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Orange County Addictions & Disabilities Resources Manual
Testimonials
Hello, my name is Hector Del Valle I am 43 years old and paralyzed from the chest down after I injured myself while I was drinking and driving almost 25 years ago at the age of 17.

The purpose of sharing my story is to help others like me who have used drugs including alcohol to cope with life. Prior to injuring myself I didn't have much to complain about at 17 years old. I was a Carpenters apprentice making 300 dollars a week, a senior in high school and captain of the gymnastics team. My girlfriend Debbie was in her first year of college and we had dreams of living together and perhaps one day getting married. At that time I couldn't see how drinking a few beers, smoking a few joints, doing a few lines or tripping a few times could cause harm.

This was my denial and it continued for years even after I injured myself. I was now paralyzed from the chest down and still driving intoxicated even with hand controls. I then started using drugs and alcohol to cope with my disability, relationships, my family and myself I used until I was sick and tired of being sick and tired. I felt I either was going to keep using until I killed myself or get help and stop using. My first attempt was in 1986 when I wheeled in to a drug and alcohol treatment facility in New Jersey asking to be admitted and then being denied because I was disabled and they were inaccessible. I was angry I was told to go to AA and NA meetings only to have 75% of them inaccessible, the ones I did find accessible were very few and then I was the only one in a wheelchair and I felt cheated, confused and embarrassed but I kept coming back as I was told and kept relapsing about every six months after almost 3 years of chronic relapsing I found a counselor who moved his office from the third floor to the first and as I saw him twice a week I went to meetings. The last time I got high was August 23, 1989. It's an awesome feeling being sober 17 years. I feel I could have saved myself three years of relapses if I could've found an accessible treatment program or professionals in the fields of addiction and disabilities who had the knowledge, awareness and resources on where, what and how people with physical disabilities could find help.

Today, 17 years later I have graduated college with a master's degree in social work employed as a senior counselor at an adult residential recovery program for men who are dually diagnosed. The Center for Drug Free Living, the company I work for, is one of the very few who are making changes in the community to educate and bring awareness on the issues of addictions and disability. If you or someone you know has a substance abuse problem and is disabled please contact me at hdvinfl@aol.com.

I hope my story has instilled some hope that recovery is possible no matter what your disability is.
Suellen’s Story

I was born in 1953 with spina bifida, and, as I would find out almost 53 years later, arrested hydrocephalus. This means that I use a wheelchair for mobility and have some skeletal deformities such as scoliosis. However, for some reason no one understands, I have a normal intellect and never had any difficulties with learning. Although given a grim prognosis for my future, my parents refused to place me in an institution, treated me as they would have treated any other child, and fought for opportunities for me to participate in life that came naturally to “normal” children. They were constant and fierce advocates for me. As I grew up I followed their lead and became a constant and fierce advocate for myself, refusing to take “no” for an answer and demanding equal treatment and opportunities in terms of schooling and work opportunities. I also refused to feel sorry for myself and belittled anyone who did, or who tried to help me. I did not realize it at the time, but I was developing a chip on my shoulder – not because of my disability, but because of the “ignorance” of those who did not recognize that I was a perfectly “normal” person. My motto in life quickly became “I’ll show you!” Consequently I became a very unhappy person.

Because my mom was alcoholic, I probably inherited a genetic predisposition toward alcoholism. When my environment presented me with my first opportunity to drink, at age 13, I had a daiquiri and loved it. At 15 I began drinking and smoking marijuana on weekends with my friends, at first just to show that I was no “goody two shoes” and just as “cool” as everyone else. Very shortly I learned that alcohol “helped” me in many ways – calming anxiety, medicating depression, alleviating loneliness, helping me say some of the things I didn’t have the guts to say in a sober state. I began drinking regularly in my early twenties, frequently blacking out on weekends. My drinking career was briefly interrupted when I reached 30 and quit for seven months after years of pleading by my father and boyfriend (now husband). I was very fortunate because when I made my decision to stop drinking (I had stopped smoking weed years earlier because I didn’t like the feelings of paranoia it produced) I was able to find several AA meetings very close to my campus apartment where I was in law school at the time. The meetings were all on ground level and wheelchair accessible. Unfortunately, I failed to make a connection with people during my first foray into recovery. I simply was not able to make an association between my anger about the way people treated me because of my disability and my drinking. I refused to talk about my anger and intellectualized everything, including the recovery program I was allegedly “working”. I also would not allow others in the program to help me because I didn’t believe I needed anyone at the time.

My sobriety, as I said, lasted seven months. Once I drank again, I didn’t return to the AA program for ten years. I had started a new career, gotten married (because I had fooled my husband into believing that I actually was in recovery), and became involved in civic activities in the community. I had cut back on my drinking and hid it from my husband and my friends. When I finally realized I was miserable, I went back to meetings briefly but wasn’t willing to stop drinking, so I stayed “out there” for a total of
fourteen years since my first attempt at sobriety until I finally hit my bottom. My defeat certainly may not have had the magnitude of those of others – I simply “blacked out” and embarrassed myself at a bar in front of some co-workers. When I offered to resign, my boss excused me by saying that “everybody does it” and other friends insisted that I was not an alcoholic, I simply was a small person who wanted to drink like a big person. Somehow, I realized that this was not true.

I came back to the AA program at the end of 1998. Again, I had no difficulty locating wheelchair-accessible meetings. However, I still refused to link my drinking with my anger toward “all those people” out there who didn’t understand me because of my disability. There were even meetings I attended where other recovering alcoholics with disabilities tried to reach out to me for help and understanding, but I rejected them because I still believed they were not like me. When able-bodied alcoholics at meetings tried to open doors for me, or help me get my wheelchair into my car, I gave them a blistering reply: “I need help with my alcoholism, not my physical situation”. It took me a long time in recovery (I recently celebrated 8 years of sobriety), a great deal of therapy and years of self-examination as a counseling student, but I have finally been able to turn the corner and let go of a lot of my anger. I now see my drinking and my hostility as defense mechanisms to shield me from the realization that I am physically different from others and from my refusal to accept myself for who I am. I am grateful for all the people I encountered in my recovery who accepted me even when I could not accept myself, and for the AA meetings which were accessible to me even when I did not really want their help. I am now working as a substance abuse counselor, something I never could have done without having gone through my own recovery program. I still go to meetings regularly, and I try to never turn anyone away who needs my help. One of my aims is to work toward making sure that recovery programs are accessible to all who need them, including those with disabilities. Our citizens – able-bodied or not, deserve nothing less.
Orange County
Drug Free Coalition

- Mission Statement
- Strategic Goals
- Addictions & Disabilities Workgroups
- Goals and Objectives
Mission Statement:
To identify and utilize the resources within Orange County that institute initiatives that effectively provide education, prevention, intervention and treatment of substance abuse issues resulting in a thriving Drug Free Community.

Strategic Goals:
Goal 1: Prevention - Stopping Use Before It Starts

Goal 2: Enforcement - Aggressively attacking unlawful drug activity

Goal 3: Treatment/Recovery - Getting Treatment Resources Where They Are Needed

Goals and Objectives:

Goal 1: Prevention - Stopping Use Before It Starts
Objective 1: Educate children, parents and other members of the community, to assist Orange County citizens to reject illicit drugs and underage alcohol and tobacco use.

Objective 2: Provide Orange County youth with access to research based substance abuse programs.

Objective 3: Encourage and assist the development of community/neighborhood groups in preventing substance abuse.

Objective 4: Educate and engage parents through forums, focus groups and advisory groups on substance abuse issues.

Objective 5: Support drug-free schools, prevention programs and others environments that promote zero tolerance for substance use.

Objective 6: Support higher education institutions ATOD prevention programs and initiatives.

Objective 7: Work with the electronic and print media on awareness of prevention activities and events.

Objective 8: Collaboration with community partners, government entities, sports organizations, business and faith groups to encourage prevention efforts in the community.
Objective 9: Encourage businesses to adopt a drug-free workplace program through education and outreach.

Objective 10: Provide awareness and outreach efforts to senior citizens on substance abuse issues affecting youth and the elderly population.

**Goal 2: Enforcement - Aggressively Attacking Unlawful Drug Activity**

Objective 1: Support law enforcement with resources, training, and coordination across jurisdictional boundaries and throughout the criminal justice system to aggressively attack drug activity.

Objective 2: Support federal, state and local law enforcement efforts toward the common objectives to decrease the supply of unlawful drugs in our community.

Objective 3: Work with electronic and print media to maximize exposure of law enforcement drug-related details

Objective 4: Support gang enforcement units and other gang enforcement organizations that provide education, prevention and suppression of gang activities which are drug-related in the community.

Objective 5: Promote law enforcement education outreach efforts focusing on substance abuse.

**Goal 3: Treatment/Recovery - Getting Treatment Resources Where They Are Needed**

Objective 1: Support treatment programs in the community.

Objective 2: Provide awareness of faith-based treatment programs available in the community.

Objective 3: Educate parents, faith leaders, and other community members on treatment programs available for youth and adults.

Objective 4: Provide awareness of recovery programs and activities in the community.

Objective 5: Work with the electronic and print media on promoting awareness on treatment availability and resources in the community.

Objective 6: Explore specific treatment needs and facilities available for persons with disabilities.
Addictions & Disabilities Workgroup

Workgroup Goals & Objectives:
- Increase awareness of the need to offer services to persons with disabilities.
- Increase awareness of what exists in regard to accommodation and access.
- Decrease barriers – physical, attitudinal, cognitive and financial.
- Explore specific treatment needs & facilities available for persons with disabilities.

Facts:
- Persons with disabilities experience substance abuse rates 2-4 times that of the general population (NAADD).
- Persons with spinal cord injuries, orthopedic disabilities, vision impairment, and amputations can be classified as heavy drinkers in approximately 40-50% of cases.
- Conditions such as deafness, arthritis or multiple sclerosis have shown substance abuse rates at least double the general population estimates.
- Substance abuse prevalence rates approach or exceed 50% for persons with TBI’s, SCI’s or mental illness vs. 10% of the general population (NAADD).
- Shortened length of rehab stays have hindered the psychological intervention secondary to the process being focused on physical independence. They need follow-up as an outpatient (NAADD).
- Disability and substance abuse can become a way of life for any race and age as a result of circumstances.
- 70-75% of individuals who sustain a spinal cord injury are a direct result from drinking and driving or using other drugs.
- According to an article published by Bombardier, 35% - 49% of people with recent-onset spinal cord injuries have shown significant self-reported alcohol related problems (article in New Mobility magazine).

Join the Addictions & Disabilities Workgroup:
- Meeting Date/Time: The workgroup meets on quarterly basis, 3rd Friday at 9:00 a.m.
  Next Meeting Dates: Quarterly Meetings
- Meeting Location: The Center for Drug Free Living, 100 W. Columbia Street.
- For More Information Contact:
  Robin Kohn, Co-Chair - 407-823-2967 or rkohn@mail.ucf.edu
  Hector Del Valle, Co-Chair - 407-245-0012 or hdvinfl@aol.com
  Carol Burkett, Drug Free Coalition Director - 407-836-7335 or carol.burkett@ocfl.net
Ms. Robin Kohn is the BSW Program Coordinator and Clinical Instructor in the School of Social Work at the University of Central Florida where she teaches many of the practice courses. Prior to arriving at UCF she had been at Florida Hospital for 6 years and ORHS Lucerne for 10 primarily in rehabilitation of individuals with neurological and/or physical injuries and disabilities. In between, Ms. Kohn was Director of Social Services at the Arbors, a sub-acute/long term care facility. Her interest areas are many including women’s issues, strengths perspective, end-of-life care, bereavement and grief, disability, addiction and health/mental health but her specialty area is health and disabilities. Educationally, Ms. Kohn received her MSW from Florida State University and is a Licensed Clinical Social Worker in the State of Florida.

Ms. Kohn continues her work within the community by coordinating the Greater Orlando Spinal Cord Injury Network and the Peer Program and is a consultant with the United Spinal Association and the Center for Comprehensive Services specializing in transitional living facilities for acquired brain and spinal cord injuries. She was asked to develop and subsequently wrote the Train the Trainers Manual for an SCI Peer Mentor Program. She assists in educating professionals about disability and addiction and trains individuals who wish to begin a peer program. Ms. Kohn is an educator, therapist and coordinator having presented on such topics as “Anger Management and SCI”, “Addictions and Disabilities”, Sexuality and Disability and Illness”, “Medical Groups and More”, “Professional Relationships, Boundaries and Ethics”, and “Accessing Abilities from a Strengths Perspective”.

She is active with the National Association of Social Workers (NASW) locally and on the state level. She serves as Chair of the Committee on Disabilities and Persons with Disabilities for NASW in Florida and for the Association of Baccalaureate Program Directors nationally.
Hector Del Valle, MSW

**Hector Del Valle** is a Senior Counselor at the Center for Drug Free Living (CFDFL) Men's Residential Recovery Program in Orlando Florida where he conducts groups and individual counseling sessions for men with co-occurring disorders. Prior to arriving to the CFDFL, Mr. Del Valle did public speaking and advocated for people with disabilities seeking accessible substance abuse treatment.

Mr. Del Valle received his Master of Social Work (MSW) from the University of Central Florida and is registered with the state of Florida as a Licensed Clinical Social Worker (LCSW) intern.

In 2002-2004 Mr. Del Valle served as a board member and treasure of the National Association on Alcohol Drugs and Disability (NAADD).

In 2009 he was awarded Counselor of the Year by the CFDFL, Central Florida's largest substance abuse program.

Mr. Del Valle is currently a member of the Orange County Drug Free Coalition where he serves as the Co-Chair of the Addictions and Disabilities workgroup.
LOUIS FAZIO, JR.

Louis A. Fazio, Jr. was born in Pittsburgh, Pennsylvania on February 9, 1964. Louis was in “special” schools/residential for the disabled up to the age of 15 and went to Delaney Senior High School in Baltimore, Maryland, graduating in the upper one-third of his class. He was one of the first four individuals to be “mainstreamed” into this high school. Louis entered University of Arizona in 1982 and graduated in 1986, with a Bachelors degree in Education, specializing in Rehabilitation Counseling.

- University of Arizona - During his college years, Louis was the first disabled New Student Orientation Counselor hired by the University of Arizona.

- Manheim’s Florida Auto Auction of Orlando - In 1987, Louis started as a manager-trainee for Manheim’s Florida Auto Auction of Orlando. In 1989, he was promoted to Public Relations Manager overseeing the Limo department, the mailroom, car repair for dealers, consignment dealers, factory and the Auction in general.

- Manheim’s Central Florida Auto Auction - In 2000, Louis transferred to Manheim’s Central Florida Auto Auction and held the position of Dealer Service Manager for one year. Louis relocated back to Manheim’s Florida Auto Auction of Orlando in 2001, to the position of Community Relations Manager, which he still holds. Louis celebrated his 20th year of service with Manheim this year.

- As Community Relations Manager, he facilitates and coordinates all community related activities for the auction, such as Founder’s Day for the City of Ocoee and the Winter Garden Centennial Celebration. He is an active member of the Winter Garden Rotary and the West Orange Chamber of Commerce Board of Directors on behalf of the Auto Auction. On November 18, 2003, Louis was installed as the Vice Chairman of Health Central Foundation. Louis is also a member of the West Orange/South Lake Transportation Task Force.

- The Florida Independent Auto Dealers Association named Louis Fazio Jr. Auction Man of the Year.

- Health Central Foundation - Chairman - November 2004

- Hispanic Chamber of Commerce - On behalf of the Auction, Louis is also involved with the Hispanic Chamber of Commerce and various other community organizations.

- Relay For Life - 2005 Louis served as Chairman and raised over $200,000.

- United Cerebral Palsy - Board of Directors – 2006 to 2007

- Disability Advisory Board of Orange County - In 2006 Louis was appointed by Theresa Jacobs, Orange County Commissioner, District One, and elected as Chairman and served from 2006 - 2008.
• Share The Care - Board of Directors - 2007

• Florida Independent Auto Dealers Association - Regional Vice President 2007 and served for one year term.

• Florida Independent Auto Dealers Association – Re-elected Regional Vice President in September 2008

• Human Relations Diversity Board, City of Ocoee - Chairman May 2008 to Present.

• Chairman Martin Luther King, Jr. 1st Annual Unity Parade City of Ocoee – May 2008 to Present

• Winter Garden Rotary
  o Vice President - 7/2008 to 7/2009
  o President - Elect 7/2009 to 7/2010
  o President 7/2010 to 7/2011
Victoria Adams, LPN,
The Center for Drug Free Living

Victoria Adams is a Licensed Practical Nurse, a Certified Criminal Juvenile Justice Specialist, Master Addiction Counselor, a Pastoral Minister and Spiritual Director. Victoria has worked with The Center for Drug Free Living, Inc since 1996. She has worked in all aspects of addictions and has extensive experience with geriatrics. She has developed many programs to improve the care of the elderly, in the field of dependency and as a Pastoral Minister.

Victoria is a member of many committees within the community SALT, TRAID, Nursing Home Task Force, a key player in The Mental Health and Substance Abuse Committee, Orange County Commission on Aging, The League of Women Voters, League of University Women and Partnership on the End of Life.

Victoria developed this program and in a short time “Medication Wisdom” has exceeded its expectations. The Medication Wisdom program was awarded a Community Service Award and a Best Practice Award and has been presented for conferences, groups, and individuals.
Drugs & Abuse

• Effects on the Body and Behavior
• Substance Abuse Terminology
**Substance Abuse Terminology**

**Addiction/ Chemical Dependency** - A point at which a person will continue to make painful or injurious decisions to abuse alcohol and other drugs in spite of recurring problems. Some of the common symptoms of dependency for persons with disabilities are heavy and inappropriate use of medications, drinking in combination with medication use, excessive time spent in using or acquiring alcohol and other drugs, frequent intoxication (sometimes without others realizing this), and continued use of drugs despite adverse consequences. Persons must experience problems for more than one month or repeatedly over a long period of time.

**Aftermath** - Clients should receive sufficient training during treatment to enable them to cope with threats of relapse. Perhaps the most important training for aftercare is training the client to make use of existing support programs in the community. In this context, AA and other 12-step groups are recognized as essential.

**Alcohol Abuse** - Consuming alcohol or other drugs to the extent that problems result from that use. These may include impaired school or work performance, deteriorating personal relationships, separation from family and regular financial problems. The amount one consumes is not as important in defining “abuse” as are the consequences experienced because of that consumption. The consumption of any illicit drug by adults is considered abuse. For persons with disabilities, it is sometimes easy to obtain illicit drugs, either by trading excess habit forming medications, or because persons provide the drug out of feelings of sympathy.

**Alcohol and Drug Prevention Education** - Any standard alcohol and other drug education curriculum can provide a good basis. Many curricula may be too abstract for individuals with cognitive disabilities. Prevention messages need to be simplified, in concrete terms and have topics repeated several times.

**Alcohol-Related Birth Defects** (Fetal Alcohol Syndrome) - Terms encompassing the spectrum of disabilities ranging from mental retardation with physical deformities and facial malformations to less obvious, mild/subtle symptoms related to learning disabilities and hyperactivity. It is often misdiagnosed and not identified.

**Alcohol Use** - The consumption of alcohol and other legal drugs by people of legal age. “Use” implies moderate consumption that has no adverse physical, psychological, or social consequences. A person with a disability may have to be particularly mindful of all medication or alcohol use due to decreased drug tolerance or other disability-related factors and the risks involved.

“**Alcoholism**” - A primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired
control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial.

**Alternatives Approach** - A commonly used prevention strategy that provides opportunities of alcohol and drug-free leisure activities. Includes athletics, arts, music and community service.

**Binge Drinking** - The consumption of 5 or more drinks in a row on at least one occasion.

**Blood Alcohol Level (BAL)** - The amount of alcohol in the bloodstream, measured in percentages. Most commonly associated with alcohol-impaired driving.

**Cross Training** - Entails training that encompasses crossing organizational boundaries and disciplines. Many agencies can work cooperatively by developing training programs for each other that are mutually beneficial.

**Denial** - The way your mind operates to avoid the painful recognition that you are in a self-destructive relationship with alcohol or other drugs. Blame may be placed for physical or emotional troubles on other things.

**Detoxification** - Treatment involving a medically-supervised withdrawal from alcohol and other drugs.

**Enabling** - “A Conspiracy of Silence”. An environment of well-meaning family, friends and professionals who inadvertently support the use of alcohol/drugs. Not talking about the issues, covering up or making excuses for another person’s behavior, protecting loved ones from the natural consequences of their behavior, pressuring the person to “join the crowd to fit in”, or doing for someone what they can be reasonably expected to do for themselves are examples of actions that support the unwanted behavior.

**In-patient Treatment** - Individuals reside in-patient for a length of stay to receive individual and group counseling and AA meetings.

**Out-patient Treatment** - Provided individual and group therapy, vocational counseling, family treatment, and drug education. Person resides in the community and comes to a facility daily for services.

**Relapse (Prevention)** - The aim is to identify the pattern of relapse as well as “triggers” and to interrupt that pattern before they begin to drink or use again. Like substance abuse, relapse occurs in a continuum: a lapse or a slip may be an isolated incident of drug use, often with warning signs evident.

**Recovery** - Four possibilities: A. Recovery is permanent, meaning lifetime, for all problematic psychoactive (mood-altering) substances. This is the IDEAL. B. Recovery is short-term and relapse quickly ensues. C. Recovery from one substance is replaced by use or abuse of another. D. Recovery is counterfeit with continued drug use successfully concealed.
Resilience/ Protective Factor - many people possess resiliency traits that help them avoid alcohol, tobacco and other drugs.

Twelve-Step/ Self-Help Programs - Groups, such as AA offers 12 steps for continuing recovery. Groups deal with shared problems of the members, empowering them to be in control of their recovery, and provide a safe environment for mutual support and fellowship.
Drugs of Abuse: Effects on the Body and Behavior

To prevent alcohol, tobacco, and other drug abuse, and to intervene effectively, it is essential to understand what effects people derive from drugs and what impact use has on their health and well-being. The effects of psychoactive drugs are complex and diverse. The particular drug’s pharmacological action is not the only factor that determines the kinds of effects it will have: the setting in which it is used, the amount or dosage consumed, the age, sex and weight of the user, and the method of administration. The presence of active or underlying mental conditions (e.g., depression, bipolar disorder, schizophrenia, attention deficit disorder) further complicate an individual’s response to a psychoactive substance.

Among drug users, multiple drug use is the norm rather than the exception. Abusers seldom restrict their intake to a single substance. The desirable effects obtained from the various drugs during the early stages of use range from the following:

- Relief of pain;
- Reduction in uncomfortable feelings of anxiety;
- Feelings of pleasure, euphoria, disinhibition, and intoxication;
- Feelings of energy and power;
- Relief of boredom or to make social interaction more exciting.

Alcohol

In America, alcohol is abused at a far greater rate than all the other drugs added together. Alcohol, a natural substance formed by the fermentation that occurs when sugar reacts with yeast, is the major active ingredient in wine, beer and distilled spirits. Whether one drinks a 12-ounce can of beer, a shot of hard liquor, or a 5-ounce glass of wine, the amount of pure alcohol per drink is the same - .5 ounce. This chemical, ethyl alcohol, can produce feelings of well-being, sedation, intoxication, or unconsciousness, depending on the amount and the manner in which it is consumed.

Alcohol is a psychoactive or mind-altering drug, as are heroin and tranquilizers. It can alter moods, cause changes in the body, and become habit forming. Alcohol “depresses” the central nervous system which is the reason why drinking excessively causes slowed reactions, slurred speech and sometimes even “passing out”. Alcohol works first on the part of the brain that controls inhibitions. As people become uninhibited, they tend to talk more, get rowdy, and participate in risky behavior. Although after several drinks they may feel “high”, their nervous systems actually are slowing down.

A person does not have to be an alcoholic to have problems with alcohol. Every year, for example, many people lose their lives in alcohol-related auto crashes, drownings, and suicides. Alcohol abuse directly contributes to the incidence of physical disabilities such as spinal cord injuries and traumatic brain injuries due to highway accidents, sports/diving accidents, falls, etc. Serious health problems can and do occur before drinkers reach the stage of addiction or chronic use.
In some studies, more than 25% of hospital admissions were alcohol-related. Some of the serious diseases associated with chronic alcohol use are alcoholism and cancers of the liver, stomach, colon, larynx, esophagus, and breast. Alcohol can also lead to serious physical problems such as damage to the brain, pancreas and kidneys; high blood pressure, heart attacks and strokes; cirrhosis of the liver; impotence and infertility; alcohol-related birth defects such as fetal Alcohol Syndrome (FAS); premature aging; and a host of other disorders, such as diminished immunity to disease, sleep disturbance, and muscle cramps.


**Ecstasy:** MDMA, a hallucinogenic stimulant or most commonly known by the street name Ecstasy. Most common Club Drug also known as XTC, Adam or MDMA. Short-term effects include: increased heart rate and blood pressure, increased body temperature, possible hyperthermia, jaw and teeth clenching, muscle tension, hypertension, dehydration and heat exhaustion, chills/sweating, nausea, blurred vision, faintness and dizziness, confusion, insomnia and paranoia. Long-term effects include: rash, depression, sleep disorders, drug craving, persistent elevation of anxiety, paranoia, and aggressive and impulsive behavior. Medical complications with continued use include: liver damage, brain damage and paralysis. Large doses can cause muscle breakdown, hyperthermia, kidney failure and cardiovascular system failure.

**Cocaine**
A very addictive stimulant grown mostly in Bolivia, Peru and Colombia. General effects include: elevated heart rate, blood pressure and respiratory rate, decreased appetite, alertness, aggression, paranoia, depression, chest pain, nausea, abdominal pains, strokes, seizures, headaches, blurred vision, tremors, twitching, fever and irritability. Long-term effects include: strong psychological dependence, varying degrees of physical tolerance, eating disorders, impotence, seizures, strokes, severe withdrawal symptoms, malnutrition, permanent damage to nasal passage. Long-term effects for crack and free base cocaine are same as cocaine plus damage to lungs and more rapid addiction potential.

**Heroin**
A highly addictive opiate which is an effective pain reliever. Short-term effects include: suppression of pain, euphoria (a “rush”), depressed respiratory rate, clouded mental functioning, nausea/vomiting, fatal overdose, spontaneous abortion. Medical complications include: scarred/collapsed veins, bacterial infections of the blood vessels and heart valves, abscesses, liver or kidney disease, lung complication and infectious disease. Long-term effects are: addiction, tolerance and physical dependence, infection of the heart lining and valves, arthritis and other rheumatologic problems, pulmonary complication, including various types of pneumonia. Withdrawal effects includes: restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes and involuntary leg movements.
Marijuana
The most frequent used illicit drug, refers to the leaves and flowering buds of the cannabis plant. Studies suggest that people who use marijuana have lower achievement scores than non-users, are more likely to accept deviant behavior, have more delinquent behavior and aggression, greater rebelliousness, poorer relationships with parents, and more associations with delinquent and drug using friends. Short-term effects include: memory and learning impairment, distorted perception, difficulty in thinking and problem solving, loss of coordination, increased heart rate, anxiety, and panic attacks. Long-term effects are: daily cough and phlegm, symptoms of chronic bronchitis, difficulty sustaining attention, difficulty shifting attention to changes in environment and difficulty in registering, processing and using information. Research suggests that greater impairment among heavy users is due to an alteration of brain activity produced by marijuana.

Alcohol-Medication Interactions
Many medications can interact with alcohol, leading to increased risk of illness, injury, or death. These are some adverse effects associated with alcohol consumption and prescription medications.
Antibiotics are used to treat infectious diseases. In combination with alcohol, they may cause nausea, vomiting, headache, and possible convulsions.
Anticoagulants are prescribed to retard the blood’s ability to clot. After alcohol consumption, there is an increased risk for life-threatening hemorrhages.
Antidepressants are prescribed for depression. Antidepressants and alcohol are frequently associated. Alcohol increases the sedative effect of these drugs.
Antidiabetic medications are prescribed to help lower blood sugar levels in diabetic patients. Alcohol interaction may produce nausea and headache.
Antihistamines are available without prescription to treat allergic symptoms and insomnia. Alcohol may intensify the sedation and may cause dizziness.
Antipsychotic medications are used to diminish psychotic symptoms such as delusions and hallucinations. Alcohol increases the sedative effect resulting in impaired coordination and breathing problems. The combination may result in liver damage.
Cardiovascular medications are prescribed to treat ailments of the heart and circulatory system. Taken with alcohol, there may be dizziness or fainting.
Narcotic pain relievers are used for moderate to severe pain. Used with alcohol, there is an increased risk of death from overdose. Non-narcotic pain relievers such as aspirin and non-prescription pain relievers may cause stomach bleeding and lowered ability for blood clotting.
Sedative and “sleeping pills” prescribed to treat anxiety and insomnia may cause severe drowsiness.
Substance Abuse Facts

Children & Teens: Disabilities and Drug Use

Physical and Intellectual Disability
- Approximately 3% of children born in the United States have congenital, or birth, defects.
- The most common birth defects are congenital heart defects, spina bifida, sickle cell disease, phenylketonuria, Down Syndrome, Fragile X Syndrome, missing or undeveloped limbs, clubfoot, and cleft lip or palate.
- These and other birth defects can result in a wide range of mobility, hearing, sight, and intellectual/emotional impairments.
- Disabilities can affect children adversely through isolation and limited social contact, resulting in depression; victimization by bullying or taunting by peers, being singled out for “special” treatment, pity, or enabling (encouraging dependency on others or tolerating otherwise unacceptable behaviors) by adults.
- Young people with disabilities may feel that substance use will help them fit in with and thereby become more accepted by non-disabled peers.
- In the U.S., there are at least 1.1 million people with visual impairments and 1.5 million with significant hearing loss.
- Researchers estimate that 33% of visually impaired people and 20% of hearing impaired are in need of substance abuse treatment.

Prenatal Drug Exposed Babies
- Low birth weight places infants at risk for behavioral and attention deficits, psychiatric problems and poor school performance.
- Prematurity - infants at risk for bleeding of brain tissue, hydrocephalus (“water on the brain”), bronchial problems, eye disease.
- Failure to thrive - infants at risk for weight loss, failure to reach developmental milestones, distractibility.

Drugs, Schools and Delinquency
- Average age of first experimentation with marijuana is 12; with alcohol, 11 (these two are the most common drugs of experimentation).
- Teens may target common, over-the-counter medications, such as Coricidin, as potential substances of abuse.
- Signs of adolescent drug use include depression, low self-esteem, being outside the mainstream, starting arguments, breaking rules, withdrawing.
- Self-reported reasons for drug use by teens include enjoying the high, for social fun, to cope with negative feelings, to alleviate boredom, and peer pressure.

Learning Disability
- It is estimated that 2 of every 10 people have some type of learning disability.
- Many students feel frustrated and give up on getting an education; the drop out rate for those with learning disabilities approaches 50%.
- It is estimated that 40% of incarcerated juveniles are learning disabled.
• 50% of children and adolescents with learning disabilities experience significant emotional problems, such as ADHD, conduct disorders, anxiety disorders, anger problems, delinquency and depression.

• Children with learning disabilities are at a higher risk for academic failure and peer rejection.
• Children with learning disabilities often have low self-esteem, poor social skills, and behavioral problems.
• Side effects of learning disabilities which are also risk factors for substance abuse include low self-esteem, academic troubles or failure, loneliness, depression, and social isolation.
• In 2005-2006, there were 315 misdemeanor and 145 felony drug-related juvenile arrests in Orange County.
• So far in 2007, 118 juveniles have met criteria and been referred to the Delinquency Drug Court program.
• In recent statistics available, at least 30% of high school students were offered, sold or given illicit drugs.
• According to Juvenile Probation and Community Corrections, statewide estimates are that 8% of juveniles have alcohol problems, and 17% have drug problems.
• According to the same source, an estimated 47% of juveniles statewide have used mood-altering drugs.

Coping Strategies: Developing Resilience in Families where Childhood Disability is Present
• Make active efforts to stay together.
• Learn to balance special needs of child with those of other family members.
• Maintain normal routines and promote shared family values and priorities.
• Avoid blaming and learn to find meaning in having challenges.
• Be flexible.
• Be proactive in learning about the disability and possible solutions to problems.
• Attempt to maintain good relationships with helping professionals.
• Communication among family members is vitally important.
• Try to find something positive in the situation.
• Actively seek out resources and opportunities.
(from Selengman and Darling, Ordinary Families, Special Children, 2007)

Web Sites
• www.samhsa.gov
• www.dhhs.gov
• www.health.org/govpubs
• www.cdc.gov
• www.silcom.com/-paladin/disabilities
• www.med.wright.edu/citar/sardi/research.html
• www.disabilityresources.org/SUBSTANCE-ABUSE.html
• www.parents.com
Substance Abuse Among Older Adults

An Invisible Epidemic - Fact sheet

The Center for Drug Free Living, Inc

To Your Health! : Providing education, prevention, intervention, treatment and in-home services for older adults for alcohol, substance abuse medication abuse or misuse, and depression. Services are free of charge

Facts:

- According to one study, 30 percent of older alcohol abusers have a primary mood disorder (Koenig and Blazer, 1996)
- Alcohol-related hospitalizations are similar to those for heart attacks (Adams 1993)
- Older adults are less likely to receive a primary diagnosis of alcoholism
- Age related changes can trigger or increase serious problems
  - Increase risk of high blood pressure, heart problems, stroke
  - Increase the inability to fight off infections (impair immune system)
  - Cancer
  - Cirrhosis and other liver diseases
  - Decrease bone density
  - Gastrointestinal bleeding
  - Depression, anxiety, and other mental health problems
  - Malnutrition
  - Sleep disorders

Fact: Reasons for this silence and lack of treatment:

- Mistaking the symptoms for those of dementia
- Depression, mismanagement of medications
- Shame: Family members or Older Adult
- Acceptance from family members
- Multitude of physicians involved in care
- Not aware of treatment services or other options

Some Physical Symptoms:

- Changes in eating habits
- Poor hygiene and self-neglect
- Agitation, Irritability without cause
- Blurred vision
- Frequent falls and unexplained bruising

For help contact: Victoria Adams (407) 245-0010 ext. 267
Risk Factors for People with Disabilities

- Substance Abuse Survey Self-Assessment
Factors which put People with Disabilities at Risk for Alcohol and Drug Abuse

- Abuse of Prescription medications
- Unemployment
- Chronic Pain
- Depression
- Fewer Social Supports
- Isolation
- Increased stress on family life
- Limited access to transportation
- Excess free time, lack of recreational and social opportunities
- Enabling by well-meaning family, friends and professionals
- Lack of access to appropriate substance abuse prevention resources
- Lack of accessible 12-step meetings and treatment programs

Reasons Why People with Disabilities are at High Risk for problems Associated with Alcohol and Drug Abuse

1. People with disabilities may be taking multiple medications prescribed by multiple physicians. Mixing alcohol and medications is a lethal combination.

2. Inadvertent enabling by well-meaning family, friends and professionals may equate to a conspiracy of silence, or “The poor guy syndrome: What else does he have in his life? If I had that problem, I would drink too.”

3. The person with a disability may use alcohol/drugs to “self-medicate” against feelings of pain, loss, frustration, or anger about the disability.

4. The person with the disability may lack social and occupational skills.

5. The person may have been abusing alcohol/drugs prior to incurring a disability. Substance abuse directly contributes to the incidence of spinal cord injuries and traumatic brain injuries.

6. Disability specialists in provider agencies receive little if any training on substance abuse and denial and may fear hurting the person’s feelings by uncovering a complex problem. Staff may not have referral sources and may have personal biases.

7. Consuming alcohol is socially acceptable, relatively inexpensive and readily available. Distorted media ads depict alcohol as a beverage instead of as a drug.
8. People with disabilities lack essential basic education about alcohol/drug prevention, especially if they were classified as a special education student as an adolescent.

9. People with disabilities may have a higher likelihood of being involved with the criminal justice system, of becoming the victim of a crime, or of being cultivated as a “friend” by addicts who see him/her as easy prey.

10. Most treatment facilities and support groups are largely inaccessible. Both physical and attitudinal barriers are widespread.
People drink or use drugs for different reasons. How important would you say that each of the following is to you as a reason for drinking or using drugs?

1. I drink and or use drugs because it helps me relax.
2. I drink and or use drugs to be sociable.
3. I drink and or use drugs because people I know drink.
4. I drink and or use drugs when I get angry.
5. I drink and or use drugs when I want to forget everything.
6. I drink and or use drugs to celebrate special occasions.
7. I drink and or use drugs because I like the taste.
8. I use drugs because I like to get high.
9. I drink and or use drugs because it helps me forget my worries.
10. A small drink improves my appetite.
11. I accept a drink and or use drugs because it’s the polite thing to do.
12. I drink and or use drugs to help cheer me up when I’m in a bad mood.
13. Drinking and or using drugs helps me feel better when I feel uptight.
14. Drinking and or using drugs helps me make friends.
Have any of the following ever happened to you while drinking and/or using drugs?

1. I spent more money than planned.

2. Friends used up more money than I wanted them to.

3. I couldn’t remember some of the time.

4. I got into a fight with someone.

5. I broke the rules at home.

6. Friends/strangers hurt my feelings.

7. Someone beat me up.

8. Someone stole from me.

9. Someone sexually assaulted me.

10. I forgot promises I made to someone.

11. I lost track of time.

12. I got stranded without transportation.

13. I did something I was ashamed of later.

“People First Language” means emphasizing the person rather than the disability. For example, say “Mary Able, who uses a wheelchair…” instead of “The wheelchair-bound Mary Able…” Notice that the preferred statement mentions Mary first.

Additionally, saying that a person is “confined” or “bound” to a wheelchair emphasizes limitations and is often incorrect (for example, many people who use wheelchairs sometimes use crutches, canes or walkers).

Most people with disabilities are healthy. Therefore, it is less than accurate to stereotype them as victims or having an illness. In fact, most people with disabilities would prefer their disability not be mentioned if it is not relevant to the situation.

Try not to use the “E-D” words preceded by “the”, Examples of this are “the disabled” and “the cerebral palsied”. Instead, say, “people who have a disability” and people who have cerebral palsy.”

Some terms and expressions used to describe disabilities are incorrect or judgmental. For example, what used to be called mongolism is now called Down Syndrome, and the words “crippled” and “suffers from’ are judgmental.

People without disabilities sometimes look up to or admire those with disabilities as having great courage and endurance. Most people with disabilities want to be thought of as ordinary people.

**IT’S THE “PERSON FIRST” – THEN THE DISABILITY**

- If you saw a person in a wheelchair unable to get up the stairs into a building would you say “There is a handicapped person unable to find a ramp?” Or would you say “There is a person with a disability who is handicapped by an inaccessible building?”

- What is the proper way to speak to or about someone who has a disability? Consider how you would introduce someone-Jane Doe-who doesn’t have a disability. You would give her a name, where she lives, what she does or what she is interested in-she likes swimming, or eating Mexican food, or watching adventure movies. Why say it differently for a person with disabilities? Every person is made up of many characteristics-mental as well as physical-and few want to be identified only by their ability to play tennis or by their love for fried onions or by the mole that is on their face. Those characteristics are just parts of us.
In speaking or writing, remember that children or adults with disabilities are like everyone else—except they happen to have a disability. Therefore, here are a few tips for improving your language related to disabilities and handicaps.

1. Speak of the person first, then the disability.

2. Emphasize abilities, not limitations.

3. Do not label people as part of a disability group—don’t say “the Disabled,” say “people with disabilities.” Don’t use “handicapped.”

4. Don’t give excessive praise or attention to a person with a disability; don’t patronize.

5. Choice and independence are important. Let the person do or speak for him/herself as much as possible. If addressing an adult say “Bill” instead of “Billy.” Speak directly to the person with a disability, not to their guardian/spouse/companion.

6. A disability is a functional limitation that interferes with a person’s ability to walk, hear, talk, learn, etc. Use handicap to describe a situation or barrier imposed by society, the environment or oneself.

7. If you are unsure how to describe a disability, ask someone who knows—or ask the person that has the disability.
Effective Communications

- People First
- Employment Assistance
<table>
<thead>
<tr>
<th>SAY......</th>
<th>INSTEAD OF......</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child with a disability</td>
<td>disabled or handicapped child</td>
</tr>
<tr>
<td>Person with cerebral palsy</td>
<td>palsied, or CP, or spastic</td>
</tr>
<tr>
<td>Without speech, nonverbal</td>
<td>mute or dumb</td>
</tr>
<tr>
<td>Developmental delay</td>
<td>slow</td>
</tr>
<tr>
<td>Emotional disorder, or mental illness</td>
<td>crazy or insane</td>
</tr>
<tr>
<td>Deaf or hearing-impaired/Communicates with sign</td>
<td>deaf and dumb</td>
</tr>
<tr>
<td>Uses a wheelchair</td>
<td>confined to a wheelchair</td>
</tr>
<tr>
<td>Person with mental retardation</td>
<td>retarded</td>
</tr>
<tr>
<td>Person with epilepsy</td>
<td>epileptic</td>
</tr>
<tr>
<td>With Down Syndrome</td>
<td>mongoloid</td>
</tr>
<tr>
<td>Has a learning disability</td>
<td>is learning disabled</td>
</tr>
<tr>
<td>Nondisabled</td>
<td>normal, healthy</td>
</tr>
<tr>
<td>Has a physical disability</td>
<td>crippled</td>
</tr>
<tr>
<td>Congenital disability</td>
<td>birth defect</td>
</tr>
<tr>
<td>Condition</td>
<td>disease (unless it is a disease)</td>
</tr>
<tr>
<td>Seizures</td>
<td>fits</td>
</tr>
<tr>
<td>Cleft lip</td>
<td>hair lip</td>
</tr>
<tr>
<td>Mobility impaired</td>
<td>lame</td>
</tr>
<tr>
<td>Medically involved or has a chronic illness</td>
<td>sickly</td>
</tr>
<tr>
<td>Paralyzed</td>
<td>invalid or paralytic</td>
</tr>
<tr>
<td>Has hemiplegic (paralysis of one side if the body)</td>
<td>hemiplegic</td>
</tr>
<tr>
<td>Has quadriplegia “tetraplegia”</td>
<td>quadriplegic</td>
</tr>
<tr>
<td>(paralysis of both arms and legs)</td>
<td></td>
</tr>
<tr>
<td>Has paraplegia (loss of function in lower body only)</td>
<td>paraplegic</td>
</tr>
<tr>
<td>Of short stature</td>
<td>dwarf or midget</td>
</tr>
<tr>
<td>Has a (disability)</td>
<td>afflicted with (a disability)</td>
</tr>
</tbody>
</table>
If you are interacting with people who have Disabilities

1. Be yourself. As in any new situation, everyone will feel more comfortable if you relax.

2. Meeting someone. People who use wheelchairs may have a variety of different abilities. Extend your hand to shake if that is what you normally do. A person who cannot shake hands will let you know. If you are meeting a blind person, identify yourself. If you have met before, remind him/her of the context; he/she won't have the visual cues to jog his memory.

3. Helping. Do not automatically give assistance; ask first if the person wants help and then follow the person’s cues, and ask if you are not sure. Be the assistant, not the director. Don’t be offended if someone refuses your offer of assistance. It’s his/her choice to be independent as he/she can be.

4. Communication. Talk directly to the person, not to an aide, friend, or interpreter. If the person has a speech impairment, listen carefully and patiently. Ask him/her to repeat if you don’t understand. If the person doesn’t understand you when you speak. Try again. If the person is deaf or hard of hearing, follow his/her lead; use gestures or write. If the person uses a wheelchair, sit down yourself and converse at eye level.

5. Socializing. Do not leave a person with a disability out of a conversation or activity because you feel uncomfortable or fear that the person will feel uncomfortable. Include the person as you would anyone else. Let it be his/her decision whether or not to participate.

6. Disability. Treat the person as an individual. Don’t assume that the person’s Disability is all he/she can talk about or is interested in. Find a topic of small talk, the way you would with anyone. Don’t treat the person as a disability.

7. Environments. Be sensitive about the setting. A noisy or dark environment, or many people talking at the same time might make it difficult for people with vision, speech, or hearing impairments to participate fully in a conversation. Be aware of clear paths of travel for people who use wheelchairs or are blind. Describe goings-on and surroundings (especially obstacles) to a blind person. A person with chemical sensitivity may have a reaction to smoke, perfume, or other toxins in the environment.

8. Touching. Do not pet guide dogs, and do not pet or touch a person with a disability unless there is a good reason (such as shaking hands in greeting or if the person has requested assistance). However, you may gently touch a deaf person to get his attention. Never push a person’s wheelchair or lean on the wheelchair without permission. Please do not recoil if you meet a person with
HIV/AIDS; shake hands as you would anyone else’s. You can’t get AIDS by touching.

9. Auxiliary Aids. Do not touch someone’s cane, wheelchair or other devise. It is part of one’s personal space.

10. Hidden Disabilities (not all disabilities are apparent). A person may have trouble following a conversation, may not respond when you call or wave, or may say or do something that seems inappropriate. The person may have a hidden disability, such as low vision, a hearing impairment, a learning disability, or mental illness. Do not make assumptions about the person or the disability.
Effective Communication

Interviewing a person using mobility aids

- Enable people who use crutches, canes or wheelchairs to keep them within reach. If it is felt the person’s ability inhibits performance of a job, ask them, “How would you perform this job.” For example: “I notice that you are in a wheelchair and I wonder how you get around. Tell me about your disability. (Inappropriate)” Instead say, “This position requires some outdoor landscaping and children’s activities, as you see from the job description. Do you see any difficulty in performing the required tasks? If so, do you have any suggestions as to how these tasks can be performed?”
- Be aware that some wheelchair users may choose to transfer themselves out of their chairs into an office chair for interview.
- When speaking to a person in a wheelchair or on crutches for more than a few minutes, sit in a chair. Always place yourself at eye level.

Reception Etiquette

- Know where accessible restrooms, drinking fountains and telephones are located. If such facilities are not available, be ready to offer alternatives, such as the private or employee restroom, a glass of water or your desk phone.
- Use a normal tone of voice when extending a verbal welcome. Do not raise your voice unless requested.
- When introduced to a person with a disability, it is appropriate to offer to shake hands. People with limited hand use or who wear an artificial limb can usually shake hands.
- Shaking hands with the left hand is acceptable.
- For those who cannot shake hands, touch the person on the shoulder or arm to welcome and acknowledge their presence.
- Call a person by his or her name only when extending that familiarity to all others present.
- Never patronize people using wheelchairs by patting them on the head or shoulder.
- When addressing a person who uses a wheelchair, never lean on the person’s wheelchair. The chair is part of the space that belongs to the person who uses it.
- When talking with a person with a disability, look at and speak directly to that person rather than through a companion who may be accompanying them.
- If an interpreter is present, speak to the person who has scheduled the appointment, not to the interpreter. Always maintain eye contact with the applicant, not the interpreter.
- Offer assistance in a dignified manner with sensitivity and respect. Be prepared to have the offer declined. Do not proceed to assist if your offer to assist is declined. If the offer is accepted, listen to or accept instructions.
- Allow a person with a vision impairment to take your arm (at or below the elbow). This will enable you to guide rather than propel or lead the person.
- Offer to hold or carry packages in a welcoming manner.
• Do not offer to hand a cane or crutches unless the individual requests.

**Conversation Etiquette**

• When talking to a person with a disability, look at and speak directly to that person not to their companion,
• Relax. Don’t be embarrassed if you happen to use accepted common expressions such as “see you later” that seem to relate to the person’s disability.
• To get the attention of a person with a hearing impairment, tap the person on the shoulder or wave your hand from the side or front and not the back of the person. Look directly at the person and speak clearly, naturally and slowly to establish if the person can read lips. Not all persons who are hearing impaired can lip-read. Those who can rely on facial expression and other body language to help in understanding. Show consideration by placing yourself facing the light source and keeping your hands away from your mouth when speaking. Please do not shout. Written notes may help.
• When talking to a person in a wheelchair for more than a few minutes, pull up a chair, whenever possible, in order to place you at the person’s eye level to facilitate conversation.
• When greeting a person with a severe loss of vision, always identify yourself and others who may be with you.
• When conversing in a group, give a vocal cue by announcing the name of the person to whom you are speaking. Speak in a normal tone of voice, indicate in advance when you will be moving from one place to another and let it be known when the conversation is at an end.
• Listen attentively when you are talking to a person who has a speech impairment. Keep your manner encouraging rather than correcting. Exercise patience rather than attempting to speak for a person with speech difficulty. When necessary, ask short questions that require short answers or a nod or a shake of the head. Never pretend to understand. Repeat what you understand, or incorporate the interviewee’s statements into each of the following questions. Open-ended questions are more appropriate than closed-ended questions.

  **Example:**

  *Closed-Ended Question:* You were a payroll assistant in your company in the human resources department for seven years. What did you do there?

  *Open-Ended Question:* Tell me about your recent position as a payroll assistant?

• Do not shout at a hearing impaired person. Shouting distorts sounds accepted through hearing aids and inhibits lip reading.
• Do not shout at a blind or visually impaired person, he or she can hear you!
• Be prepared to offer a visual clue to a hearing impaired person or an audible cue to a vision impaired person, especially when more than one person is speaking.

**Interviewing Scheduling Etiquette**

• Some interviewees with visual or mobility impairments will phone in prior to the appointment date, specifically for travel information. The scheduler should be
very familiar with the travel path in order to provide interviewees with detailed information.

- Make sure the place where you plan to conduct the interview is accessible, such as,
  - Is parking accessible?
  - Is there a ramp or step-free entrance?
  - Are there accessible restrooms?
  - If the interview is not on the first floor, does the building have an elevator?
  - Are telephone and water fountains at the proper height for a person in a wheelchair to use?
  - If the site is inaccessible, inform the person about the barriers prior to the interview and offer to make arrangements for an alternate site.
  - When scheduling interviews with persons with disabilities, take their needs into consideration.
  - When giving directions to a person in a wheelchair, consider distance, weather conditions and physical obstacles such as stairs, curbs, and doors to open.
  - Use specifics such as “take a left when you get off the elevator after approximately 20 feet, then take a right about ten feet, the entrance door is the first door on the right”.
  - Be considerate of travel time that may be required by a person with a disability. People with disabilities use a variety of transportation services when traveling to and from work. Be aware that the person might be required to make a reservation 24 hours in advance, plus travel time. Provide the interviewee with an estimated time to schedule the return trip when arranging the interview appointment.
  - Familiarize the interviewee in advance of the names of all persons he or she will be interviewing with. This courtesy allows the person to be aware of the names and faces that they will meet during the interview.
  - Remember, people with disabilities expect equal treatment, not special treatment.

**Interviewing Technique Etiquette**

- Conduct interviews in a manner that emphasizes abilities, achievements and individual qualities.
- Conduct your interview as you would with anyone. Be considerate and do not patronize.
- When interviewing a person with a speech impairment, do not complete the person’s sentences.
- If it is felt the person’s ability inhibits performance of a job, ask them, “How would perform this job. For example: “I notice that you are in a wheelchair and wonder how you get around. Tell me about your disability. (Inappropriate)”
- Instead say, “This position requires some outdoor landscaping and children’s activities, as you see from the job description. Do you see any difficulty in performing the required tasks? If so, do you have any suggestions as to how these tasks can be performed?”
• Be aware that some wheelchair users may choose to transfer themselves out of their chairs into an office chair for the interview.
• When speaking to a person in a wheelchair or on crutches for more than a few minutes, sit in a chair. Always place yourself at eye level.
Employment Assistance

Finding a job is easy. Getting the job is a little harder. However, there are a number of local and/or internet websites available to job-seekers, a few specifically focused on individuals with disabilities.

The Florida Department of Education’s Vocational Rehabilitation Program Services offers a vocational rehabilitation program for individuals with disabilities. Services include job development, job coaching, and/or assistive devices.
Contact VR at 407-897-2710 or visit the website www.myflorida.com.

The Florida Department of Education’s Division of Blind Services offers services similar to the Vocational Rehabilitation Program, however, this agency serves individual with visual impairments.
Contact DBS at 407-245-0700 or visit the website www.myflorida.com.

Goodwill Industries offers vocational evaluations and job placement services which includes a self-sufficiency job center.
Contact Goodwill at 407-235-1500 or visit the website www.goodwillcfl.org.

Center for Independent Living offers job placement assistance. In addition, CIL offers training in resume writing, and job interviewing.
Contact CIL at 407-623-1070 or visit the website www.cilorlando.org.

There are also a few websites to assist individuals in finding competitive employment: www.monster.com publishes a monthly newsletter focusing on diversity and inclusion. Visiting the website allows an individual to post a resume and sign up for the newsletter which includes valuable information for job seekers.

www.bis.gov is the US Department of Labor’s Bureau of Labor Statistics’ Occupational Outlook Handbook. The website provides information on training/education requirements, working conditions, and job prospects for specific occupations.

www.jan.wvu.edu provides free consulting services regarding job accommodations, and self-employment opportunities.

Helpful hints:

1. Do your research. Know the company’s history, and mission statement (if there is one). Most companies and agencies have their own websites.

2. Make sure you have the qualifications required for the job. Employers are willing to do some on the job training, but you have to have the necessary skills for the job.
3. Use the resources available to help you write your resume and cover letter. The Internet and your local library have valuable tools to help you write a resume that will guarantee you that interview.

4. When applying for jobs online, be precise, and list the most important skills you possess. Space is usually limited on the online applications, so be short, but precise.

5. Be on time for your interview. If given the opportunity try to be the 1st applicant interviewed. If at all possible, try and avoid being the last applicant interviewed for the day.

6. Remember, an interview is just a conversation. An important of course, but don’t get nervous. Answer all questions truthfully. Think about the question before you answer. A slight hesitation gives you an opportunity to BREATHE.

7. Finally, be yourself. Let your personality shine. Employers are not only looking for what skills you possess, but how you will interact with current employees.

**Reasonable Accommodations in the Workplace**

Reasonable accommodations enhance the opportunity for qualified individuals with disabilities who may not otherwise be considered for a job or to be or remain employed. The purpose of providing reasonable accommodations is to enable employers to hire or retain employees regardless of their disability by eliminating barriers to their employment.

According to the Department of Justice government wide regulations, Section 41.53, Reasonable Accommodation, “A recipient shall make reasonable accommodation to the known physical or mental limitations of an otherwise qualified handicapped employee or applicant unless the recipient can demonstrate that the accommodation would impose an undue hardship on the operation of its program.”

Inquiries made of an individual about limitations in job performance must be directly related to the prospective or existing position. Accommodations are tailored for a certain job or situation that an individual is hired to perform. The law requires that each person with a disability must be consulted prior to the planning and be involved in the implementation of an accommodation.

Types of Accommodations include:
- Assistive devices
- Reassignment
- Modified work schedules
- Job modifications
- Relocation
- Change in physical plant (location)
- Examples of assistive devices often used in the work place include:
TTY/TDD teletypewriter or telephone amplifier, often used by persons with hearing impairments
Wooden blocks to elevate desks and tables for wheelchair users
Large type computer terminals and Braille printers to assist person with vision impairments

Decisions to implement an accommodation should include making a choice that will best meet the needs of the individual by minimizing limitation and enhancing his or her ability to perform job tasks, while serving the interests of your majority work force.

**Interviewing a person who is blind or has Vision Impairments**
- Always identify yourself and introduce anyone else who might be present.
- If the person does not extend their hand to shake hands, verbally extend welcome.
- When offering seating, talk to the person and tell them where a chair is located and place the person’s hand on the back of the seat. Give verbal cues first.
- Let the person know if you move or need to end the conversation. Allow people who use crutches, canes or wheelchairs to keep them within reach.
- Give your whole attention with interest when talking to a person who has a speech impairment.
- Ask short questions that require short answers but you receive the specific information you are looking for.
- Don’t raise your voice. Most speech-impaired persons can hear and understand.

**Interviewing a person who is Deaf or Hearing Impaired**
- Touch him or her on the shoulder from the front or side to attract their attention.
- If the person lip-reads, remember to look directly at them and do not exaggerate your lip movements. It is estimated that only four out of ten spoken words are visible on the lips. The person will rely on your facial expressions, gestures and eye contact.
- Always check with the person you are interviewing if an interpreter is requested and note taking is not possible. ADL is a language used in the United States but it is no the language needed by a non-English speaking person. Be certain to retain an interpreter that speaks and interprets in the language of the person. Remember that interpreters are facilitators; they are not to be consulted during an interview.

**Other Do’s and Don’t About Disability**
- Do learn where to find and recruit people with disabilities (Workforce, Vocational Rehabilitation, Division of Blind Services, Brain & Spinal Cord Injury program, Business leadership Networks).
- Do learn how to communicate with people who have disabilities.
- Do ensure that your applications and other employment forms do not ask disability-specific questions and that they are in formats that are accessible to all persons with disabilities.
- Do consider having written job descriptions that identify the essential functions of each job.

Orange County Addictions & Disabilities Resources Manual 33
- Do ensure that requirements for medical examinations comply with the American with Disabilities Act (ADA).
- Do provide reasonable accommodations that the applicant will need to compete (equal opportunity) for the job.
- Do treat an individual with a dignity and respect.
- Don’t assume that people with disabilities do not want to work.
- Don’t assume that certain jobs are more suited to persons with disabilities.
- Don’t hire a person with a disability if that person is at significant risk of substantial harm to the health and safety of the public and there is no reasonable accommodation to reduce the risk or harm.
- Don’t hire a person with disability who is not qualified to perform the essential functions of the job even with a reasonable accommodation.
- Don’t assume you have to retain unqualified employee with a disability.
- Don’t assume that supervisor’s will need special training to learn how to work with people with disabilities.
- Don’t assume that reasonable accommodations are expensive. The average cost of a reasonable accommodation is around $500.
- Don’t assume that you don’t have any jobs that a person with a disability can do.
- Don’t make medical judgments.
**Resources**

**National Resources**
NAAD (National Association on Alcohol, Drugs and Disabilities)
2165 Bunker Hill Drive
San Mateo, CA 94402
650-579-8047 TTY: 650-631-1829

RRTC/SARDI (Rehabilitation Research and Training Center on Drugs & Disability)
Wright State University – School of Medicine, Dayton Ohio
937-775-1484

NCADI/SAMHSA 800-729-6686
ADA Info Hotline 800-514-0301 TTY: 800-514-0383
AA/Alcoholics Anonymous 212-870-3400
ALA-Call 212-683-3900
AL-ANON 800-344-2666

**National Websites**
Substance Abuse and Mental Health Services Administration www.samhsa.org
National Association on Alcohol, Drugs & Disability www.naadd.org
National Clearinghouse for Alcohol and Drug Information www.ncadi.gov
National Council on Alcoholism and Drug Dependence of NJ www.ncaddnj.org
National Institute on Alcohol Abuse and Alcoholism www.niaaa.nih.gov
National Institute of Health www.nih.gov
Ohio Valley Center for Brain Injury Prevention & Rehabilitation www.ohiovalley.org
SARDI/Substance Abuse Resources & Disability Issues www.med.wright.edu/citar/sardi/products
ADA Information Line www.usdoj.gov/crt/ada
Community Anti-Drug Coalitions of American (CADCA) www.cadca.org
**State Resources**

Florida Alcohol and Drug Abuse Association  
www.fadaa.org

Florida Office of Drug Control  
www.fligov.com

Florida Department of Children and Families  
www.state.fl.us/cf_web/

Florida Department of Health  
www.doh.state.fl.us

*Florida Alcohol and Drug Treatment Centers*

Behavioral Health of the Palms Beaches  
www.bhpalmbeach.com

Florida Center for Recovery, Ft. Pierce  
www.centerforrecovery.com

Phoenix House, Tampa  
www.phoenixhouse.org

**Local Resources**

United Way of Central Florida  
hfuw.org/211  
2-1-1

Orange County Coalition for A Drug Free Community  
407-836-7335  
www.drugfreecoalition.org

Orange County ADA Office  
www.ocfl.net  
407-629-1599

Orange County Sheriff's Office  
407-836-3700

Orange County Community Action Center  
407-836-8476

Orange County CLUB  
www.theoclub.net  
407-836-9790

Boys & Girls Club  
407-841-6855

YMCA  
407-896-9220

Boy Scouts of America  
407-889-4403

Girl Scouts Citrus Council  
407-896-4475

Orange County Public Schools SAFE Program Office  
407-317-3327
<table>
<thead>
<tr>
<th>Substance Abuse Resources</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Addiction Receiving Center</td>
<td>407-245-0012</td>
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<tr>
<td>Community Based Prevention</td>
<td>407-245-0010</td>
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<tr>
<td>Orlando Counseling Center</td>
<td>407-245-0014</td>
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<tr>
<td>Center for Drug Free Living Main Office</td>
<td>407-245-0045</td>
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<tr>
<td>Clarcona Point Adolescent Residential</td>
<td>407-521-2495</td>
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<tr>
<td>Central FL Mental Health Association</td>
<td>407-843-1563</td>
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<tr>
<td>Chemical Dependency/Psychiatric Disorders</td>
<td>1-800-275-4524</td>
</tr>
<tr>
<td>Devereux Florida Treatment Network</td>
<td>407-296-5300</td>
</tr>
<tr>
<td>Quest Counseling</td>
<td>407-331-7199</td>
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<tr>
<td>S.T.E.P.S. Inc.</td>
<td>407-522-2144</td>
</tr>
<tr>
<td>Grove Counseling Center</td>
<td>407-327-1765</td>
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<tr>
<td>Youth/Family Counseling</td>
<td>407-273-7117</td>
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<tr>
<td>Family Care Program</td>
<td>407-425-4491</td>
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<tr>
<td>Family Support and Visitation Center</td>
<td>407-999-5577</td>
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<tr>
<td>Residential Treatment Center</td>
<td>407-296-5300</td>
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<tr>
<td>Therapeutic Day School</td>
<td>407-521-7460</td>
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<tr>
<td>Transitional Living Center</td>
<td>407-977-0336</td>
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<tr>
<td>Alcohol and Drug Abuse Helpline</td>
<td>1-800-821-4357</td>
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<tr>
<td>Cocaine Information Referral Service</td>
<td>1-800-262-2463</td>
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<tr>
<td>Clearinghouse for Drugs and Alcohol</td>
<td>1-800-729-6686</td>
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<tr>
<td>Lifeline of Central Florida</td>
<td>407-425-2624</td>
</tr>
<tr>
<td>Lakeside Alternatives</td>
<td>407-875-3700</td>
</tr>
<tr>
<td>National Alliance for the Mentally Ill (NAMI) of</td>
<td>407-253-1900</td>
</tr>
</tbody>
</table>
Greater Orlando
Orange County Drop-In Center 407-843-5530
Mental Health Crisis 407-875-3700

**Faith Based Resources**

First Orlando Baptist, 3000 So. John Young Parkway 407-514-4277
Special Needs Ministry Support Group
Gail Brown [www.firstorlando.com](http://www.firstorlando.com)

Lift Disability Network, Pastor Jim Hukill 407-210-3916
[www.liftdisabilitynetwork.org](http://www.liftdisabilitynetwork.org)
301 E Pine Street, #150 Orlando, Phone, email:
[info@liftdisabilitynetwork.org](mailto:info@liftdisabilitynetwork.org)

NET Training Institute 407-236-9400
Bibliography
Bibliography


Orange County Coalition for A Drug Free Community, Orange County Government