
Chapter 14

Substance-related Disorders in Persons with Developmental Disabilities

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Learning objectives

Readers will be able to:

1. Describe substance abuse disorders.
2. Identify how frequently they are diagnosed in this group of people.
3. Describe how substance abuse affects persons with a developmental disability.
4. Describe how effectively we can treat and manage these disorders in persons with developmental disabilities.

Introduction

Think how often you have encountered people in your life who either use substances of abuse as social entertainment or as a stress reliever, or simply because they have become addicted to these substances. Consider your feelings and knowledge on this issue. Mind and perception-altering substances are very dangerous to individuals and also to the public in general due to the inevitable accidents, misbehaviour and/or social inappropriateness which result from their use. We also share the

view that early recognition, appropriate treatment, and development of social networks are of extreme importance in facing and coping with these disorders. The same is true for persons with developmental disabilities who abuse substances. These persons need all the help and support they can get to assess and treat them when faced with these disorders, as well as attempting to prevent further abuse. These measures not only help to modify the frequency of occurrence of these disorders in people with a developmental disability, but they also assist in minimizing the sequelae such as criminal records, incarceration and other negative restrictions.

In this book, the biopsychosocial model has been used in assessment, treatment and prevention of mental health disorders. As a result, we need to understand how these disorders come to exist, what factors affect their occurrence, and how individual treatment and social networks are of extreme importance in modifying their outcome.

What are substance-related disorders?

According to the Diagnostic and Statistical Manual, (APA, 1994), substance-related disorders include “disorders related to the taking of a drug of abuse (including alcohol), to the side effects of medication, and to a toxin exposure”. In this chapter, we will only deal with disorders related to drug abuse. The issues of side effects of medication and/or toxin exposure are being dealt with elsewhere in this manual.

The essential feature of substance dependence is a cluster of cognitive, behavioural and physiological symptoms indicating continuous use of the substance despite significant substance-related problems. This pattern of abuse exhibits itself as a re-

peated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behaviour. In order to understand the various aspects associated with substance-related disorders, we have to define Substance Dependence according to the DSM-IV (APA, 1994).

Substance Dependence is defined as a cluster of three or more symptoms as follows, as defined by APA (1994):

- Tolerance (Criterion 1): *This is the need for greatly increased amounts of the substance to achieve intoxication to avoid a very much-diminished effect with the continued use of the same amount of the substance* (p. 181).
- Withdrawal (Criterion 2a): *This is a maladaptive behavioural change with physiological and cognitive concomitants that occur when blood or tissue concentrations of the substance decline in an individual who has maintained prolonged use of the substance.*

In order to relieve or avoid the effects of withdrawal, the person is likely to take the substance (Criterion 2b), typically using the substance throughout the day.

- A pattern of compulsive substance use (Criterion 3) has to be present. *This means that individuals take the substance in larger amounts or over a longer period than was originally intended despite their recognition that this behaviour is alien to themselves and beyond their control.*

What are the common substance-related disorders?

The most common substance-related disorders are:

- Alcohol-related disorders

- Amphetamine related disorders
- Caffeine-related disorders
- Cannabis-related disorders
- Cocaine-related disorders
- Hallucinogen-related disorders
- Inhalant-related disorders
- Nicotine-related disorders
- Opioid-related disorders
- Phencyclidine-related disorders
- Sedative-Hypnotic or anxiolytic-related disorders

How frequent are these disorders in the person with developmental disability?

The identification, assessment and treatment of substance-related disorders in this population, has received little attention in the past. The relative rarity of review articles and/or research studies on this topic is strong evidence of the lack of understanding and acknowledgement of the frequency of these disorders in the dually diagnosed group.

With deinstitutionalization, and the move of these persons to community settings, the opportunity and availability of substances of abuse to this group have arisen greatly (Longo, 1997). As a result, the prevalence of these disorders has increased in recent years (Westermeyer, Phaoblong, & Neither, 1988; Westermeyer, Crosby, & Nugent, 1998; Longo, 1997).

In the National Household Survey on Drug Abuse (1994) conducted by the Substance Abuse and Mental Health Administration, 10.8 percent of respondents admitted to the use of illicit drugs in the past twelve months. In their well-publicized study, Drs. Westermeyer, Crosby, and Nugent (1998) surveyed

642 persons receiving substance abuse treatment at two university-affiliated clinics. They identified two subgroups with substance-related disorders, the MR + SD group (Mental Retardation and Substance Disorder) and the SD only group (SD, Substance Disorder).

They found that the MR + SD group comprised 6.2 percent of their total population. This finding is very troubling, if we consider that persons with Developmental Disability comprise about 1-3% of the general population. This could indicate that the person with a developmental disability experiences addiction-related crises and mental health problems at almost twice the rate of the general population.

Other data seem to emerge indicating the seriousness and high frequency of developmental disability in substance-related disorders. The Wright State University School of Medicine in Dayton, Ohio, operates the Substance Abuse Resources and Disability Issues (SARDI) Program and the Rehabilitation Research and Training Centre (RRTC). In 1996, the RRTC published results indicating that developmental disability was the primary disability in 4.3% of the respondents; learning disability was the primary disability in 14.3% of the total respondents' group. In the same survey, 12.8% of the respondents were self-identified as having mental retardation/developmental disability, and abused illicit drugs in the past twelve months.

Despite the limited data available in this area, it appears that a person with a developmental disability has the same or higher prevalence of substance related disorders (Annand & Rug, 1998). S/he also appears to develop crises and is in need of specialized services almost twice as much as the general popu-

lation. Additionally, s/he experiences a lower overall rate of recovery. The pattern of inheritance is similar to that of the general population. More specifically, the fathers of the DD + SD group were found to have had increased rate of alcoholism (Westermeyer et al, 1998). This may indicate that initially, the cause of the developmental disability was the abnormalities in the sperm, and/or that environmental influence is of great importance in the genesis of these disorders (Edgerton, 1986; Westermeyer et al., 1998).

What are the characteristics of substance-related disorders in the person with developmental disability?

As already discussed, persons with developmental disabilities develop substance-related disorders in a similar fashion to the general population. However, there are specific characteristics that these individuals present as compared to the general population. They are as follows:

- Substance-related disorders, as other mental health problems, are linked to the degree of cognitive impairment/potential. The higher the IQ, the higher the prevalence of these disorders (Edgerton, 1986; Campbell & Malone, 1991).
- The commonly held belief that people with DD + SD would be more vulnerable to the intoxicating effect of the substance of abuse has been, in part, borne out.
- People with developmental disabilities tend to drink alcohol or use illicit drugs in lower amounts as compared to the general population. As a result, they are more difficult to identify. Often, caregivers consider

this to be part of the individual's "life pattern".

- The inherent limitation that persons with developmental disabilities face in their lives, and the resulting anxiety and depressive disorders (Stavrakaki, 1999; Stavrakaki & Mintsioulis, 1995; 1997) tend to render these individuals vulnerable to increased use and abuse of mind altering substances in order to relieve stress, or as a self-medication (Longo, 1997; Ruf, 1999).
- Mental Disorders that are common in this population such as Bipolar Mood Disorder, and Schizophrenia, tend to increase the prevalence of substance-related disorders in this group (Westermeyer et al., 1998; Longo, 1997).

Social Factors

Social factors that seem to influence the occurrence of substance-related disorders in people with developmental disability are:

- Level of education:
It was found that their level of education was lower by 2-3 academic years compared to the general population.
- Marital Status/Residence:
It was found that persons who were developmentally disabled and experienced substance-dependence tended to be single and live alone.

Other differences found between the two groups were:

- **Age of onset:**
It was found that the age of onset of the abuse was later than that of the general population.
- The severity of the substance disorder was less in the group of persons with mental retardation.
- The crises related issues were found to be higher in this group.
- The individuals with developmental disabilities that have become chemically dependent are more difficult to treat effectively with short-term interventions.
- Lack of specialized services and social networks specifically related to chemical dependence and developmental disabilities account for the rather resistive process and poorer outcomes.
- The level of cognitive limitation is also linked with the poorer prognosis (the lower the IQ, the more resistive the process and the poorer the outcome) (Longo, 1997; Westermeyer et al., 1998; Ruf, 1999).

What types of addictions do we encounter in persons with developmental disabilities?

In reviewing the recent literature, it seems that all types of substance-related disorders can be found in this group. Certain types of substance abuse, however, are more frequent than others. This could be due to the fact that there is greater availabil-

ity and opportunity for this group to use substances of abuse, such as, caffeine, nicotine and alcohol. It is also true that higher functioning persons with developmental disabilities are more afflicted by these disorders. Indeed, very few examples of moderately afflicted people, and almost none with severe and profound degrees of involvement have been quoted in the literature as suffering from substance-related disorders. This is in part due to the fact that the identification of these disorders in these persons is very challenging, and in part due to the lack of availability and/or opportunity for these persons to access such substances.

Caffeine and nicotine-related disorders are, by far, the most frequently found in this group. As in other disabled populations, caffeine and nicotine are substances that are consumed in greater quantities, as they are easily accessible and relatively inexpensive.

The Case of Christopher

Christopher, a 24 year old male, lived with family until two years ago when he had a “nervous breakdown” and was hospitalized. He was diagnosed with schizophrenia (Axis I), Dependent Personality Disorder (Axis II) and Developmentally Disability to mild or moderate degree (Axis II).

Following his hospitalization, Christopher was moved to a community setting, since his parents were not able to deal with problems and daily issues of his illness. Social supports through a community agency were offered to Chris, who, by reports through a community agency were offered to Chris, who by then was able to manage reasonably well

on his own.

A parental interview revealed that the most disturbing of Chris's behaviours had been:

- *restlessness*
- *agitation*
- *aggressivity*
- *insomnia*
- *explosiveness*

When further questioned on Christopher's daily routine, his parents expressed their frustration that he woke up very early (4 a.m.), and began to smoke cigarettes and drink coffee. Chris would then continue to chain smoke and drink coffee "all day long". By 4 to 6 p.m. Chris' "temper" would be impossible to control, and any attempt to pacify him would fail.

The only way that he would be "liveable" would be to allow him to continue his "terrible habits". Consequently, his parents were forced into a very difficult position. They had to lock their bedroom door for fear of being attacked, and would "feed his habits" (caffeine and nicotine addiction) to have relative peace. They had not realized, nor were they ever told, that these two substances as common as they may be in everyday lives, were very addictive, and that Chris suffered from the classic symptoms of both addictions. He had developed a dependence on caffeine. This was exemplified by symptoms of withdrawal and the need to take more of the substance to avoid these symptoms.

He also began to take incredible amounts of abuse substances to achieve the same results (tolerance). He exhibited compulsive substance taking. His addiction occupied all of his day and greatly interfered with his attendance at any day program.

Through daily rehabilitation for two years in a day hospital setting, Chris was able to modify his addictions to more appropriate levels (i.e., smoking only ten cigarettes daily, and drinking decaffeinated coffee only, up to two cups a day). In order to maintain the good results, Chris requires a case manager who sees him every third week, or more frequently if necessary. A friend volunteer is helping Chris with his budgeting and shopping, and a housekeeper attends to his housekeeping needs.

Chris' story illustrates how 'deceptive' the addictions can be, and how easily they can be missed by family, caseworkers, managers, and counsellors. It also exemplifies the social issues faced by individuals like Chris, and the increased need for treatment and social support to prevent the mental health occurrences and "revolving door" scenario.

Caffeine can be consumed from a number of different sources, including coffee, tea, caffeinated soda, over the-counter analgesics and cold remedies, stimulants and weight-loss aids. The average intake of caffeine in the United States is approximately 200 mg/day. Individuals who drink large amounts of coffee display some aspects of dependence on caffeine and exhibit tolerance and perhaps withdrawal. (See Table 1 for the full diagnostic criterion for caffeine intoxication.)

Table 1- Caffeine Intoxication

(adapted from APA, 1994, p. 213)

A diagnosis is reached if there is excess consumption of caffeine, usually more than 2-3 cups of coffee, which results in at least five symptoms, which may include the following:

restlessness, nervousness, excitement, insomnia, flushed face, diarrises, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech tachycardia or cardiac arrhythmia, periods of inexhaustibility, and/or psychomotor agitation.

The impact of the symptoms must be clinically significant to the extent that it affects social, occupational or other impairment on the person's functioning.

The DSM-IV (APA, 1994) distinguishes between caffeine intoxication and the following:

- A. Caffeine-induced anxiety disorder, which is anxiety symptoms due to the direct physiological effects of caffeine.
- B. Caffeine-induced sleep disorder, where severe disturbance in sleep is produced by the effects of caffeine.

All caffeine-related disorders have been found amongst the developmentally disabled group. They have to be considered when agitation, aggression, sleeplessness and nervousness are the symptoms and behaviours in this population. These disorders have to be identified and treated before any other diagnosis or mental health problems are presumed. Caffeine-related disorders are preventable to some extent;

therefore, the ways and means to do so have to be considered very seriously. Other non-addictive substances can be used to modulate this issue.

Nicotine-Related Disorders

Nicotine dependence and withdrawal can develop with use of all forms of tobacco. The relative ability of these products to produce dependence and/or to induce withdrawal, is associated with the rapid absorption characteristic of the route of administration (oral over transdermal), and the nicotine content of the product. Nicotine dependence is very common in individuals who have a developmental disability. As in the general population, a larger number of addicted individuals attempt to stop smoking. However, a very small number (up to 5%) are successful in doing so. Chain-smoking is very characteristic of nicotine dependence, and is highly prevalent amongst higher functioning developmentally disabled adults. The harmful effects of nicotine are well known. Persons with developmental disabilities not only suffer the ill effects of smoking, but also financial consequences in an already limited budget. Prevention of nicotine dependence in this group, as in others, is by far the better approach in the long run.

The Case of Paul

Paul, is a 27-year-old male who lives in a high support community group home. Paul lived with foster parents until the age of 18 years, when he had a "breakdown" and had to be hospitalized. During this hospitalization, Paul was diagnosed as suffering from:

- *anxiety/depressive disorders (Axis I)*
- *Dependent Personality Disorder (Axis II)*
- *mild degree of Developmental Disability (Axis II)*

He was treated with antidepressant medication and counselling and was released after two months. Since his parents had many difficulties coping with Paul's "extreme behaviours", Paul was placed in an apartment, living alone with staff's support (daily visiting, assistance with budgeting, shopping, and homemaking). During the following six months, it was observed by several staff members that, at times, "Paul seemed rather high, excitable, almost euphoric". They also noticed that on one occasion, empty beer bottles were stacked at the side of the kitchen counter. Staff also noticed that Paul, at other times, would be "depressed, dejected, withdrawn and highly anxious". It was during those times that Paul's behaviour would be at its worst. Behaviours such as:

- *aggression*
- *agitation*
- *restlessness*
- *insomnia*
- *fatigue*
- *tremors of upper extremities*
- *decreased appetite*

Upon further questioning of Paul's staff support members, it was noted that:

- *Paul always had a drinking habit.*
- *This habit would wax and wane based on "Paul's*

moods” (worse when down and depressed, less when high and excitable).

- *These moods were present since Paul was 14 years old, and his drinking habit started close to that time.*

His parents were asked at the hospital about Paul’s drinking habit. They felt that “this was Paul”, and did not report it. Parents also felt that his excessive moods were part of “Paul’s personality”. Never did it occur to them to link this with the history of Paul’s uncle who had similar patterns of behaviour (highs and lows). The uncle was an alcoholic. Following the discovery and recognition of Paul’s primary mental disorder as Bipolar Mood Disorder, treatment became more appropriate, and rehabilitation of the alcohol abuse was started with reasonable results. However, Paul had to be moved to a more protective and consistent environment of a high support community.

Paul’s story illustrates that the use and abuse of substances such as alcohol is a means of self-medication in the presence of mental illness. This remained undiagnosed for a lengthy period of time. It also identifies the issues of lack of understanding, and early recognition of addictions by parents, professionals, and caregivers.

In most cultures, alcohol is the most frequent substance of abuse, and the cause of considerable morbidity and mortality. Alcohol-related disorders are frequent in persons with developmental disabilities (APA, 1994; Ferrara, 1992).

Based on DSM-IV criteria, these disorders include:

- Alcohol dependence/abuse
- Alcohol-induced disorders, such as, intoxication, withdrawal, delirium dementia, psychotic, mood and anxiety disorders.

Higher functioning people with developmental disabilities tend to suffer most from these disorders. An accurate estimation of the prevalence of alcohol-related disorders in this group is difficult to establish. Under-reporting of substance abuse, as well as life patterns of being single and living alone, make it impossible to have exact rates of prevalence in this population.

The ill effects of substance abuse are not only chemically related but also socially-related. Westermeyer et al. (1998) reported several cases of substance abuse in people with developmental disabilities who invariably had been victimised during or following an episode of intoxication. For men, this involved being robbed and/or beaten. For women, this involved being raped and/or beaten (or both). Perpetrators of this violence had been people whom they met in the alcohol or drug use context, although the assaults typically occurred elsewhere.

Other Substance-Related Disorders

Persons with developmental disabilities are frequently “treated” with multiple prescription drugs and other related substances. As a result, they can become addicted to over-the-counter or prescribed medication as the following case illustrates multiple substance abuse.

The Case of Irene

Irene is a 40 year old woman, who at present resides in a boarding home. Irene had spent her initial twenty years with her family. Unfortunately, Irene's mother died when Irene was 20 years old. Her father and her other siblings felt that they could not care for Irene the same way, and "placed her" at a nearby institution.

During her stay, Irene was diagnosed as suffering from:

- *grief reaction*
- *anxiety and depression disorders (Axis I)*
- *mild degree of developmental disability (Axis II)*

Various medication regimes were given, and Irene ended up with multiple medication use. In later interviews, Irene would recall her need to be safe and protected, the "panic and shakiness" that she experienced "deep to her soul", and how these problems "would go away" when she received medication, sometimes as simple as Tylenol.

At 30 years, Irene was discharged from the institution, and moved to a community boarding home. She felt "very insecure initially", but "liked the change". A month following her move to her new home, Irene started getting "bad attacks" when she felt "insecure and unprotected". She made it a habit to go to the staff and asked for "peace medication". When staff refused to comply with her request, Irene fulfilled her need at the local pharmacy. She took Tylenol daily. Eventually, Irene's inability to afford this medication forced her to resort to shoplifting. She was caught and reported to police. Her apprehension led

to her rehabilitation in a specialized unit. Irene responded well to counselling and individual psychotherapy, somewhat alleviating the feelings of guilt that Irene had carried for so many years over the loss of her mother

Irene's history highlights the major difficulties that people with developmental disabilities face in their lives, and the amount of support that they require in order to avoid such occurrences. It also addresses the multifaceted nature of the substance-related disorders as they apply to this group.

Why early identification and appropriate levels of treatment are so important for this group

As the previous cases exemplify, addictions and substance-related disorders tend to be "low key", and as such, do not attract notice. They are also often considered as part of the "person's life and habits", so that the magnitude of the detrimental effects of these so called "habits" is denied. Parents and caregivers are often reluctant to report their son/daughter/client because of feelings of guilt and betrayal. Lack of systematic observation of daily habits and routines can also become difficult since many individuals live alone, and are quite "secretive" about their lives. Privacy and confidentiality are very important social values that we all enjoy. However, when issues of physical or mental health arise, our rights to privacy and confidentiality have to be seriously questioned, and appropriate measures to restore the person's health should prevail. In the face of a mental health problem, early identification, correct diagnosis and appropriate treatment are of paramount importance since these disorders can lead to

problems that are almost impossible to solve.

In the case of Chris, his dependence on caffeine and tobacco were masked by his major mental illness. However, in part, his symptoms were the result of these abuses, and led to social disarray in his life.

In the case of Paul, his dependence was the result of his primary mental illness. However, the dependence itself caused major ill effects, and complicated his treatment further by prolonging his hospitalization. They also necessitated major social intervention, resulting in a more restricted and less independent social life than he could have enjoyed should these complications not have existed.

In the case of Irene, the chemical dependence served as a stress reliever initially, but subsequently became a damaging interference in her life as the dependence increased.

In all three examples, the substance-related disorders were either familial in nature (running in the family), or caused by other mental health problems and/or life circumstances. Early recognition and appropriate handling of the underlying pathology of these problems would have minimized the complications of these addictions.

What is known to help these individuals in their plight?

Many Detoxification/Rehabilitation Centres are generic in their application of the various treatment modalities for substance-related disorders. The long waiting lists and lack of specificity in addressing the DD + SD group makes it virtually impossible to accommodate and modify the disorders suffi-

ciently, and address the specific needs of our clients. Additionally, many treatment modalities offered, cannot benefit this group of people since the cognitive limitation does not allow their participation on an “equal level” during such processes as group sessions, group counselling, or individual therapies not adapted to these clients. The resulting feelings of insecurity, frustration, inadequacy and low self-esteem may become a detriment to these clients.

The lack of specialized expertise amongst the various professional teams, including psychiatry, makes it very difficult for these clients. In order for the full benefit of these centres to be felt, these clients need one-to-one support, specific explanations /instructions, and acknowledgement of the realities of their lives (limited community participation, limited finances, limited extended family supports, and fewer networks).

Let us take a look now into the various ways that substance-related disorders can be addressed. It is advisable to emphasize, once again, that prevention (primary and secondary) is the best way of avoiding these problems. Improved public education and awareness of the many ill effects of substance abuse cannot only prevent a person from becoming addicted, but also can reduce the incidence of the developmental disabilities/learning disabilities in total.

Treatment Modalities

As in any other mental disorder, substance related disorders could be treated by following the biopsychosocial model.

Biological Remedies/Medication

Medication continues to be a helpful adjunct treatment available to professionals in the treatment of mental illness. In persons with developmental disability who experience substance abuse, few such remedies can provide improved rate of success in combination with other approaches. The primary medications, which are specific to these individuals, are as follows:

Specific interventions include the following:

- *Serotonin Stabilizers:* Serotonin is responsible for and can affect areas such as: mood, impulse control, emotionality and negative self-feelings. As such, medications that enhance the serotonin transmission (e.g., fluoxetine, sertraline, citalopram, to name a few) may moderately decrease the alcohol consumption.
- *Anti-anxiety Agents:* Anti-anxiety medication has been found very helpful in the treatments of substance abuse especially when linked with underlying anxiety disorder. However, some of the anti-anxiety medications can cause dependence. As a result, they are used usually in acute crisis situations, and are avoided by many professionals. Buspirone (Buspar) is a non-benzodiazepine anti-anxiety agent that may also stabilize serotonin, and may alleviate alcohol or other substance abuse.
- *Naltrexone:* Naltrexone is one of the most promising medications in alcohol abuse and alcohol craving. Studies of adults in veteran's hospitals have shown that naltrexone reduced relapse rate of heavy alcohol consumption over a

twelve-week period by about 50%. It also appeared to decrease alcohol craving greater than placebo did. More studies specific to our clients are necessary in order to establish the efficacy of Naltrexone in this population.

- *Antabuse*: Antabuse has been in use for many years and has been found somewhat helpful in the treatment of alcohol abuse. Antabuse works by blocking acetaldehyde dehydrogenase, the liver enzyme responsible for the removal of acetaldehyde, the major breakdown product of alcohol. When a person has taken Antabuse and consumes alcohol, he/she experiences very unpleasant side effects. However, these ill effects can be at times, very dangerous. Therefore, for the developmentally disabled population, it is preferable to use Naltrexone.
- For caffeine and nicotine addiction, measures such as healthier diet, stress relieving exercises, and other programmes that improve self-esteem and decrease anxiety levels, are very beneficial in the treatment of these disorders. New ways of addressing nicotine addictions can include the patch, Zoben (an anti-compulsive agent), lower nicotine-content cigarettes, and gum.
- In other major addictions, more specific interventions with medication, therapies, hospitalization, day programme, and detoxification/rehabilitation programmes may be needed to modify and ameliorate the addictions.

There is not enough data to date to evaluate treatment outcome specific to this population. More research is needed to provide useful information, and to serve as a springboard for further developments. Treatment centres such as the Waryas House in

Poughkeepsie, New York were established to serve this population better and improve outcome.

Psychological Therapies

These are of primary importance in the therapeutic process of these disorders. All types of psychotherapies can be very useful in addressing these disorders in persons with developmental disabilities. Modification of applied psychotherapies to fit the level of cognitive ability is very important, as is the recognition that every therapeutic step has to be broken down into smaller, easier to understand steps. Cognitive therapy, brief focussed therapy, and art/play therapies have been used very successfully in various addiction centres to address underlying issues such as depression, anxiety, and low self esteem. Group and family therapies are very important as adjunct therapies. They improve existing relationships, and increase the individual's and/or family's understanding of the illness itself, as well as other factors that contribute to the continuation of these disorders.

Social therapies – Environmental/Milieu Therapies

Social interventions are of equal importance and have to be offered simultaneously if it is at all possible with the other approaches. These remedies address the life of the individual in its totality. Housing, finances, day occupation, social networks, recreational activities and physical exercises are of paramount importance in establishing a healthier way of living. They complement the other therapies, and provide higher success rate in improving symptom presentation as well as in preventing further relapses, and the “revolving door” scenario.

Dr. Matthew Ferrara has developed an addiction treatment model for persons with DD/SD. His advice is that counsellors should expect the treatment to take longer (perhaps up to three to four times longer), to repeat all interventions many times, to use written assignments judiciously, and keep them simple.

The barriers for successful intervention identified by the various experts are:

- high staff turnover
- longer-term support needed
- familial patterns and collusion within the family system
- feelings of negative self-esteem and frustrations that may continue the negative spiral of the addiction
- loneliness, social isolation, and single status may aid in keeping these individuals “trapped in their addictions”
- cognitive limitations that can hinder best outcome
- family and counsellors who may be “overly sympathetic” and may not confront the family member/client on his/her addiction.
- existing services for Substance Disorders that are disorganized and geared towards “rapid recoveries” that are not conducive to the persons who have a developmental disability and who abuse substances

Finally, technological and medicinal advances, increased financial support, and specific programmes for these clients would certainly improve outcome, offer better quality of life, and increase our understanding of these disorders.

As Tomasulo stated in 1998, for persons with developmental disabilities and addiction, the usual channels for treating substance abuse are neither prepared nor inclined to provide effec-

tive services. He further states that the combination of cognitive limitations, developmental delay, and psychiatric intervention create a need for a different approach to the treatment of alcohol abuse.

Summary

This chapter has attempted to provide you with helpful information on the substance-related disorders as they apply to the person with a developmental disability. Ways of recognizing these disorders in this group, as well as early identification, assessment, and existing treatment approaches have been presented with real life vignettes to enable you to understand the course and processes of the disorders themselves, and the individual's plight. Ways of preventing many of these disorders/addictions have been highlighted to assist in the primary prevention process so much needed in this population.

Do You Know?

1. What are substance-related disorders?
2. Which of these disorders mostly affect persons with developmental disabilities?
3. What are the specific characteristics of the substance disorders in this population?
4. What is known to help these individuals in their plight?
5. Are some of these disorders preventable?
6. What supports do we need to develop to assist this group?

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