

Substance Abuse and Women With Disabilities

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In this guide, the term “women with disabilities,” refers to women who have primarily physical disabilities. However, having a substance abuse problem is also a disability. It prevents a woman from being able to take care of her emotional, physical and mental well being. A substance abuse problem hinders her ability to attend to critical aspects of her life such as personal relationships, employment, family and social obligations. Therefore, when a woman with a disability has a substance abuse problem the substance abuse becomes her primary disability. Until a chemical dependency is successfully addressed, a woman will be unable to make informed, healthy choices about her life, or to effectively meet the challenges associated with her other disabilities.

THE RATE OF SUBSTANCE ABUSE AMONG WOMEN WITH DISABILITIES

Existing studies suggest that the rate of substance abuse for people with disabilities is as high or even higher than for individuals in the general population (Ford and Moore, 1992). Research findings have also shown that a physical, mental, or psychological disability can put a person at greater risk for difficulties related to alcohol and other drug use than people who do not have disabilities (Li and Ford, 1996). However, specific studies examining the rate of substance abuse among disabled women, and their patterns of alcohol and drug use, are yet to be conducted, and the data that is available about gender differences in this population is generally inferred from studies identifying the rate of substance abuse for both men and women with disabilities. Unfortunately, in studies conducted on alcohol and drug problems among women and girls, information about disability is not collected.

One multi-state survey on substance use among people with disabilities showed that alcohol use is at least as common among women with disabilities as it is among women in the general population (Li and Ford, 1996). In another study conducted in Wisconsin in 1985 by the Department of Health and Social Services, Offices for Persons with Physical Disabilities, it was found that individuals with physical disabilities alone had a 50% higher rate of alcohol and drug abuse than the general population (Finkelstein, 1990). The National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimates that people with disabilities share at least the same rate of alcoholism as non-disabled persons, which is estimated at about 8% of the population. This suggests that at least 2.8 million people with disabilities are alcoholics. It is estimated that up to one third of these multi-disabled alcoholics may be women (Finkelstein, 1990).

POSSIBLE CONTRIBUTING FACTORS TO SUBSTANCE ABUSE AND BARRIERS TO SEEKING TREATMENT AMONG WOMEN WITH DISABILITIES

Physical and Sexual Abuse

Physical or sexual abuse experienced during childhood has been documented to be a major contributing factor to alcohol abuse among women (Kress, 1989; Laurence, Weinhouse, 1991). An emerging issue among women with disabilities is the astronomically high rate of sexual and physical abuse. In a national Delphi survey of women with disabilities, abuse and violence were rated number one as a public policy priority (Berkeley Policy Associates, 1996). Research has shown that people with disabilities are more likely than others of the same age or sex to be victimized, that the abuse is often more prolonged and severe, and that the effects may be more serious and chronic (Sobsey, 1994). The rate of abuse of people with disabilities is staggering – research has found that as many as 85% of women with disabilities have experienced domestic abuse (Feuerstein, 1997). A unique issue that many women with disabilities face is that they rely on others to assist them in their daily living. Some of these caregivers are spouses or family members, some are paid providers, some are staff of institutions. Research has shown that caregivers commit at least one fourth of all crimes against people with disabilities (Sobsey, 1994).

Dependent on Abusers

As noted above, some women with disabilities may depend on personal relationships for their basic survival. It is not uncommon for women with disabilities to rely on upon family members and friends for assistance with eating, dressing, bathing, transportation, and managing their finances, among other critical supports. If a disabled woman's support system consists of individuals who abuse alcohol or other drugs, she may be vulnerable to abusing substances herself and it may be quite difficult for her to seek treatment, and, subsequently, to maintain her recovery status.

Fear of Losing Children

With the new trend of incarcerating drug-addicted mothers, women are often hesitant to seek help for their addiction for fear of losing their children. Possibly having already encountered professionals who doubt their ability to parent, mothers with disabilities may have valid concerns to disclose their alcohol or drug problem to a public agency.

Prescription Medication Abuse

Medication abuse, such as self-medication for chronic pain, is a significant risk factor for both men and women with disabilities (Ford and Moore, 1992). Certain medications such as anti-depressants, tranquilizers, barbiturates and amphetamines, are regularly prescribed to women at between 2-3 times the rate they are prescribed to men (Finkelstein, 1990). In a five-state survey of over 1000 persons with disabilities, women reported chronic pain more often, and 60.3% were prescribed pain medication as compared to 46.6% of the men who reported chronic pain. Also, women with disabilities were more likely than men with disabilities to use alcohol and to abuse medications for pain management (Moore, 1992).

Physicians may not even be aware when their patients with disabilities are over medicating themselves (Ford and Moore, 1992). Substance abuse providers cite easy access to prescription medications as a common contributor to abuse. Many physicians may share societal attitudes of pity and have feelings of professional inadequacy towards people who cannot be "cured" and, consequently, may be too lenient in prescribing potentially addicting drugs (Hepner et al, 1980). In addition, many physicians are not experienced in dealing with substance abuse issues and focus primarily on the medical needs of the disability.

Women with physical disabilities who also have chronic pain problems may be at risk of self-medicating with alcohol and other drugs, or over-medicating with prescription drugs. There is also a concern that persons not mix prescription drugs such as Valium (a medication still sometimes prescribed – although there are better alternatives – for spasticity) with recreational drugs, since some combinations such as that of depressants and barbiturates, can be deadly (McCornack, 1996).

Enabling by Family, Caregivers and Friends

Oftentimes family, friends and service providers perceive persons with disabilities to use alcohol or other drugs to help cope with the emotional or physical pain of having a disability (Ford and Moore, 1992; Hepner et al, 1980). This perception, combined with a projection of how family members or friends might feel if they were, themselves, disabled, can often prevent family members and loved ones from confronting the issue. In addition to avoiding the problem, individuals close to disabled women may in fact enable their use of alcohol and other drugs by purchasing it for them and physically facilitating use.

Social Isolation and Lack of Vocational Opportunities

Individuals with disabilities tend to experience greater social isolation and occupational impairment than individuals without disabilities, women with disabilities even more so (Ford and Moore, 1992). Although the population of women with disabilities is quite diverse, most are single, having no primary partner on whom to depend and to share support. According to the 1993 Survey of Income and Program Participation, 43% of women with disabilities are married compared to 60% of women without disabilities (BPA, 1997). Women with disabilities are also less likely to be employed than women without disabilities. If they are employed, they tend to work in low-paying, low skilled service and domestic jobs (Braddock and Bacheider, 1992). A low employment rate can be a risk factor for a higher incidence of drug and alcohol abuse. The combination of stress and isolation, with an excess amount of unstructured time, can contribute to depression and poor self esteem, placing women at risk for substance abuse.

Inaccessible Substance Abuse Treatment Programs

Substance abuse services that are otherwise available to a wide range of participants may be inaccessible to women with disabilities for many reasons. The following statement from the National Association on Alcohol, Drugs, and Disability concisely addresses the lack of program accessibility that exists for people with disabilities:

“Our contemporary understanding of substance abuse defines it as a complex bio-psycho-social process. People with disabilities face more risk factors and disenfranchisement than most other Americans in this regard. The tragedy is not that people with disabilities experience substance abuse; this condition impacts persons in every stratum of our society. Instead, the tragedy is that prevention, intervention, and treatment services continue to be inaccessible to persons with disabilities because of attitudinal, cognitive, and physical barriers. By continuing to hide or ignore this problem, we make it far worse, and more costly for everyone. (NAADD Fact Sheet on Alcohol, Drugs, and Disability, 1997.)”

Insufficient Referral to Treatment Programs

When a woman recognizes that she has an alcohol or other drug problem and seeks help, it is crucial that she receive it or is properly referred as soon as possible. That window of opportunity when she is actively seeking help can be quite short, anywhere from a few hours to a few days. If she is rejected, chances are slim that she will persist in her pursuits or try again anytime soon.

There is evidence that many disabled individuals in need are not being referred to drug and alcohol programs or receiving treatment. In a survey conducted in 1988 in five counties in the San Francisco Bay Area by the Coalition on Disabilities and Chemical Dependency, it was found that both substance abuse programs and medical rehabilitation agencies failed to refer individuals with disabilities with drug and alcohol problems to treatment programs. In 1998, the National Association on Alcohol, Drugs and Disability conducted a limited review of accessibility of treatment programs in four states and found that most were inaccessible and services were under utilized by the estimated number of persons with disabilities in need (NAADD, 1999). This problem stems from professionals in these two fields narrowly viewing the client in terms of their own frame of reference or expertise. Medical rehabilitation agencies either ignore or are unable to detect alcohol or other drug problems; unfortunately, many signs of substance abuse such as irresponsibility, lack of motivation and poor physical health are often attributed to having a disability. Conversely, many substance abuse treatment programs avoid serving people with disabilities because their staff have the misconception that people with disabilities need services that are focused on their disability first, and their addiction problem is a secondary disorder. Therefore, a person with a disability is typically referred back to the "gatekeeper" who had referred her for help with her substance abuse problem in the first place.

HOW TO IDENTIFY WHEN A WOMAN WITH A DISABILITY HAS A SUBSTANCE ABUSE PROBLEM

In assessing need for treatment, it is important to keep in mind that patients frequently underestimate their consumption. This underestimation may be attributed to denial, one of the hallmarks of the disease process of substance abuse. Question patients about their drug or drugs of choice and the frequency, amount, and method of use. Obtain information on prior detoxifications, concomitant use of other substances, date of first use, and time interval from last use. There are several assessment tools to determine if an individual has a substance abuse problem. The CAGE is a four-item questionnaire that a practitioner can administer during a routine check up or include on an intake form. The questions are as follows:

- C Have you ever felt you should cut down on your drinking or drug use?
- A Have people annoyed you by criticizing your drinking or drug use?
- G Have you ever felt bad or guilty about your drinking or drug use?
- E Do you ever take a drink or use drugs first thing in the morning to steady your nerves or get rid of a hangover (Do you ever have an “eye opener?”)

Because these questions reflect self-perception, they can apply to alcohol use, prescription medication and illicit drugs. A single positive response to the CAGE questions is considered suggestive of a problem, and 2 or more positive responses indicate the presence of such a problem with a sensitivity and specificity of approximately 90% in most studies. However, some studies have suggested that the CAGE score may be less accurate in white females (Bradley, 1998). This suggests the importance of gathering a more complete picture rather than completely relying on this questioning technique. Two longer instruments, the MAST (Michigan Alcohol Screening Test) and the DAST, are included in the Appendix.

Identifying substance abuse in a patient may be even more difficult if the patient has a co-existing disability. Oftentimes behaviors that are a result of substance abuse are confused with behaviors that are related to having a disability. Some examples are listed below.

Not caring for herself. You may notice that the patient is losing (or gaining) weight, appears disheveled or has not bathed. Her wheelchair or other mobility aid may be in disrepair. In these cases, it is important to acknowledge these changes and inquire as to the cause. It is common for disability-related problems to be the cause, such as an attendant or other caregiver wasn't available to help, and that well may be the case. However, substance abuse can create a general inability to organize assistance with personal tasks.

Missing appointments. A patient chronically late to appointments or missing them altogether may be experiencing substance abuse. Reasons given may be wheelchairs breaking, caregivers not showing up, or transportation not being available. These occurrences may be true. It may be a hardship to get to medical appointments. For examples, transportation is a critical issue for women with disabilities, particularly those who use mobility aids such as wheelchairs. Yet, resources, such as paratransit, Dial-A-Ride, etc, are available in most communities. Substance abuse hinders one's wherewithal to arrange transportation, maintain one's mobility aids and coordinate personal assistance efficiently.

Chronic medical problems and injuries. Some women with disabilities are prone to specific medical problems, such as urinary tract infections, decubitis (sp?) or other skin problems. Still it is critical to identify when the incidences of such problems seem extraordinarily high. The influence of alcohol and drugs can alter one's judgment, making one willing to put one's self in risky situations. Consistently sustaining injuries such as sprained and broken bones, burns, and cuts could be signs of substance abuse.

General lack of motivation. When a patient has a chemical dependency, their strongest motivation will be to obtain and consume whatever is her drug of choice. All other aspects of life will be secondary. If a patient is not following your medical directions, then it is recommended that you probe for the cause. Another red flag may be if you

note that a patient does not appear to be pursuing goals or interests in other aspects of her life, such as in the employment, family or social arenas.

WHAT HEALTH CARE PRACTITIONERS CAN DO

The most critical action you can take is to acknowledge the substance abuse problem. Talk to the patient directly. Treat it as you would any other medical condition – make a plan of treatment, refer her for help and follow up. Opinions differ as to the benefit of noting this information in the patient's chart as a matter of course, as there may be employment, insurance, or other issues to consider before making it part of an official record. But as the following story illustrations, there is a risk that without noting it as a problem, substance abuse can go un-addressed:

Melissa (not her real name), a woman with muscular dystrophy, describes the following experience:

"When I was twenty-two, I began to spiral down pretty quickly. One night I closed down a bar with a friend. When we got home, I passed out and she couldn't wake me up. She called an ambulance and they took me to the hospital with a blood alcohol content of .3. Hospital staff monitored me, reviving me periodically with smelling salts. I remember being asked if I was unhappy or depressed and answering affirmatively. Once they were satisfied I was alert, they transported me back home. A month later, my doctor received the ambulance report and called my house, but I wasn't home. She spoke to my roommate, asking her if I had a problem, if I was depressed, suicidal. Feeling awkward, my roommate kept repeating that the doctor should ask me these questions; that she (my roommate), shouldn't really say. The doctor did not leave a message for me to phone her back nor did she call back to speak to me directly. She never even mentioned it to me. I don't know what prevented her or the hospital staff from intervening when I was clearly in a sick state."

It is impossible to know what prevented Melissa's doctor from taking any action. Maybe she assumed it was an isolated incident, or a common event related to Melissa's age. Perhaps she had a personal discomfort dealing substance abuse issues. Maybe her inaction was a result of her perceptions of Melissa as a woman with a disability with few social options outside of drinking. Melissa also describes that on her initial intake with that doctor she reported having numerous alcoholic drinks several times per week, which raised no apparent concern.

All health professionals, including physicians, might consider examining their own attitudes and perceptions regarding alcohol and drug use and abuse. Everyone has either someone in his or her family or someone whom they've known intimately who has a substance abuse problem. Substance abuse touches everyone's life at some point. Therefore, every person has opinions and attitudes that are colored by their experiences. In order to objectively care for patients with substance abuse problems, it is critical to be aware of your thoughts and feelings about these issues.

RESOURCES

National Association on Alcohol, Drugs and Disability (NAADD)

The mission of NAADD is to create public awareness of issues related to alcohol and drug use among people with disabilities. NAADD seeks to establish better access to services, information, education, and substance abuse prevention through the collaboration of committed individuals and organizations nationwide. For more information contact:

NAADD
 John de Miranda
 Executive Director
 2165 Bunker Hill Drive
 San Mateo, CA 94402
 650-578-8047
www.naadd.org

SARDI Project: Substance Abuse Resources and Disability Issues

SARDI provides direct, disability-specific ATOD (alcohol, tobacco and other drug) and HIV prevention services to youth with disabilities while transferring this expertise to agency staff. SARDI conducts educational training with agency staff to enhance their knowledge and awareness of ATOD and HIV issues.

SARDI can provide several resource materials, or refer people to other existing materials. Some of SARDI's resources are listed below in publications. SARDI is also the home of the federally-funded Rehabilitation Research and Training Center (RRTC) on Drug Abuse and Disability. The RRTC focuses on the relationship between drug abuse and the vocational success of individuals with disabilities, conducting epidemiological studies, evaluating model systems, and providing training and technical assistance.

SARDI
 Wright State University
 School of Medicine
 P.O. Box 927
 Dayton, OH 45401-0927
 937-259-1384 (Voice/TTY)
 937-259-1395 (FAX)
sardi@wright.edu

The University of California Center on Deafness (UCCD)

UCCD is a federally designated research and training center focusing on deafness and mental health. They have a variety of materials including a training video entitled, "Meeting the Challenge: Working with Deaf People In Recovery" for alcohol and drug service providers and "I CAN: Stories of Deaf and Hard of Hearing People in Recovery."

UCCD
 3333 California Street, Suite 10
 San Francisco, CA 94143-1208
 415-476-4980 (Voice)
 415-476-7600 (TDD)

National Clearinghouse for Alcohol and Drug Information (NCADI)

NCADI is a federal resource for alcohol, tobacco and other drug information sponsored by Substance Abuse and Mental Health Services Administration (SAMHSA), under the Department of Health and Human Services. NCADI carries articles, publications and videotapes on the topic of substance abuse and disability. Call for a current publication catalog.

National Clearinghouse For Alcohol and Drug Information (NCADI)

P.O. Box 2345
Rockville, MD 20847-2345
800-729-6686 or 301-468-2600 (Voice)
800-487-4889 (TDD)
301-468-6433 (FAX)
info@health.org.

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