

*Recent takes on a recurring theme:  
Substance use disorders and persons  
with disabilities*

**Transforming Systems, Transforming Lives -  
Integrating Care to Support Recovery**

**Oct 1, 2007**

**Yakima Convention Center  
Yakima, Washington**

**Dennis Moore, Ed.D.  
Professor, Department of Community Health  
Boonshoft School of Medicine  
Wright State University**

# About SUD and co-existing disability

# Critical Functional Impairments associated with Co-existing Disability

Cognition – memory

Cognition – judgment

Stamina

“Secondary” medical conditions

Poverty

# Medical conditions and MI/SUD comorbidity

Almost one-fourth of all stays in U.S. community hospitals for patients age 18 and older—7.6 million of nearly 32 million stays—involved depressive, bipolar, schizophrenia and other mental health disorders or substance use related disorders in 2004

*Agency for Healthcare Research and Quality (AHRQ/HHS,  
April 2007)*

# Population based studies

- Buss, A., & Cramer, C. (1989). *Incidence of alcohol use by people with disabilities: A Wisconsin survey of persons with a disability*. Madison, WI: Office of Persons with Disabilities.
- Dufour, M. C., Bertolvic, D., Cowell, C., Stinson, F., & Noble, J. (1989). Alcohol-related morbidity among the disabled: The MediCare experience 1985. *Alcohol Health & Research World*, 13(2), 158-161.
- Gilson, S.F., Chilcoat, H.D., & Stapleton, J.M. (1996). Illicit drug use by persons with disabilities: Insights from the National Household Survey on Drug Abuse. *American Journal of Public Health*, 86(11), 1613-15. NAADD Access Denied

# Population based studies

- Kessler, R.C., Crum, R.M., Warner, L.A., Nelson, C.B., Schulenberg, J., & Anthony, J.C. (1997, April). Lifetime co-occurrence of DSR-III-R alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Survey. *Archives of General Psychiatry, 54*, 313-321.
- Moore, D. & Li, L. (1998). Prevalence and risk factors of illicit drug use by people with disabilities. *The American Journal on Addictions, 7*, 93-102.
- Heinemann, A. W., Lazowski, L., Moore, D., Miller, F., & McAweeney, M. (submitted) Development of a Substance Abuse Screening Instrument for Use in Vocational Rehabilitation Settings.

# Population based studies

Sinclair LB and Campbell VA. 2001. Health Risk Factors Among People with and without Disabilities Related to the Healthy People 2010 (HP2010) Leading Health Indicators (LHIs). Poster presentation at Behavioral Risk Factor Surveillance System 18th Annual Conference; Atlanta GA.

Hollar, D. & Moore, D. (2004). Relationship of substance use by students with disabilities to long-term educational, employment, and social outcomes. *Substance Use & Misuse*, 39(6), 931-962

Tate, D. G., Forchheimer, M. B., Krause, J.S., Meade, M.A., & Bombardier C. H. (2004) Patterns of alcohol and substance use and abuse in persons with spinal cord injury: risk factors and correlates. *Archives of Physical Medicine and Rehabilitation*, 8, 1837-1847

National HP 2010 Disability Chapter 6  
includes only one AOD health indicator –  
on alcohol use by pregnant women with  
disabilities (CDC)

TEDS and National Survey on Drug Use  
and Health do not measure disability  
(SAMHSA)

Most national surveys and cohort studies  
do not link substance use and disability

# ADHD

- ❑ ADHD has correlation with alcohol and/or cocaine use – but medication for hyperactivity does not appear to increase AOD abuse risk
- ❑ Rapidly expanding literature linking ADHD and SUD, with efforts to study this spanning nearly 5 decades
- ❑ ADHD elevates risk for certain drugs of abuse
- ❑ Use of some illicit drugs creates ADHD symptoms
- ❑ Should have ADHD screening at intake into TX

# MR/DD

- ❑ Growing awareness of need for treatment for MR/DD re: tx accommodations
- ❑ DD/MR and elderly have lower AOD use rates, but more severe consequences if using
- ❑ Reduced judgment and prescribed drug tolerance if using alcohol or illicit drugs
- ❑ Family of origin often contributes to abuse

# Estimate of MR/DD WA state

**Estimate 5% of DD adult population may have a substance use disorder. Therefore, based on the estimated prevalence of MR/DD in the general population of WA state, and the current census of DDD, suggests over 2,500 persons in WA state with DD who may require SUD treatment. Many may not be current clients of DDD.**

**However, in separate survey, 41 DD case management providers in the state estimated that over 19% of their adult caseloads have a problem with substance abuse, and in the majority of cases it was not been officially diagnosed.**

*Final Consultation Report to WA State DDD and DASA; RRTC on Drugs and Disability, Wright State School of Medicine, February, 2003*

# TBI

- TBI, SCI, traumatic injuries have high pre- and post-morbid rates of AOD abuse
- Increase cerebral insult with TBI, reduced judgment and drug tolerance
- Returning vets – IED's and nature of conflict increase likelihood of TBI
- High un-diagnosed rate of TBI in SUD tx populations

# TBI

The CDC's National Center for Injury Prevention and Control estimates that 5.3 million U.S. citizens (2% of the population) are living with disability as a result of a traumatic brain injury (TBI). By comparison, MR is believed to be approximately 3-4% of the population.

# MI/PTSD

- MI has high correlation with AOD abuse
- Emergence of co-occurring disorders continues, as are models of tx; however, multiple co-morbidities not addressed in models
- PTSD is growing in awareness as issue in civilian and veteran populations

# Deaf

- Deaf, blind, MS have rates similar to or lower than general population – but higher risk if using any AOD
- SUD rates may be comparable among mobile, integrated Deaf - higher prevalence among others who are disenfranchised
- Significant communication, comprehension issues re: identification of SUD, referral, treatment

# HIV – HEP C

- ❑ Growing federal concern and focus on issues
- ❑ High co-occurrence of SUD with HIV/HEP C
- ❑ SUD and 2ndary conditions impair employment more than HIV
- ❑ HEP C will become larger public health issue within 15 years, likely surpassing HIV
- ❑ Significant issues with re-entry populations

# Findings - adults with disabilities

- ❑ Significant prevalence of SUD's among persons seeking employment
- ❑ "Hidden" substance abuse may impact many systems
- ❑ Costs of rehabilitation are high in some cases
- ❑ Persons with disabilities have difficulty accessing appropriate CD treatment
- ❑ Stigma impedes progress on issue
- ❑ Approaches must cross disciplines and cultures
- ❑ Involvement of disability community pivotal to success
- ❑ Poverty, lack of employment, social disenfranchisement increase AOD abuse risk

# Persisting Functional SUD Limitations

---

- ❑ Poor ability to take criticism
- ❑ Poor appearance
- ❑ Low work tolerance
- ❑ Anger - poor interpersonal skills
- ❑ Defensive behavior
- ❑ Risk taking/safety problems
- ❑ Overcompensation
- ❑ Memory problems
- ❑ Illness and health problems
- ❑ Depression
- ❑ Low frustration tolerance
- ❑ Rationalizing/blaming
- ❑ Poor personal hygiene
- ❑ Finance difficulties
- ❑ Commitment difficulties

**Disability Reported At Intake SUD Programs  
NY OASAS 1999 (N = 146,782)**

**Persons entering tx = 12.3% have another disability**

**Persons entering tx = 17.7% have two or more other disabilities**

**Total 30.0%**

**SUD + One other disability = 28.3% have MI as this disability**

**SUD + Two or more disabilities = 91.7% have MI as one of them**

Moore, D. & Weber, J. (2000)

# Estimated number of persons with disabilities in U.S. needing AOD treatment services in 1999

**Estimate - all needing treatment in year      3 – 5 million**

(SAMHSA formula based on number of persons currently served (1.8 Mil), and estimated SUD rates in general population, 2000)

**Estimate – needing tx with disabilities      396,000 – 660,000**

(based on assumption that persons with disabilities equally likely to experience SUD than general population, and averaging disability population prevalence from U.S. Census, S.I.P.P.)

**-OR-**

**Estimate – needing tx with disabilities      903,000 – 1,505,000**

(based on observed rate of recorded disability in NY OASAS 1999 treatment episode dataset = 0.301)

Source: *RRTC on Drugs and Disability, 2003*

# Challenges for providing accessible and appropriate services

# AOD Treatment Barriers Requiring Research

- **Attitudinal**
- **Discriminatory policies, practices**
- **Communication barriers**
- **Architectural barriers**
- **Funding inadequacy and managed care**
- **Lack of referrals from disability providers**

## AOD Treatment Denials

- 1. Individual with seizure disorder and history of traumatic brain injury denied residential treatment while taking prescribed anti-convulsant, Phenobarbital.**
- 2. Man with Cystic Fibrosis denied residential treatment for severe alcoholism due to medical condition. Judge kept him in jail rather than release to unsupervised setting.**
- 3. Individual with brain injury and mild mental retardation discharged from treatment for non-compliance after 3 hours attendance. He became agitated about toothbrush, and staff would not honor client request to make sure that toothbrush was packed in his luggage.**
- 4. Young man with work and alcohol-related blindness denied treatment because of his visual impairment. Told to wait “one year then come back when your vision improves”.**

# Factors Limiting Disability Provider Success with SUD Referral

Limited or No expertise in SUD

Few people WANT AOD service

Lack of alternatives for treatment

Funding restrictions/ unavailability of support

System may be set up to ignore these issues

No clear policies/practices

Client choice issues

# Factors Limiting SUD Provider Success with Persons with Disabilities

Limited or No exposure to persons with disabilities

No awareness that this is a problem

Perceived small number of persons needing AOD service

High volume, little individualization

No clear policies/practices regarding disability accommodations

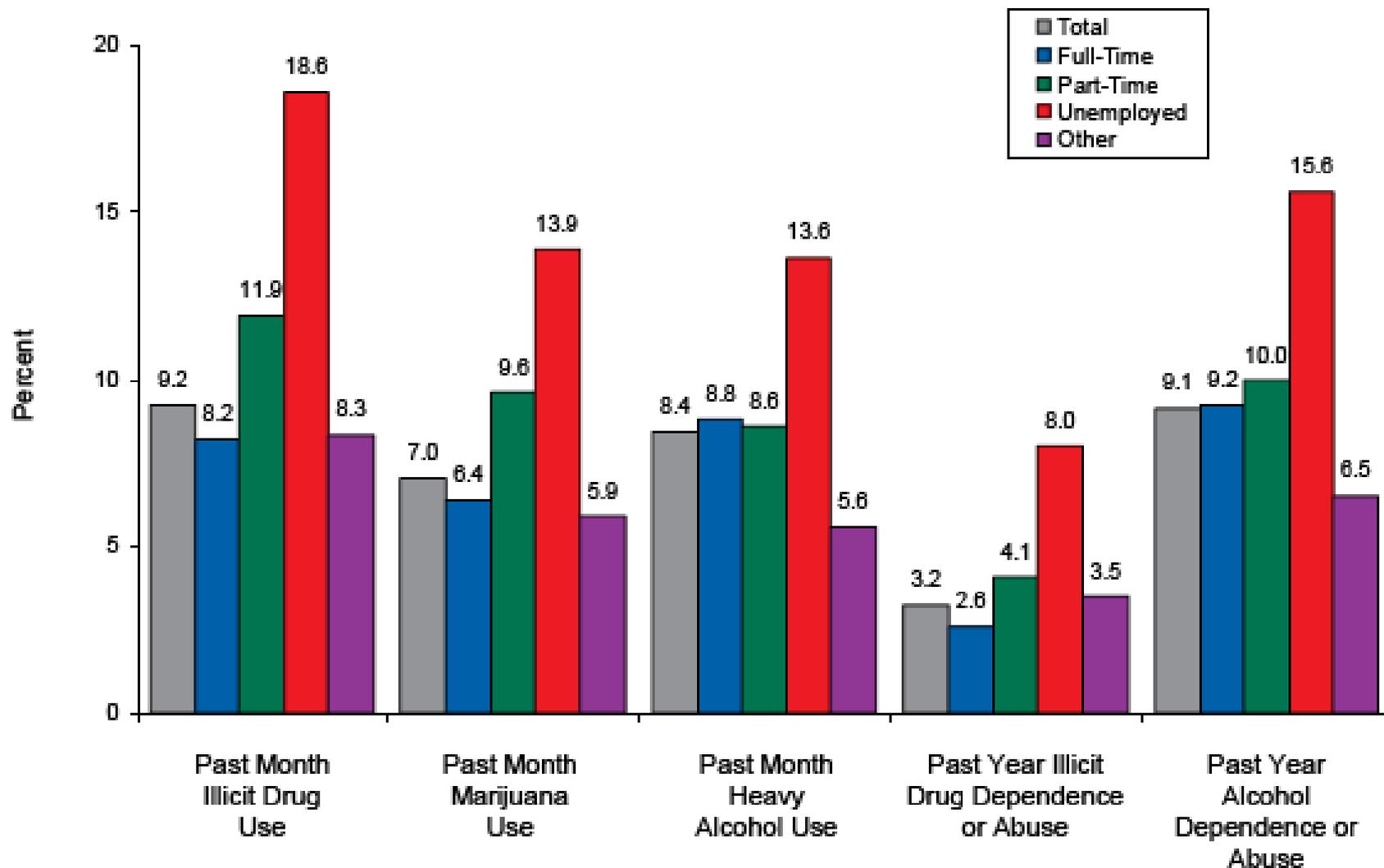
Little flexibility in treatment alternatives via managed care

# Other inhibiting factors

- ❑ SUD tx workforce capacity issues, diminishing workforce
- ❑ Reduced margins for unit costs
- ❑ Greater emphasis on group-oriented tx
- ❑ Lack of funding for case management
- ❑ Lack of disability or functional impairment identification

# Integrating employment for persons with SUD & co- existing conditions

**Figure 2.1 Past Month Substance Use and Past Year Substance Dependence or Abuse among Persons Aged 18 to 64, by Employment Status: 2002-2004 Combined**



# Federal-State Vocational Rehabilitation as example of issues

---

## **State based Vocational Rehabilitation programs**

- ❑ 600,000 persons with disabilities served/ yr, with 25%+ SUD estimated in adults**
- ❑ No standard policies/practices for addressing SUD (vary from .90% - 28.3% of VR program census-2005 data)**
- ❑ No standardized screening for SUD**

## **% SUD as primary or secondary diagnosis by state – RSA 911**

<b>AR (0.90)</b>	<b>OH (2.57)</b>	<b>WV (3.58)</b>	<b>TN (3.70)</b>	<b>IN (3.72)</b>
<b>IL (4.02)</b>	<b>FL (4.04)</b>	<b>AZ (4.35)</b>	<b>MA (4.67)</b>	<b>WI (4.72)</b>
<b>NH (5.46)</b>	<b>IA (6.09)</b>	<b>RI (6.68)</b>	<b>NE (6.80)</b>	<b>CO (6.80)</b>
<b>GA (6.89)</b>	<b>OK (7.16)</b>	<b>MT (7.36)</b>	<b>SD (7.56)</b>	<b>KA (7.78)</b>
<b>NV (8.57)</b>	<b>WY (9.24)</b>	<b>DE (9.41)</b>	<b>CT (9.64)</b>	<b>OR (10.01)</b>
<b>WA (10.46)</b>	<b>MN (10.53)</b>	<b>MO (10.69)</b>	<b>NC (10.81)</b>	<b>MS (10.88)</b>
<b>VT (11.37)</b>	<b>VA (11.61)</b>	<b>CA (11.65)</b>	<b>LA (12.16)</b>	<b>AL (12.19)</b>
<b>TX (12.33)</b>	<b>NM (13.56)</b>	<b>KY (14.87)</b>	<b>MI (14.94)</b>	<b>ID (15.46)</b>
<b>AK (15.58)</b>	<b>PA (15.66)</b>	<b>UT (15.83)</b>	<b>NJ (16.04)</b>	<b>ND (16.14)</b>
<b>MD (18.42)</b>	<b>MA (19.85)</b>	<b>NY (22.80)</b>	<b>HI (26.94)</b>	<b>SC (28.32)</b>

# Philosophical underpinnings of Individualized Placement and Support

## Assume integration with dual disorder treatment

- ❑ IPS can double employment rate for persons with SMI
- ❑ People opt for work even if treatment is ongoing and sobriety is marginal
- ❑ Consumer directly works on finding employment
- ❑ Team interacts with employer
- ❑ Employment provides stability and recovery support
- ❑ Relapse may be component of process
- ❑ Jobs become increasingly more stable and lead to career ladder

# Integrating policy and practice

*Federal Level: External Workgroup on Disability  
Policy Recommendations to CSAT/SAMHSA 2007*

- 1: Train SAMHSA staff in disability-issues and ADA-policies**
- 2: Mandate data collection on disabilities in TEDS and the National Household Survey on Drug Use and Health**
- 3: Enforce ADA-compliance Matrix for State Block Grants and discretionary programs**
- 4: Identify cadre of national trainers skilled in disability-related interventions**
- 5: Develop ADA Compliance Curriculum for states and treatment organizations**
- 6: Develop SAMHSA website for persons with disabilities**
- 7: Issue grants for treatment of youths and adults with physical and cognitive disabilities**

# Change increasingly falls to state, rather than federal government

- ❑ Changes in Medicaid – money follows the person
- ❑ Changes in criminal justice-SUD tx collaborations
- ❑ Changes in youth services
- ❑ Health care and disability plans

## State level challenges for addressing SUD and disability

- ❑ Funding to provide SUD tx to MR/DD must come from some budget that already is fully allocated. Services may have to be established at the detriment of another that already exists.
- ❑ State agencies, although similar in central office staff number and budget, often very different mandates and timeframes for delivery of service. (*e.g., DDD serves clients for an extended time, often for a person's lifetime, whereas DASA is intended to provide more specific and short term support.*)
- ❑ State government is often in flux. (*e.g., DDD's recent move into another department of state government.*)

## State level challenges for addressing SUD and MR/DD: *supply side*

- Referral of persons with DD and substance use disorders may be difficult to identify by DDD staff due to large case loads and manner in which services are delivered.
- “Client choice” issues may make it more difficult for DDD personnel to know when and how to make an alcohol or drug referral.

## State level challenges for addressing SUD and MR/DD: *treatment side*

- ❑ Limited funding and manpower to adapt programs to sufficient level necessary
- ❑ Low incidence nature of referrals relative to normal client referral profiles
- ❑ Lack of standards of care and training to address treatment demands for this population

Evidence suggests that solutions should include:

- ❑ Data collection related to disability in multiple settings, including SUD treatment
- ❑ “Integrated treatment” shows greatest potential for addressing diverse and individualized needs
- ❑ “money follows the person” for SUD and MI treatment, as well as housing and health care (*e.g., eliminate silos*)
- ❑ Shared responsibility for complying with existing statutes and standards of care
- ❑ Case management, incentives, longer duration-less intensity, functional level grouping, integration of plans with providers of housing, family services, TANF, employment, health care