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ABSTRACT

This booklet addresses the issues involved in working with children and adolescents who have disabling conditions and use alcohol and other drugs. An introductory chapter notes the need for increasing attention to alcohol and drug problems among individuals with disabling conditions. The second chapter provides evidence suggesting that the incidence of use and abuse of alcohol and drugs in this population is similar to that in nondisabled populations, with some groups at particular risk. The importance of understanding personal competence and contextual issues associated with alcohol and drug use is stressed. The third chapter looks at implications for practitioners, focusing on the need for practitioners to develop a basic understanding of the issues associated with alcohol and drug abuse in this group. The last chapter examines implications for program development, stressing the need for programs to be comprehensive, integrated into community-based efforts, and targeted to multiple environmental or contextual influences as well as individual behavior. The book also includes 88 references; a resource list of publications, agencies and organizations, and special projects and curricula; and a treatment selection checklist. (DB)

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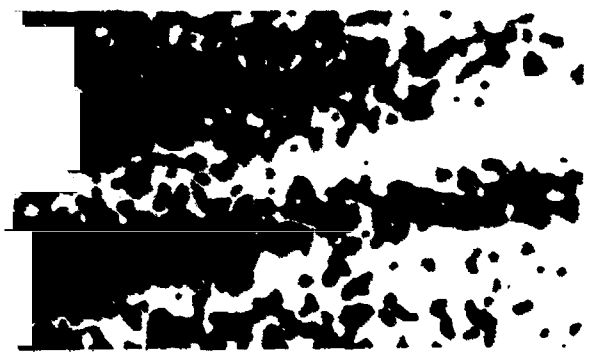
Peter E. Leone

CEC Mini-Library
Exceptional Children At Risk



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Foreword

EXCEPTIONAL CHILDREN AT RISK
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Many of today's pressing social problems, such as poverty, homelessness, drug abuse, and child abuse, are factors that place children and youth at risk in a variety of ways. There is a growing need for special educators to understand the risk factors that students must face and, in particular, the risks confronting children and youth who have been identified as exceptional. A child may be at risk *due to* a number of quite different phenomena, such as poverty or abuse. Therefore, the child may be at risk *for* a variety of problems, such as developmental delays; debilitating physical illnesses or psychological disorders; failing or dropping out of school; being incarcerated; or generally having an unrewarding, unproductive adulthood. Compounding the difficulties that both the child and the educator face in dealing with these risk factors is the unhappy truth that a child may have more than one risk factor, thereby multiplying his or her risk and need.

The struggle within special education to address these issues was the genesis of the 1991 CEC conference "Children on the Edge." The content for the conference strands is represented by this series of publications, which were developed through the assistance of the Division of Innovation and Development of the U.S. Office of Special Education Programs (OSEP). OSEP funds the ERIC/OSEP Special Project, a research dissemination activity of The Council for Exceptional Children. As a part of its publication program, which synthesizes and translates research in special education for a variety of audiences, the ERIC/OSEP Special Project coordinated the development of this series of books and assisted in their dissemination to special education practitioners.

Each book in the series pertains to one of the conference strands. Each provides a synthesis of the literature in its area, followed by practical suggestions—derived from the literature—for program developers, administrators, and teachers. The 11 books in the series are as follows:

- *Programming for Aggressive and Violent Students* addresses issues that educators and other professionals face in contending with episodes of violence and aggression in the schools.
- *Abuse and Neglect of Exceptional Children* examines the role of the special educator in dealing with children who are abused and neglected and those with suspected abuse and neglect.
- *Special Health Care in the School* provides a broad-based definition of the population of students with special health needs and discusses their unique educational needs.
- *Homeless and in Need of Special Education* examines the plight of the fastest growing segment of the homeless population, families with children.
- *Hidden Youth: Dropouts from Special Education* addresses the difficulties of comparing and drawing meaning from dropout data prepared by different agencies and examines the characteristics of students and schools that place students at risk for leaving school prematurely.
- *Born Substance Exposed, Educationally Vulnerable* examines what is known about the long-term effects of exposure *in utero* to alcohol and other drugs, as well as the educational implications of those effects.
- *Depression and Suicide: Special Education Students at Risk* reviews the role of school personnel in detecting signs of depression and potential suicide and in taking appropriate action, as well as the role of the school in developing and implementing treatment programs for this population.
- *Language Minority Students with Disabilities* discusses the preparation needed by schools and school personnel to meet the needs of limited-English-proficient students with disabilities.
- *Alcohol and Other Drugs: Use, Abuse, and Disabilities* addresses the issues involved in working with children and adolescents who have disabling conditions and use alcohol and other drugs.
- *Rural, Exceptional, At Risk* examines the unique difficulties of delivering education services to at-risk children and youth with exceptionalities who live in rural areas.

- *Double Jeopardy: Pregnant and Parenting Youth in Special Education* addresses the plight of pregnant teenagers and teenage parents, especially those in special education, and the role of program developers and practitioners in responding to their educational needs.

Background information applicable to the conference strand on juvenile corrections can be found in another publication, *Special Education in Juvenile Corrections*, which is a part of the CEC Mini-Library *Working with Behavioral Disorders*. That publication addresses the demographics of incarcerated youth and promising practices in responding to their needs.

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I would like to acknowledge the assistance of Jane Burnette and Bruce Ramirez at The Council for Exceptional Children and Rob Farrell at the University of Maryland for assistance in locating the materials reviewed for this book. Also, the work of former research associate Kevin Allison and graduate students Kathy Richardson, Ellen Spero, and others was invaluable.

P. L.

1. Introduction

While alcohol and drug use is prevalent, little attention has been devoted to alcohol and drug problems among individuals with disabling conditions.

Ours is a drug-taking society. In recent years the use and abuse of alcohol and other drugs by adolescents and adults in the United States and Canada have received widespread attention. In one recent report, researchers from the University of Michigan estimated that, among the industrialized nations of the world, the United States has the highest rate of substance abuse among high school students and young adults (Johnston, O'Malley & Bachman, 1988). Current trends indicate that use of many illicit drugs including marijuana, cocaine, and PCP has been declining among high school seniors (Johnston et al., 1988). While these trends may be encouraging, Johnston and his colleagues (1988) have reported that approximately 36% of all high school seniors have used some illicit drug other than marijuana before leaving high school; approximately 37% of all seniors engage in heavy drinking (five or more drinks in a row during a 2-week period); and about 19% smoke cigarettes on a daily basis.

In response to problems associated with drug use and abuse, the federal government has launched major initiatives that include monies for prevention, education, treatment, and interdiction of drugs. A major initiative, The Drug Free Schools and Communities Act (P.L. 101-226), distributed more than $1.3 billion between its inception in 1986 and 1991 for a range of programs including prevention and education (*Drug education: School-based programs*, 1990). In addition to governmental efforts, self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) and public interest and support groups such as Mothers Against Drunk Driving (MADD) and National Federation of Parents for Drug-Free Youth (NFP) have widely disseminated information concerning alcohol and drug use. These and many other organizations provide services locally in schools, churches, and community centers to individuals coping with problems associated with chemical dependency and its sequelae. Many of these organizations and their affiliates throughout the country lobby to improve access to services, publicize problems associated with use of alcohol and other drugs, and/or press for sanctions against abusers.

While much attention has been directed toward understanding and responding to alcohol and drug use among young people in general, problems associated with alcohol and drug use and abuse among children and adolescents with disabilities have been largely overlooked.

Numerous surveys of adolescent alcohol and drug use have been conducted during the past 20 years, but few of those studies have independently examined use by students enrolled in special education or have included students with disabilities in their samples. The data that do exist come primarily from clinical studies and geographically limited samples, and the technical adequacy of many of the studies is questionable.

With regard to prevention of drug and alcohol use, most recent information suggests that, although millions of federal dollars are available to schools through the Drug Free Schools and Communities Act (P.L. 101-226) to develop curricula and programs, none of the monies are targeted for special education students ("Drug Education," 1991). While schools can use these funds to develop specialized services, the number of programs and initiatives that have been designed to deter drug use by children and adolescents with disabilities is limited.

Educational Entitlement of Alcohol- and Drug-Dependent Youth

Children and youths with problems of alcohol and drug dependence typically do not have specific rights to educational services that extend beyond those entitlements provided to all students. An Office of Educational Research and Improvement survey conducted several years ago indicated that the majority of school districts in the United States respond punitively to infractions of their alcohol and drug use policies (U.S. Department of Education, 1987). Typical responses include exclusion from school for first or second violations of school policies.

Drug- and alcohol-dependent students are not identified in the IDEA (Individuals with Disabilities Education Act, formerly the Education for All Handicapped Children Act, P.L. 94-142) as a group entitled to special education and related services. In response to a 1979 inquiry, the Office of Special Education Programs (at that time the Bureau of Education for the Handicapped) responded that chemical dependency did not meet the definition of "handicapped" under the "other health impairment" category because it did not result from injury or disease (*Education for the Handicapped Law Report* [EHLR], 1979). However, state-level due process hearing officers have ruled that students' alcohol or drug use does not unilaterally exclude them from referral or assessment for special education and related services (EHLR, 1985; 1985–86). More recently, the Office for Special Education Programs of the U.S. Department of Education, in response to an inquiry from the District of Columbia Public Schools, noted that alcohol and drug addiction is not a disabling condition under the meaning of Public Law 94-142 but students with addiction may be eligible for services for other reasons ("Drug Induced Outbursts," 1989).

With regard to Section 504 of the Vocational Rehabilitation Act of 1973, the Office for Civil Rights of the U.S. Department of Education ruled that a student's drug addiction fell within the definition of physical or mental impairment (EHLR, 1985). In a recent clarification of the effect of the Americans with Disabilities Act on Section 504 regulations, the Office for Civil Rights stated that individuals who illegally use alcohol or drugs are no longer defined under 504 as individuals with disabilities. Furthermore, schools may discipline students with disabilities for use or possession of illegal drugs or alcohol if the students are currently using those controlled substances ("OCR Clarifies," 1991). The effect of this recent opinion on services for students with disabilities who are drug- and alcohol-dependent remains to be seen. While schools appear to have more latitude in disciplining drug- and alcohol-dependent students, quality of services and access to programs may suffer. In the abstract, few school administrators would deny access to services to students who have disabilities as well as alcohol and/or drug dependency. However, in light of current political forces, getting tough on *drugs* may mean excluding some students from educational services and referral to treatment.

2. Alcohol and Drug Use Among Children and Adolescents with Disabilities

For most individuals with disabilities, limited evidence suggests that use and abuse of alcohol and drugs is comparable to that of nondisabled individuals. Several groups of adolescents with disabilities appear to be at greater risk than their peers for abuse of alcohol and drugs. Understanding personal competence and contextual issues associated with alcohol and drug use places problems of youths with disabilities in a broader perspective.

The incidence of substance abuse among individuals with disabilities may be no greater than it is among the general population (cf. Dean, Fox, & Jensen, 1985; DiNitto & Krishef, 1984; Issacs, Buckley, & Martin, 1979; Krishef, 1986). However, the impact of alcohol and other drugs on children and adolescents with disabilities may be more debilitating than on their peers. Reviews of the research literature (Moore & Polsgrove, 1991; Prendergast, Austin, & de Miranda, 1990) and field work with substance abuse treatment providers (*Community Based Research*, 1987) indicate that little attention has been directed to alcohol and drug use among youth with mental retardation, sensory and physical disabilities,

behavior disorders, and learning disabilities. In particular, educators, mental health professionals, and substance abuse treatment providers have limited information about the prevalence and incidence of substance abuse among individuals with various disabling conditions.

Mental Retardation

Very few studies of alcohol and drug use have been conducted with participants identified as having mental retardation, and most of the individuals participating in those studies have been adults (Delaney & Poling, 1990). Huang (1981–1982) studied the drinking patterns of Florida students identified as educable mentally retarded and their nonretarded agemates. Students in both groups were junior and senior high school students and ranged in age from 13 to 18 years. Only 32% of the 190 students classified as having mental retardation reported using alcohol two or more times during the year prior to the survey. In contrast, 59% of the comparison group reported drinking alcohol two or more times during the previous year. In general, while more comparison students identified themselves as occasional users, more students identified as having mental retardation indicated that they drank alcohol on a weekly basis. Students identified as having retardation also perceived greater peer pressure to drink compared to the comparison group students.

Zetlin (1985) conducted a retrospective study of 46 young adults in Los Angeles who were identified as having mild mental retardation. All respondents were living independently, had no evidence of mental illness or significant physical disability, and were Caucasian. Data collected through interviews with participants and their families indicated an 87% agreement between parents and their children on the nature of problem behavior during adolescence. While 84% of the sample experienced behavior problems during adolescence, only 8% reported use of drugs or alcohol as the troublesome behavior. The author found no significant relationship between type of family relationships ("supportive," "dependent," or "conflict ridden") and alcohol and drug use.

DiNitto and Krishef (1984; Krishef, 1986) investigated the alcohol consumption patterns of 214 adult clients served by programs for people with mild mental retardation in Florida. More than half of their respondents, who were 70% Caucasian and 54% male, reported using alcohol sometime during their lives. Of these, 7% reported daily drinking and 33% reported drinking on a weekly basis. Among the drinkers, 13% reported family discord related to their drinking and 7% reported trouble with the police because of their drinking. The authors concluded that the drinking patterns of the individuals they interviewed were comparable to those of the general population.

Edgerton (1986), in an ethnographic study of adults identified as having mild mental retardation, unobtrusively observed alcohol and drug use in community settings and interviewed families, friends, relatives, and employers to determine individuals' exposure to drugs. Findings suggest that, although a large majority of the 181 individuals studied had access to drugs through personal contacts, only a minority used alcohol or drugs. The author attributed the relatively low rate of use to negative role models and to low income among the sample he studied.

Krishef and DiNitto (1981) surveyed Associations for Retarded Citizens (ARCs) and Alcohol Treatment Programs (ATPs) in metropolitan areas to determine their perceptions concerning alcohol use among clients identified as having mental retardation. Approximately 50% of each type of organization responded to the survey. In general, the ATPs identified twice as many individuals with alcohol problems as did the ARCs. Further, one third of the ARCs responding to the survey reported that they did not have resources available for individuals with alcohol problems.

Sensory and Physical Disabilities

A few studies have been conducted of drug and alcohol use by individuals with sensory and physical disabilities. Locke and Johnson (1981) studied drug and alcohol use by 46 students enrolled in a senior high school for students with hearing impairments. In their sample, 26 students (all of whom were juniors, seniors, or were 16 to 18 years old) reported current use of alcohol, and 15 reported current drug use. The majority of alcohol and drug users reported initial use prior to age 14, and the most frequently used drugs included marijuana, hashish, depressants, and narcotics.

In a study of 42 college students with sensory, motor, and metabolic disabilities, Motet-Grigoras and Schuckit (1986) found reports of drinking at a younger age, more citations for drinking, and more overall drug use than a large group of nondisabled survey respondents. Additionally, students with disabilities reported more symptoms of depression and higher rates of alcoholism in their families than the comparison group of students.

Issacs and colleagues (1979) investigated alcohol use among adults with hearing impairments in Rochester, New York. The 39 survey respondents, who classified themselves as deaf (82%), hard of hearing (15%), and hearing impaired (3%), reported quantity, frequency, and variability of alcohol consumption comparable to a sample with nonimpaired hearing.

A broad-based survey conducted by the Wisconsin Department of Health and Social Services (1985) assessed alcohol use by persons with

disabilities. Of the 597 individuals who indicated they had spinal cord injuries or disease, 49% were classified on the basis of their responses as moderate or heavy drinkers, and 40% of the blind or visually impaired respondents were also classified as moderate or heavy drinkers. In general, the study concluded that persons with disabilities have a 50% higher reported use of alcohol than the general population.

Finally, alcohol and other drug use is associated with approximately half of all traumatic brain injury (Jones, 1989). For some adolescents, identification as students in need of special education and related services is preceded by alcohol and/or drug use and subsequent trauma. O'Donnell, Cooper, Gessner, Shehan, and Ashley (1981–1982) studied 47 patients with traumatic spinal cord injury identified during a 6-month period in 1980. The 39 males and 8 females in their study were identified as having moderate or severe paraplegia or quadriplegia. Of the injuries experienced by this group, 62% were alcohol or drug related. Of the 47 individuals studied, 41 (87%) had prior histories of substance abuse, and self-report and family report, as well as staff observation, indicated that 32 (68%) resumed use of alcohol and other drugs after their injury.

Heinemann, Doll, and Schnoll (1989) found similar results in a study of alcohol abuse among 103 recent spinal cord injury patients at a Chicago rehabilitation hospital. Of their sample, 65% reported the onset of drinking problems prior to their spinal cord injury, 6% reported drinking subsequent to their injury, and 29% reported no drinking problems prior to or following their injury.

In an epidemiological study of alcohol-related morbidity among adults with disabilities, Dufour, Bertolucci, Cowell, Stinson, and Noble (1989) compared alcohol-related hospital discharge rates for 1985 among adults aged 45 to 64 for the general population with the discharge rates for patients with disabilities. Data from the National Discharge Survey of the National Center for Health Statistics indicated that, among the general population, alcohol-related discharge rates were 44.2 per 10,000 population for any alcohol-related diagnosis.[1] Information from the Medicare Provider Analysis and Review database for patients with disabilities (including those unable to work because of disability) indicated that alcohol-related discharge rates were 93.4 for any alcohol-related diagnosis, more than twice the rate for the general population. While the data sets differ in some respects, if anything, the results underestimate the extent of the problem. While alcohol-related morbidity rates suggest that the pattern of alcohol-related problems among those with disabilities parallels that of the general population, differences in the two

[1] Alcohol-related discharge rates are the frequency of any alcohol-related diagnostic category on a patient discharge record. Alcohol-related diagnoses include acute alcoholic intoxication, acute alcoholic hepatitis, alcohol abuse, alcoholic cirrhosis of the liver, and others (Dufour et al., 1989).

databases suggest the extent of the problem may be greater. The Medicare database only includes those who meet the criteria for the Social Security Disability Insurance Program. In contrast, the National Hospital Discharge Survey randomly samples discharges from non-federal hospitals with more than six beds and an average stay of under 30 days and presumably includes individuals with disabilities in its national estimates.

Emotional and Behavioral Disorders

The literature on psychosocial disorders and substance abuse among young adults suggests that alcohol and drug abuse are often correlates of behavior disorders or emotional disturbances (Brown, Ridgely, Pepper, Levine, & Ryglewicz, 1989). Many of the behavioral characteristics of substance-abusing students are similar to those exhibited by students identified as having an emotional or behavioral disorder.

Leone, Greenberg, Trickett, and Spero (1989) surveyed drug and alcohol use by 283 secondary school students in six schools in a large urban and suburban school district. Of the students participating in the study, 55 were identified as having behavioral disorders and were enrolled in special schools. Another 99 students, enrolled in special education classes and identified as having mental retardation or learning disabilities, were attending either middle school, junior high school, or high school, and 129 non-special-education students enrolled in the same schools also completed the survey. Results indicated that students identified as having behavioral disorders and attending school in restrictive settings reported a much wider range of drugs used and were significantly more likely to be currently using alcohol, cigarettes, and marijuana than the special education students in the comprehensive school settings or their non-special-education agemates. The only significant difference in the patterns or rates of consumption of controlled substances between special education students and others in the comprehensive schools suggested that, among high school students, non-special-education students were more likely to be currently using alcohol than were students with mild disabilities.

Several researchers have examined use of alcohol and drugs by adolescents identified as psychiatric hospital patients and those with behavioral problems or psychiatric symptoms. Klinge, Vaziri, and Lennox (1976) reviewed the patterns of substance abuse among 143 inpatient adolescents at a psychiatric treatment facility. Self-report and urinalysis confirmed that all of the 81 males and 62 females in their study had used and/or abused drugs (not including alcohol) prior to admission. Of the sample studied, 72% (103) reported abusing two drugs simultaneously. No differences were found in the duration, frequency, and patterns of substance abuse between males and females. Clements and Simpson

(1978) reported similar findings from a survey of 47 adolescents from a state inpatient mental health center who were diagnosed as having behavior disorders or social maladjustment. All subjects had a history of illicit drug use and indicated peer pressure as motivation for initial use.

In a similar study, Reichler, Clement, and Dunner (1983) reviewed the charts of 76 adolescents in a general hospital who were diagnosed as having both an alcohol abuse problem and a psychiatric disorder. These researchers found no gender-related differences in the incidence of alcohol abuse or referral for detoxification but did find that, while depression and sociopathy occurred with about equal frequency for the males, depression was more frequent for females.

In addition to emotional and behavioral disorders that might result in placement of a student in special education, researchers have found depression, low self-esteem, and related factors associated with use of alcohol and other drugs. Paton, Kessler, and Kandel (1977) conducted a longitudinal study of drug use and depression among a sample of 8,206 high school students. They found that multiple drug users were significantly more depressed than were either nonusers or users of marijuana only.

Lie (1984) examined correlates of alcohol consumption among a group of 146 adolescents aged 13 to 18 during a 2-year period. The results suggest that, for the sample studied, depression at the time of both assessments predicted alcohol use.

Pandina and Schuele (1983) found that adolescents receiving treatment for substance abuse experienced higher levels of psychological distress, reported lower levels of general self-esteem, and reported more negative events associated with drug and alcohol use than adolescents who were not in treatment. In addition to an association between depression and use of alcohol and other drugs, investigators have found depression associated with the use of amphetamines among adolescents (Kashani, Keller, Solomon, Reid, & Mazzola, 1985). Alcohol and drug use also appears to be associated with adolescent suicide (Garfinkel, Froese, & Hood, 1982; Shafii, Carrigan, Whittinghill, & Derrick, 1985) and eating disorders (Jonas, Gold, Sweeney, & Pottash, 1987; Muuss, 1986; Winstead & Willard, 1983).

Learning Disabilities, Hyperactivity, and Attention Deficit Disorders

Symptoms of learning disabilities, like behavioral disorders, can overlap considerably with characteristics of substance abuse (Fox & Forbing, 1991). While few studies have examined drug and alcohol consumption among individuals identified as having learning disabilities, a number of clinical and retrospective studies have examined drug and alcohol use

among individuals diagnosed with MBD (minimal brain dysfunction), ADD (attention deficit disorder), or hyperactivity as children.

Bruck (1985) investigated a group of 101 adolescents and young adults identified as having learning disabilities as children and a group of nondisabled peers. Among other things, she found no differences in heavy alcohol or drug use between the 101 individuals who were identified as having learning disabilities at an earlier age and 50 of their peers.

August, Stewart, and Holmes (1983) followed a group of 52 boys 4 years after an earlier diagnosis of hyperactivity. Through structured interviews with parents when their children were young adolescents, they found that the boys diagnosed as hyperactive-unsocialized aggressive at an earlier age had significantly more drug and alcohol problems than the boys diagnosed as purely hyperactive.

Beck, Langford, MacKay, and Sum (1975) assessed current and past drug use among 30 adolescents aged 14 to 17 who had received chemotherapy at an earlier age for MBD and a comparison group of inpatient medical and surgical patients without a history of psychiatric illness, chronic disability, or chemotherapy. These researchers found less drug use and fewer problems of substance abuse among the adolescents who had received chemotherapy than among the comparison group.

Several investigations of adult psychiatric patients found that alcoholism was more frequent in patients who were identified as having childhood hyperactivity than it was in a psychiatric control group that did not report childhood hyperactivity (De Olbidia & Parsons, 1984; Morrison, 1979; Tarter, McBride, Buonpane, & Schneider, 1977). As young adults, individuals who had been diagnosed as hyperactive during childhood had higher rates of substance abuse and court involvement over a 5-year period as compared to "normal" controls, although there were few significant differences between the groups during the year prior to evaluation (Hechtman, Weiss, & Perlman, 1984).

Gittleman, Mannuzza, Shenker, and Bonagura (1985) found higher rates of substance use among adolescents and young adults who had been hyperactive as children but also found that conduct disturbance associated with hyperactivity predicted later increased substance use. Substance abuse appeared to follow the onset of conduct disturbance in most cases (Gittleman et al., 1985). These findings, similar to the work of August and colleagues (1983), suggest that it is perhaps the *combination* of hyperactivity with other conduct disturbances that leads to a higher probability of substance involvement.

Gold and Sherry (1984) reviewed the impact of maternal alcohol consumption during pregnancy on the subsequent performance of their children. The studies they reviewed indicated that learning disabilities, hyperactivity, short attention span, and emotional problems were more prevalent among children whose mothers drank during pregnancy.

Alldadi (1986) and Clampit and Pirkle (1983) reviewed studies and clinical reports of substance use and abuse among adolescents who had been treated at an earlier age for hyperactivity or ADD. Both reports suggest that at the present time the evidence does not indicate that adolescents with a history of prescribed medication to control hyperactivity or attention deficit disorders are at greater risk for substance abuse.

Methodological Concerns

There are a number of problems with the adequacy of the research just reviewed. In addition to being geographically limited and few in number, many of the studies did not adequately describe their samples or provide information on how their samples were selected for the study. Another shortcoming of many studies is that analyses did not control for differences related to gender, race or ethnicity, or other personal or contextual variables that could influence the results. Unfortunately, much of the research literature that exists focuses on adults rather than children and adolescents with disabilities. Patterns and tolerance of alcohol and other drug use among adults with disabilities have been shaped by a different set of attitudes, values, and experiences surrounding both disability and substance abuse than those experienced by youths today. Each succeeding generation of children and adolescents with disabilities presumably will have greater access to services, experience greater understanding of disability and individual differences among their family and the general population, and have greater access to a wider range of licit and illicit substances than older generations of individuals with disabilities. These generational differences suggest that studies reporting alcohol and other drug use among adults with disabilities should be interpreted cautiously with regard to adolescents.

The studies just reviewed, in spite of methodological problems, suggest that there is no clear evidence that the risks for alcohol and other drug abuse are higher for most children and adolescents with disabilities than for the general population. However, the limited number of studies reviewed suggests that for individuals with behavioral, psychological, or psychiatric disorders and those who have experienced spinal cord or traumatic brain injury, the risk for substance abuse and the prevalence of substance abuse may be higher than for other individuals.

Competence and Context

Understanding alcohol and drug use among children and adolescents with disabilities requires a broad-based perspective on the problem of substance abuse. The concept of substance abuse, like the concept of disability, is not monolithic. Rather, it is a multifaceted phenomenon that transcends classifications such as "able" and "disabled" (Allison, Leone,

& Spero, 1990). Alcohol and drug use among youths with disabilities is influenced by individual differences and competencies and by the multiple ecological contexts experienced by various groups.

From a person-centered perspective, youths who use and abuse alcohol and other drugs may not possess the *competencies* that enable them to cope in a healthy way with opportunities to use and abuse controlled substances. From a social-contextual perspective, students placed in a special class, school, or program and educated with other youths with academic and social skills deficits may experience a very different educational *context* from that of their nonlabeled peers (Trickett, Leone, Fink, & Braaten, 1991). In order to understand alcohol and other drug use by children and adolescents, both personal and contextual factors associated with substance use and abuse must be considered (Allison et al., 1990; Blum & Singer, 1983; Kaplan, Martin, & Robbins, 1984; Wallack & Corbett, 1990; White, Johnson, & Horowitz, 1986). A review of the literature in these two areas can place the use of alcohol and other drugs by individuals with disabilities in b:oader perspective and suggest ways in which educators, parents, and communities can respond to the problem.

Personal Competence. Looking beyond disability classifications and viewing personal competence broadly, a number of studies have found strong associations among alcohol and drug abuse, school failure, and low commitment to sch..l (Friedman, Glickman, & Utada, 1985; Jessor & Jessor, 1978; Smith & Fogg, 1978) although the direction of the relationships is unclear. Other reports have identified school failure and low commitment to school as predictors of both delinquent behavior and substance abuse (Hawkins, Lishner, Jenson, & Catalano, 1987).

Jessor and Jessor (1978) conducted a 3-year study of drug use among 483 students in the Rocky Mountain region. Their analyses revealed that nonusers were more likely to value academic achievement and expect academic success, while drug users were more likely to show a lack of interest in school.

Smith and Fogg (1978) conducted a 5-year study on the psychological predictors of marijuana use among 651 high school students in Boston. They found that nonusers were more likely to value study habits and have higher grade point averages than users. Similarly, Mills and Noyes (1984) found low grades to be significant predictors of cannabis, pill, cocaine, and hallucinogen consumption among a sample of 2,036 male and female adolescents in Maryland secondary schools.

Kandel, Kessler, and Margolies (1978) examined the relationship of student drug use to parental use of drugs (including prescription), friends' use of drugs, and students' personal values and lifestyle among 5,423 high school students in New York State. The study did not identify a clear relationship between drug use and school performance, number

of classes cut, or absenteeism. However, Kandel and colleagues (1978) noted that their sample did not survey students who dropped out or were absent at the time of the survey. Because all subjects were volunteers and were predominantly Caucasian and middle-class, and because attrition occurred between testing points, results of these studies may underestimate the extent of the problem and distort the personal correlates of alcohol and drug use.

Studies by Anhalt and Klein (1976) and Friedman and colleagues (1985) support the results of these longitudinal studies. Anhalt and Klein (1976) surveyed 3,807 eighth and ninth graders in five school districts in Nassau County, New York, and found that illegal drug use was highly correlated with low academic achievement, family conflict, and personal problems.

In a similar study, Friedman and colleagues (1985) compared the school dropout rate among adolescent nonusers, occasional or casual drug users, and regular drug users in two Philadelphia high schools. The study found that students who did not like school were more likely to be involved with drugs. In addition, 26% of the nonusers and 30% of the casual users dropped out as compared to 51% of the regular users. Friedman and colleagues (1985) also noted that the temporal relationship between school problems and drug involvement remains unclear. Drug use and school dropout could in fact be "concomitant" effects to a "more basic state of dissatisfaction" (Friedman et al., 1985, p. 363). Over all, these studies support the conclusion that substance-using adolescents are less committed to education and at greater risk for leaving school before graduating than their nonusing peers.

Svobodny (1982) reviewed demographic characteristics of adolescents in residential programs for substance abuse and a comparison group of high school students. Among other factors, she found that those in treatment had lower grades and higher rates of absenteeism than the comparison group.

The association between substance abuse and juvenile delinquency has been well established in the research literature (Clayton, 1981). Studies also suggest that delinquency precedes drug use (Dishion, Patterson, & Reid, 1988; Farrow & French, 1986; Kandel, Simcha-Fagen, & Davies, 1986). While some researchers have concluded that there is a causal relationship between delinquent behavior and adolescent drug use, others maintain that delinquency and drug use may be related outcomes of some generalized factor.

Other researchers have hypothesized that specific skill deficits may be associated with alcohol and drug use (Marlatt & Donovan, 1981; Wills & Schiffman, 1985). Some evidence suggests that adolescents who learn specific social competencies (Pentz, 1985; Pentz et al., 1989) and adolescents and adults who receive skills instruction and social network

development instruction (Hawkins, Catalano, & Wells, 1986) are more likely to be able to avoid drug use and cope with stress.

Context. In addition to assessing personal competence, an understanding of the etiological processes involved in the use of alcohol and other drugs requires an assessment of contexts or environments. The emerging literature on alcohol and drug use suggests that there are a number of contextual factors that affect adolescent alcohol and drug involvement. These variables include peer use, family use, age at initial use, socioeconomic status, gender, educational status (i.e., school placement level), ecological setting, and attachment to social institutions (e.g., church and school). Recent research suggests that various influences may be specifically related to the use of different drugs; that is, an adolescent who smokes marijuana may be influenced by different factors than an adolescent who drinks or another who uses PCP.

Alcohol and drug use in the United States and other industrialized nations occurs within many different cultural contexts. Use of controlled substances may be medicinal, experimental, episodic, social, recreational, religious, compulsive, or abusive (Floyd & Lotsof, 1978). Moreover, patterns of use vary within and across various ethnic and racial groups (Allison & Leone, 1990), occupations, and income levels. An individual's decision to use or abstain from controlled substances is shaped by the norms, beliefs, and values within his or her social context or community.

In the United States at the present time, approximately 57 million people are addicted to cigarettes and another 18 million to alcohol (Gerbner, 1990). These two substances contribute to more deaths and addiction than all illicit drugs combined. In contrast, about 1 million people are addicted to opiates and their derivatives and hallucinogens (Gerbner, 1990). However, the use of tobacco and alcohol is controlled and legal. Youths, including those who are unable to procure these drugs legally, get the message through various media that the good life and good times are associated with their use (Gitlin, 1990).

Thus, while the schools may teach about abstaining from a wide range of controlled substances including opiates, hallucinogens, alcohol, and tobacco, children are well aware that alcohol and tobacco are both widely used and promoted in the community. For some students this creates an "our drugs versus your drugs" dichotomy in which they justify their use of alcohol and drugs by claiming that adults have their drugs of choice just as youths do. There is also ample evidence that peers and older siblings exert a powerful influence on attitudes toward drug use and drug-using behaviors (Needle et al., 1986).

While society, through its media, provides a broad context for understanding use and abuse of alcohol and drugs, within neighborhoods, ethnic communities, and occupational and social groups the use of specific substances is punished, ignored, or promoted. As children and

adolescents develop a sense of personal and group identity, the need to affiliate with a particular group can be a powerful force promoting or deterring the use of alcohol and other drugs. Assessing contextual factors for children or adolescents with disabilities requires an understanding of the multiple family, neighborhood, peer, and social contexts that shape beliefs and behaviors concerning alcohol and other drugs for all youths.

3. Responding to Problems of Alcohol and Other Drug Use: Implications for Practitioners

Professionals working with children and adolescents with disabilities should develop a basic understanding of the issues associated with alcohol and drug use among this group.

We turn now to more practical matters. The question before us at this point is, Based on what we know about alcohol and drug use among youths with disabilities, how should educators and others respond to the problem?

Schools need to acknowledge that some students receiving special education services, like their nondisabled peers, use alcohol and other drugs. At the present time however, there are few schools that have examined the prevalence of use or abuse among children with disabilities or have developed specialized prevention and education activities ("Drug Education," 1991; Moore & Ford, 1991). The exclusionary responses of many school districts to students who use drugs and alcohol (U.S. Department of Education, 1987) would appear to violate the intent of the Supreme Court's decision in *Honig* v. *Doe* (108 U.S. S. Ct. 592 [1988]) for special education students if those exclusions lasted for more than 10 days or involved expulsion from school. Paradoxically, however, an internal Office for Civil Rights memorandum on use of alcohol and drugs by students with disabilities indicates that local education agencies may discipline those students without the protection of Section 504 to the same extent as nondisabled students (OCR Clarifies, 1991). With regard to prevention, very few projects have been developed for specialized populations across the country and very limited curricula exist.

Personal experience, field-based studies (*Community Based Research*, 1987), and anecdotal reports (Shannon, 1986) suggest that many teachers and administrators are uncomfortable dealing with problems of alcohol and drug use in the school. The reluctance on the part of some prac-

titioners to respond to incipient problems may be associated with fear of reprisals from parents who are unaware of or who deny that an alcohol and/or drug problem exists. Also, the punitive rather than rehabilitative policies developed by many school districts (Marcus et al., 1985; U.S. Department of Education, 1987) may deter teachers and others from addressing the issue because they do not want to create additional problems for the students.

When problems associated with alcohol and drug use are exhibited by students with disabilities, misperceptions and myths about disabilities and substance use can contribute to the problem (Moore & Ford, 1991). Teachers and administrators who have direct contact with students with disabilities should be aware of four major issues. First, as elementary as it may seem, practitioners need to know that some students with disabilities use alcohol and other drugs. The literature reviewed here and elsewhere (Moore & Polsgrove, 1991; Prendergast et al., 1990) suggests that children and adolescents with disabilities use alcohol and other drugs at rates comparable to their peers and, for some students with disabilities, at a higher rate.

A second issue for practitioners is that some disabilities can obscure use and abuse of controlled substances (Fox & Forbing, 1991). Following guidelines in the schools' substance-abuse policies, teachers and administrators need guidance in detecting and responding appropriately to suspected use. A third concern involves enabling behavior. Direct service professionals need to know that they contribute to students' problems when they ignore or avoid dealing with suspected student use or abuse (Johnson, 1988). While many educators are reluctant to get involved with problems of alcohol and drug use in general, they may be more reticent when the suspected problem involves a student with disabilities.

Finally, practitioners need to know that substance-abuse treatment services are not well developed for adolescents with disabilities. Teachers and others may have to work with parents or guardians to assist them in getting students into appropriate treatment. Once students are in treatment, practitioners may have to help substance-abuse counselors who have limited prior contact with clients with disabilities adapt treatment to the youths' individual characteristics.

These four areas—awareness of alcohol and drug use among disabled youths, responding to suspected use and abuse, the consequences of avoiding suspected problems, and the need to assist parents and substance-abuse treatment providers—can form the basis for staff development activities. The emphasis placed on any one of the four areas during training can be determined through a needs assessment and discussion with staff.

A vehicle for addressing these issues could be the development or review of school or program policies. If an alcohol and other drug policy

exists, an initial step might be to ensure that all faculty and staff are aware of its existence. Subsequently, faculty should review the policy to ensure that it addresses prevention; is linked to community-based activities; does not exclude students with disabilities from services or referrals; and provides adequate support to students, staff, and parents or guardians dealing with the problems of alcohol and drug use.

4. Responding to Problems of Alcohol and Other Drug Use: Implications for Program Development

Effective programs are comprehensive; they are integrated into community-based efforts; and they target multiple environmental or contextual influences in addition to individual behavior.

Programs designed to deter alcohol and drug use and respond appropriately to problems experienced by youths should be comprehensive. They should be integrated into school-wide policies that address teacher and student behavior concerning suspected abuse or use of alcohol and/or other drugs, the role of prevention and education efforts, and involvement of parents and guardians in developing and monitoring the policies. School policies concerning suspected use or abuse of controlled substances by students should acknowledge and include students enrolled in special education programs (Spero, Leone, Walter, & Wilson, 1989).

Program developers need to link their efforts to community-based initiatives and establish ongoing relationships with those who provide intensive substance abuse treatment services. Two important aspects of program development are prevention and referral and reentry.

Prevention

At the present, time we do not know whether school-based prevention programs developed to deter youngsters from using alcohol and other drugs are successful or not. While many programs have changed students' attitudes and have increased knowledge concerning alcohol and other drugs, we have little information concerning whether those activities actually reduce consumption of controlled substances (*Drug Education: School-Based Programs*, 1990). Most prevention efforts continue to focus on the individual and his or her *competence* ("Just say no") and fail to deal with the broader and potentially more powerful contex-

tual and cultural influences that shape individual propensity to use controlled substances. Wallack and Corbett (1990), in a U.S. Office of Substance Abuse Prevention Monograph, maintain that current (and largely ineffective) prevention activities targeted on changing individuals are the norm because they are politically safe and they focus on a manageable unit of analysis and intervention, the person. However, there is some evidence that broad-based prevention efforts that target multiple environmental influences as well as individual behavior can be successful in reducing student alcohol and drug use (Pentz et al., 1989; Wallack & Corbett, 1990). If we consider that one of the correlates of alcohol and drug use and abuse among adolescents is school failure and low commitment to school, an important preliminary step that program developers concerned about youths with disabilities can take is to improve the quality of their school experiences. Improving the school context or climate can ensure that *all* students receive high-quality instruction and develop positive relationships with peers or staff within their schools.

For many youths, disciplinary sanctions associated with drug or alcohol use on school grounds are not an effective deterrent to substance use or abuse. While drug distribution on school grounds presents different and more serious problems, a school policy that provides students with treatment, counseling, or other alternatives to disciplinary sanctions when they use drugs at school or come to school high has the potential for involving the family and community agencies in a positive way.

Wallack and Corbett (1990) acknowledge that only in recent years have prevention efforts moved toward a more comprehensive understanding of factors associated with alcohol and other drug use. Successful prevention efforts, they argue, place the individual in the broad context of schools, families, peer groups, and the community. Effective substance abuse prevention programs view drug problems as complex, take an integrated approach to the problem, involve long-term planning, and acknowledge that information about drugs is necessary but not sufficient to change behavior. Finally, successful prevention programs are comprehensive; that is, program developers assess the relationship among problems, resources, needs, and goals and examine conflicting interests associated with alcohol and drug use (Wallack & Corbett, 1990).

For some groups of students with disabilities, specialized education and prevention curricula may be appropriate. Experimental curricula have been developed for students with sensory impairments, learning disabilities, mental retardation, and behavioral disorders (Carlton, 1990; Moore & Ford, 1991). Resources are listed at the end of this booklet.

Referral and Reentry

A second aspect of program development involves clarifying the steps and criteria for referring students who need specialized services within the school and those available in the community. Students who need counseling or therapy can be referred as well as those whose chronic or debilitating involvement with drugs or alcohol may require hospitalization for detoxification or inpatient treatment. When the severity of the problem requires out-of-school placement for a time, the school must develop a liaison to those providing services to maintain continuity in the child's educational program. Referral systems must ensure that students enrolled in special education programs are not unilaterally included or excluded from the referral process. When a student enrolled in special education is placed out of the school, a multidisciplinary team meeting with the parents and relevant staff should be convened to ensure that the child's special education needs can be met within the substance abuse treatment program.

Helping parents or guardians ensure that their child receives appropriate services involves understanding the nature of the child's disabling condition and substance abuse problem and locating a treatment facility. Considerations include access, costs, education services available, aftercare, and extent of family involvement. (A Treatment Selection Checklist designed to assist those making referrals or assisting parents is contained in the resources section.)

When a student returns from treatment, the school needs to develop a reentry plan to support the student's efforts to remain drug free. Counselors and student assistance teams can play a vital role in supporting students and promoting healthy prosocial behaviors within the school. For a student enrolled in special education, a multidisciplinary team meeting like the one held as the child went into treatment should be convened to modify the individualized educational program (IEP) if necessary and plan appropriate educational services and support.

In many jurisdictions in the United States, initial residential treatment typically lasts 4 to 6 weeks. Inpatient services are typically followed by ongoing services that frequently involve individual or family counseling and self-help group meetings such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).

Summary

At the present time, while drug use among high school students in the United States appears to be declining slightly, frequent use of alcohol remains at fairly high levels. The existing data suggest that for most students identified as disabled the prevalence of alcohol and drug use is

comparable to that of their agemates However, most prevention efforts have not targeted special education students nor have special educators applied for federal grants to develop drug-use prevention programs ("Drug Education," 1991). Those ir terested in the welfare of children and adolescents with disabilities need to become aware of the problems associated with alcohol and drug use and abuse and become involved in prevention and treatment efforts. Practitioners should work with school administrators and staffs to develop positive alternatives to the punitive responses that characterize many school substance-abuse policies (Marcus et al., 1985; U.S. Department of Education, 1987). Another positive step would be to strengthen the links between schools, mental health, juvenile justice, and other community agencies that serve youths who may be using and/or abusing alcohol or drugs. Interagency collaboration among these service providers could ensure that professionals respond to problem behavior associated with drug or alcohol use in a consistent manner and that educators learn about how their owr behavior might deter student substance abuse and support those in recovery (Johnson, 1988).

Prevention programs for students with disabilities should be comprehensive in scope, acknowledge the complex nature of the problem, and target contextual as well as individual factors associated with alcohol and drug use. Substance use and abuse, like disability, are not monolithic concepts. Just as those with disabilities may experience a range of cognitive, motoric, or perceptual problems, so, too, individuals who use and abuse controlled substances exhibit a wide range of behaviors and may report that they take drugs or use alcohol for a variety of reasons. The challenge for educators and others concerned about individuals with disabilities is to become informed about the drug culture in their community, know when to discuss incipient problems with parents or guardians, and refer students to treatment when necessary.

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Resources

Bibliographies, Special Publications, and Newsletters

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Allison, K. W., & Richardson, K. A. (1989). Annotated bibliography of substance abuse among individuals with disabilities and those at high risk. College Park, MD: Department of Special Education, University of Maryland. (ERIC Document Reproduction Service No. ED 312 799)

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Agencies and Organizations

National Center for Youth with Disabilities. University of Minnesota, Box 721-UMHC, Harvard Street at East River Rd., Minneapolis, MN 55455. Publishes annotated bibliographies on health care and related issues. (Ph. 612-626-2825).

National Clearinghouse for Alcohol and Drug Information (NCADI), 6000 Executive Blvd., Suite 402, Rockville, MD 20852. Collects and disseminates a wide range of information on alcohol and drug use and abuse and treatment. (Ph. 301-468-2600).

Resource Center on Substance Abuse Prevention and Disability, 1331 F St., N.W., Suite 800, Washington, DC 20004. Operates as a part of RADAR (Regional Alcohol and Drug Awareness Resource). Provides information and technical assistance. (Ph. 202-783-2900; TDD 202-737-0645).

Special Projects and Curricula

(Adapted from National Center for Youth with Disabilities [1990]). *CYD-LINE Reviews: Substance abuse by youth with disabilities and chronic illnesses.* Minneapolis: University of Minnesota.)

Addiction Intervention with the Disabled, Sociology Depart.nent, Kent State University, Kent, OH 44242. (Ph. 214-672-2440). *Prevention Curriculum Guide for Looking at Alcohol and Other Drugs—Special Education 7–12 is available.*

James Stanfield Publishing Co., P.O. Box 1995H, Santa Monica, CA 90406. (Ph. 800-421-6534; in CA, 213-395-7466). Publishes a curriculum designed for students with mental retardation.

Milwaukee Council on Drug Abuse, 1442 N. Farwell St., Suite 304, Milwaukee, WI 53202. (Ph. 414-483-271-7822). *Drugs and Decisions—A Prevention Program for People Who are Developmentally Disabled* is available.

Project OZ, 201 East Grove St., 2nd Floor, Bloomington, IL 61701. Curricular materials and training for educators with a focus on drug education and prevention among children with disabilities. *A Special Message*, drug education curriculum for students identified as learning disabled or behavior disordered and *Me, Myself, and I*, a curriculum for students identified as educable mentally handicapped, are available.

SARDI (Substance Abuse Resources for Disabled Individuals), Wright State University School of Medicine, Dayton, OH 45435. Print and video training materials available for professional and adolescent and adult clients. (Contact Jo Ann Ford or Dennis Moore, 513-873-3588).

Southeast Virginia Planning District Commission, 723 Woodlake Drive, Chesapeake, VA 23320. (Ph. 804-420-8300). Publishes *Prevention Time*, a prevention curriculum for upper elementary school and middle school students with mental retardation and learning disabilities.

South Carolina School for the Deaf and Blind, Cedar Springs Station, Spartanburg, SC 29302. *Substance Abuse Prevention Curriculum for Hearing Impaired Students*, and sign language videotape "Signs of AIDS" available. (Contact Greg Harris, 803-585-7711).

Substance and Alcohol Intervention Services (SAIS) for the Deaf, Rochester Institute of Technology, 50 W. Main St., 6th floor, Rochester, NY 14614. (Ph. 716-475-4978). Has a guide, *VIP PEERS*, available. Material is designed to assist prevention efforts for hearing impaired and deaf students in mainstream and residential settings.

Treatment Selection Checklist

When looking for substance abuse treatment services, families, counselors, or others making a referral often must act quickly and, frequently, under stress or in crisis. The process of finding appropriate services often generates numerous questions for those seeking help. However, at times it is not even clear what questions to ask. The checklist that follows suggests questions that may be useful to families and professionals seeking additional information about a particular program.

It is not necessary to have all questions on the checklist answered prior to referring a youngster to a treatment program. Some of the checklist items, in fact, are only relevant to certain types of facilities or particular adolescents' problems. Ask those questions which seem important in a particular situation and add any questions you feel are appropriate.

No single treatment or program is appropriate for everyone. Each adolescent and each family has unique needs and concerns. Determine which program(s) appear to most closely meet the needs and values of the adolescent requiring assistance and his or her family.

A. Philosophy and Program Structure

_____ 1. How does the program view chemical dependency or substance abuse? (For example, does the program view drug or alcohol dependency as an illness? A mental health problem? Similarly, does the program view drug dependency as a primary or secondary problem?)

_____ 2. How does the program view disabilities? Is any substance use seen as an acceptable means to cope with severe physical or sensory disabilities?

_____ 3. Does the program offer residential, outpatient, detoxification, or aftercare treatment? How long does treatment average?

_____ 4. Are most admissions voluntary or involuntary? How are involuntary admissions handled?

_____ 5. Are adolescents treated separately or w''h adults? What is the gender and age breakdown of clients in treatment?

(Adapted from Leone, P. E., Trickett, E. J., Greenberg, J. M., Foley, K., Gould, J., & O'Neil, J. (1987). *The adolescent directory: A guide to alcohol and drug abuse treatment and special education services for adolescents in the Washington Metropolitan area.* College Park: University of Maryland, Department of Special Education.)

_____ 6. Does the facility treat clients with problems other than substance abuse? If so, are adolescents with substance abuse problems grouped with other clients?

_____ 7 What procedure is followed in a medical emergency? Where is the nearest hospital that is equipped to handle emergencies? Will transportation to the hospital be easily accessible to people with physical or sensory disabilities?

_____ 8. Is the treatment facility accessible to individuals with physical or sensory disabilities?

B. Treatment Components

_____ 1. How are treatment goals for each adolescent determined? How is progress or success determined? How often is an individual treatment program reassessed?

_____ 2. What is the structure of the program? What would a typical session, day, or week be like?

_____ 3. What types of therapy are used? How often are they provided and who provides them? (These might include therapies such as individual, small-group, large-group, family, multifamily-groups, psychodrama, peer counseling, and occupational).

_____ 4. Does the program address dual diagnosis (i.e., substance abuse in addition to other disabling conditions)? If so, how does treatment for adolescents with dual diagnosis differ from treatment for other adolescents? Are interpreters or supportive technologies provided? Are visual or audio materials adapted to special learning or sensory needs?

_____ 5. How frequently does the program treat adolescents with any particular type of physical or sensory disability?

_____ 6. Is involvement in self-help groups encouraged or incorporated into treatment? Are these groups open to adolescents?

_____ 7. Does treatment include an exercise regimen or wilderness program? How are these adapted to the needs of adolescents with physical or sensory disabilities? What is done to promote good nutrition and overall health? Will diets be adjusted to accommodate special health needs?

C. Education

_____ 1. What, if any, educational (academic) services are provided? Do these include special education services? How are these services incorporated into the total treatment program? Who teaches the classes offered?

_____ 2. Can academic credits earned be transferred to the adolescent's home school? Can a GED (General Educational Development) certificate be earned?

D. Aftercare

_____ 1. What support is provided as adolescents leave treatment and move toward full participation in school, work, or community activities? How long does the aftercare program typically last? Is the cost of aftercare included in the basic charge for treatment?

_____ 2. What are the characteristics of the adolescents most likely to complete the program successfully? How is successful program completion determined?

_____ 3. Do adolescents go to further treatment, halfway houses, or long-term residential treatment facilities after discharge or completion of treatment at this facility?

E. Family Involvement

_____ 1. Is the entire family included in the treatment, recovery, or aftercare process? If so, how? Are self-help groups recommended for family members?

_____ 2. Is there a particular staff member who is available to communicate with and answer questions of parents or guardians throughout treatment?

_____ 3. Are all components of family involvement accessible to family members with physical or sensory disabilities?

F. Staff

_____ 1. What is the staff-to-adolescent ratio?

_____ 2. What are the qualifications of the staff (e.g., education, training, experience)? Does the staff include persons who are themselves recovering from alcohol or other substance abuse? Does the staff include persons with disabilities? Do staff members receive any training in disabilities or special health care needs?

_____ 3. How long have staff members been working in the program? Can an adolescent reasonably expect to have the same therapists and/or counselors throughout his or her initial and aftercare treatment programs?

_____ 4. Are there physicians, nurses, or other appropriate health care providers present at the program to handle special health care needs? During what hours? Are consultants available?

G. Finances

_____ 1. What is the cost of the treatment program? Are all charges included? If not, what extra expenses might be incurred (e.g., aftercare, urinalysis, or medications)?

_____ 2. Is the program qualified to receive insurance payments (e.g., Medicare, Medicaid, CHAMPUS)?

_____ 3. Does the program have a sliding fee scale? Does the program help families locate financial assistance?

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