor nutrition (missing meals); (4) inadequate care of self, clothing and home; (5) lack of physical exercise; (6) social isolation (avoiding friends and family); (7) loss of interest in normal activities (hobbies, family); (8) spending more time with drinking friends and spending more money on alcohol; (9) loss of effectiveness of medications; (10) loss or other life changes (retirement, death of loved ones, or change in living arrangements); and (11) chemical-related health problems (liver disease and ascites). All of the above specific content areas and behaviors should be assessed by instruments screening older adults.

Strategies for Screening Older Adults

In light of the absence of elderly-specific screening instruments, the question of how to screen for alcohol and other drug abuse among older adults arises. A recent study has suggested at least one strategy in addressing this question.

Although there is some controversy about whether current screening instruments are appropriate for use with older adults (Graham 1986), one group of investigators used a current instrument to assess alcohol abuse in older adult men (Willenbring et al. 1987).

These investigators found the Michigan Alcoholism Screening Test (MAST) to be effective in discriminating older adult male alcoholic patients hospitalized for alcohol treatment, from older adult nonalcoholic patients hospitalized for nonalcohol-related medical reasons (Willenbring et al. 1987).

The question arises: What are the possible strategies to address the absence of a screening instrument for the identification of chemical abuse in older adults? There are at least three strategies which could be implemented: (1) employ a current instrument with older adults; (2) revise a current instrument to make it more appropriate for an older adult population; or (3) develop a new tool designed specifically for older adults.

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SCREENING FOR CHEMICAL ABUSE IN PERSONS WITH SEVERE AND PERSISTENT MENTAL ILLNESS

Debra Hole, B.A.

Introduction

The coexistence of substance abuse problems and psychiatric disorders has been described in the literature for many years, yet information on the actual incidence of coexisting substance abuse and psychiatric illnesses, and on how to identify and treat people with this type of dual-diagnosis is scattered and limited. In addition, several different terms have been used to describe this group of people and the same terminology can have different definitions depending on which research you are reading. For example, sometimes the term "dual-diagnosis" or "mentally ill chemical abuser" is used to refer to people suffering from chemical dependency and what may be transient and mild emotional disorders such as anxiety attacks, while at other times the term is used to describe people suffering from chemical dependency and more severe persistent mental illnesses such as schizophrenia.

The focus of this report is on those people suffering from "severe and persistent" mental illnesses who also have substance abuse problems. Specifically, this report will discuss the prevalence of substance abuse in people with severe and persistent mental illness, the reasons why they may be especially vulnerable to the use of mood-altering chemicals, and the difficulties present in identifying substance abuse in this population.

Proposed amendments to the Minnesota Comprehensive Mental Health Act of 1987 define "severe and persistent" mental illness as:

> persons diagnosed as having schizophrenia, bipolar disorder, major depression, or borderline personality disorder who have a significant impairment of functioning and who either have had periods of psychiatric hospitalization recently or are likely to have such episodes in the future unless an ongoing community support services program is provided (Flanigan 1988, 1).

The term substance abuse refers to the use of mood-altering chemicals, including alcohol -- street drugs, prescription drugs and over-the-counter medications -- which results in adverse consequences for the user. These consequences can be: legal (driving while intoxicated, theft, vandalism), familial (divorce, domestic abuse), social, medical (cirrhosis, pancreatitis, high-blood pressure) or school/employment problems.

Lifestyle

Although people with severe and persistent mental illness are by no means a homogeneous group, they have several characteristics common to many of them which influence their lifestyle and their ability to function independently in society. Some of these characteristics will be described here because they may also have an impact on the vulnerability of this population to substance abuse, as well as on our ability to recognize and treat their substance abuse problems.

Typically, the onset of severe mental illness occurs when a person is in their early 20's. While their peers are struggling with the usual developmental tasks of young adulthood such as establishing

an identity and seeking job training and satisfying work, people who begin experiencing symptoms and episodes of a major illness such as schizophrenia will have a much more difficult time attending to these same developmental tasks. An episode of mental illness may disrupt their job training and they may lose friends and family who are not able or willing to tolerate their "different" behavior. While a peer might be busy establishing their identity and learning to live independently from their family, a person being treated for a major psychotic episode may need to focus all their energy on coping and adjusting to their illness. As a result, people with severe and persistent mental illness do not often have the skills to support themselves, develop meaningful social relationships, or care for themselves independently (Pat Parchem, interview, 8 July 1988).

In the era before the deinstitutionalization movement, these issues did not cause as much difficulty for people with severe and persistent mental illness as they now do. Before the creation and widespread use of psychotropic medications, people with severe and persistent mental illness would have spent most of their lives in psychiatric institutions. These facilities provided for patients' housing, medical care, nutrition, material needs and daily activities. Life in an institution also meant life in a structured, supportive environment, away from outside pressures and expectations. A person's identity as a patient was also clearly established, giving patients a defined role with definite expectations (Minkoff 1987). People who were destined to spend a major portion of their lives in institutional settings did not need to establish their own identity,

find satisfying relationships, or develop social or job skills.

Although the intent of the deinstitutionalization movement was to offer a more humane lifestyle to people with severe and persistent mental illness, adequate programming has not been available in the community to assist them in attaining the highest level of functioning possible. As a result, people with severe and persistent mental illness who did not have the opportunity to develop survival skills because of the onset of their illness, are thrust into the community to navigate through an often uncoordinated system of community care.

Some people can get lost in the system and not have anyone to provide consistent monitoring and support. Without this support, a person can deteriorate in their ability to function, yet may not come to the attention of the social service system until their situation is at a crisis point. It is more costly and time-consuming to intervene since their deterioration has become so serious (Flanigan 1988). In an attempt to provide these people with a more humane existence, society relinquished control over their activities; and despite good intentions, "loss of control over the life circumstances of patients diminishes care." (Mechanic and Aiken 1987)

The development of psychotropic medications has improved the lives of people with severe and persistent mental illness by moderating their symptoms to the extent that they can remain in the community and have a better opportunity to function as others do. Unfortunately these medications do not cure mental illness, they can only lessen the severity of the symptoms and the probability of relapse. In fact, professionals estimate that 40% of people with

schizophrenia who are discharged from the hospital will suffer a relapse within two years, despite their continued use of psychotropic medication (Flanigan 1988). In addition, many of the psychotropic medications produce side effects which make them very unappealing to take. For example, people taking an anti-psychotic medication such as Thorazine can experience muscle stiffness, blunted affect, slowed speech and tardive dyskensia. Also, although anti-psychotics can partially control delusions, hallucinations and bizarre behavior in schizophrenia, they do not help the emotional and social withdrawal also associated with the disease (Goodwin and Guze 1984).

Deinstitutionalization has had an effect both on people with extensive histories of long-term institutionalizations and on younger people whose onset of mental illness occurred after the deinstitutionalization movement. The difference in how these two groups have adapted to their new roles has been significant enough for professionals to discuss the appearance of a different type of client, often referred to as the "young chronically mentally ill." Generally the age range for this group is defined as 18 to 40 years old. This group although not homogeneous, may differ from their older counterparts in several ways, ways which may also influence their use of mood-altering chemicals and our ability to recognize and treat their substance abuse issues.

Since these "young chronic" patients are institutionalized less often and for shorter stays than their older counterparts, they are less willing to accept the label of mental patient. Although this lack of labeling was an intention of the deinstitutionalization

movement, it results in serious consequences for this group. They are less accepting of their need for ongoing medication for their mental illness, and do not believe they are impaired enough to need consistent support by the community services provided for them (Pepper, Kirshner and Ryglewicz 1981). As a result, they are often characterized by their use of services in a "revolving door" fashion and they also have difficulty realizing that their use of mood-altering chemicals is more dangerous for them than for their peers (Pepper et al. 1981). Thus, high rates of substance abuse are often found in younger people, and some have postulated that their use of mood-altering chemicals is the characteristic which most separates them from older people suffering from the same mental disorders (Safer 1987).

Prevalence of Substance Abuse

The reported prevalence of substance abuse in people with severe and persistent mental illness varies across studies due to different research designs and a lack of standard definitions. Thus it is difficult to generalize from the information in any of these findings to accurately describe the prevalence of substance abuse in people with severe and persistent mental illness. However, despite these limitations, it seems clear that substance abuse problems occur frequently in people with mental illness, and is an issue which requires closer attention.

Appendix A shows summary of the findings from selected studies describing substance abuse in psychiatric populations. The percentage of psychiatric patients with a history of substance abuse ranges from

18 to 73% in these studies. Estimates of current substance use or abuse range from 9 to 76%. Also of note is the number of homeless people that are victims of both severe mental illness and substance abuse. In a study of homeless people on skid row in Los Angeles, Breakey (1987) found that 16% were chronically mentally ill substance abusers.

Vulnerability Factors

Although people suffering from severe and persistent mental illness are exposed to the same risk factors for substance abuse that all of us are, there may be unique risk factors for them which make them an exceptionally vulnerable population.

Self-Medication One risk factor which may be unique to this population is that they may use mood-altering chemicals to self-medicate either their psychiatric symptoms, or the side effects of psychotropic medications.

Since psychotropic medications do not relieve all the symptoms of a psychiatric disorder, some people may use mood-altering chemicals to relieve some of the remaining symptoms. For example, Treffert (1978) reported that schizophrenics are at a particularly high risk for using marijuana when they are experiencing the depression that follows a major psychotic episode. Alcohol can relieve muscle tension and the often severe anxiety experienced by schizophrenics (Daley, Moss and Campbell 1987). Hall, Stickney, Gardner, Perl and LeCann (1979) reported that about half of the patients in their study began to abuse chemicals in an attempt to self-medicate after the first appearance of their psychiatric problems.

The side effects of psychotropic medications can also be so aversive that even though the medication is helpful in relieving some of the psychiatric symptoms, it is still very difficult for someone to motivate themselves to remain on the medication (Pat Mitchell, interview, 7 July 1988). In a study of marijuana use by schizophrenics Knudsen and Vilmar (1984, 173) concluded that "treatment with neuroleptics may be 'too effective,' in the sense that hallucinations and delusions may be suppressed to such an extent that the patient feels empty, joyless, inactive and unimaginative." The patients in their study reported that their use of marijuana seemed to suppress these undesirable side effects.

In addition, people taking medication for a severe and persistent mental illness may have sincere difficulty in understanding the difference between "good" drugs and "bad" drugs. McKelvy, Kane and Kellison (1987) describe the paradox these people face. Clients with a severe mental illness are told to take their prescribed psychotropic medication regularly. Many of these people can easily describe the reasons they would prefer not to take their medication: the unpleasant and stigmatizing side effects, the constant reminder that they are different, and the inability of the medication to provide a sense of well-being. However, although they are told not to use alcohol, marijuana and street drugs, they can easily identify benefits from these forbidden substances, benefits that may even relieve the same symptom as a prescribed medication.

Social Factors Since people with a severe and persistent mental illness have not often had a chance to develop social skills and

satisfying interpersonal relationships, they may find forbidden substances that facilitate this process attractive. A bar may be the most social place for these people, and sharing alcohol or other drugs can provide them with a way to fit in. Their "weird" behavior may also be less noticeable in a setting of substance abusers and they may be ridiculed less often for being different (Pat Parchem, interview, 8 July 1988).

Also, since people with mental illness often reside in areas of high crime and poverty, they may be exposed daily to substance abuse in their environment and thus have easy access to illegal substances. One unfortunate result of the deinstitutionalization movement may be that these people, in an attempt to normalize and fit in with the community, develop the same maladaptive behaviors their peers do, including substance abuse. Bachrach (1986-87) thus feels that although some use drugs to self-medicate, the primary reason may be "to be a part of a peer group."

Substance abuse may also provide an identity for people who haven't had an identity other than that of mental patient. As Minkoff (1987, 948) stated, "for many, it is preferable to acquire the identity of an alcoholic or drug addict rather than that of a mental patient."

The Dangers of Substance Abuse

In addition to being uniquely vulnerable to substance abuse, people with mental illness can experience a multiplication of the negative effects of substance abuse. Although all people who abuse chemicals and all people who suffer from mental illness are vulnerable

people, the danger for those with both disorders is much higher. Both mental illness and substance abuse diagnoses carry with them a powerful societal stigma, a potential suicide/ violence risk, a high relapse rate, and severe impairment of family and social relationships. Overall quality of life is often extremely poor. It is our experience that having both problems in effect multiplies the risk and the impairment. (McKelvy, Kane and Kellison 1987)

In fact, since the risks of substance abuse are multiplied for this population, it has been suggested that the usual levels of frequency and quantity of substance use which indicate abuse may not be appropriate for this population. Since substance abuse may exacerbate psychiatric symptoms and complicate the process of identifying and treating the problem, it may be that any level of use could qualify as abuse (Ridgley, Goldman and Talbott 1986). Some of the difficulties substance abuse can cause in the severely and persistently mentally ill are described below.

Interactive Effects Since a majority of people in this population are taking psychiatric medication to help control their symptoms, interactive effects between a prescribed medication and alcohol or other nonprescription drugs can result in negative effects or even decompensation.

Alcohol If alcohol tolerance develops, the response to psychotropic medication will be altered since alcohol and the psychotropics both affect neurotransmitter receptor sites. Similarly, alcohol and

anti-psychotics both interfere with the brain's body temperature regulation, and people under the influence of both substances will have difficulty adjusting their body temperature. Also, people taking prescribed tranquilizers with alcohol will experience an increased sedative effect since alcohol is also a CNS depressant (McBride 1988).

Marijuana Marijuana use has, even in small doses, been found to exacerbate schizophrenic symptoms in people whose symptoms were well controlled with medication (Treffert 1978). Knudsen and Vilmar (1984) have hypothesized that marijuana acts as an antagonist to neuroleptic medication, therefore limiting the effectiveness of the prescribed medication. Another direct result of marijuana use is a motivational syndrome which will only add to the withdrawal experienced in schizophrenia.

Stimulant use such as with cocaine can also cause an exacerbation of psychotic symptoms since stimulants increase the activity of the neurotransmitters thought to be involved in psychotic symptomology (McBride 1988).

The danger of these interactive effects is described by Hall, Popkin, DeVaul and Stickney (1977) who found that in psychiatric outpatients, those who were covertly using drugs had a higher prevalence of adverse reactions attributable to the interaction of their prescribed medication with the illegal drug than their counterparts who were not abusing drugs. The highest rates of adverse reactions occurred in clients using barbiturates (50%), or

amphetamines (50%), or who were poly-drug users (44%).

Misdiagnosis In addition to dangerous interactive effects between prescribed medications and forbidden substances, unrecognized chemical use can make proper diagnosis and treatment difficult. Unacknowledged chemical use can result in a misdiagnosis since the symptoms of psychiatric illnesses and substance abuse problems can closely resemble each other.

For example, social withdrawal can result from the use of depressants or from psychosis. Hallucinations can happen when someone is in a psychotic state or after they've become intoxicated from alcohol. Hall et al. (1977) found a significant difference in the level of misdiagnosed schizophrenia between groups of abusers and nonabusers; they reported that 85% of the population who were covertly abusing drugs were misdiagnosed. All of the abusers failed to meet diagnostic criteria for schizophrenia, in contrast to only 14% of the non-abusers.

On admission, patients who were later determined to be covert abusers often complained of "anxiety, social incapacitation, life-space disruption, and feelings of alienation" which the authors felt led clinicians to diagnose schizophrenia without further exploration due to a fear that the patient would decompensate (Hall et al. 1977). Safer (1987) also found that,in his sample of young chronic patients, misdiagnosing substance abuse as schizophrenia or bipolar disorder was not uncommon and in each case of misdiagnosis, the psychotic episodes appeared only in relation to substance abuse.

Snyder, Pitts and Pokorny (1986) reported that the irritability,

restlessness, hostility, and brief psychotic episodes found in borderline people may be from their incomplete detoxification from drugs rather than simply from an underlying personality disorder or syndrome. This distinction is crucial since people with borderline personality traits have a high liability towards substance abuse (Snyder 1980).

Due to the high probability of misdiagnosis, most experts suggest that if a person is under the influence of alcohol or other drugs, they should be observed for at least two weeks before a final determination is made on any psychiatric symptoms. Even when someone has already been diagnosed with a psychiatric illness it's important, in any instance of decompensation, to consider the possibility of substance abuse in order to provide the most effective treatment possible.

Increased Treatment Failure Misdiagnosis can lead to inappropriate treatment plans and, as a result, substance abusers may have more difficulty in either maintaining their current level of functioning or increasing their ability to live in the community. There are numerous citations in the literature to confirm this suspicion. For example, one study found that patients who were drinking while hospitalized for psychiatric problems had a higher rate of treatment management and drinking related problems that interfered with their treatment than their nonproblem drinking counterparts (Alterman, Erdlen, McLellan and Mann 1980). Differences in treatment compliance between covert abusers and nonabusers were compared and the abusers had more cancelled appointments, were more often referred to

another therapist, terminated treatment on their own more often and had more medications prescribed for them (Hall et al. 1977).

Reports also exist on young, chronic patients whose treatment was complicated by substance abuse. Safer (1987) reported that young patients who persistently used chemicals had "an annual rate of psychiatric hospitalization two to three times greater" than a similar group of nonusers. Solomon and Davis (1986) tracked patients after their discharge from state psychiatric facilities to measure their use of services after their discharge. They found that those assessed as needing alcoholism services were significantly less likely to make contact with any of their aftercare services. This group also had fewer days of contact with community mental health centers. Their findings also suggest that patients with alcoholism problems are likely to be readmitted to a hospital more quickly than nonabusing patients. Richardson, Craig and Haugland (1985) conducted a retrospective, longitudinal study of service utilization by young chronic schizophrenic patients. They found that drug abusers experienced significantly more inpatient psychiatric admissions, although these admissions were of shorter duration.

In contrast, people who receive concurrent treatment for their substance abuse and their psychiatric disorder may have a better prognosis. People treated in a pilot outpatient program which uses both substance abuse and psychiatric treatment techniques spent fewer days in the hospital after beginning the pilot program in comparison to their hospitalization rates before the program. (Kofoed et al. 1986).

Why Substance Abuse is Unrecognized

Unfortunately, despite the higher rate of substance abuse in people with severe and persistent mental illness, and despite the increased danger for people suffering from both disorders, substance abuse is too often an unrecognized problem in this population. This section describes some possible factors which may influence the lack of attention to substance abuse in people with mental illness.

Frequency of Unrecognized Substance Abuse Several of the research studies reviewed in Appendix A provide examples of how often substance abuse may go unrecognized in people being treated for psychiatric conditions. In fact, although subjects in most of these studies were prescreened to eliminate substance abuse, closer questioning or chemical analysis of blood or urine revealed previously unfounded use.

Hall et al. (1977) found, by the use of urine screens, that 13% of psychiatric outpatients were abusing drugs. In a later study of psychiatric inpatients not initially diagnosed as drug abusers, Hall et al. (1979) determined, through questionnaires and interviews, that 58% had a history of substance abuse. Rockwell and Ostwald (1968) used urine screening to determine the rate of concealed stimulant use in psychiatric inpatients. Only 50% of the subjects with stimulant traces in their urines had revealed their use during routine questioning. McLellan, Druley and Carson (1978) discovered that only 50% of their sample of psychiatric inpatients with a history of substance abuse problems had reported these problems to staff at the time of admission.

Similar Symptomology One large factor which may lead to the lack

of recognition of substance abuse is that it may be difficult to distinguish psychiatric symptoms from symptoms of substance abuse. Thus, if a clinician is not aware of this duplicity, a problem may be treated as a psychiatric symptom while the substance abuse goes unrecognized and untreated. Although an exhaustive discussion of the factors involved in making a differential diagnosis between substance abuse and psychiatric symptoms is beyond the scope of this review, I will discuss a few examples to illustrate and underline the importance of considering substance abuse as a probable cause for an exacerbation of psychiatric symptoms or a lack of treatment success.

For example, a professional who is not aware of the symptoms of a physical dependence on chemicals such as loss of appetite, sleep disturbance; tremors and forgetfulness may mistakenly identify these as symptoms of a psychiatric illness (Mulinski 1988). A disheveled appearance to the point of self-neglect may be due to a client's focus on the attainment and use of mood-altering chemicals, or may indicate psychotic impairment. Auditory hallucinations can be found in both schizophrenia and alcohol hallucinosis (Daley et al. 1987).

It may also be difficult to notice changes in social functioning in people who already experience these problems because of their psychiatric symptoms. Since, for example, clients with character disorders frequently have problems in interpersonal relationships, it may be difficult to spot a relationship problem caused by their substance abuse (Mulinski 1988). People who have been suffering from psychiatric symptoms for many years may have already lost touch with family members, or have difficult relationships with them, thus any

problems in these relationships due specifically to substance abuse may be difficult to identify (Pat Parchem, interview, 8 July 1988).

Lack of Training of Mental Health Professionals Another factor contributing to unidentified substance abuse problems in people who are severely and persistently mentally ill is that the professionals who have the most contact with this group do not usually have training in how to recognize substance abuse in their clients. Graduate or professional training for social service workers may only offer alcoholism education as an elective (Googins 1984). As a result, the background of the intake interviewer and program staff can determine which problems get addressed. If the substance abuse is not obvious, the professional may focus on the more familiar psychiatric aspects of the problems and miss entirely the effect substance abuse had on the problem (Mulinski 1988).

Staff people who are not trained in how to recognize substance abuse may also feel uncomfortable questioning clients about their use of mood-altering substances. Professionals who are not experienced in asking detailed questions about chemical use and it's complications are often afraid to ask too many questions; they fear being intrusive. Staff may also hesitate to ask about chemical abuse because they may not know what steps to take if a chemical abuse problem does exist, and may feel they don't have the time to address another issue. If the client is also unaware that chemical use is causing or complicating their problems, and doesn't give any verbal clues to the professional, the professional may entirely miss the chemical connection and place all blame on the psychiatric illness

(Mulinski 1988).

Often, questions about substance abuse may not be asked at all or may not be asked beyond an initial probe. Googins (1984) randomly surveyed social work agencies in the Boston area and found that only 40% of the agencies included questions about alcohol use as part of their intake process. Even if clients are routinely asked if they use mood-altering chemicals, more detailed, respectful questioning may be required to identify an issue that the clients themselves may not identify as a problem.

Client Issues Most of our knowledge on identifying substance abuse is based on an individual's ability to associate their chemical use with adverse consequences. As an alternative, those people close to a substance abuser who observe behavior changes can also supply evidence of a chemical problem. However, for people with severe and persistent mental illness, it may be more difficult to obtain information on adverse consequences.

First of all, people with mental illness may not be able to accurately recount how much and how often they use drugs or alcohol; not necessarily because they are "in denial" but because they cannot remember. Likewise, since many people with severe and persistent mental illness also experience a lack of historicity, they may not associate their chemical use with the negative side effects they've experienced (Pat Mitchell, interview, 7 July 1988). People who have been suffering from a mental illness for many years, may no longer have any close friends or family members who would be able to identify the adverse consequences of their chemical use. Many mentally ill people live in isolation, thus a substance abuse problem may go

unnoticed for a long time.

The literature is not in agreement on how often severely and persistently mentally ill clients will use denial when questioned about their chemical use. Most likely, this will vary depending on the age of the client (younger patients may be more apt to deny problems), who is asking the question, and the consequences of admitting to chemical use or problems. Safer (1987) reported that a group of young adult patients denied their substance abuse during a psychiatric interview and that evidence of their substance abuse often came from family members, other concerned persons and observations from clinicians and court records. On the other hand, some professionals have found certain clients to be honest about their chemical use and any consequences they are able to recognize (Pat Mitchell, interview, 7 July 1988).

Lack of Continuity of Care Deinstitutionalization may also make it more difficult for professionals to identify people with substance abuse problems. People who do not live in a hospital or residential setting have more opportunity to purchase and use chemicals, and any adverse consequences of their use can progress unnoticed since no one is in a position to closely monitor small changes in their behavior.

Screening For Substance Abuse

A first step in identifying people with substance abuse problems is to incorporate questions about substance use into the routine intake process. Screening items which can be easily incorporated into an interview are recommended.

In addition to the use of a brief screening tool, some more

practical considerations include:

-- View the screening as a collaborative effort rather than a confrontation. It is helpful for a professional to share their concern about the client's substance use with the client (Mulinski 1988).

-- Take time to sort out which problems may be related to psychiatric symptoms and which may be related to substance use.

-- Explore adverse interactions between prescribed medication and mood-altering chemicals.

-- Since even moderate levels of substance use may cause problems in this population, do not rely on simply the quantity or frequency of their use. Instead, focus on the consequences of any amount of substance use.

-- Attempt to obtain more collateral information from previous records, family, or other persons knowledgeable about the client.

Issues Specifically Related to Women

Just as the literature in the chemical dependency field contains references mainly to studies done with male subjects, there is also a lack of information specific to women who suffer from both a severe and persistent mental illness and substance abuse problems. What little is known shows that women who have a severe and persistent mental illness have similar issues around their substance abuse as do women substance abusers who are not dealing with a mental illness. Women are more likely to abuse substances other than alcohol (Nancy

Moulton, interview, 23 June 1988), and women are more likely to be covert abusers (Hall et al. 1977). Women are also more likely to have secondary issues such as harmful relationships with men and to be histories of physical abuse (Pat Mitchell, interview, 7 July 1988).

In terms of differences which may apply particularly to the screening process, professionals should be aware that they may have to look harder to identify women's problems with chemicals. It cannot necessarily be observed by the smell of alcohol on their breath or by liquor bottles and beer cans in their living environment. Also, since borderline personality disorder and borderline traits are far more common in women, special consideration for possible substance abuse is necessary since their lack of impulse control may often lead to substance abuse.

APPENDIX A
Review of Prevalence Studies

Study Author Year	Sample/Setting	Age/Gender	Psychiatric Diagnosis	Substance Abuse Criteria	Prevalence of Substance Abuse	Other Findings
Alterman, et al. (1980)(a)	101 psychiatric ward patients	99 men average age 45 years	Schizophrenia with secondary alcoholism	Questionnaire completed by nursing staff after chart review structured interview with patient	55% currently drinking 45% became intoxicated in hospital	
Ibid (b)	25 of patients identified above as problem drinkers				76% consuming alcohol three or more times a week 64% intoxicated at least three times a week	Over one-quarter frequently experienced hallucinations, physical illness, blackouts, memory lapses, shakes
Alterman et al. (1981)	979 psychiatric inpatients		11% primary alcohol related diagnosis (ARD) 13% secondary or tertiary alcohol related diagnosis (ARD) 75% no diagnosis related to alcohol	Ward nurse provided frequency of use and intoxication	9% consuming alcohol 6% becoming intoxicated Patients with ARD more likely to be drinking and/or intoxicated 15% of patients without primary ARD had secondary or tertiary ARD	Negative attitudes towards treatment and verbal abusiveness most common symptoms of drinking. Incidence of ARD in non-primary ARD patients is lower than other reported rates of 20%+
Alterman et al. (1982)	533 patients in acute or subacute psychiatric wards		83% schizophrenic	Chart review and interviews of nurses	18% history of drug or alcohol/drug problems	Drug users were younger Most common consequences of drug use: negative attitudes towards treatment (55%) cliquishness/secretiveness (47%) need more staff attention (46%)

Review of Prevalence Studies

Study Author Year	Sample/Setting	Age/Gender	Psychiatric Diagnosis	Substance Abuse Criteria	Prevalence of Substance Abuse	Other Findings
Crowley et al. (1974)	50 adult psychiatric ward admissions		6% organic brain syndrome 22% schizophrenia 6% affective psychoses 30% neuroses 36% character and behavior disorders	At admission patients asked about alcohol and drug use, also blood and urine tests	40% had alcohol or drugs in blood/urine tests 16% concealed drug use	Drug abuse rare among schizophrenics Long term substance use contributed to need for admission in over one-third of sample
Davis (1984)	General hospital medical/surgical patients (N=2969) and inpatient and outpatient psychiatric patients (N=298)			Measured substance abuse using Substance Use and Abuse Survey (SUAS) and Brief-MAST	Male and female psychiatric patients had significantly higher frequency of heavy and/or problem substance use	None of male psychiatric outpatients had heavy use of prescribed substances
Hall et al (1977)	195 psychiatric outpatients	41% male average age 33	27% schizophrenia 22% neuroses 14% personality disorders 15% drug dependence 22% other	Urine samples to determine drug use Drug history questionnaire	13% covert abusers with positive urines	Covert abusers had more adverse medication reactions, more cancelled appointments (cancelled by patient or therapist), more transfers to other therapists or agencies, 85% were misdiagnosed Females were most frequent covert abusers
Hall et al. (1979)	57 psychiatric inpatient admits, excluding those with substance abuse histories	49% male average age 35	Most common: 18% schizophrenia 14% depression 11% acute psychotic 21% personality disorder 7% schizo-affective (multiple diagnosis)	Substance abuse questionnaire and interviews Drug abuse defined as recent non-medical use of drug 3 or more times per week	58% history of substance abuse 43% abused 4 or more substances	Abusers had: increased hospital stay by 10%, AMA discharge 3 times higher Admitted with major psychotic episode twice as often About 50% began drug use after psychiatric symptoms appeared to self-medicate

APPENDIX A
Review of Prevalence Studies

Study Author Year	Sample/Setting	Age/Gender	Psychiatric Diagnosis	Substance Abuse Criteria	Prevalence of Substance Abuse	Other Findings
McLellan et al. (1978)	156 male psychiatric inpatients excluded those in treatment for alcohol/drug problems		(approximate) 30% paranoid schizophrenic 30% chronic schizophrenic 30% depression 10% other	alcohol/drug problems brief interview	50% reported substance abuse problem sometime in life 60% used substances while in treatment 24% classified as dependent as secondary problem	Less than half of substance abuse problems were reported at admission
Pepper et al. (1981)	294 young adults ages 18-30 who were chronic patients at CMHC		58% schizophrenic 8% major affective disorder 1% psychotic disorder 13% personality disorder 6% behavior disorder 4% alcohol abuse/ drug dependence 6% organic brain syndrome mental retardation learning disability 9% neuroses	Chart review	37% abuse alcohol 37% abuse other drugs	
Richardson et al. (1985)	56 persons admitted to inpatient psychiatric facility	73% male average age 27	Schizophrenia	Reviewed medical records for clinicians' reports of substance abuse	55% history of drug abuse 27% history of alcohol abuse	Marijuana most widely abused 79% High association between violence and substance abuse Substance abusers had more inpatient admissions and more non-treatment periods and were younger at first inpatient admission
Rockwell and Ostwald (1968)	Psychiatric and general hospital admissions age 17-60			Chart review for amphetamine use	14% of psychiatric admissions amphetamine use 6% of general hospital amphetamine use	Only 50% of patients with amphetamine in urine admitted use during routine questioning

APPENDIX A
Review of Prevalence Studies

Study Author Year	Sample/Setting	Age/Gender	Psychiatric Diagnosis	Substance Abuse Criteria	Prevalance of Substance Abuse	Other Findings
Safer (1987)	41 young adult (19-49 years) chronic psychiatric outpatients on SSI and SSDI			Measured substance abuse case record review and treating clinicians provided information	73% history of substance abuse 44% regularly using	Substance abuse most distinguishes young adult chronic (19-39 years) from middle-aged (40-49 years) chronic, young more likely to abuse LSP, PCP, amphetamines
Simon et al. (1968)	534 elderly admitted to psychiatric ward with no psychiatric hospitalizations prior to age 60			Interviews and record review for alcohol use, classified into four use categories		23% diagnosed alcoholic and alcohol implicated in admission
Test et al. (1985)	105 patients in contact with CMHC crisis or outpatient teams (N=65) or inpatient psychiatric services (N=40) with diagnosis of schizophrenia or related disorder	69 male 36 female ages 18-30	70% schizophrenia 21% schizoaffective 5% schizotypal personality 5% not indicated	Subjects were asked about use of alcohol/drugs ever and in past six months	In past six months: 28% using alcohol several times a week or more 26% using marijuana several times a week or more. None using other street drugs	Men and women did not differ significantly in six-month frequency of alcohol or drug use

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SCREENING FOR CHEMICAL ABUSE IN PEOPLE WITH PHYSICAL DISABILITIES

Kathleen Gilmore, M.S.W.

Purpose

The State of Minnesota, Chemical Dependency Program Division has identified that people with physical disabilities are at risk for developing alcohol and other drug problems. Generally, Minnesotans with physical disabilities are under-identified as having alcohol and other drug problems. This paper will explore the reasons for that under-identification and recommend ways to improve the screening for chemical problems in this population.

Specifically, the purpose of this review is to define issues related to the assessment of alcohol and other drug problems in people with physical disabilities. This paper will be divided into three sections. The first section will define **disability** and the **extent** of alcohol and other drug problems in people with physical disabilities. The second section will identify **factors** influencing the screening or assessment process. Finally, the third section, will define **recommendations** for researchers and practitioners as they conduct routine alcohol and other drug screenings on their clients.

EXTENT OF ALCOHOL AND OTHER DRUG PROBLEMS IN PEOPLE WITH PHYSICAL DISABILITIES

Disability: Definition and Characteristics

This paper will use the following definition of physical disability. "Disability is present, or a person is disabled, when a

set of functions, either desired or required, exists, which cannot be independently performed when attempted in a specific environment" (Stolov and Clowers 1981). For example, someone with a spinal cord injury must, like all of us, buy food. Transportation is a necessary function for food shopping, and since many people with spinal cord injuries have lost some independence by no longer being able to drive, they are considered disabled.

An important characteristic of disability is that the capacity to remove a disability problem is dependent upon a person's "residual capacity for physiological and psychological adoption" (Stolov and Clowers 1981). This writing suggests the misuse of chemicals is a factor influencing successful adaption.

This review will focus on physical impairment as opposed to cognitive or mental impairment. To set the stage for a discussion of factors in the screening for alcohol and other drug problems, consider this hypothetical example of a person with a severe physical disability.

> "Anna Lawrence is a nineteen year old woman, who fractured her cervical spine in a diving accident, resulting in quadriplegia. At the time of the accident, Anna had been partying with friends on a river. The spinal cord injury resulted from diving in a shallow area of the river. Anna had been drinking just prior to the accident. A complete evaluation was undertaken after her admission to a rehabilitation center. The following problem list for Anna came out of the comprehensive evaluation.
>
> 1. C7 (seventh cervical vertebra) fracture dislocation
> 2. C7 complete quadriplegia
> 3. Ambulation dependent
> 4. Transfer skills dependent
> 5. Eating, dressing, personal hygiene skills dependent
> 6. Bowel incontinence
> 7. Bladder incontinence
> 8. Decreased respiratory function
> 9. Potential for pressure sore

10. Potential for thrombophlebitis
11. Immature personality
12. Reactive depression
13. Home architecture incompatible with paralysis
14. Financially dependent
15. Estranged from parents
16. Unemployed, no work history
17. Homemaking skills deficient
18. Transportation dependent (list adapted from Stolov and Clowers 1981)

Limitations, as in the case of Anna, can be and are faced "realistically without becoming overwhelmed by the changes these limitations bring about" (DeLoach and Greer 1981). For psychological well-being a disabled person needs to accept themselves, behave responsibly, and learn to practice stress-reduction techniques to relieve stress and to cope with the behavior of others. The majority of people with disabilities do learn how to cope.

There is a subgroup of the disabled where positive adaption does not take place. Part of this group abuses chemicals which interfere with their ability to function psychologically, socially and physically. For example, people with spinal cord injuries who abuse chemicals are at a greater risk of developing physical complications such as circulatory problems, urinary tract infections or decubitus ulcers (bedsores). There is a greater risk of injury when judgement, perception and motor skills are impaired by chemical abuse (Heinemann 1986). Most people with disabilities do learn to maintain fitness to avoid developing physical complications. Physical activity can reduce pain; careful skin care and attention to movement can reduce pressure and help prevent decubiti; and maintaining joint mobility can reduce atrophy (Bedbrook, Tech & McLaren, 1985).

In a broader context, the societal stigma associated with

discernible physical differences is great and can be a significant factor in the well-being of someone with a disability. Although each person's response to being disabled varies, research indicates that for some "disablement has a significant negative impact on self-concept, with the greatest effect being in the areas of identity and the physical and family selves" (Bolton 1975).

Nature of the Problem

Research is inconclusive in defining whether substance abuse typically precedes or follows a disabling condition. Some evidence suggests that substance abuse occurs before the disabling event (Alterman and Tarter 1985; Frisbee and Tun 1984; Fullerton et al. 1981; Heinemann (in press)b; O'Donnell et al. 1981-82; Schashl and Straw 1987; Sweeney & Foote, 1982). See Table 1.

Table 1

Evidence of Prior Alcohol or Other Drug Use

Sample	Results
103 spinal cord injured (SCI) patients: 30% Black, Hispanic or Asian; 21% women (Heinemann in press, a)	* 95% prior alcohol use * 5.9 drinks was mean weekday quantity of alcohol consumed 6 mo. prior to disabling event
30 SCI patients in S. Wisconsin rehab university hospital, average age 27.5, 3 women (Fullerton et al. 1981)	* 50% drinking just before disabling event * 5 drunk at time of accident * 4 dx as CD prior to accident
36 male SCI vets at California VAMC in voluntary inpt CD program (Sweeney and Foote 1982)	* 64% prior history drug abuse
137 SCI patients, average age 50, (Frisbie and Tun 1984)	* 28% drank average of 6 drinks day of injury
Random sample, 2000 vets (Kirubakaran et al. 1986)	* 54% response rate, 60% respondents were 50+ in years, married * 70% regular drug use before SCI * 75% started regular recreational drug use after injury
47 SCI patients on hospital unit (O'Donnell et al. 1981-82)	* 62% had alcohol/drug related injuries * 87% prior history drug abuse

What professionals do know is that substance abuse can significantly interfere with the rehabilitation process, especially in areas of medical, psychological and social functioning. Dr. Heinemann from the Chicago Rehab Institute has emphasized that "substance use that interferes with cognition or adaptive coping skills can interfere with learning," and can actually create or intensify the medical, social and psychological problems identified above (Heinemann 1986). For example in the description of Anna above, Anna had a significant problem with alcohol and other drugs prior to her accident. As is the nature of chemical dependency, dependent people lose sight of the world around them and their relationship with alcohol or other drugs supercedes their relationships with people and their ability to attend to their health needs.

Anna's accident did not cure her of her drug problem. Anna continued having a drug problem after her accident and developed decubitus ulcers as a result of her inattention to her physical needs. Anna has the ability, through adaptive exercise; to feed and partially dress herself, although she had not yet developed these skills. Anna's continued abusive use of alcohol and marijuana also added to her isolation and withdrawal from a potentially supportive family. Dr. Heinemann indicates that substance abuse can adversely affect the outcome of rehabilitation efforts. "Medical complications and poor vocational functioning can result when substance use becomes a habitual part of a person's lifestyle." (Heinemann 1986)

Prevalence of Alcohol and Other Drug Problems

Evidence of alcohol and other drug problems in the general population range from 8 to 10%, while estimates of chemical problems in people with physical disabilities varies from 10 to 60%. As noted by Dr. Heinemann (1986), studies examining substance use in this population "are rare and tend to focus on defining the prevalence of substance use or problems in identifying persons in rehabilitation settings who have substance use problems." See Table 2.

Table 2
Evidence of Substance Use Problems in Persons with Physical Disabilities

Sample	Findings
Clients from Independent Living centers and DVR - 8000 surveys sent (Wisconsin Dept. Health & Social Service, 1985	* 40% response rate * 50% higher use of alcohol in people with disabilities than in general population
273 trainees at technical institute and rehabilitation center (Rasmussen and DeBoer 1980-81)	* 62% had serious alcohol use problems * 50% of problem users met DSM criteria for alcoholism
103 spinal cord injured people at a rehabilitation institute (Heinemann in press, a)	* 49% scored above a 5 on MAST, indicating problematic alcohol use
Random sample of 2000 paralyzed vets: white married, unemployed (Kirubakaran et al. 1986)	* 54% response rate * 73% reported alcohol use compared to 91% reported alcohol use in national sample
Disabled(D) and non-disabled(ND) students at rural midwest university, half female (Dean, Fox and Jensen 1985)	* ND response rate 46% * D response rate 48% * NDS reported more use of alcohol and drugs

Although this body of evidence suggests that people with disabilities do have problems with alcohol and other drugs, further study is required. A study by Kirubakaran and associates (1986), in which the prevalence of alcohol use was found to be lower in physically disabled

persons compared to a national sample, cautions us in making the statement that people with disabilities have a greater risk for alcohol and other drug problems. Dean, Fox and Jensen (1985) found that a group of nondisabled college students reported more frequent use of alcohol and other drugs than a disabled sample.

Why are drugs a problem?

People with disabilities are part of an oppressed minority (Hepner 1980-81). High levels of frustration related to the physical and emotional pain of accepting and adapting to a disability is a major factor adding to the picture of why drugs are a problem for this population. Movement, mobility, personal care and hygiene, tool use and communication are excessive stressful demands. Physical concerns needing medical attention such as muscle spasms, chronic pain and/or excessive spasticity make for easy access to drugs (Greenwood 1984). A reliance on drugs can worsen any existing medical complication such as impotence and incontinence (Sweeney and Foote 1982). Use of prescribed drugs can mask a persons feelings and prevent them from grieving for the loss of their independence and of the activities they are no longer able to participate in (Helm 1988). To deal with their feelings of frustration and lack of environmental control some choose to use chemicals.

FACTORS INFLUENCING THE SCREENING OR EARLY IDENTIFICATION OF ALCOHOL AND OTHER DRUG PROBLEMS IN PEOPLE WITH PHYSICAL DISABILITIES

Every human being has the potential for a productive and happy life. Alcohol and other drug problems prevent this potential from being realized. The literature on substance abuse and the physically

disabled repeatedly identifies four areas or sets of factors influencing early identification of alcohol and other drug problems.

Screening for chemical dependency in this population is really no different than in the general population. What is different is the assessor's approach to doing the assessment, and her knowledge of disability. Each assessor comes in with a set of beliefs about the world. The stigmas, negative societal attitudes and myths common to our society regarding physical disability must be addressed within each of us (Greer 1986). This is especially true for professionals who conduct assessments. We must take time to learn new information about disability, understand rehabilitation and work toward helping people learn new ways to adapt in this world. Negative attitudes of pity and fear will only stand in the way of making accurate assessments.

Attitudes

In a telephone survey of professionals working in the area of chemical dependency and physical disabilities, attitudes were identified as a major factor influencing the identification of alcohol and other drug problems in people with disabilities (Gilmore, 1988). The following paragraphs discuss how our beliefs, perceptions and

negative attitudes can affect identification of alcohol and other drug problems.

Helplessness/Fragility - This attitude conveys the message that the person with a disability is not a whole person. Also, this attitude conveys the message that the disabled person is incapable of handling normal adult responsibilities (Helm 1988). It is not unusual to hear of counselors or public servants who feel a sense of futility in working with people with physical differences. An example may be a police officer who picks up a disabled woman for a DWI (Driving While Intoxicated), feels sorry for her and then releases her. Another example may be a counselor working with a disabled person who lowers their expectations of that person. Both examples illustrate situations where a disabled person is not getting the help they need.

Pity - Pity acts as an attitudinal barrier to early identification. For example, a helping professional might say "If I had paraplegia, the only thing left in life would be to get loaded. I'd do it too." In other words the professional is saying, let them drink so they won't see how terrible their life really is.

Guilt - "Why not me?" or "Why didn't I do something sooner?" are attitudes that come especially from families and significant others, attitudes which create unhealthy enabling of alcohol and drug problems. Guilt produces "placating behaviors" which translates into avoiding hostile encounters by giving the disabled person something pleasurable. (O'Donnell 1981-82)

Guise of Professionalism - One barrier to adequate screening for alcohol and other drug problems is program staff who insist that they

work only in one problem area. Counselors in rehabilitation say they only deal with the quadriplegia for example, while counselors in chemical dependency treatment say they are not equipped to work with handicapped people.

Fear - Fear of the unfamiliar keeps professionals and the public from interacting with people with disabilities as whole human beings. This fear, and a lack of knowledge about people with disabilities, emotionally affects the professional and keeps them stuck in denial about any dependency problems.

Helping - Physicians' perceptions of what help means can interfere with getting disabled people the help they need. They can, for example, become frustrated when they cannot fix a disability and may feel that "If I can't fix the disability, I certainly can fix the pain." Interestingly, it was reported that 41% of clients at the Center for Independent Living felt many of the drugs they were prescribed were unnecessary.

Perhaps underlying these attitudes is the pervasive myth that suggests one must be physically normal to lead a useful and fulfilling life. Rehabilitation professionals as well as health care/mental health professionals are "not immune to the generally negative attitudes toward persons with discernible physical differences (DeLoach and Greer 1981). The tendency of the public to form negative impressions of people with disabilities discourages professionals from making too much of the issue (Heinemann in press, a). In other words, professionals have a reluctance to add one more

disability to an already stigmatized person. In addition, this avoidance of recognizing alcohol and other drug problems tends to enable the disease process to be perpetuated longer for a disabled person than for someone who is not disabled (Helm 1988).

Interpersonal Beliefs

Someone with a physical disability and an alcohol and other drug problem has **two distinct and important conditions** to deal with: their physical disability and the chemical problem. A disabled person may use their disability as an excuse for their emotional and physical problems, and as an excuse for taking drugs. Two disabilities can be perceived as overwhelming to deal with for the disabled person, especially in the **amount of energy** needed to work on two significant issues. Also, for the person with disabilities there is an **increased risk** taken with each step toward independence (Greenwood 1984). For example, many disabled people receiving pensions may risk losing it if they get a job. This risk factor becomes a disincentive to change.

Fear of cumulative stigma is a significant interpersonal barrier especially in light of the lack of social acceptance of people with disabilities (Greenwood 1984). Those with an alcohol and other drug problem typically have a **negative self-concept** (Bolton 1975). Self-doubt can stand in the way of their ability to change their circumstances, and can contribute to their lack of motivation in moving from an isolated existence toward an integrated lifestyle in a not always accepting community. In addition, self-doubt can block their ability to find coping mechanisms for addressing their feelings

of anger, depression and boredom (Sweeney and Foote 1982).

Program Realities

Chemical dependency treatment programs, as well as rehabilitation programs create barriers to the early identification of alcohol and other drug problems in people with disabilities. There are numerous examples of program realities which create barriers to screening, assessment and treatment. The **lack of communication vehicles** for hearing impaired people or people with disabilities is a significant problem. One-to-one communication with a hearing impaired person may require a sign interpreter, if sign language is not the common language. People with hearing impairments may have varying levels of knowledge of American Sign Language (ASL). Persons with limited language ability, may have difficulty understanding the concepts such as of denial and Higher Power. (Janet Pray, correspondence, November 1988) Both concepts are very important to gain a clear understanding of chemical dependency. Also, most chemical dependency programs lack TDD, typewritten telecommunication devices allowing hearing impaired people to use the phone.

Assuming that an assessment of chemical dependency is made, other programmatic barriers exist to prevent the disabled people from receiving services. For example, many chemical dependency programs have a strict **policy** on **medication** use. For some disabled people, such as a person with epilepsy, a strict policy of no medication use would preclude their entrance into the program because they need medication to control their seizures (BAP 1988). With rehabilitation programs, policies or lack of policies regarding possession and use of certain drugs/alcohol in hospital settings and recreation/social-

ization programs need to be reevaluated (Cherry 1988; Heinemann 1986; Hepner 1980-81).

Programs need to take steps toward ahealing environment rather than an avoidance environment. Another barrier is the need for **private rooms**. People with quadriplegia need privacy for personal cares such as dressing, bowel program and bathing. Also there are numerous adaptive devices such as battery chargers which need a place for storage (Dennis Straw, personal communication August 3, 1988). **Appropriate staffing** can be a programmatic barrier for the assessment and treatment process. Staff knowledge about the communication skills and functioning of hearing impaired people, is critical to successful screening (Greenwood 1984).

To adequately serve a chemically dependent disabled person both chemical dependency and rehabilitation staff need to understand the complications of disabilities, drug abuse and their permutations (Sweeney & Foote 1982; Lowenthal and Anderson 1986). Appropriate **sensitivity training is** also an issue not addressed in chemical dependency programs. Lack of **availability of tools** such as large print literature, tapes or braille literature, can act as a barrier to serving the needs of disabled people (Greenwood 1984; Greer 1986).

Architectural Barriers

A large area that impedes early identification and treatment has to do with the architectural barriers faced by people with disabilities. Architectural accessibility is a factor often assumed to be nonproblematic in organizations. Current laws require entrance **ramps** to buildings, grab bars in lavatories and handicapped **parking** in

close proximity to building entrances. Having these features is important, but they are certainly not the only features needed for truly accessible spaces. other areas of need are doorways fitting narrow and wide wheelchairs, bathroom sinks low enough for use by wheelchair users, even commodes or showers accessible to wheelchairs. Budgets are often mentioned as barriers to serving this population, when in reality only few changes of minor cost are necessary.

Cultural Barrier

Mainstream society often uses technical concepts to convey derogatory communications toward people with disabilities. Historically, someone with a spinal cord injury would have been called a cripple, while today the term orthopedically impaired or mobility impaired is the preferred word. The use of antiquated words continues and acts to build fences rather than bridges. DeLoach and Greer and other specialists in rehabilitation stress the importance of using current up-to-date language. The affective connotation of words can act as a distinct barrier in communications with people with discernible physical differences. An able-bodied person's use of words like gimp, crip, spazz, blinks, or sticks is demeaning to people with disabilities, although the disabled may in fact use these words readily among each other (DeLoach and Greer 1981). Other barriers cited by DeLoach and Greer which inhibit effective communication include: 1) a person's wanting to get close to a person with disability by convincing them of their knowledge of disability or their relationships with others in wheelchairs; 2) a person's reference to saying disabled person, as if the disability comes

first; and 3) a person's reference to "normal" people, suggesting that people with a discernible physical differences are not normal. See Table 3.

Table 3

Barriers to Screening and Assessment of Alcohol and Drug Problems in Persons with Disabilities

Societal Attitudes

Helplessness/Fragile
Pity
Guilt
Guise of Professionalism
Fear
"Helping"

Architectural Barriers

Accessible ramps
Handicapped parking
Grab bars in lavatories
Size of doorways
Height of sinks and toilets
Signs of danger for hearing impaired

Interpersonal Beliefs

Energy needed to work on 2 disabilities
Risk taking steps toward independence
Fear of cumulative stigma
Negative self-concept

Cultural/Language

Use of antiquated language
Use of words with affective (negative) connotations
Ineffective communication techniques

Program Realities

Lack of communication devices
Lack of appropriate staff
Lack of sensitivity training
Lack of policies to consciously serve the disabled
Policy of medication use in substance abuse programs
Lack of training tools: braille books, large print, audio devices
Policy on alcohol/drug use in rehabilitation programs
Availability of private rooms
Licensing requirements
Budget restraints

Issues Specifically Related to Women

Research on women with alcohol and drug problems has been limited historically. In this review, no information was identified to help elucidate chemical problems in women with physical disabilities. Fine and Asch (1985) note that very little research has been conducted on disabled women and analysis of their experiences is limited. It has been suggested by experts in the field that women with disabilities are expected to deal with their limitations better than men with disabilities (Deegan, 1985). Fine and Asch also mention that women with disabilities as well as others perceive women with disabilities more negatively than disabled men. (1985)

In terms of differences which may apply to the screening process, helping professionals will have to look harder to identify women's problems with chemicals. Attitudes of protecting women and keeping their problem in a closet continue to pervade our society.

Screening for Substance Abuse

The need for early identification of alcohol and other drug problems in people with physical disability has been described. A first step in early identification is the routine administration of a screen for substance abuse. A brief screen which can easily be incorporated into an assessment interview is preferred. Further issues to consider in screening for alcohol and drug problems are mentioned below.

1. The use of a screening tool should address alcohol problems as well as prescription drugs, over the counter drugs and illicit drug problems.
2. A screening tool should define a timeframe, to distinguish between a current problem versus a historical problem.
3. For the person with disability, research on spinal cord injury suggests asking questions related to use of chemicals at time of injury as well as past use of chemicals.
4. Research suggests that the items chosen for a screen are perhaps secondary to working through attitudinal barriers presented by helping professionals. Researchers and clinicians cited in this writing recommend sensitivity training for counselors in screening positions. Such training can act to identify clinician bias and perhaps set the stage for more accurate screening.
5. With the potential for depression in this population, consideration should be given to screening for depression. Screening for cognitive problems may be appropriate for specific disabled persons, such as closed head injuries.

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DESCRIPTION OF CURRENT ASSESSMENT INSTRUMENTS

Ken C. Winters, Ph. D. and Randy S. Stinchfield, Ph. D.

(1) Addiction Severity Index (ASI)

Source: McLellan, A.T.; Luborsky, L.; Woody, G.E.; & O'Brien, C.P. 1980. An improved diagnostic evaluation instrument for substance abuse. The Journal of Nervous and Mental Disease. 168: 26-33

Description: The ASI is a structured clinical interview developed for use as a research and clinical tool in the field of alcohol and other drug abuse. The 40-minute interview produces 10-point problem severity ratings for several problem areas associated with chemical addiction. Its relatively straightforward design and scoring procedure makes it easy for trained technicians to administer.

Content: The content areas of the ASI focus on seven areas commonly affected by addiction: medical, employment, alcohol, drug, legal, family/social, and psychiatric. These problem areas are viewed as important in formulating an initial treatment plan and in providing a general prognosis for treatment. In addition, a subset of ASI items from each problem area can be combined and weighted to form a score for use in showing change (e.g., use as a treatment outcome index).

Findings: The ASI enjoys a wealth of reliability and validity data. Correlational analyses using the severity ratings indicate considerable independence between the problem areas, suggesting that chemical abuse severity is not always related to other client treatment problems. The ASI has also received a great deal of recent attention as an effective tool to match patients with treatments.

(2) Alcohol Clinical Index (ACI)

Source: Skinner, H.A. and Holt, S. 1987. The Alcohol Clinical Index: Strategies for identifying patients with alcohol problems. Toronto: Addiction Research Foundation.

Description: The ACI, based on Skinner's previous instrumentation work with the Alcohol Use Inventory and the Alcohol Dependence Scale (see below), consists of clinical addiction and medical history items. The ACI serves as an aid in detecting varying degrees of alcohol abuse and dependence and in developing treatment plans and follow-up procedures.

Content: The ACI consists of 17 clinical signs that reflect the alcohol dependence syndrome, and 13 medical history items often associated with excessive alcohol use.

Findings: Psychometric data indicate that the ACI can detect alcohol abuse with a probability exceeding 0.90 if 4 or more clinical signs or 4 or more medical history items are present.

(3) Alcohol Use Inventory (AUI)

Source: Wanberg, K.W.; Horn, J.L.; and Foster, F.M. 1977. A differential assessment model for alcoholism: The scales of the Alcohol Use Inventory. Journal of Studies on Alcohol. 38: 512-543

Description: The AUI is a psychometrically sophisticated, 147-item paper and pencil inventory that measures 16 relatively independent aspects of alcohol use behavior. It was developed out of research with a large community alcohol treatment clinic population.

Content: The items of the AUI cover three conceptually distinct domains: styles of alcohol use; unfavorable results of drinking (symptoms); and beneficial results of drinking. The instrument's authors have identified four broader, more basic factors underlying the 16 separate scales, which they label "self-enhancement drinking," "obsessive-sustained drinking," "anxiety related to drinking," and "alcoholic deterioration."

Findings: A general factor underlying the AUI, "general alcoholism," was found to correlate substantially ($r = .83$) with the MAST (Skinner 1979), indicating that the AUI and MAST converge on a similar alcoholism construct. Skinner's (1981) factor analysis of the AUI suggests that four factors or alcoholism "syndromes" are tapped by the AUI. These syndromes and their associated scales include:

I. Alcohol Dependence

Loss of Control

Psychoperceptual Withdrawal (e.g., DT's)

Psychophysical Withdrawal (e.g., "shakes")

Social Maladaptation

Prior Help (for drinking)

Obsessive-Compulsive Drinking

Daily Quantity

Post-drinking Guilt

Drinking to Change Mood

II. Perceived Benefits from Drinking

Social Benefit Drinking

Mental Benefit Drinking

Sustained Drinking Style

III. Marital Discord

Marital Conflict

Marital Problems

IV. Polydrug Abuse

Drug Use

Gregarious Drinking Style

Skinner's findings support a multiple syndrome notion of alcohol problems. Of particular interest is his identification of separate alcohol dependence and polydrug abuse syndromes. Scores on the alcohol dependence factor were uncorrelated with age, indicating that this syndrome could be found across age

categories. Individuals manifesting the polydrug abuse syndrome tended to be younger, socially deviant, and rebellious. While no relationship was found between MAST and polydrug syndrome scores, the alcohol dependence syndrome was shown by Skinner to correlate highly with MAST scores (r = .75).

Footnote: As a follow-up to the analysis of the AUI, Skinner developed the Alcohol Dependence Scale (ADS). This 29-item, single dimension measure consists of items that are the most closely correlated with Alcohol Dependence factor on the AUI.

(4) The CAGE Questionnaire (CAGE)

Source: Mayfield, D.; McLeod, G.; and Hall, P. 1974. The CAGE Questionnaire: Validation of a new alcoholism screening instrument. American Journal of Psychiatry. 131: 1121-1123.

Description: The CAGE is the most brief alcoholism screening device: a 4-question interview. It has been widely used among general hospital populations as a quick screen for alcoholism.

Content: CAGE is an acronym for the item content: attempts to Cut down; Annoyance at others' criticism of own drinking; Guilt related to drinking; and use of an Eye-opener drink.

Findings: A preliminary validation study indicated that CAGE scores were significantly (if imperfectly) related to

independent clinical diagnoses of alcoholism. Thus, it appears to have validity as a rough alcoholism screen.

(5) Drinking Behavior Interview (DBI)

Source: Shelton, J.; Holister, L.E.; and Gocka, E.F. 1969. The Drinking Behavior Interview: An attempt to quantify alcoholic impairment. Diseases of the Nervous System. 30: 464-467.

Description: The 32 items of the DBI were developed and used successfully in a hospital-based research project. While the interview appears to have face validity, it has not found use in other settings. No standardization norms are available.

Content: Items were selected to represent three domains relevant to the diagnosis of alcoholism: patterns of drinking; social impairment; and occupational impairment. Only a single cumulative score is derived, however.

Findings: Scores on the DBI successfully differentiated social and problem drinkers in the original hospital study. The DBI also appeared sensitive to post-treatment changes in drinking problem severity.

(6) Drug Abuse Screening Test (DAST)

Source: Skinner, H.A. 1982. The Drug Abuse Screening Test. Addictive Behaviors. 7: 363-371.

Description: The DAST is a paper and pencil instrument intended for use in screening drug, rather than alcohol, problem severity. The DAST was developed by Skinner out of the

items of the MAST, with minor revisions made to reflect drug use.

Content: Like the MAST, the content of the DAST is weighted toward problem recognition (by self and others), and the effects and consequences of use. Skinner's factor analysis of the DAST indicates that it is essentially unidimensional.

Findings: Limited research indicates that the DAST can successfully differentiate adults with drug or drug and alcohol problems from those having only alcohol use problems. Correlations between scores on the MAST and the DAST for clinical samples were modest, indicating that these instruments measure problem severity specific to alcohol or drug use, respectively, rather than a more general problem.

(7) Michigan Alcoholism Screening Test (MAST)

Source: Selzer, M.L. 1971. The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. American Journal of Psychiatry. 127: 1653-1658.

Description: The 25-item (24 items are scored) MAST is the bestknown, most frequently used alcoholism screen for adults. The MAST has been used in both interview and questionnaire formats of varying length and can be administered in about 15 minutes.

Content: Although intended as a unidimensional index of problem severity, factor analyses of the MAST indicates that t

taps several relatively distinct domains: recognition of alcohol problems by self and others; legal, work and social consequences of use; marital and family difficulties; and seeking help (Skinner 1979; Zung 1978). This suggests that each of these domains would be amenable to independent assessment in a comprehensive instrument.

Findings: Diagnoses based on MAST cutting scores have shown substantial agreement with independent clinical diagnoses of alcoholism in a number of published studies. Of special interest to assessors of older adults, the MAST has been validated with an older adult male population (Willenbring et al, 1987).

(8) Minnesota Assessment of Chemical Health (MACH)

Source: Kincannon, J.C. 1984. MACH. Chaska, MN: International Professional Services.

Description: The MACH is a computer-assisted assessment tool that is administered by the professional in about 30 minutes. MACH structure is organized around several relevant criteria: DSM-111-R, MAST, Mortimer-Filkins, Minnesota-specific Blue Cross/Blue Shield, and Minnesota Rule-25. In addition to diagnostic-related information, MACH provides a graphic display of the referral options suggested by different combinations of problem severity and environmental factors.

Content: The MACH program organizes the assessment information to specify the severity of problems related to substance use in eight major life areas: parents, spouse, child, friends, homemaker, leisure, medical and law. Also, client problems are described in the context of meeting criteria according to DSM-111-R abuse and dependence diagnoses and Minnesota-specific determinations (e.g., Blue Cross/Blue Shield; Rule 25).

Findings: No formal psychometric evaluations have been published on the MACH. However, given that its content focuses on existing abuse/dependence criteria, the MACH does have face validity.

(9) Stages Index (STAGES)

Source: Mulford, H.A. 1977. Stages in the alcoholic process: Toward a cumulative, nonsequential index. Journal of Studies on Alcohol. 38: 563-583.

Description: The Stages Index grew out of two decades of Iowa adult alcohol use surveys. Several generations of scale development resulted in brief scales for measurement of four problem areas associated with alcohol abuse. An individual's problem severity or "stage" score is the number of the four scales on which his score exceeds the scale cutting point. Thus, individual problem areas can be derived. This index has found modest use in both clinical and research settings.

Content: Stages Index items concern four problem areas: drinking related troubles; preoccupied (extreme, deviant) drinking; drinking for personal effects (to reduce anxiety); and uncontrolled drinking.

Findings: Preliminary validation studies indicated that 90% of clients in community alcoholism centers scored problematic in at least one problem area; 75% had problems in three or more areas. Treatment outcomes were found inversely related to the total STAGE scores.

(10) Unitary Alcoholism Factor (UAF)

Source: Overall, J.E.and Patrick, J.H. 1972. Unitary alcoholism factor and its personality correlates. Journal of Abnormal Psychology. 79: 303-309.

Description: The UAF is a problem severity instrument developed specifically for use in research relating problem severity to personality type. The 42 items of the questionnaire were selected as those most statistically representative of an initial set of 135 indicators of alcohol use problems. As a result, the items have strong factor validity in addition to face validity.

Content: The items of the UAF reflect a variety of signs of symptomatic consumption and effects and consequences of alcohol abuse. As its name implies, the items of the UAF form a unidimensional index of problem severity.

Findings: The UAF has been used mainly in research relating problem severity to MMPI profile types. The results obtained in these studies provide preliminary support for the validity of the scale as a measure of problem severity.

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Hazelden Screening Study

Report of Instrument Analysis

Randy Stinchfield, Ph.D, Ken Winters, Ph.D. and
Jayne Fulkerson, M.A.

Adolescent Assessment Project
Wilder Research Center

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Introduction

There is a need for instruments to screen for chemical problems among such special populations as the elderly, mentally ill and physically disabled. Brief screening instruments were developed for each special population. To examine the reliability and validity of each instrument and to determine appropriate cut scores, they were administered to two groups within each special population (experimental and control groups). The experimental groups included those persons who had an identified problem with chemicals and the control groups included those persons who did not have a problem with chemicals.

Method

Participants. The elderly sample included 60 experimental participants and 42 control participants. The elderly experimental group was obtained from the following CD programs for the elderly: St. Mary's (n=18), DARTS (n=8), Sage Crossing (n=10), Bridgeway Residential Program (n=8) and HealthEast Senior CD Program at Bethesda Hospital (n=16). The elderly experimental group included 32 males and 25 females. Their ages ranged from 54 to 87 with an average age of 65. In terms of race, there were 51 Whites, 5 Blacks and one Native American. Five were single, 24 were married, 11 were divorced/separated, and 17 were widowed. Nine worked full-time, 3 worked part-time, 33 were retired.

The elderly control group was obtained from Goodhue-Wabasha Community Health Service (n=29) and Hennepin County Community Health Department Pre-Admission Screening Program (n=13). The elderly control group included 13 males and 26 females. Their ages ranged from 64 to 93 with an average age of 80. All elderly control group participants were white and were retired. In terms of marital status, three were single, nine were married, 2 were divorced/separated, and 24 were widowed.

The mentally ill sample included 14 experimental participants and 30 control participants. The mentally ill experimental group was obtained from Anoka State Hospital (n=1) and Bill Kelly House (n=13). The experimental group included 8 males and 6 females with ages ranging from 18 to 40 (average age of 26). This group consisted of 11 Whites, 2 Blacks and 1 Native American. Eleven were single and 3 were divorced.

The mentally ill control group was obtained from Mental Health Resources, Inc. (n=30). This group included 8 males and 22 females with ages ranging from 19 to 58 (average age of 35). This group consisted of 28 Whites and 1 Black. Nineteen were single, 3 were married and 8 were divorced/separated.

The physically disabled sample included 6 experimental participants and 22 control participants. The physically disabled experimental group was obtained from Abbott-Northwestern Chemical Dependency/Physical Disability Program (n=6). This group included five males and one female with ages ranging from 28 to 51 (average age of 42). All participants were White. Two

were single, two were married and two were divorced/separated.

The physically disabled control group was obtained from Sister Kenny Institute (n=22). This group included 17 males and 5 females with ages ranging from 16 to 83 (average age of 51). This group included 20 whites and 2 blacks. Five participants were single, 13 were married, 3 were divorced/separated and 1 was widowed.

Instruments. Three brief paper and pencil instruments, one for each special population, were developed to screen for problems with chemicals. The screening tool for the elderly sample included 12 items, the screening tool for the mentally ill sample included 9 items and the screening tool for the physically disabled sample included 8 items. See Appendix A for copies of these three instruments. Each instrument was scored by assigning one point for each affirmative response and then summing all of the affirmative responses to obtain a total "problem severity" score.

Procedure. The staff at each participating facility were trained in the administration of the screening tool. Clients/patients were asked to volunteer to participate in this research project. All volunteers signed a consent form.

Some control group participants answered "no" to all of the preliminary questions about using chemicals in the recent past. By doing so, the instructions on the questionnaire booklet indicate that the subject need not complete the remainder of the questionnaire. Since it is fair to assume that those subjects would have responded "no" to the screen items, their items were coded as negative responses. While this assumption was judged to be a safe one, it is important to consider this decision when interpreting the study results. (It is recommended that these preliminary items be dropped when the instruments are used in natural settings).

Results

The results section is divided into four sections: (1) item analyses; (2) reliability; (3) validity; and (4) selection of cut scores.

Item Analysis

The results of an item analysis are presented in Tables 1, 2, and 3 for elderly, mentally ill, and physically disabled samples, respectively. The item mean is the proportion of subjects who answered the question in the affirmative. The item-total correlation (corrected for part-whole overlap) is the degree of relationship between that item and the scale score. The item-total correlation computation included both experimental and control subjects. "Good" items are ones that correlate highly with the total scale score (Nunnally, 1978).

For the elderly sample, all items, except item 6 and item 7

have moderate to substantial item-total correlations. For the mentally ill sample, all items, except items 10 and 11, have moderate to substantial item-total correlations. For the physically disabled sample, all items have moderate to substantial item-total correlations.

All of the items with low item-total correlations addressed the misuse of prescription medication. These items appear to address content not related to the content of the other items in the scale (at least not in these development samples). If the items are thought to make an important assessment contribution to the screening process, they could be retained on the instrument, but not included in the total scale score. Their inclusion does not change the estimated accuracy of the scale in discriminating experimental from control subjects. In light of the small sample sizes, it is suggested that more data be collected before the decision is made about whether to delete these items.

Reliability

Scale reliability was examined in terms of internal consistency (coefficient alpha). The screening tool for the elderly, mentally ill and physically disabled yielded reliability coefficients of .91, .92 and .89, respectively. These large coefficients suggest that proper sampling of the content domain occurred during instrument development. To put these findings in a larger context, the estimates of internal consistency reliability are comparable to similar screening tests such as the Michigan Alcohol Screening Test (MAST; Skinner, 1979) and the Drug Abuse Screening Test (DAST; Skinner, 1982).

Validity

Validity was examined in terms of the instrument's ability to discriminate between experimental and control groups. It was predicted that the experimental groups, in light of their identified problems with chemicals, would obtain significantly higher scale scores than the control groups in each special population. Group comparisons were examined by t-tests. As summarized in Table 4, the experimental and control groups were significantly different on the scale score for each of the three special populations.

Selection of Cut Score

Finally, analyses were conducted to select appropriate cut scores and determine their interpretations. This procedure involved setting a cut score and placing participants who obtained a score equal to or greater than the cut score in one category and all other participants in the other category. In this study, a cut score was used to determine whether or not the respondent should receive an evaluation for chemical dependency (i.e., scores equal to or greater than the cut score indicate the need for an evaluation).

There are a number of important indices to evaluate the accuracy of a test cut score, including sensitivity, specificity,

predictive power, hit rate, and classification error rate (false-positives and false-negatives). Sensitivity is the rate of positive test results among persons with the condition (true-positive). Specificity, on the other hand, is the rate of negative test results among those who do not have the condition (true-negative). Positive predictive power is the rate of true-positives among all positive test results. Negative predictive power is the rate of true-negatives among all negative test results. Hit rate is the proportion of participant's who are correctly classified. Cut scores yield two types of errors: false-positives and false-negatives. False-positives occur when the test classifies someone as having an alcohol/drug problem when in fact they do not have a problem. False-negatives occur when the test classifies someone as not having an alcohol/drug problem when in fact they do have a problem.

As a first step in selecting a cut score, it should be determined whether one type of error (either false-positives or false-negatives) is of more importance than the other type of error. If one type of error is judged to have more severe consequences than the other type of error, the cut score may be selected at a point which reduces the error associated with the more severe consequences. However, when you select a cut score which reduces the frequency of cases in one type of error, the result is that you increase the frequency of cases in the other type of error. For example, if it is judged that the occurrence of false-negatives is of greater consequence than the occurrence of false-positives, the cut score may be selected at the point which reduces false-negative cases, while allowing an increase of false positive cases. In this study it was assumed that both types of errors were of equal importance. In such instances, the cut score should be set at the point that maximizes the hit rate and minimizes the misclassification rate.

To achieve this goal, test score frequency distributions, indices of cut score accuracy and discriminant function analyses were used. The test score frequency distributions for the elderly, mentally ill and physically disabled samples are presented in Figures 1, 2, and 3, respectively.

The results of the analyses of accuracy indices are presented in Table 5. For all three special population groups, the cut score that maximized the hit rate and minimized classification errors was 4+ (i.e., scores greater than or equal to 4). Sensitivities for the elderly and mentally ill samples approximate those of similar instruments such as the MAST (Moore, 1972; Selzer, 1971) and the PEI Problem Screens (Winters & Henly, 1989). The sensitivity for the physically disabled sample is low, which is likely due, at least in part, to the small sample size.

The most appropriate interpretation of the cut score is that it identifies individuals who are likely to need a comprehensive chemical dependency evaluation. This interpretation is based on the fact that the cut score is fairly accurate in discriminating two known criterion groups (i.e., experimental versus control

groups). See Appendix B for a description of the scoring and interpretation for each screening tool.

There may be a temptation for potential users to assume that the questionnaires lead to diagnostic decisions. This would represent misuse of the tool. An instrument with so few items is subject to unreliability and thus it would be inappropriate to infer from test scores more than the relative need for a comprehensive chemical dependency evaluation.

Discussion

The psychometric analyses of the three screening instruments indicate that evidence exists for their reliability and validity. Satisfactory internal consistency reliability estimates were found and each tool was able to differentiate experimental from control groups. In terms of scale accuracy, the elderly and mentally ill questionnaires exhibited evidence of adequate sensitivity, specificity, and overall hit rates. The poor sensitivity rate for the physically disabled group may be due to the extremely small sample size (i.e., six experimental subjects). Indeed, because of the small sample sizes in all studied groups, the results of the present study should be considered as pilot data and interpretation should proceed cautiously.

Further research should be conducted to provide additional information about the psychometric properties of the screening instruments and about the tool's ability to accurately identify those persons in need of a chemical dependency evaluation. The position of the cutting score should be evaluated periodically and modified, if necessary. Future validity evaluations need to include a comparison of screening results with independent clinician ratings as to the need for a chemical dependency evaluation.

It should be noted that the experimental groups included persons who had identified themselves as having a problem with chemicals and had sought help. This type of person is thought to be different, in terms of their responses to a screening questionnaire, from a person who has a problem with chemicals, but who has neither identified himself/herself as a person with a problem nor sought help (Kaplan, Pokorny, Kanas & Lively, 1974).

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Table 1

Item analysis of the screening instrument for the elderly

Item	Exp. Group Item Mean	Control Group Item Mean	Item-total r
1. Has your use of alcohol or prescription drugs caused you a problem?	.83	.07	.82
2. Have you ever thought you used too much alcohol or prescription drugs?	.80	.17	.74
3. Have you ever felt you should cut down on your drinking or prescription drug use?	.85	.19	.78
4. Have you ever felt bad or guilty (e.g., things said to you by friends, family, other people) about your use of alcohol or prescription drugs?	.70	.05	.75
5. Has anyone (e.g., family member, friend, doctor) expressed concern that you used too much alcohol or prescription drugs?	.87	.14	.78
6. Have you ever used prescription medication without a prescription or more than was prescribed for you?	.03	.00	.16
7. Have you ever used prescription medication for something other than what it was prescribed for?	.05	.07	.14
8. Have you skipped meals or failed to take care of yourself when you were using alcohol or prescription drugs?	.60	.07	.67
9. Have you had any accidents or injuries (e.g., falls, burns, DUI's, driving accidents) when you were using alcohol or prescription drugs?	.55	.02	.63
10. Have you ever been hospitalized or received treatment or emergency care for alcohol or prescription drug problems?	.65	.05	.75

Item	Exp. Group Item Mean	Control Group Item Mean	Item-total r
11. Do you have any medical problems related to your alcohol or prescription drug use (e.g., liver disease)?	.42	.00	.59
12. Have you ever neglected your family or missed social obligations or work because of your use of alcohol or prescription drug use (e.g., not come home when you said you would, spent more money than you should, absent from work because of use or a hangover, or lost a job)?	.45	.02	.64

Experimental N=60, Control N=42, Total N=102

Table 2

Item analysis of the screening instrument for the mentally ill

Item	Exp. Group Item Mean	Control Group Item Mean	Item-total r
3. In the past six months, has your use of alcohol or other drugs caused you problems such as problems with relationships, jobs/school, housing, nutrition, treatment agencies, finances, arrests or other legal problems?	.93	.13	.87
4. In the past six months, have you thought you've used too much alcohol or other drugs?	.93	.07	.82
5. In the past six months, have you felt you should cut down on your drinking or other drug use?	1.00	.10	.85
6. In the past six months, have you felt bad or guilty about your use of alcohol or other drugs?	.86	.10	.82
7. In the past six months, has anyone else (e.g., family, friends, doctor) expressed concern that you've used too much alcohol or other drugs?	.93	.10	.86
8. Prior to any hospitalizations were you drinking or using other drugs?	.93	.10	.82
9. Have you ever been treated for alcohol or other drug problems?	.71	.07	.66
10. In the past six months, have you used prescription medication without a prescription, or for reasons other than the medication was prescribed?	.29	.07	.42
11. In the past six months have you used more than the recommended dose of any over-the-counter medication, or used any of these medications for reasons other than they were intended?	.36	.03	.23

Experimental N=14, Control N=30, Total N=44

Table 3

Item analysis of the screening instrument for the physically disabled

Item	Exp. Group Item Mean	Control Group Item Mean	Item-total r
1. Has your use of alcohol, prescription drugs or other drugs caused you a problem?	.67	.09	.86
2. Have you ever thought you used too much alcohol, prescription drugs or other drugs?	.67	.18	.83
3. Have you ever felt you should cut down on your drinking, prescription drug or other drug use?	.67	.18	.59
4. Have you ever felt bad or guilty (e.g., things said to you by friends, family, other people) about your use of alcohol, prescription drugs, or other drugs?	.83	.18	.62
5. Has anyone (e.g., family member, friend, doctor) expressed concern that you used too much alcohol, prescription drugs, or other drugs?	.50	.14	.71
6. Have you ever used prescription medication without a prescription or more than was prescribed for you?	.17	.05	.66
7. Have you ever used prescription medication for something other than what it was prescribed for?	.17	.05	.66
8. Have you ever been hospitalized or received treatment or emergency care for alcohol and/or drug problems?	.33	.00	.52

Experimental N=6, Control N=22, Total N=28

Table 4

Group comparison between experimental and control group scores

		Experimental	Control	t
Elderly	Mean	6.8	.8	13.4**1
	SD	2.8	1.6	
	N	60	42	
Mentally Ill		6.9	.9	11.9**
		1.4	1.6	
		14	30	
Physically Disabled		4.0	.9	3.5*
		2.7	1.8	
		6	22	

**p < .001
*p < .01
1Separate variance estimate due to heterogeneity of variance.

Table 5

Comparison of indices of accuracy for different cut scores in each special population

Special Population	Cut Score	Sensitivity	Specificity	PPP	NPP	Hit Rate
Elderly	3+	.88	.83	.88	.83	.86
	4+	.87	.95	.96	.83	.90
	5+	.83	.98	.98	.80	.89
Mentally Ill	3+	1.00	.87	.78	1.00	.91
	4+	1.00	.93	.88	1.00	.95
	5+	.93	.93	.87	.97	.93
Physically Disabled	3+	.67	.86	.57	.91	.82
	4+	.67	.91	.67	.91	.86
	5+	.50	.95	.75	.88	.86

PPP: Positive Predictive Power
NPP: Negative Predictive Power

Appendix A

Screening Instruments for each of the three special populations

Identification #_____

Screening Tool: Older Adults

INSTRUCTIONS:

(**Please read to client**) Thank you for agreeing to participate in this research study. I'd like to take a minute to read you the instructions. The instructions are as follows. This form is a list of 13 questions. The questions refer to your experiences over the last 2 years. The questions below concern alcohol and prescription drug use. In these questions, alcohol refers to beverages such as wine, beer and whiskey and prescription drugs refer to medication prescribed by a doctor such as sleeping drugs, tranquilizers or over-the-counter medications. After each question is read to you, please answer 'yes' or 'no'. There are no right or wrong answers. Again, thank you for participating in this research study.

Please check (X) appropriate response:

	YES	NO
A. DO YOU DRINK ALCOHOL?	__	__
B. DO YOU USE PRESCRIPTION DRUGS OR OVER THE COUNTER MEDICATION...		
B1. ..TO HELP YOU SLEEP?	__	__
B2 ..TO CALM YOU DOWN?	__	__
B3 ..TO FEEL BETTER **e.g.**, LESS SHY?	__	__

INSTRUCTIONS:

A. If the response to any one of items 'A' through 'B' is 'yes', proceed to the set of questions on the next page. (If all responses to the above questions are 'no', please end the interview.) When reading the following questions to the client, please refer to the substances which they answered positively to in the above questions A through B. **For exampie**, if a client only responded 'yes' to drinking, and 'no' to prescription drugs, then question # 1 would be read like this: *Has your use of alcohol caused you a problem?* **Another example**, if a client responded 'yes' to using prescription drugs to calm down and alcohol, question #1 would be read like this: *Has your use of prescription drugs to calm you down and alcohol caused you a problem?*

B. (**Please read the following to the client**): The following questions are only related to your use of either alcohol and/or prescription drugs you identified above.

PROCEED TO NEXT PAGE PLEASE

	YES	NO
1. HAS YOUR USE OF ALCOHOL OR PRESCRIPTION DRUGS CAUSED YOU A PROBLEM?	—	—
1A. WHAT TYPE OF PROBLEM DID YOU HAVE? _____		
2. HAVE YOU EVER THOUGHT YOU USED TOO MUCH ALCOHOL OR PRESCRIPTION DRUGS?	—	—
3. HAVE YOU EVER FELT YOU SHOULD CUT DOWN ON YOUR DRINKING OR PRESCRIPTION DRUG USE?	—	—
4. HAVE YOU EVER FELT BAD OR GUILTY (**e.g.**, THINGS SAID TO YOU BY FRIENDS, FAMILY, OTHER PEOPLE) ABOUT YOUR USE OF ALCOHOL OR PRESCRIPTION DRUGS?	—	—
5. HAS ANYONE (**e.g.**, FAMILY MEMBER, FRIEND, DOCTOR) EXPRESSED CONCERN THAT YOU USED TOO MUCH ALCOHOL OR PRESCRIPTION DRUGS?	—	—
6. HAVE YOU EVER USED PRESCRIPTION MEDICATION WITHOUT A PRESCRIPTION OR MORE THAN WAS PRESCRIBED FOR YOU?	—	—
7. HAVE YOU EVER USE PRESCRIPTION MEDICATION FOR SOMETHING OTHER THAN WHAT IT WAS PRESCRIBED FOR? EXAMPLE:_____	—	—
8. HAVE YOU SKIPPED MEALS OR FAILED TO TAKE CARE OF YOURSELF WHEN YOU WERE USING ALCOHOL OR PRESCRIPTION DRUGS ?	—	—
9. HAVE YOU HAD ANY ACCIDENTS OR INJURIES (**e.g.**, FALLS, BURNS, DUI'S, DRIVING ACCIDENTS) WHEN YOU WERE USING ALCOHOL OR PRESCRIPTION DRUGS ?	—	—
10. HAVE YOU EVER BEEN HOSPITALIZED OR RECEIVED TREATMENT OR EMERGENCY CARE FOR ALCOHOL OR PRESCRIPTION DRUG PROBLEMS?	—	—
11. DO YOU HAVE ANY MEDICAL PROBLEMS RELATED TO YOUR ALCOHOL OR PRESCRIPTION DRUG USE (**e.g.**, LIVER DISEASE)?	—	—
12. HAVE YOU EVER NEGLECTED YOUR FAMILY OR MISSED SOCIAL OBLIGATIONS OR WORK BECAUSE OF YOUR USE OF ALCOHOL OR PRESCRIPTION DRUG USE? (**e.g.**,NOT COME HOME WHEN YOU SAID YOU WOULD, SPENT MORE MONEY THAN YOU SHOULD, ABSENT FROM WORK BECAUSE OF USE OR A HANGOVER, OR LOST A JOB)	—	—

PLEASE TURN PAGE

13. BEFORE WE END THE INTERVIEW, ARE THERE ANY COMMENTS OR CONCERNS YOU WOULD LIKE TO SHARE ABOUT THE INTERVIEW, THE INTERVIEW QUESTIONS OR YOUR REACTION TO THEM?

_____
_____
_____
_____

THANK YOU FOR PARTICIPATING IN THIS RESEARCH STUDY.
(Interviewer: please complete rest of form)

Interviewer Questions

	YES	NO
14. DUE TO THE CLIENT'S MODE OF RESPONDING, CLINICAL INTUITION AND INFORMATION FROM OTHER SOURCES, DOES ASSESSMENT SEEM INDICATED?	__	__

15. PLEASE COMMENT ON HOW ACCURATE YOU PERCEIVE THE INTERVIEW WAS. COMMENT IF THE MENTAL STATUS OF THE CLIENT COULD HAVE AFFECTED THE ACCURACY OF THE RESULTS. (Please use back of page for additional comments.)

_____
_____
_____

16. PLEASE ADD ANY ADDITIONAL COMMENTS/PERCEPTIONS YOU HAVE ABOUT THE SCREENING TOOL: (Please use back of page for additional comments.)

_____
_____
_____
_____

THANK YOU!

Identification #_____

Screening Tool: Person with Physical Impairment

INSTRUCTIONS:

(Please read to client) Thank you for agreeing to participate in this research study. I'd like to take a minute to read you the instructions. The instructions are as follows. This form is a list of 13 questions. The questions refer to your experiences over the last 2 years. The questions below concern alcohol, prescription drug use and other drug use. In these questions, alcohol refers to beverages such as wine, beer and whiskey; prescription drugs refer to medication prescribed by a doctor such as sleeping drugs, tranquilizers or over-the-counter medications; other drugs refers to drugs such as marijuana and cocaine. After each question is read to you, please answer 'yes' or 'no'. There are no right or wrong answers. Again, thank you for participating in this research study.

Please check (x) appropriate response:

	YES	NO
A. DO YOU DRINK ALCOHOL?	__	__
B. DO YOU USE PRESCRIPTION DRUGS OR OVER-THE-COUNTER MEDICATION... (circle response)		
B1 ..TO HELP YOU SLEEP?	__	__
B2 ..TO CALM YOU DOWN	__	__
B3 ..TO PEP YOU UP	__	__
C. DO YOU TAKE MEDICATION FOR MUSCLE SPASMS?	__	__
D. DO YOU USE OTHER DRUGS E.G./MARIJUANA, COCAINE?	__	__

INSTRUCTIONS:

A. If the response to any one of the items 'A-D' is 'yes', proceed to the set of questions on the next page. (If all responses to the above questions are 'no', please end the interview.) When reading the following questions to the client, please refer to the substances which they answered positively to in the above questions A through D. **For example**, if a client only responded 'yes' to drinking, and 'no' to prescription and other drugs, then question #1 would be read like this: *Has your use of alcohol caused you a problem?* **Another example**, if a client responded 'yes' to using prescription drugs to calm down and alcohol, question #1 would be read like this: *Has your use of prescription drugs to calm down and /or alcohol caused you a problem?*

B. (Please read the following to the client): The following questions are only related to your use of either alcohol, prescription drugs or the other drugs you identified above.

PROCEED TO NEXT PAGE PLEASE

	YES	NO
1. HAS YOUR USE OF ALCOHOL, PRESCRIPTION DRUGS OR OTHER DRUGS CAUSED YOU A PROBLEM?	__	__
1A. WHAT TYPE OF PROBLEM DID YOU HAVE? _____		
2. HAVE YOU EVER THOUGHT YOU USED TOO MUCH ALCOHOL, PRESCRIPTION DRUGS OR OTHER DRUGS?	__	__
3. HAVE YOU EVER FELT YOU SHOULD CUT DOWN ON YOUR DRINKING, PRESCRIPTION DRUG OR OTHER DRUG USE?	__	__
4. HAVE YOU EVER FELT BAD OR GUILTY (E.G., THINGS SAID TO YOU BY FRIEND, FAMILY MEMBER, OTHER) ABOUT YOUR USE OF ALCOHOL, PRESCRIPTION DRUGS OR OTHER DRUGS?	__	__
5. HAS ANYONE (e.g., FAMILY MEMBER, FRIEND, DOCTOR) EXPRESSED CONCERN THAT YOU USED TOO MUCH ALCOHOL, PRESCRIPTION DRUGS OR OTHER DRUGS?	__	__
6. HAVE YOU EVER USED PRESCRIPTION MEDICATION WITHOUT A PRESCRIPTION OR MORE THAN WAS PRESCRIBED FOR YOU?	__	__
7. HAVE YOU EVER USED PRESCRIPTION MEDICATION FOR SOMETHING OTHER THAN WHAT IS WAS PRESCRIBED FOR? EXAMPLE: _____	__	__
8. HAVE YOU EVER BEEN HOSPITALIZED OR RECEIVED TREATMENT OR EMERGENCY CARE FOR ALCOHOL AND/OR DRUG PROBLEMS?	__	__

9. BEFORE WE END THE INTERVIEW, ARE THERE ANY COMMENTS OR CONCERNS YOU WOULD LIKE TO SHARE ABOUT THIS INTERVIEW, THE INTERVIEW QUESTIONS OR YOUR REACTION TO THEM?

_____

_____

_____

_____

THANK YOU FOR PARTICIPATING IN THE RESEARCH STUDY.
(Interviewer: please complete back of form)

TURN PAGE PLEASE

INTERVIEWER: PLEASE COMPLETE THE FOLLOWING QUESTIONS

	YES	NO
10. DUE TO THE CLIENT'S MODE OF RESPONDING, CLINICAL INTUITION AND INFORMATION FROM OTHER SOURCES, DOES ASSESSMENT SEEM INDICATED?	--	--
11. WAS THE CLIENT USING ALCOHOL OR DRUGS AT THE TIME OF DISABLEMENT?	--	--

12. **IF YES** TO QUESTION #11, PLEASE IDENTIFY THE SOURCE OF INFORMATION:

__ (1) CLIENT
__ (2) FRIEND/SIGNIFICANT OTHER
__ (3) MEDICAL RECORD
__ (4) POLICE RECORD
__ (5) OTHER, PLEASE SPECIFY

13. (Do not complete for individuals with recent injuries /accidents) DOES YOUR PROFESSIONAL OPINION OR PATIENT HISTORY/ MEDICAL RECORD SUGGEST THIS PATIENT HAS MEDICAL PROBLEMS (**e.g.** PRESSURE SORES, CIRCULATORY PROBLEMS) RELATED TO ALCOHOL OR DRUG USE?	--	--

14. **IF YES** TO QUESTION #13, PLEASE IDENTIFY TYPE OF MEDICAL CONDITION/PROBLEM:_____

15. DOES THE MEDICAL RECORD OR PATIENT HISTORY SUGGEST PROBLEMATIC CHEMICAL USE IN THE FAMILY?	--	--

16. PLEASE COMMENT ON HOW ACCURATE YOU PERCEIVED THE INTERVIEW WAS? COMMENT IF THE MENTAL STATUS OF THE CLIENT AFFECTED THE ACCURACY OO RESULTS? (USE BACK OF PAGE IF NECESSARY.)

17. OTHER INTERVIEWER COMMENTS:

THANK YOU!

Identification # _____

Screen For Alcohol and Drug Problems

Instructions: (Interviewer: please read to client. Note that if client has come to your program from residential treatment, substitute the phrase "in the six months prior to your admission to residential program name" for the phrase "in the past six months".) **Following is a list of 11 questions. The questions refer to your experiences during the past six months . These questions concern alcohol and other drug use. After each question is read to you, please answer 'yes' or 'no'. There are no right or wrong answers. Thank-you for participating in this research study.**

(Interviewer: if the client responds 'yes' to any of the substances in questions #1 or #2, please ask "**How often have you used _____?**" and enter the appropriate code under 'FREQ'. Codes are as follows: 1= Every day or nearly every day, 2=3 to 4 times a week, 3=1 to 2 times a week, 4=1 to 3 times a month, 5=3 to 5 times in the past six months, 6=once or twice in the past six months, 9=can't remember.)

	YES	NO	FREQ
1. In the past six months, have you used alcohol?	___	___	___
2. I'm going to read you a list of drugs. Please answer 'yes' if you have used any of these drugs in the past six months. (Interviewer: you may substitute, or add, "slang" or "street" names for any of these drugs.) Have you used			
cocaine/crack?	___	___	___
marijuana?	___	___	___
inhalants?	___	___	___
heroin/other opiates?	___	___	___
hallucinogens?	___	___	___
speed/stimulants?	___	___	___
downers?	___	___	___
any others? Please name: _____	___	___	___

Interviewer: If the client has answered 'NO' to all of the above, SKIP to question #10. If any of the above items were answered 'YES', proceed to question #3 below. Read the following to the client: **"The next seven questions are related to your use of alcohol or other drugs which you identified using above."**

	YES	NO
* 3. In the past six months, has your use of alcohol or other drugs caused you problems, such as problems with . . .(Interviewer: ask questions in the following areas, elaborate as necessary with examples.)		
relationships?	___	___
jobs/school?	___	___
housing?	___	___
nutrition? (shopping, eating)	___	___
treatment agencies?	___	___
finances?	___	___
arrests or other legal problems?	___	___
4. In the past six months have you thought you've used too much alcohol or other drugs?	___	___
5. In the past six months have you felt you should cut-down on your drinking or other drug use?	___	___
6. In the past six months have you felt bad or guilty about your use of alcohol or other drugs?	___	___
7. In the past six months has anyone else (e.g. family, friends, doctor) expressed concern that you've used too much alcohol or other drugs?	___	___
* 8. Prior to any hospitalizations were you drinking or using other drugs?	___	___

	YES	NO
9. Have you ever been treated for alcohol or other drug problems? (Interviewer: if 'yes' ask 9A and 9B. Note that Alcoholics Anonymous is not treatment.)	___	___

9A. How long ago were you last treated for alcohol or drug problems? (Interviewer: circle the best answer based on client's response.)
less than three months /three to six months
/over six months and up to one year
/over one year and up to 18 months
/over 18 months and up to two years
/two or more years.

9B. What was your longest period of abstinence after your last treatment? (Interviewer: circle the best answer based on client's response.)
less than three months /three to six months
/over six months and up to one year
/over one year and up to 18 months
/over 18 months and up to two years
/two or more years.

(Interviewer: for items 10 and 11, if client responds 'yes', ask, "How often?" and enter the appropriate code under the column labeled 'FREQ'. Codes are as follows: 1= Every day or nearly every day, 2=3 to 4 times a week, 3=1 to 2 times a week, 4=1 to 3 times a month, 5=3 to 5 times in the past six months, 6=once or twice in the past six months, 9=can't remember.)

	YES	NO	FREQ
10. In the past six months have you used prescription medication without a prescription, or more than was prescribed for you, or for reasons other than the medication was prescribed?	___	___	____
11. In the past six months have you used more than the recommended dose of any over-the-counter medications, or used any of these medications for reasons other than they were intended?	___	___	____

Interviewer: please read to client: "**Thank-you for participating in this study.**" Then, please turn to next page to record your impressions of the interview.

	YES	NO
12. Interviewer: Due to client's mode of responding, clinical intuition or information from other sources, does assessment seem indicated?	___	___

13. Interviewer: Please comment on how accurate you perceive the interview was. Comment if the mental status of the client could have affected the accuracy of the results.

_____

_____

_____

_____

These items are based on questions developed by Kathleen Sciacca, M.A., program developer for mentally ill chemical abuse programs in New York, NY.

Appendix B

Scoring and interpretation for each of the three screening instruments

****

Elderly Sample

Scoring: 1) Give one point for each affirmative response
2) Compute sum
3) Score range: 0-12

Score	Suggested Action
0-3	No action or monitor and reassess at a later date
4+	Refer for a chemical dependency evaluation

This cut score correctly classified 90% of the elderly development sample.

****

Mentally Ill Sample

Scoring: 1) Give one point for each affirmative response (give one point for item 3 if any of the problems have an affirmative response)
2) Compute sum
3) Score range: 0-9

Score	Suggested Action
0-3	No action or monitor and reassess at a later date
4+	Refer for a chemical dependency evaluation

This cut score correctly classified 95% of the mentally ill development sample.

****

Physically Disabled Sample

Scoring: 1) Give one point for each affirmative response
2) Compute sum
3) Score range: 0-8

Score	Suggested Action
0-3	No action or monitor and reassess at a later date
4+	Refer for a chemical dependency evaluation

This cut score correctly classified 86% of the physically disabled development sample.

Figure 1

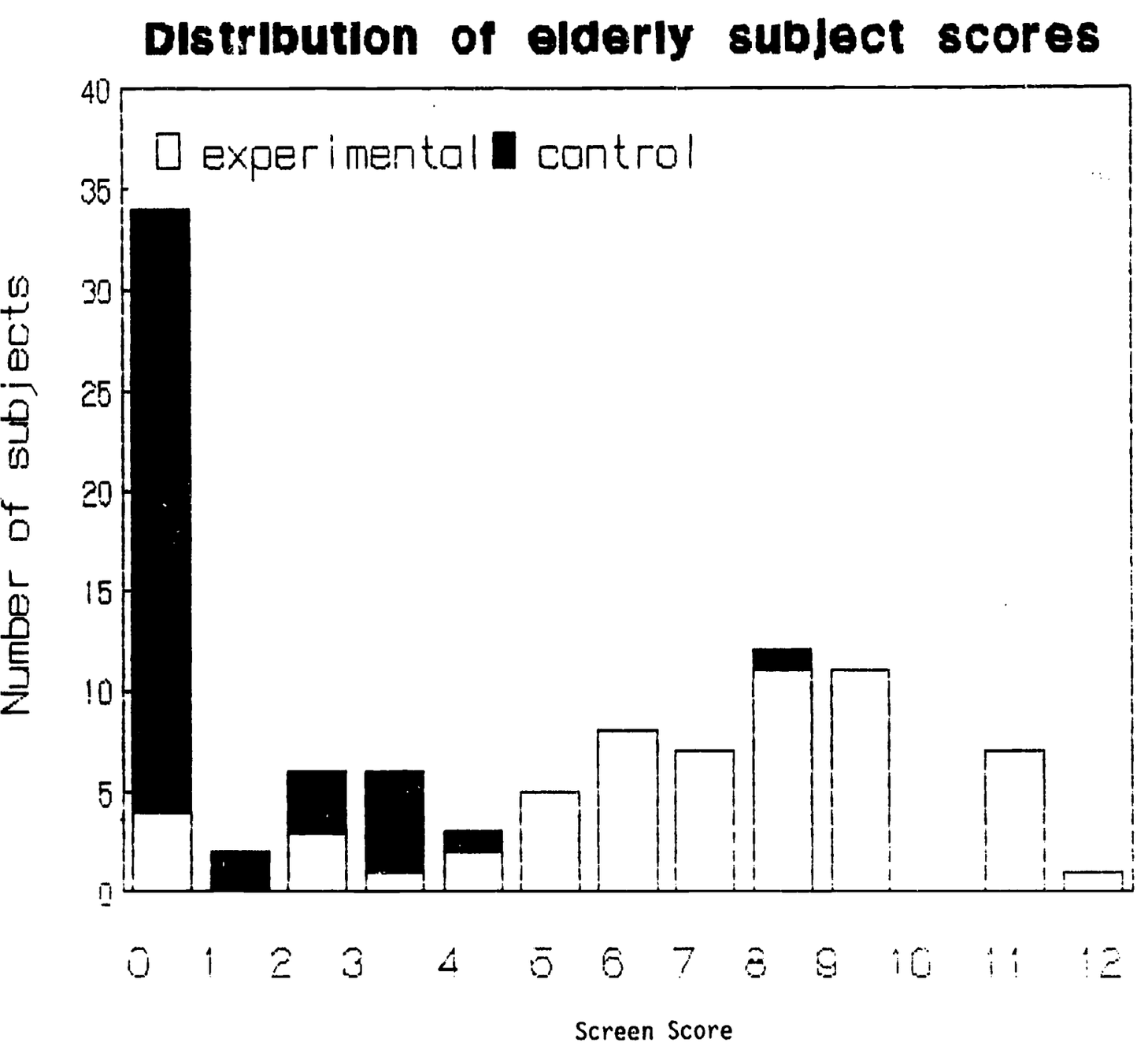

Distribution of elderly subject scores
experimental
control
Number of subjects
0
5
10
15
20
25
30
35
40
0 1 2 3 4 5 6 7 8 9 10 11 12
Screen Score

Figure 2

DISTRIBUTION OF PSYCHIATRIC SUBJECT SCORES

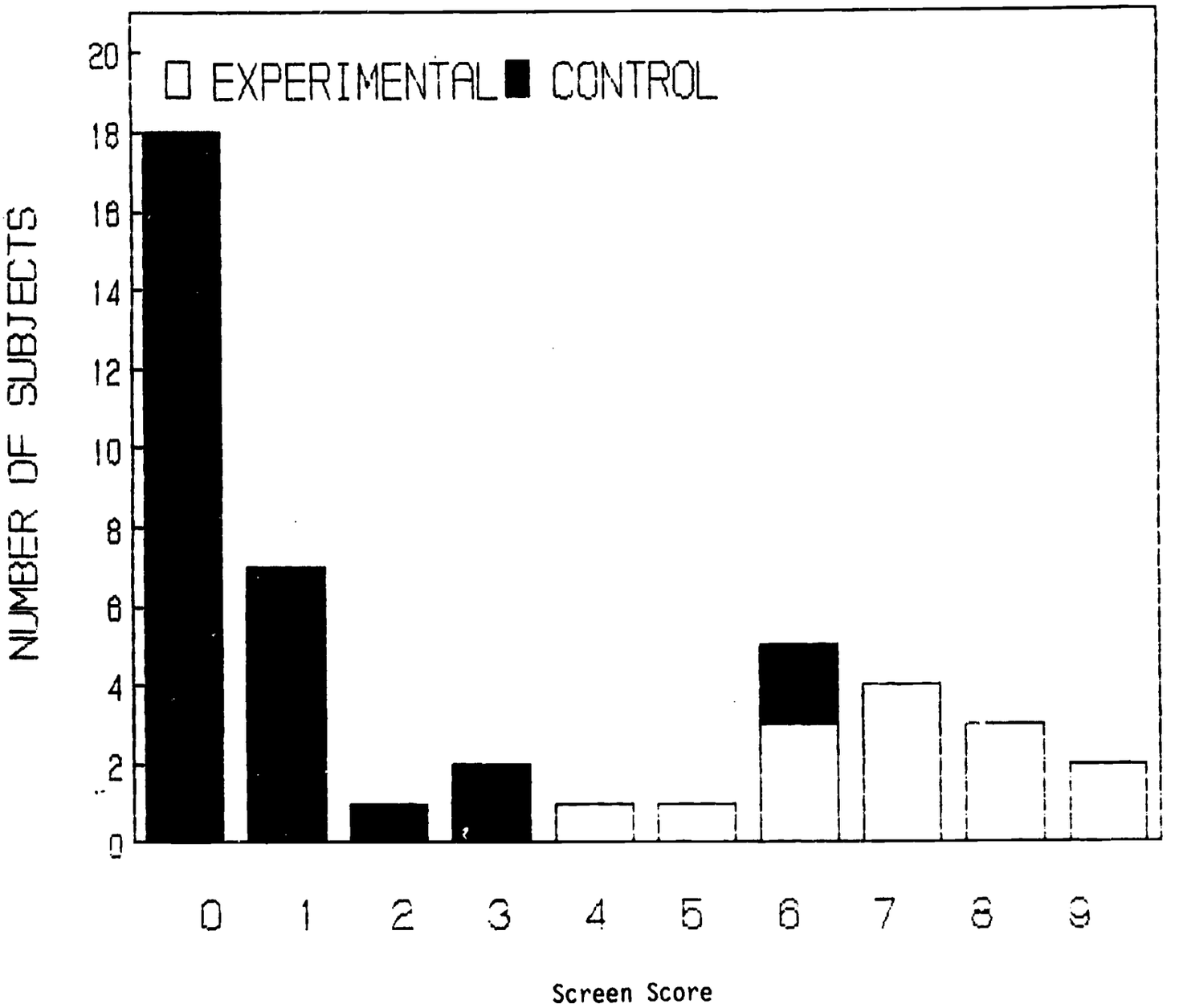
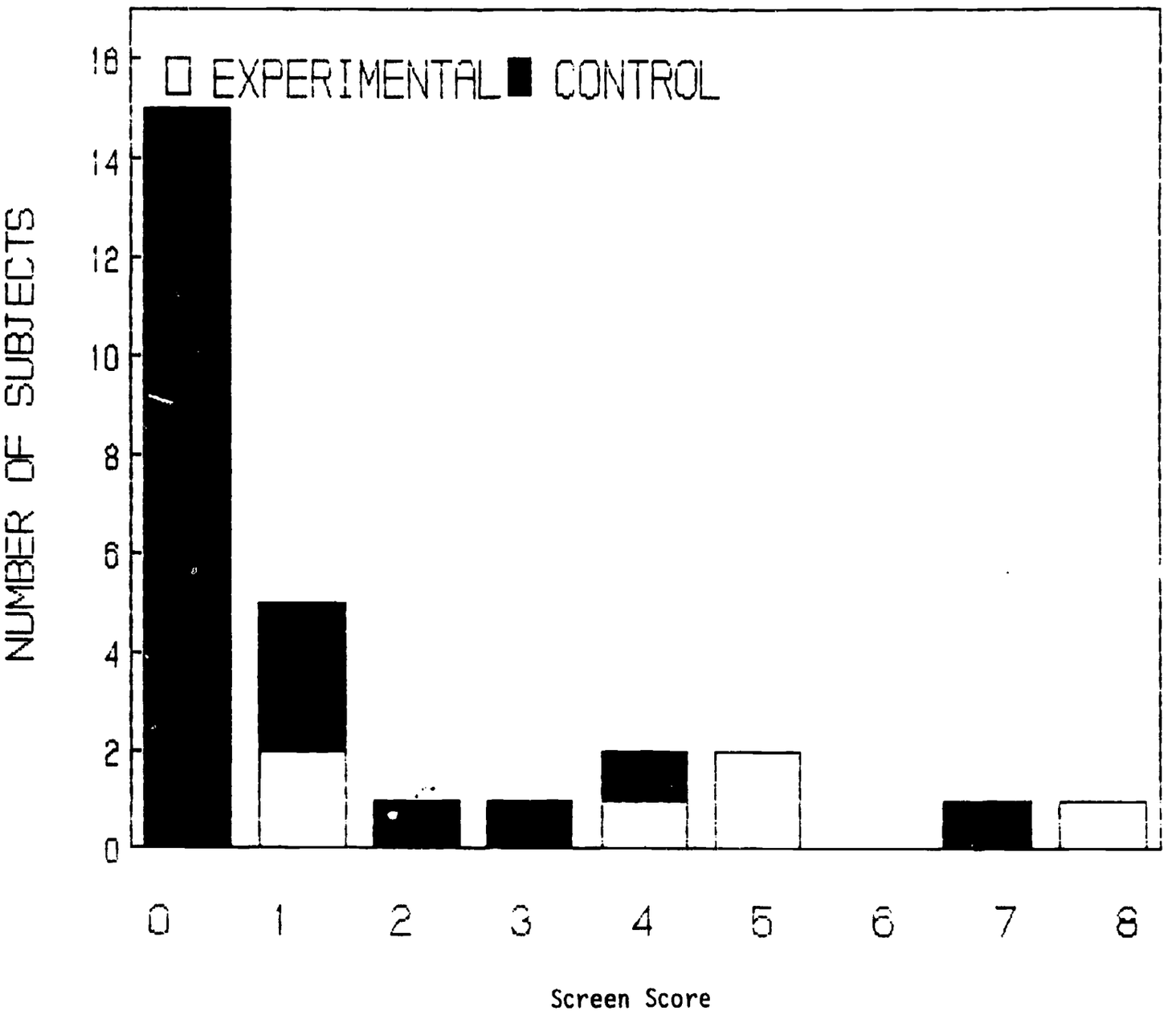


Figure 3

DISTRIBUTION OF PHYSICALLY DISABLED SUBJECT SCORES



Guidelines: Interview Protocol

1.) Remind the interviewee that responses to research questionnaires or interviews will not affect treatment service.

2.) Speak clearly and slow enough to be easily understood.

3.) Ask the questions exactly as they appear. Please do not alter or add words for conversational purposes. A change in wording can produce a change in response.

4.) Ask questions directly-without hesitance or apology. (If the interviewer is uncertain or embarrassed in his questioning, he will get a corresponding response.)

5.) If pertinent, repeat the considerations of confidentiality and that information will only be used for research.

6.) Be friendly and understanding especially if the information is sensitive, but do not bias the response by approval or criticism.

7.) Best guarantees against falsifying - look the subject in the eyes, keep the interview moving, keep your notes brief and do not show surprise at the response.

8.) If a person is having difficulty answering 'yes' or 'no', please suggest they answer the response that is most true. If they are still unable to answer the question, please leave it blank.

9.) If you are not clear about the meaning of a response do not assume the answer, ask him/her to repeat it.

10.) Always thank the interviewee at the end of the interview.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CALL KATHY GILMORE OE DEBRA HOLE AT 462-7700.

SCREENING CONSENT FORM

YOU ARE INVITED TO PARTICIPATE IN A SCREENING STUDY. FROM THE PROJECT, WE HOPE TO LEARN NEW WAYS TO IDENTIFY ALCOHOL AND DRUG PROBLEMS. YOU WERE SELECTED AS A POSSIBLE PARTICIPANT IN THIS STUDY BECAUSE YOU ARE A CLIENT IN_____ _____ PROGRAM.

ANY INFORMATION OBTAINED IN CONNECTION WITH THIS STUDY THAT CAN BE IDENTIFIED WITH YOU WILL REMAIN CONFIDENTIAL. IN ANY WRITTEN REPORTS OR PUBLICATIONS, NO ONE WILL BE IDENTIFIED AND ONLY GROUP/AGGREGATE INFORMATION WILL BE PRESENTED. YOUR NAME WILL NOT BE LISTED ON ANY RESEARCH FORMS.

YOUR DECISION WHETHER OR NOT TO PARTICIPATE WILL NOT AFFECT YOUR RELATIONS WITH ___ _____. IF YOU DECIDE TO PARTICIPATE YOU ARE FREE TO DISCONTINUE PARTICIPATION AT ANY TIME WITHOUT AFFECTING SUCH RELATIONSHIPS.

YOU WILL BE ASKED TO DECIDE WHETHER OR NOT YOU WANT TO PARTICIPATE IN THE STUDY. YOU WILL ALSO BE ASKED TO DECIDE WHETHER YOU GIVE APPROVAL FOR A SIGNIFICANT OTHER OF YOURS, e.g. friend, spouse, family member, TO ALSO PARTICIPATE IN THE STUDY. THE SIGNIFICANT OTHER WOULD BE ASKED TO RESPOND TO THE SAME QUESTIONS, IN ORDER TO VERIFY YOUR RESPONSES.

ALTHOUGH PARTICIPATING IN THIS RESEARCH WILL HAVE NO DIRECT BENEFITS TO YOU, IT MAY BE OF ENORMOUS BENEFIT TO OTHERS WHO MAY HAVE PROBLEMS WITH ALCOHOL AND DRUGS.

IF YOU HAVE ANY QUESTIONS, PLEASE ASK US. IF YOU HAVE ANY ADDITIONAL QUESTIONS LATER, KATHY GILMORE, THE PROJECT MANAGER (462-7700 X4072) WILL BE HAPPY TO ANSWER THEM.

YOU WILL BE OFFERED A COPY OF THIS FORM AND THE RESEARCH FORM TO KEEP.

YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTICIPATE. YOU ARE MAKING A DECISION T
APPROVE A SIGNIFICANT OTHER OF YOURS TO PARTICIPATE IN THE STUDY. YOUR SIGNATURE
INDICATES THAT YOU HAVE READ THE INFORMATION PROVIDED ABOVE AND HAVE DECIDED TO
PARTICIPATE AND APPROVED THE PARTICIPATION OF YOUR SIGNIFICANT OTHER. YOU MAY
WITHDRAW AT ANY TIME WITHOUT PREJUDICE AFTER SIGNING THIS FORM SHOULD YOU CHOOSE TO
DISCONTINUE PARTICIPATION IN THIS RESEARCH STUDY.

SIGNATURE	DATE
WITNESS (if necessary)	DATE
SIGNATURE OF THE INVESTIGATOR	DATE

* use a solid line to delete portion of the consent form you do not give consent to.

Identification #_____

DEMOGRAPHIC INFORMATION FOR FIELD TEST (CLIENTS WITH PHYSICAL DISABILITIES)

Completed by Screener: The following information is requested to assess if the alcohol/drug screen works better for clients with specific characteristics. The demographic information will be used to validate screening information. Please complete for each client participating in the field test.

1. Gender:
   _____ (1) Female
   _____ (2) Male

2. Age of Client: _____ (years)

3. Marital Status:
   _____ (1) Single
   _____ (2) Married
   _____ (3) Divorced/Separated
   _____ (4) Widowed
   _____ (5) Missing information

4. Type of living arrangement:
   _____ (1) Alone
   _____ (2) With spouse
   _____ (3) With relatives
   _____ (4) With others
   _____ (5) Missing information

5. Education:
   _____ (1) Less than high school
   _____ (2) High School education
   _____ (3) Partial college
   _____ (4) College degree
   _____ (5) Graduate school
   _____ (6) Student
   _____ (7) Missing information

6. Living Location:
   _____ (1) Own house
   _____ (2) Supervised living
   _____ (3) Apartment
   _____ (4) Other _____
   _____ (5) Unknown

7. Occupational Status:
   _____ (1) Working full-time
   _____ (2) Working part-time
   _____ (3) Unemployed
   _____ (4) Missing information

8. How long has the client been in your program as of today?_____
   (in days)

9. Cultural Background:
   _____ (1) White
   _____ (2) Black
   _____ (3) Hispanic
   _____ (4) Native American
   _____ (5) Asian
   _____ (6) Other _____
   _____ (7) Missing information

10. Number of previous treatments for CD:
    _____ (1) None
    _____ (2) One
    _____ (3) Two
    _____ (4) Three or more
    _____ (5) Missing information

11. Age of first treatment for CD:
    _____ (Years)

12. **(For CD programs only)**
    Current CD Diagnosis:
    (Use code number from DSMIIIR, if not available, write out dx.)
    (1)_____ (2)_____
    (3)_____ (4)_____
    (5)_____ (6)_____
    (7)_____ (8)_____

13. **(For CD programs only)**
    Standardized Scores:
    MMPI/MacAndrews - **Please list scores on reverse side.**
    MAST _____
    Rule 25 Rating _____
    Other _____

14. Type of disablement (identify):
    _____

14a. Cause:
    _____ (1) Injury/accident
    _____ (2) Stroke
    _____ (3) Congenital
    _____ (4) Other_____

TURN PAGE

MMPI/MacAndrews Scales

L _____
F _____
K _____
1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
0 _____

MacAndrews _____

15. Cognitive/mental status score _____

Identification #_____

DEMOGRAPHIC INFORMATION FOR FIELD TEST (CLIENTS WITH MENTAL ILLNESS)

Completed by Screener: The following information is requested to assess if the alcohol/drug screen works better for clients with specific characteristics. The demographic information will be used to validate screening information. Please complete for each client participating in the field test.

1. Gender:
   _____ (1) Female
   _____ (2) Male

2. Current DSMIIIR - Axis I psychiatric diagnosis:
   _____
   _____

3. Age of Client: ____ (in years)

4. Marital Status:
   _____ (1) Single
   _____ (2) Married
   _____ (3) Divorced/Separated
   _____ (4) Widowed
   _____ (5) Missing information

5. Occupational Status:
   _____ (1) Working full-time
   _____ (2) Working part-time
   _____ (3) Retired
   _____ (4) Unemployed
   _____ (5) Student
   _____ (6) Homemaker
   _____ (7) Volunteer
   _____ (8) SSI
   _____ (9) Missing information

6. Education:
   _____ (1) Less than high school
   _____ (2) High School diploma
   _____ (3) Partial college
   _____ (4) College degree
   _____ (5) Graduate degree
   _____ (6) Missing information

7. Cultural Background:
   _____ (1) White
   _____ (2) Black
   _____ (3) Hispanic
   _____ (4) Native American
   _____ (5) Asian
   _____ (6) Other _____
   _____ (7) Missing information

8. Age of first treatment for CD:
   _____ (Years)

9. Number of previous CD treatments:
   _____ (1) None
   _____ (2) One
   _____ (3) Two
   _____ (4) Three or more
   _____ (5) Missing information

10. (For CD programs only)
    Current Substance Use Disorder Diagnoses:
    (Use code number from DSMIIIR, if not available, write out dx.)
    (1)_____ (2)_____
    (3)_____ (4)_____
    (5)_____ (6)_____
    (7)_____ (8)_____

11. (For CD programs only)
    Standardized Scores:
    MMPI/MacAndrews - please list scores on reverse side.
    MAST _____
    Rule 25 Rating _____
    Other _____

12. Length of time in your program (in days): _____

MMPI/MacAndrews Scales

L _____
F _____
K _____
1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
0 _____

MacAndrews _____

Date of test (if available) _____

Identification #_____

DEMOGRAPHIC INFORMATION FOR FIELD TEST (CLIENTS WITH MENTAL ILLNESS)

Completed by Screener: The following information is requested to assess if the alcohol/drug screen works better for clients with specific characteristics. The demographic information will be used to validate screening information. Please complete for each client participating in the field test.

1. Gender:
   _____ (1) Female
   _____ (2) Male

2. Current DSMIIIR - Axis I psychiatric diagnosis:
   _____
   _____

3. Age of Client: ____ (in years)

4. Marital Status:
   _____ (1) Single
   _____ (2) Married
   _____ (3) Divorced/Separated
   _____ (4) Widowed
   _____ (5) Missing information

5. Occupational Status:
   _____ (1) Working full-time
   _____ (2) Working part-time
   _____ (3) Retired
   _____ (4) Unemployed
   _____ (5) Student
   _____ (6) Homemaker
   _____ (7) Volunteer
   _____ (8) SSI
   _____ (9) Missing information

6. Education:
   _____ (1) Less than high school
   _____ (2) High School diploma
   _____ (3) Partial college
   _____ (4) College degree
   _____ (5) Graduate degree
   _____ (6) Missing information

7. Cultural Background:
   _____ (1) White
   _____ (2) Black
   _____ (3) Hispanic
   _____ (4) Native American
   _____ (5) Asian
   _____ (6) Other _____
   _____ (7) Missing information

8. Age of first treatment for CD:
   _____ (Years)

9. Number of previous CD treatments:
   _____ (1) None
   _____ (2) One
   _____ (3) Two
   _____ (4) Three or more
   _____ (5) Missing information

10. **(For CD programs only)**
    Current Substance Use Disorder Diagnoses:
    (Use code number from DSMIIIR, if not available, write out dx.)
    (1)_____ (2)_____
    (3)_____ (4)_____
    (5)_____ (6)_____
    (7)_____ (8)_____

11. **(For CD programs only)**
    Standardized Scores:
    MMPI/MacAndrews - please list scores on reverse side.
    MAST _____
    Rule 25 Rating _____
    Other _____

12. Length of time in your program (in days): _____

MMPI/MacAndrews Scales

L _____
F _____
K _____
1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
0 _____

MacAndrews _____

Date of test (if available) _____

Identification #_____

DEMOGRAPHIC INFORMATION FOR FIELD TEST (ELDERLY)

Completed by Screener: The following information is requested to assess if the alcohol/drug screen works better for clients with specific characteristics. The demographic information will be used to validate screening information. Please complete for each client participating in the field test.

1. Gender:
   _____ (1) Female
   _____ (2) Male

2. Age of Client: _____ (years)

3. Marital Status:
   _____ (1) Single
   _____ (2) Married
   _____ (3) Divorced/Separated
   _____ (4) Widowed
   _____ (5) Missing information

4. Type of living arrangement:
   _____ (1) Alone
   _____ (2) With spouse
   _____ (3) With relatives
   _____ (4) With others
   _____ (5) Missing information

5. Living Location:
   _____ (1) Own house
   _____ (2) Senior hi-rise
   _____ (3) Apartment
   _____ (4) Other _____
   _____ (5) Unknown

6. Occupational Status:
   _____ (1) Working full-time
   _____ (2) Working part-time
   _____ (3) Retired
   _____ (4) Missing information

7. Education:
   _____ (1) Less than high school
   _____ (2) High School degree
   _____ (3) Partial college
   _____ (4) College degree
   _____ (5) Graduate degree
   _____ (6) Missing information

8. Cultural Background:
   _____ (1) White
   _____ (2) Black
   _____ (3) Hispanic
   _____ (4) Native American
   _____ (5) Asian
   _____ (6) Other _____
   _____ (7) Missing information

9. Number of previous treatments for CD:
   _____ (1) None
   _____ (2) One
   _____ (3) Two
   _____ (4) Three or more
   _____ (5) Missing information

10. Appropriate age of first treatment for CD:
    _____ (Years)

11. **(For CD programs only)**
    Current CD Diagnosis:
    (Use code number from DSMIIIR, if not available, write out dx.)
    (1)_____ (2)_____
    (3)_____ (4)_____
    (5)_____ (6)_____
    (7)_____

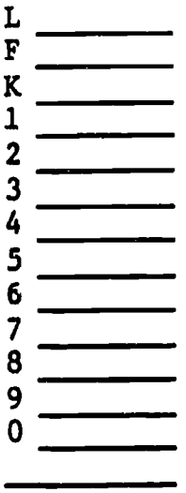
12. **(For CD programs only)**
    Standardized Scores:
    MMPI/MacAndrews - **Please list scores on reverse side.**
    MAST _____
    Rule 25 Rating _____
    Other _____

13. Number of days client is in the program to date _____

14. Mental status score _____

TURN PAGE

15. MMPI/MacAndrews Scales



NON-CD PROGRAMS: FEASIBILITY/UTILITY QUESTIONNAIRE

Date: _____
Name: _____
Program Name: _____

To be completed by each interviewer after all screens are completed.

Please answer all of the following questions, as indicated, by a rating or open-ended response. Feel free to comment on any additional changes that you feel are needed. If you need more space, please use the back of the page or an additional sheet of paper. Thank you.

1. On the average, how many minutes did it take for you to complete the screen? _____

2. Please comment on the length of the screening questions:

   _____ (1) Too long
   _____ (2) About right
   _____ (3) Too short

3. Were the screening questions asked at the appropriate time in the assessment process?

   _____ (1) Yes
   _____ (2) No

   If no, when would be a better time to ask the set of alcohol and drug screening questions? _____

4. What reactions (positive, negative or neutral) did your clients have about these alcohol and drug screening questions?

   _____
   _____
   _____ _____

5. Please rate the level of difficulty/ease you had in asking the screening questions?

   _____ (1) Very difficult
   _____ (2) Somewhat difficult
   _____ (3) Neutral
   _____ (4) Fairly easy
   _____ (2) Very easy

6. Please comment on the appropriateness of the language (words, phrases, questions) of the screening tool to your client. Consider the age, ethnic background, and physical or mental functioning of your client.

7. Do you believe it is important to ask a set of alcohol and drug screening questions during your assessment of clients? Why?

_____
_____
_____

8. The purpose of the alcohol and drug questions is to identify potential alcohol and drug problems in your clients. In your opinion, how good were the questions in screening potential problems?

_____ (1) Very poor
_____ (2) Poor
_____ (3) Fair
_____ (4) Good
_____ (5) Very good

9. What specific suggestions do you have for improving the screening tool? _____
_____
_____
_____

10. Other comments: _____
_____
_____
_____
_____

Thank you for participating in this study!

Identification #_____

DEMOGRAPHIC INFORMATION FOR FIELD TEST (CLIENTS WITH MENTAL ILLNESS)

Completed by Screener: The following information is requested to assess if the alcohol/drug screen works better for clients with specific characteristics. The demographic information will be used to validate screening information. Please complete for each client participating in the field test.

1. Gender:
   _____ (1) Female
   _____ (2) Male

2. Current DSMIIIR - Axis I psychiatric diagnosis:
   _____
   _____

3. Age of Client: ____ (in years)

4. Marital Status:
   _____ (1) Single
   _____ (2) Married
   _____ (3) Divorced/Separated
   _____ (4) Widowed
   _____ (5) Missing information

5. Occupational Status:
   _____ (1) Working full-time
   _____ (2) Working part-time
   _____ (3) Retired
   _____ (4) Unemployed
   _____ (5) Student
   _____ (6) Homemaker
   _____ (7) Volunteer
   _____ (8) SSI
   _____ (9) Missing information

6. Education:
   _____ (1) Less than high school
   _____ (2) High School diploma
   _____ (3) Partial college
   _____ (4) College degree
   _____ (5) Graduate degree
   _____ (6) Missing information

7. Cultural Background:
   _____ (1) White
   _____ (2) Black
   _____ (3) Hispanic
   _____ (4) Native American
   _____ (5) Asian
   _____ (6) Other _____
   _____ (7) Missing information

8. Age of first treatment for CD:
   _____ (Years)

9. Number of previous CD treatments:
   _____ (1) None
   _____ (2) One
   _____ (3) Two
   _____ (4) Three or more
   _____ (5) Missing information

10. **(For CD programs only)**
    Current Substance Use Disorder Diagnoses:
    (Use code number from DSMIIIR, if not available, write out dx.)
    (1)_____ (2)_____
    (3)_____ (4)_____
    (5)_____ (6)_____
    (7)_____ (8)_____

11. **(For CD programs only)**
    Standardized Scores:
    MMPI/MacAndrews - **please list scores on reverse side.**
    MAST _____
    Rule 25 Rating _____
    Other _____

12. Length of time in your program (in days): _____

MMPI/MacAndrews Scales

L _____
F _____
K _____
1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
0 _____

MacAndrews _____

Date of test (if available) _____

Identification #_____

Screening Tool: Older Adults

INSTRUCTIONS:

(**Please read to client**) Thank you for agreeing to participate in this research study. I'd like to take a minute to read you the instructions. The instructions are as follows. This form is a list of 13 questions. The questions refer to your experiences over the last 2 years. The questions below concern alcohol and prescription drug use. In these questions, alcohol refers to beverages such as wine, beer and whiskey and prescription drugs refer to medication prescribed by a doctor such as sleeping drugs, tranquilizers or over-the-counter medications. After each question is read to you, please answer 'yes' or 'no'. There are no right or wrong answers. Again, thank you for participating in this research study.

Please check (X) appropriate response:

	YES	NO
A. DO YOU DRINK ALCOHOL?	--	--
B. DO YOU USE PRESCRIPTION DRUGS OR OVER THE COUNTER MEDICATION...		
B1. ..TO HELP YOU SLEEP?	—	--
B2 ..TO CALM YOU DOWN?	—	--
B3 ..TO FEEL BETTER **e.g.**, LESS SHY?	—	--

INSTRUCTIONS:

A. If the response to any one of items 'A' through 'B' is 'yes', proceed to the set of questions on the next page. (If all responses to the above questions are 'no', please end the interview.) When reading the following questions to the client, please refer to the substances which they answered positively to in the above questions A through B. **For example**, if a client only responded 'yes' to drinking, and 'no' to prescription drugs, then question # 1 would be read like this: *Has your use of alcohol caused you a problem?* **Another example**, if a client responded 'yes' to using prescription drugs to calm down and alcohol, question #1 would be read like this: *Has your use of prescription drugs to calm you down and alcohol caused you a problem?*

B. (Please read the following to the client): The following questions are only related to your use of either alcohol and/or prescription drugs you identified above.

PROCEED TO NEXT PAGE PLEASE

	YES	NO
1. HAS YOUR USE OF ALCOHOL OR PRESCRIPTION DRUGS CAUSED YOU A PROBLEM? **1A.** WHAT TYPE OF PROBLEM DID YOU HAVE? _____ _____ _____	—	—
2. HAVE YOU EVER THOUGHT YOU USED TOO MUCH ALCOHOL OR PRESCRIPTION DRUGS?	—	—
3. HAVE YOU EVER FELT YOU SHOULD CUT DOWN ON YOUR DRINKING OR PRESCRIPTION DRUG USE?	—	—
4. HAVE YOU EVER FELT BAD OR GUILTY (**e.g.**, THINGS SAID TO YOU BY FRIENDS, FAMILY, OTHER PEOPLE) ABOUT YOUR USE OF ALCOHOL OR PRESCRIPTION DRUGS?	—	—
5. HAS ANYONE (**e.g.**, FAMILY MEMBER, FRIEND, DOCTOR) EXPRESSED CONCERN THAT YOU USED TOO MUCH ALCOHOL OR PRESCRIPTION DRUGS?	—	—
6. HAVE YOU EVER USED PRESCRIPTION MEDICATION WITHOUT A PRESCRIPTION OR MORE THAN WAS PRESCRIBED FOR YOU?	—	—
7. HAVE YOU EVER USE PRESCRIPTION MEDICATION FOR SOMETHING OTHER THAN WHAT IT WAS PRESCRIBED FOR? EXAMPLE:_____	—	—
8. HAVE YOU SKIPPED MEALS OR FAILED TO TAKE CARE OF YOURSELF WHEN YOU WERE USING ALCOHOL OR PRESCRIPTION DRUGS ?	—	—
9. HAVE YOU HAD ANY ACCIDENTS OR INJURIES (**e.g.**, FALLS, BURNS, DUI'S, DRIVING ACCIDENTS) WHEN YOU WERE USING ALCOHOL OR PRESCRIPTION DRUGS ?	—	—
10. HAVE YOU EVER BEEN HOSPITALIZED OR RECEIVED TREATMENT OR EMERGENCY CARE FOR ALCOHOL OR PRESCRIPTION DRUG PROBLEMS?	—	—
11. DO YOU HAVE ANY MEDICAL PROBLEMS RELATED TO YOUR ALCOHOL OR PRESCRIPTION DRUG USE (**e.g.**, LIVER DISEASE)?	—	—
12. HAVE YOU EVER NEGLECTED YOUR FAMILY OR MISSED SOCIAL OBLIGATIONS OR WORK BECAUSE OF YOUR USE OF ALCOHOL OR PRESCRIPTION DRUG USE? (**e.g.**,NOT COME HOME WHEN YOU SAID YOU WOULD, SPENT MORE MONEY THAN YOU SHOULD, ABSENT FROM WORK BECAUSE OF USE OR A HANGOVER, OR LOST A JOB)	—	—

PLEASE TURN PAGE

13. BEFORE WE END THE INTERVIEW, ARE THERE ANY COMMENTS OR CONCERNS YOU WOULD LIKE TO SHARE ABOUT THE INTERVIEW, THE INTERVIEW QUESTIONS OR YOUR REACTION TO THEM?

_____
_____
_____
_____

THANK YOU FOR PARTICIPATING IN THIS RESEARCH STUDY.
(Interviewer: please complete rest of form)

Interviewer Questions

	YES	NO
14. DUE TO THE CLIENT'S MODE OF RESPONDING, CLINICAL INTUITION AND INFORMATION FROM OTHER SOURCES, DOES ASSESSMENT SEEM INDICATED?	__	__

15. PLEASE COMMENT ON HOW ACCURATE YOU PERCEIVE THE INTERVIEW WAS. COMMENT IF THE MENTAL STATUS OF THE CLIENT COULD HAVE AFFECTED THE ACCURACY OF THE RESULTS. (Please use back of page for additional comments.)

_____
_____
_____

16. PLEASE ADD ANY ADDITIONAL COMMENTS/PERCEPTIONS YOU HAVE ABOUT THE SCREENING TOOL: (Please use back of page for additional comments.)

_____
_____
_____
_____

THANK YOU!

Identification #_____

Screening Tool: Person with Physical Impairment

INSTRUCTIONS:

(Please read to client) Thank you for agreeing to participate in this research study. I'd like to take a minute to read you the instructions. The instructions are as follows. This form is a list of 13 questions. The questions refer to your experiences over the last 2 years. The questions below concern alcohol, prescription drug use and other drug use. In these questions, alcohol refers to beverages such as wine, beer and whiskey; prescription drugs refer to medication prescribed by a doctor such as sleeping drugs, tranquilizers or over-the-counter medications; other drugs refers to drugs such as marijuana and cocaine. After each question is read to you, please answer 'yes' or 'no'. There are no right or wrong answers. Again, thank you for participating in this research study.

Please check (x) appropriate response:

	YES	NO
A. DO YOU DRINK ALCOHOL?	__	__
B. DO YOU USE PRESCRIPTION DRUGS OR OVER-THE-COUNTER MEDICATION... (circle response)		
B1 ..TO HELP YOU SLEEP?	__	__
B2 ..TO CALM YOU DOWN	__	__
B3 ..TO PEP YOU UP	__	__
C. DO YOU TAKE MEDICATION FOR MUSCLE SPASMS?	__	__
D. DO YOU USE OTHER DRUGS E.G./MARIJUANA, COCAINE?	__	__

INSTRUCTIONS:

A. If the response to any one of the items 'A-D' is 'yes', proceed to the set of questions on the next page. (If all responses to the above questions are 'no', please end the interview.) When reading the following questions to the client, please refer to the substances which they answered positively to in the above questions A through D. **For example**, if a client only responded 'yes' to drinking, and 'no' to prescription and other drugs, then question #1 would be read like this: *Has your use of alcohol caused you a problem?* **Another example**, if a client responded 'yes' to using prescription drugs to calm down and alcohol, question #1 would be read like this: *Has your use of prescription drugs to calm down and /or alcohol caused you a problem?*

B. **(Please read the following to the client)**: The following questions are only related to your use of either alcohol, prescription drugs or the other drugs you identified above.

PROCEED TO NEXT PAGE PLEASE

	YES	NO
1. HAS YOUR USE OF ALCOHOL, PRESCRIPTION DRUGS OR OTHER DRUGS CAUSED YOU A PROBLEM? 1A. WHAT TYPE OF PROBLEM DID YOU HAVE? _____ _____	—	—
2. HAVE YOU EVER THOUGHT YOU USED TOO MUCH ALCOHOL, PRESCRIPTION DRUGS OR OTHER DRUGS?	--	--
3. HAVE YOU EVER FELT YOU SHOULD CUT DOWN ON YOUR DRINKING, PRESCRIPTION DRUG OR OTHER DRUG USE?	--	--
4. HAVE YOU EVER FELT BAD OR GUILTY (E.G., THINGS SAID TO YOU BY FRIEND, FAMILY MEMBER, OTHER) ABOUT YOUR USE OF ALCOHOL, PRESCRIPTION DRUGS OR OTHER DRUGS?	--	--
5. HAS ANYONE (e.g., FAMILY MEMBER, FRIEND, DOCTOR) EXPRESSED CONCERN THAT YOU USED TOO MUCH ALCOHOL, PRESCRIPTION DRUGS OR OTHER DRUGS?	--	--
6. HAVE YOU EVER USED PRESCRIPTION MEDICATION WITHOUT A PRESCRIPTION OR MORE THAN WAS PRESCRIBED FOR YOU?	--	--
7. HAVE YOU EVER USED PRESCRIPTION MEDICATION FOR SOMETHING OTHER THAN WHAT IS WAS PRESCRIBED FOR? EXAMPLE: _____	--	--
8. HAVE YOU EVER BEEN HOSPITALIZED OR RECEIVED TREATMENT OR EMERGENCY CARE FOR ALCOHOL AND/OR DRUG PROBLEMS?	--	--

9. BEFORE WE END THE INTERVIEW, ARE THERE ANY COMMENTS OR CONCERNS YOU WOULD LIKE TO SHARE ABOUT THIS INTERVIEW, THE INTERVIEW QUESTIONS OR YOUR REACTION TO THEM?

_____

_____

_____

_____

THANK YOU FOR PARTICIPATING IN THE RESEARCH STUDY.
(Interviewer: please complete back of form)

TURN PAGE PLEASE

INTERVIEWER: PLEASE COMPLETE THE FOLLOWING QUESTIONS

	YES	NO
10. DUE TO THE CLIENT'S MODE OF RESPONDING, CLINICAL INTUITION AND INFORMATION FROM OTHER SOURCES, DOES ASSESSMENT SEEM INDICATED?	--	--
11. WAS THE CLIENT USING ALCOHOL OR DRUGS AT THE TIME OF DISABLEMENT?	--	--

12. IF YES TO QUESTION #11, PLEASE IDENTIFY THE SOURCE OF INFORMATION:

__ (1) CLIENT
__ (2) FRIEND/SIGNIFICANT OTHER
__ (3) MEDICAL RECORD
__ (4) POLICE RECORD
__ (5) OTHER, PLEASE SPECIFY

13. (Do not complete for individuals with recent injuries /accidents) DOES YOUR PROFESSIONAL OPINION OR PATIENT HISTORY/ MEDICAL RECORD SUGGEST THIS PATIENT HAS MEDICAL PROBLEMS (**e.g.** PRESSURE SORES, CIRCULATORY PROBLEMS) RELATED TO ALCOHOL OR DRUG USE?	--	--

14. IF YES TO QUESTION #13, PLEASE IDENTIFY TYPE OF MEDICAL CONDITION/PROBLEM:_____

_____

15. DOES THE MEDICAL RECORD OR PATIENT HISTORY SUGGEST PROBLEMATIC CHEMICAL USE IN THE FAMILY?	--	--

16. PLEASE COMMENT ON HOW ACCURATE YOU PERCEIVED THE INTERVIEW WAS? COMMENT IF THE MENTAL STATUS OF THE CLIENT AFFECTED THE ACCURACY OO RESULTS? (USE BACK OF PAGE IF NECESSARY.)

_____
_____
_____

17. OTHER INTERVIEWER COMMENTS:

_____
_____
_____
_____

THANK YOU!

Identification # _____

Screen For Alcohol and Drug Problems

Instructions: (Interviewer: please read to client. Note that if client has come to your program from residential treatment, substitute the phrase "in the six months prior to your admission to residential program name" for the phrase "in the past six months".) **Following is a list of 11 questions. The questions refer to your experiences during the past six months . These questions concern alcohol and other drug use. After each question is read to you, please answer 'yes' or 'no'. There are no right or wrong answers. Thank-you for participating in this research study.**

(Interviewer: if the client responds 'yes' to any of the substances in questions #1 or #2, please ask **"How often have you used _____?"** and enter the appropriate code under 'FREQ'. Codes are as follows: 1= Every day or nearly every day, 2=3 to 4 times a week, 3=1 to 2 times a week, 4=1 to 3 times a month, 5=3 to 5 times in the past six months, 6=once or twice in the past six months, 9=can't remember.)

	YES	NO	FREQ
1. In the past six months, have you used alcohol?	___	___	___
2. I'm going to read you a list of drugs. Please answer 'yes' if you have used any of these drugs in the past six months. (Interviewer: you may substitute, or add, "slang" or "street" names for any of these drugs.) Have you used			
cocaine/crack?	___	___	___
marijuana?	___	___	___
inhalants?	___	___	___
heroin/other opiates?	___	___	___
hallucinogens?	___	___	___
speed/stimulants?	___	___	___
downers?	___	___	___
any others? Please name: _____	___	___	___

Interviewer: If the client has answered 'NO' to all of the above, SKIP to question #10. If any of the above items were answered 'YES', proceed to question #3 below. Read the following to the client: **"The next seven questions are related to your use of alcohol or other drugs which you identified using above."**

	YES	NO
* 3. In the past six months, has your use of alcohol or other drugs caused you problems, such as problems with . . .(interviewer: ask questions in the following areas, elaborate as necessary with examples.)		
relationships?	___	___
jobs/school?	___	___
housing?	___	___
nutrition? (shopping, eating)	___	___
treatment agencies?	___	___
finances?	___	___
arrests or other legal problems?	___	___
4. In the past six months have you thought you've used too much alcohol or other drugs?	___	___
5. In the past six months have you felt you should cut-down on your drinking or other drug use?	___	___
6. In the past six months have you felt bad or guilty about your use of alcohol or other drugs?	___	___
7. In the past six months has anyone else (e.g. family, friends, doctor) expressed concern that you've used too much alcohol or other drugs?	___	___
* 8. Prior to any hospitalizations were you drinking or using other drugs?	___	___

	YES	NO
9. Have you ever been treated for alcohol or other drug problems? (Interviewer: if 'yes' ask 9A and 9B. Note that Alcoholics Anonymous is not treatment.)	___	___

9A. How long ago were you last treated for alcohol or drug problems? (Interviewer: circle the best answer based on client's response.)
less than three months /three to six months
/over six months and up to one year
/over one year and up to 18 months
/over 18 months and up to two years
/two or more years.

9B. What was your longest period of abstinence after your last treatment? (Interviewer: circle the best answer based on client's response.)
less than three months /three to six months
/over six months and up to one year
/over one year and up to 18 months
/over 18 months and up to two years
/two or more years.

(Interviewer: for items 10 and 11, if client responds 'yes', ask, "**How often?**" and enter the appropriate code under the column labeled 'FREQ'. Codes are as follows: 1= Every day or nearly every day, 2=3 to 4 times a week, 3=1 to 2 times a week, 4=1 to 3 times a month, 5=3 to 5 times in the past six months, 6=once or twice in the past six months, 9=can't remember.)

	YES	NO	FREQ
10. In the past six months have you used prescription medication without a prescription, or more than was prescribed for you, or for reasons other than the medication was prescribed?	___	___	___
11. In the past six months have you used more than the recommended dose of any over-the-counter medications, or used any of these medications for reasons other than they were intended?	___	___	___

Interviewer: please read to client: "**Thank-you for participating in this study.**" Then, please turn to next page to record your impressions of the interview.

	YES	NO
12. Interviewer: Due to client's mode of responding, clinical intuition or information from other sources, does assessment seem indicated?	___	___

13. Interviewer: Please comment on how accurate you perceive the interview was. Comment if the mental status of the client could have affected the accuracy of the results.

_____

_____

_____

_____

* These items are based on questions developed by Kathleen Sciacca, M.A., program developer for mentally ill chemical abuse programs in New York, NY.

RECOMMENDATIONS
FOR A
COORDINATED SERVICE DELIVERY SYSTEM

OLDER ADULTS

The advisory committee met on two occasions and identified steps to be taken by the State of Minnesota Chemical Dependency Program Division to work toward a coordinated service delivery system for the older adult population in a service area. The steps below are not in a priority order. Some of the steps have already been approached by the grant project. The recommendations aimed at fostering a coordinated system are organized in four sections: Identification of Services, Raise Awareness of Service Providers, Finding Solutions to Referral Problems, and Factors to Consider in Serving Older Adults. The committee felt strongly that acheiving a coordinated system would require a long-term solution. After this set of recommendations was accomplished, it would be necessary to consider ways to enhance communication between various service providers.

1. Identification of Services

A. Identify range of older adult services in a service area.
B. Identify range of CD services serving older adults in a service area.

2. Raise Awareness of Older Adult Service Providers

A. Provide training to helping professionals working with older adults. Training is needed in the following areas:

1. Identification of cues to problem chemical use versus problems with medication management

2. Demonstration of intervention techniques

3. Demonstration of chemical abuse screening techniques

   a. attitudinal impact on screening process
   b. client reactions and strategies for coping
   c. interpretation of responses
   d. use of screening tools
   e. what to do when problem identified
      - how to refer for CD assessment

4. Clarification of attitudes

   a. societal attitudes toward older adults
   b. societal attitudes toward persons with alcohol and drug problems
   c. attitudes of other fields towards CD field
   d. attitudes of CD field toward case-finding and case-management

5. Clarification of legal questions

   a. Can public human service programs make a referral for CD assessment?
   b. What liability exists for the referral agent if a client does not follow up with referral and injures himself or others?
   c. What federal confidentiality rules apply?
   d. Use of release of information
   e. Client competency issues

6. Working with caregivers

   a. Education on intervention
   b. Strategies for client motivation
   c. Ways to reduce anxiety about identified problem
   d. Increase leverage through family involvement

7. Resource availiability
   a. programs
   b. funding/eligibility for coverage
      -medicare
      -medicaid/GAMC
      -HMO
      -3rd party
      -self pay
      -other: HEART, free care

Raise Awareness of Chemical Dependency Service Providers

A. Identification of older adult culture
B. Identification of societal attitudes interfering with assessment and treatment
C. Signs and symptoms of alcohol and prescription drug problems versus medication management - specific to the older adult
D. Attitudes toward case-finding and case-management
E. Breaking through attitudinal barriers presented by older adult services toward the problem of chemical abuse

4. **Find Solutions to Identified Referral Problems**

A. Metropolitan counties have a 2-4 week waiting lists to receive a Rule 25 CD assessment.

B. The accessibility of Rule 25 assessors may be a problem to a population group who may experience more mobility impairment than the general population.

C. Rule 25 assessors may not be knowledgable about signs and symptoms of alcohol and prescription drug problems in the older adult or sensitive to older adult culture.

D. No incentives for programs capable of serving older adults who are not currently serving this population group.

6. **Factors to Consider in Maintaining the Dignity and Respect of the Older Adult Client**

A. It is likely that only 10% of the older adult population in any given service area has a problem with chemical dependency.

B. With the aging of America, increasing attention is being given to the assessment of of older adult issues. Older adults in the human service delivery system are assessed for cognitive functioning, mental health functioning, alcohol and drug abuse among other assessment areas. A word of caution to the helping professional is in order. By the nature of the questions we ask, we do not want clients feeling that we are calling them stupid or calling them crazy or calling them drunk.

C. With various life crises from loss of a caregiver, to an accident or fall, to a loss of home, older adults may be experiencing chaotic times when they enter the human service delivery system.

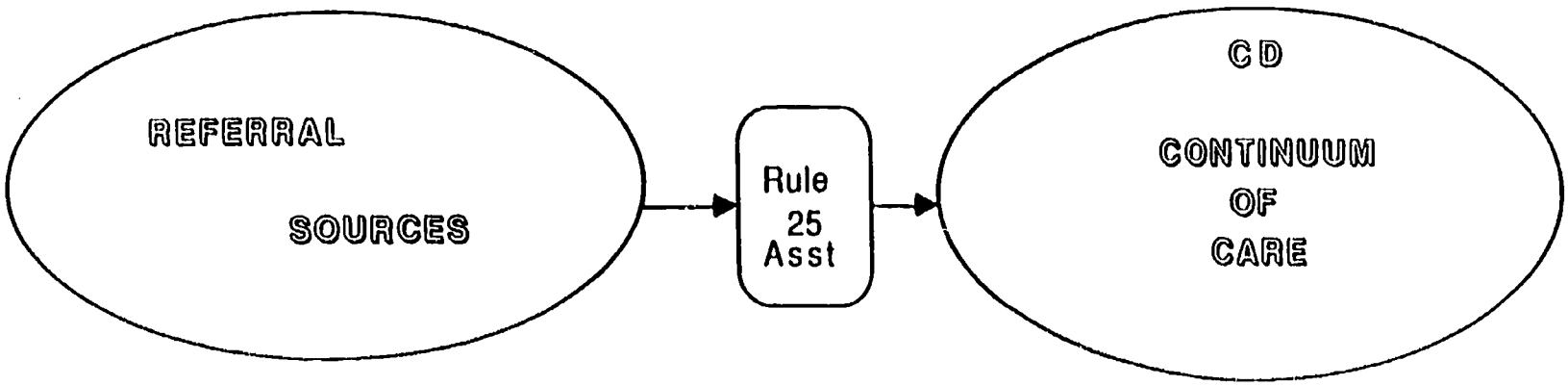
COORDINATED SERVICE DELIVERY SYSTEM

OLDER ADULT SERVICES

* cues to problem use
* medication management
* intervention techniques
* screening techniques
* attitudes
* legal questions
* caregivers
* resource availability

CHEMICAL DEPENDENCY SERVICES

* older adult culture
* societal attitudes
* signs & symptoms
* medication management
* case-finding/case-mngt
* attitudinal barriers



1. Identify range of older adult and chemical dependency services
2. Address training needs of older adults and cd service providers
3. Find solutions to identified referral problems

IDENTIFYING CHEMICAL ABUSE IN SPECIAL POPULATIONS: Older Adults, Persons with Physical Disabilities, and Persons with Mental Illness

A Workshop for Service Providers

This workshop is offered by Hazelden, in conjunction with a grant received from the State of Minnesota Chemical Dependency Program Division.

IDENTIFYING CHEMICAL ABUSE IN SPECIAL POPULATIONS: Older Adults, Persons with Physical Disabilities, and Persons with Mental Illness

SCHEDULE:

8:15 - 8:30	Registration
8:30 - 9:00	Welcome & Introductions
9:00 - 9:50	Overview of Chemical Dependency (For Non-Chemical Dependency Professionals)
9:50 - 10:10	Break
10:10 - 12:00	Impact of Chemical Dependency on Special Populations: A Research Review
12:00 - 1:00	Lunch
1:00 - 2:00	Population Specific Screening: Demonstration Track I: Older Adult Track II: Mental Illness Track III: Physical Disabilities
2:00 - 2:15	Break
2:15 - 3:15	Popluation Specific Screening: Practice Track I: Older Adult Track II: Mental Illness Track III: Physical Disabilities
3:15 - 3:45	Process/Discussion/Questions
3:45 - 4:00	Wrap-up/Evaluations/Certificates

RIGHTS & RESPONSIBILITIES WORKSHEET
(Workshop Guidelines)

Instructor

1. The trainer's responsibilities
   a. speak clearly
   b. keep training session moving and on course
   c. answer questions, clarify, explain
   d. actively involve the participants
   e. know training materials thoroughly
   f. announce breaks and stay on schedule

2. The trainer is also responsible for course content
   a. clearly organized
   b. use examples and clarify
   c. provide necessary data
   d. use examples as relevant as possible
   e. state course objectives
   f. well prepared
   g. adaptable

Participants

1. The participant's responsibilities
   a. listen, be attentive
   b. not side track seminar with inappropriate behavior
   c. ask or be willing to give feedback, to say "I need more information", "I don't understand", etc.
   d. willing to participate in exercises or discussions
   e. have the right to disagree and verbalize that disagreement, but not to stop workshop
   f. return from breaks on time

2. Participant's responsibilities for content
   a. keep an open mind until complete ideas are presented
   b. adapt or transfer information into meaningful examples. (The instructor will use as many relevant examples as possible, but can't possibly give examples for every situation or position.)
   c. course objectives are stated in general - participants are responsible to seek out instructor to modify course objectives if they do not meet your needs.

Reprinted with permission of author: Merwin, Sandra, "Evaluations: A Guide to Evaluating Seminars, Workshops & Classroom Training". Deephaven, MN, Merwin Enterprises, 1981.

*5. Confidentiality

*3. Confidentiality

*CONFIDENTIALITY: Must adhere to and respect all policies regarding patient's rights, anonymity and confidentiality of all patients past and present. This covers any written or verbal communications regarding a patient's identity, address and nature of their problems.

SESSION TITLE: Overview of Chemical Dependency

GOAL: Understand the signs and symptoms of chemical dependency.

OBJECTIVES: Participants will:

1) Understand the continuum of drinking and using behavior.

2) Overview the symptoms of chemical dependency and how they are manifested in each of the three populations.

3) Identify the characteristics of addiction.

LEARNING ACTIVITIES: Lecture
Discussion

RESOURCE: Workbook outline

CHEMICAL DEPENDENCY QUESTIONNAIRE

True False

1. A chemically dependent person is someone who
   a. drinks too much once in a while.
   b. usually can't stop drinking once he or she has one drink.
   c. has problems because of his or her drinking.
   d. must get drunk every day to be called an alcoholic.
2. It's impossible for someone to become a chemically dependent person by drinking just beer.
3. Most chemically dependent persons have jobs and live with their families.
4. Almost all chemically dependent persons are men.
5. Chemically dependent persons are usually people who, if they wanted to, could easily "pull themselves together" and stop drinking without outside help.
6. Most chemically dependent persons are skid row bums
7. There are many more alcoholic persons in this country than drug addicts.
8. Once people become chemically dependent, it's too late to help them.
9. Problem drinkers can sometimes control whether they drink and how they drink; chemically dependent persons usually cannot.
10. Problem drinkers are often chemically dependent in an early stage of their disease.

OVERVIEW OF CHEMICAL DEPENDENCY

I. The drinking/using continuum

Abstinence	Use	Abuse	Addiction
•	•	•	•

II. Nature of Addiction

A. Characteristics of Addiction

1) Loss of choice

2) Primacy of need

3) Autonomous need

4) Indelible imbedding of experience

B. Symptoms of Addictive Use of Alcohol/Drugs (Heilman)

1) Preoccupation

2) Increased tolerance

3) Rapid intake

4) Use as medicine

5) Using alone

6) Blackouts

7) Protecting supply

8) Non-premeditated use

BEHAVIORAL SYMPTOMS OF CHEMICAL DEPENDENCY

SYMPTOM	OLDER ADULT	MENTALLY ILL	DISABILITY
1. Preoccupation			
2. Increased Tolerance			
3. Rapid Intake			
4. Use as medicine			
5. Using alone			
6. Blackouts			
7. Protecting supply			
8. Non-premeditated use			

SESSION TITLE: Impact of chemical dependency on special populations.

GOALS: 1) Identify how chemical dependency is manifested in older adults, persons with physical disabilities and persons with chronic mental illness.

2) Explore the obstacles in the identication process of chemical dependency in these three populations.

OBJECTIVES: Participants will:

1) Explore factors influencing development of chemical dependency in three populations.

2) Identify how chemical dependency is manifested in each population.

3) Identify some of the obstacles to screening/treatment of each population.

LEARNING ACTIVITIES: Panel discussion
Questions/Answers

RESOURCE: Workbook outlines

IMPACT OF CHEMICAL DEPENDENCY ON OLDER ADULTS

1. Intro population and chemical dependency

   ...demographics

   ...chemical dependency underidentified

   ...consequences of failure to identify

2. Characteristics of older adults

   ...heterogenous

   ...older adult agenda

   ...beliefs, values

3. Symptoms/"red flags" of chemical dependency

4. Importance of interviewer attitudes

5. Interviewing approaches

...develop relatonship, trust before discussing use

...semantics - language older adults can relate to

...respectful confrontation

6. Typical client responses

...denial vs "honest no"

...shame, moralistic attitudes

7. Need for corroborating information

...cognitive problems, denial

...family

...physician, others involved

8. Attitudes of other professionals

...don't know chemical dependency

...don't want to/don't know how to deal with

9. Conclusion

..."permission giving"

...identification and treatment can end "revolving door" syndrome

...restoration of maximum functioning

...community network

IMPACT OF CHEMICAL DEPENDENCY ON PERSONS WITH CHRONIC MENTAL ILLNESS

1. Population descriptors - discussion of diagnoses, substances abused, interactive effects and complications to diagnosis.

2. Factors involved in underdiagnosis of this problem in persons with mental illness.

3. Presentation of vulnerabilities to effects of substances - brief overview of neurochemical interactions and medication interactions.

4. Beneficial and negative effects of substance use, function chemical plays in persons life.

5. Screening tips.

SUGGESTED CONTENT FOR CHEMICAL DEPENDENCY/PHYSICAL DISABILITY PRESENTATION

1. The scope of the issue

   - the incidence of chemical dependency for disabled persons.

2. Factors which perpetuate chemical dependency for disabled persons

SUGGESTED CONTENT FOR CHEMICAL DEPENDENCY/PHYSICAL DISABILITY PRESENTATION

3. The impact of chemical dependency on disability adjustment in major areas of life

4. Use of mood-altering chemicals for disabled persons

   - medications/alcohol/street drugs

SUGGESTED CONTENT FOR CHEMICAL DEPENDENCY/PHYSICAL DISABILITY PRESENTATION

5. High-risk indicators in disabled persons

6. Barriers to recognizing, addressing, treating chemical dependency in disabled persons

SUGGESTED CONTENT FOR CHEMICAL DEPENDENCY/PHYSICAL DISABILITY PRESENTATION

7. Addressing chemical use issues with disabled persons

8. Program models

SUGGESTED CONTENT FOR CHEMICAL DEPENDENCY/PHYSICAL DISABILITY PRESENTATION

9. Accessing/creating resources

SESSION TITLE: Population Specific Screening

GOAL: Observe and practice the use of a population specific screening tool and identify cues indicating the need for its use.

OBJECTIVES: Participants will:

1) Observe a demonstration of a population specific screening tool

2) Understand special strategies for screening for chemical abuse in each population.

3) Practice use of screening tool

LEARNING ACTIVITIES: Videotape demonstration
Role play practice
Group discussion

RESOURCES: Workbook outline
Screening tool form

SCREENING TOOL FOR CHEMICAL ABUSE OLDER ADULTS

INSTRUCTIONS:

Please read the following paragraph to the client.

The following questions refer to your experiences over the last 2 years. They concern alcohol use, prescription drug use and other drug use. In these questions, alcohol refers to beverages such as wine, beer and whiskey; prescription drugs refer to medication prescribed by a doctor such as sleeping drugs, tranquilizers or over-the-counter medications; other drugs refers to drugs such as marijuana and cocaine. After each question is read to you, please answer 'yes' or 'no'. There are no right or wrong answers.

	YES	NO
1. IN THE PAST TWO YEARS, HAS YOUR USE OF ALCOHOL OR PRESCRIPTION DRUGS CAUSED YOU A PROBLEM?	☐	☐
1A. WHAT TYPE OF PROBLEM DID YOU HAVE? _____		
2. IN THE PAST TWO YEARS, HAVE YOU EVER THOUGHT YOU USED TOO MUCH ALCOHOL OR PRESCRIPTION DRUGS?	☐	☐
3. IN THE PAST TWO YEARS, HAVE YOU EVER FELT YOU SHOULD CUT DOWN ON YOUR DRINKING OR PRESCRIPTION DRUG USE?	☐	☐
4. IN THE PAST TWO YEARS, HAVE YOU EVER FELT BAD OR GUILTY (e.g., THINGS SAID TO YOU BY FRIEND, FAMILY MEMBER, OTHER) ABOUT YOUR USE OF ALCOHOL OR PRESCRIPTION DRUGS?	☐	☐
5. IN THE PAST TWO YEARS, HAS ANYONE (e.g., FAMILY MEMBER, FRIEND, DOCTOR) EXPRESSED CONCERN THAT YOU USED TO MUCH ALCOHOL OR PRESCRIPTION DRUGS?	☐	☐
6. IN THE PAST TWO YEARS, HAVE YOU EVER USED PRESCRIPTION MEDICATION WITHOUT A PRESCRIPTION OR MORE THAN WAS PRESCRIBED FOR YOU?	☐	☐
7. IN THE PAST TWO YEARS, HAVE YOU EVER USED PRESCRIPTION MEDICATION FOR SOMETHING OTHER THAN WHAT IT WAS PRESCRIBED FOR? EXAMPLE: _____	☐	☐
8. IN THE PAST TWO YEARS, HAVE YOU SKIPPED MEALS OR FAILED TO TAKE CARE OF YOURSELF WHEN YOU WERE USING ALCOHOL OR PRESCRIPTION DRUGS?	☐	☐

9. IN THE PAST TWO YEARS, HAVE YOU HAD ANY ACCIDENTS OR INJURIES (e.g., FALLS, BURNS, DUI'S DRIVING ACCIDENTS) WHEN YOU WERE USING ALCOHOL OR PRESCRIPTION DRUGS? ☐ ☐

10. HAVE YOU EVER BEEN HOSPITALIZED OR RECEIVED TREATMENT OR EMERGENCY CARE FOR ALCOHOL OR PRESCRIPTION DRUG PROBLEMS? ☐ ☐

11. IN THE PAST TWO YEARS, HAVE YOU HAD ANY MEDICAL PROBLEMS RELATED TO YOUR ALCOHOL OR PRESCRIPTION DRUG USE (e.g., LIVER DISEASE)? ☐ ☐

12. IN THE PAST TWO YEARS, HAVE YOU EVER NEGLECTED YOUR FAMILY OR MISSED SOCIAL OBLIGATIONS OR WORK BECAUSE OF YOUR USE OF ALCOHOL OR PRESCRIPTION DRUG USE? (e.g., NOT COME HOME WHEN YOU SAID YOU WOULD, SPENT MORE MONEY THAN YOU SHOULD, ABSENT FROM WORK BECAUSE OF USE OR A HANGOVER, OR LOST A JOB). ☐ ☐

POPULATION SPECIFIC SCREENING: PERSONS WITH CHRONIC MENTAL ILLNESS

Notes:

SCREENING TOOL FOR CHEMICAL ABUSE MENTAL ILLNESS

Instructions:

(Interviewer: please read to client. Note that if client has come to your program from residential treatment, substitute the phrase "in the six months prior to your admission to residential program name" for the phase "in the past six months".)

Following is a list of 11 questions. The questions refer to your experiences during the past six months. These questions concern alcohol and other drug use. After each question is read to you, please answer 'yes' or 'no'. There are no right or wrong answers.

(Interviewer: if the client responds 'yes' to any of the substances in questions #1 or #2, please ask "How often have you used _____?" and enter the appropriate code under 'FREQ'. Codes are as follows: 1 = Every day or nearly every day, 2 = 3 to 4 times a week, 3 = 1 to 2 times a week, 4 = 1 to 3 times a month, 5 = 3 to 5 times in the past six months, 6 = once or twice in the past six months, 9 = can't remeber.)

	YES	NO	FREQ
1. IN THE PAST SIX MONTHS, HAVE YOU USED ALCOHOL?	☐	☐	☐

2. I'M GOING TO READ YOU A LIST OF DRUGS. PLEASE ANSWER 'YES' IF YOU HAVE USED ANY OF THESE DRUGS IN THE PAST SIX MONTHS. (Interviewer: you may substitute, or add "slang" or "street" names for any of these drugs.)

HAVE YOU USED....			
COCAINE/CRACK?	☐	☐	☐
MARIJUANA?	☐	☐	☐
INHALANTS?	☐	☐	☐
HERION/OTHER OPIATES?	☐	☐	☐
HALLUCINOGENS?	☐	☐	☐
SPEED/STIMULANTS?	☐	☐	☐
DOWNERS?	☐	☐	☐
ANY OTHERS? PLEASE NAME: _____	☐	☐	☐

Interviewer: If the client has answered 'NO' to all of the above, SKIP to question #10. If any of the above items were answered 'YES', proceed to question #3 below. Read the following to the client:

"The next seven questions are related to your use of alcohol or other drugs which you identified using above."

	YES	NO
* 3. IN THE PAST SIX MONTHS, HAS YOUR USE OF ALCOHOL OR OTHER DRUGS CAUSED YOU PROBLEMS, SUCH AS PROBLEMS WITH ... (Interviewer: ask questions in the following areas, elaborate as necessary with examples.)		
RELATIONSHIPS?	☐	☐
JOBS/SCHOOL?	☐	☐
HOUSING?	☐	☐
NUTRITION? (shopping, eating)	☐	☐
TREATMENT AGENCIES?	☐	☐
FINANCES?	☐	☐
ARRESTS OR OTHER LEGAL PROBLEMS?	☐	☐
4. IN THE PAST SIX MONTHS HAVE YOU THOUGHT YOU'VE USED TOO MUCH ALCOHOL OR OTHER DRUGS?	☐	☐
5. IN THE PAST SIX MONTHS HAVE YOU FELT YOU SHOULD CUT-DOWN ON YOUR DRINKING OR OTHER DRUG USE?	☐	☐
6. IN THE PAST SIX MONTHS HAVE YOU FELT BAD OR GUILTY ABOUT YOUR USE OF ALCOHOL OR OTHER DRUGS?	☐	☐
7. IN THE PAST SIX MONTHS HAS ANYONE ELSE (e.g., FAMILY, FRIENDS, DOCTOR) EXPRESSED CONCERN THAT YOU'VE USED TOO MUCH ALCOHOL OR OTHER DRUGS?	☐	☐
* 8. PRIOR TO ANY HOSPITALIZATIONS WERE YOU DRINKING OR USING OTHER DRUGS?	☐	☐

SCREENING TOOL FOR CHEMICAL ABUSE MENTAL ILLNESS

Instructions:

(Interviewer: please read to client. Note that if client has come to your program from residential treatment, substitute the phrase "in the six months prior to your admission to residential program name" for the phase "in the past six months".)

Following is a list of 11 questions. The questions refer to your experiences during the past six months. These questions concern alcohol and other drug use. After each question is read to you, please answer 'yes' or 'no'. There are no right or wrong answers.

(Interviewer: if the client responds 'yes' to any of the substances in questions #1 or #2, please ask "How often have you used _____?" and enter the appropriate code under 'FREQ'. Codes are as follows: 1 = Every day or nearly every day, 2 = 3 to 4 times a week, 3 = 1 to 2 times a week, 4 = 1 to 3 times a month, 5 = 3 to 5 times in the past six months, 6 = once or twice in the past six months, 9 = can't remeber.)

	YES	NO	FREQ
1. IN THE PAST SIX MONTHS, HAVE YOU USED ALCOHOL?	☐	☐	☐

2. I'M GOING TO READ YOU A LIST OF DRUGS. PLEASE ANSWER 'YES' IF YOU HAVE USED ANY OF THESE DRUGS IN THE PAST SIX MONTHS. (Interviewer: you may substitute, or add "slang" or "street" names for any of these drugs.)

HAVE YOU USED....			
COCAINE/CRACK?	☐	☐	☐
MARIJUANA?	☐	☐	☐
INHALANTS?	☐	☐	☐
HERION/OTHER OPIATES?	☐	☐	☐
HALLUCINOGENS?	☐	☐	☐
SPEED/STIMULANTS?	☐	☐	☐
DOWNERS?	☐	☐	☐
ANY OTHERS? PLEASE NAME: _____	☐	☐	☐

POPULATION SPECIFIC SCREENING: PERSONS WITH A PHYSICAL DISABILITY

Notes:

	YES	NO
9) HAVE YOU EVER BEEN TREATED FOR ALCOHOL OR DRUG PROBLEMS?	☐	☐
10) IN THE PAST SIX MONTHS HAVE YOU USED PRESCRIPTION MEDICATION WITHOUT A PRESCRIPTION, OR FOR REASONS OTHER THAN THE MEDICATION WAS PRESCRIBED?	☐	☐
11) IN THE PAST SIX MONTHS HAVE YOU USED MORE THAN THE RECOMMENDED DOSE OF ANY OVER-THE-COUNTER MEDICATION, OR USED ANY OF THESE MEDICATIONS FOR REASONS OTHER THAN THEY WERE INTENDED?	☐	☐

* These items are based on questions developed by Kathleen Sciacca,M.A., program developer for mentally ill chemical abuse programs in New York, N.Y.

SCREENING TOOL FOR CHEMICAL ABUSE
PHYSICAL DISABILITY

INSTRUCTIONS:

Please read the following paragraph to the client.

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	YES	NO
1. IN THE PAST TWO YEARS, HAS YOUR USE OF ALCOHOL, PRESCRIPTION DRUGS OR OTHER DRUGS CAUSED YOU A PROBLEM?	☐	☐
1A. WHAT TYPE OF PROBLEM DID YOU HAVE? _____		
2. IN THE PAST TWO YEARS, HAVE YOU EVER THOUGHT YOU USED TOO MUCH ALCOHOL, PRESCRIPTION DRUGS OR OTHER DRUGS?	☐	☐
3. IN THE PAST TWO YEARS, HAVE YOU EVER FELT YOU SHOULD CUT DOWN ON YOUR DRINKING, PRESCRIPTION DRUG OR OTHER DRUG USE?	☐	☐
4. IN THE PAST TWO YEARS, HAVE YOU EVER FELT BAD OR GUILTY (e.g., THINGS SAID TO YOU BY FRIEND, FAMILY MEMBER, OTHER) ABOUT YOUR USE OF ALCOHOL, PRESCRIPTION DRUGS OR OTHER DRUGS?	☐	☐
5. IN THE PAST TWO YEARS, HAS ANYONE (e.g., FAMILY MEMBER, FRIEND, DOCTOR) EXPRESSED CONCERN THAT YOU USED TO MUCH ALCOHOL, PRESCRIPTION DRUGS OR OTHER DRUGS?	☐	☐
6. IN THE PAST TWO YEARS, HAVE YOU EVER USED PRESCRIPTION MEDICATION WITHOUT A PRESCRIPTION OR MORE THAN WAS PRESCRIBED FOR YOU?	☐	☐
7. IN THE PAST TWO YEARS, HAVE YOU EVER USED PRESCRIPTION MEDICATION FOR SOMETHING OTHER THAN WHAT IT WAS PRESCRIBED FOR? EXAMPLE: _____	☐	☐
8. HAVE YOU EVER BEEN HOSPITALIZED OR RECEIVED TREATMENT OR EMERGENCY CARE FOR ALCOHOL AND/OR DRUG PROBLEMS?	☐	☐