

Substance Abuse: A Hidden Problem Within the D/deaf and Hard of Hearing Communities

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Abstract:

Current research indicates that D/deaf (See glossary for definition of D/deaf) and hard of hearing clients seeking treatment for substance abuse often encounter obstacles in receiving the help they need. Many of these obstacles are the result of a lack of knowledge and experience with regard to treating D/deaf and hard of hearing people. Programs designed for hearing people that attempt to serve those with a hearing loss often do more harm than good. Even the identification of D/deaf or hard of hearing individuals with substance abuse problems is ineffective. This article reviews factors that result in disparities in substance abuse treatment for this population including approaches, accessibility and adapted materials

Introduction

The negative impact of alcohol and drug abuse on our society is well documented. Data from the Robert Wood Johnson Foundation indicates that about 10 percent of the general population has a substance use disorder (Robert Wood Johnson Foundation, 1994). Various population groups within the general population may experience even higher rates of alcohol and other drug problems. Studies have consistently found that 20 percent or more of all persons qualifying for state vocational rehabilitation services exhibit symptoms of substance abuse or substance dependence (Schwab and DiNitto, 1993). Individuals with disabilities appear to be at a higher risk for misusing alcohol and/or other drugs than the general population.

Incidence and Prevalence Among Persons Who Are D/deaf or Hard of Hearing

Demographic information indicates that 7% of the general population is considered to be hard of hearing with one out of every fourteen individuals identifying themselves as having difficulty hearing (Schein, 1974). Lipton and Goldstein (1997) reported that four million people have a serious bilateral hearing loss and reported that there are approximately 21,000,000 D/deaf people (National Institute on Deafness and Communication Disorders, 1989). The largest population of D/deaf individuals are the Late Deafened and elderly, and 2,250,00 people are identified as profoundly D/deaf. The National Council on Health Statistics indicates that 4.5 million individuals use hearing

aids, amplified telephones, closed caption television, and other assistive devices due to hearing loss.

The National Council on Alcoholism suggests that at least 600,000 individuals experience both alcoholism and hearing loss (Kearns, 1989). There are few studies that give reliable information about the prevalence of substance abuse in the D/deaf and hard of hearing community. Experts estimate that alcohol abuse within the D/deaf community is at least equal to or greater than the hearing population (Boros, 1981; Boros & Sanders, 1977; Isaacs, Buckley, Martin, 1979; Johnson & Locke, 1978; Lane, 1989; Watson, Boros, Zrimec, 1979). Based on this assumption, Dr. William Mc Crone (1994), projected approximately 5,105 D/deaf crack users, 3,505 D/deaf heroin users, 31,915 D/deaf cocaine users and 97,745 D/deaf marijuana users in the U.S. Robert Wood Johnson Foundation (1993) estimates more than 800,000 people in alcohol and drug abuse treatment at any given time. Based on one half of one percent of the population represented by D/deaf people, there would be 4,000 D/deaf and hard of hearing people in drug or alcohol treatment on any given day (McCrone, 1994). No evidence of this level of treatment service for D/deaf people is seen at the present time. It is predicted that one out of every ten individuals in the hearing population will be chemically dependent in comparison to one out of every seven D/deaf or hard of hearing individuals (Guthmann, 2000).

According to figures from a report completed in 1980 by the National Institute on Drug Abuse (NIDA) there are approximately 73,000 D/deaf alcoholics, 8,500 D/deaf heroin users, 14,700 D/deaf cocaine users and 110,000 D/deaf people who use marijuana on a regular basis. This totals a startling 206,200 D/deaf people who are substance abusers. In 1996 in the United States it was estimated that over 600,000 D/deaf people have substance abuse problems; however, only a handful are assisted in a treatment facility (Alcoholism & Drug Abuse Weekly (ADAW), 1996). It is difficult to ascertain how many D/deaf and hard of hearing people need access to treatment centers for their substance abuse. These people remain isolated and hidden in the D/deaf community due to communication barriers and lack of understanding about Deaf Culture.

Views of Deafness

Deafness is commonly considered from two different perspectives. One perspective identifies deafness as a disability and is commonly referred to as the medical model. The second perspective recognizes D/deaf people as a cultural group with common language, experiences and values. These perspectives offer different views of the D/deaf population. Conflicts may arise between the D/deaf client's cultural view of him/herself and the more common medical-model view of the hearing world. Those who provide services to D/deaf and hard of hearing people are well-advised to be aware of both viewpoints and the possibility for conflict they raise.

People who are D/deaf or hard of hearing are referred to as having a hidden disability. The disability does not become evident until the person begins to communicate. It is assumed by the hearing community, that if a person wears a hearing aid, then all listening and hearing problems are solved. Unfortunately, this is not true. Many D/deaf and hard of hearing individuals are excluded from normal conversations because others do not realize that they cannot hear even with a hearing aid. Often hearing aids amplify and at the same time can distort sound.

The Deaf community is a small close-knit group with a strong communication network or grapevine for sharing information on a national basis. While the grapevine is an important aspect of the culture, it can cause problems for a D/deaf person in treatment where confidentiality is fundamental to the program. D/deaf people are more likely to encounter other patients or staff that they know or have "heard about". With more treatment options, hearing people are less likely to encounter this type of situation.

The Use of Interpreters and American Sign Language Within the Deaf Community

One of the primary languages used for communication within the Deaf Community is American Sign Language (ASL). American Sign Language (ASL) is a visual language that uses gestures, facial expression, body movements and finger spelling for the letters of the individual words. ASL is a recognized language with its own grammar, syntax and vocabulary. As with any other language, ASL is also shaped by the culture of the people who use it to communicate. These are two of the reasons that information about chemical dependency has not been well-communicated in the Deaf Community. In treatment

settings designed for hearing people, language and communication are both barriers to participation among D/deaf and hard of hearing individuals. Good communication is essential in the educational, therapeutic and peer interaction dimensions of a well-designed treatment program.

Not all D/deaf persons use the same communication method. While many D/deaf people use ASL, some prefer other methods of communication. The client should be given the opportunity to select the communication mode that is most effective for him/her. Treatment programs serving D/deaf people should be prepared to provide support for the communication method that best suits the client.

Interpreters are professionals who facilitate communication for everyone involved with the conversation, both hearing and D/deaf. Sign language interpreters translate from one language (English) to another (sign language). In addition to sign language interpreters, there are also oral and tactile interpreters. Oral interpreters work with consumers who rely on speech-reading for communication. An oral interpreter enunciates, repeats and/or rephrases a speaker's remarks using natural lip movements, gestures and carefully chosen words that are more visible on the lips. Tactile interpreters use touch to communicate with D/deaf or hard of hearing individuals who have a significant visual impairment.

Interpreters are more than people who know sign language; they are professionals who receive formal training and are certified by the National Registry of Interpreters for the Deaf or other accrediting agencies. A "signer", on the other hand, is generally someone who has taken sign language classes. A "signer" could have a range of communication skills and should not be thought of as an "interpreter". Agencies are generally advised against using as an interpreter a family member who signs.

Some Facts About Deaf People

The following is information that can a person who is unfamiliar with D/deaf people begin to understand the experience of being D/deaf

- At least 90% of D/deaf children are born to hearing parents.
- D/deaf people can have a wide range of hearing loss that may have very different effects on a person's ability to process sound and, thus, to understand speech.

- Hearing aids may be beneficial for some people but do not “cure” a hearing loss.
- D/deaf people have varying abilities to produce intelligible speech. This is related to the degree and frequency range of the hearing loss as well as the age of onset.
- Lipreading/speechreading ability varies from person to person (hearing and D/deaf alike) and is generally ineffective for communicating since many spoken words look alike on the lips.
- Many D/deaf people, although intelligent, do not have a good command of written English. For D/deaf people with ASL as their first language, English language learning is secondary.

Challenges for D/deaf and Hard of Hearing Persons Seeking Services

People who are D/deaf cannot receive equivalent services and benefits from treatment the way hearing people do with some accommodations. Communication is the primary obstacle that D/deaf people face.

An individual who is D/deaf can experience their first barrier to treatment when they go to have an assessment for a potential substance abuse problem. Obtaining a valid substance abuse assessment is difficult since there are no formalized assessment tools normed or specifically designed to use with this population. The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals has developed one screening tool that can be used to help assess if an individual may be in need of a referral for treatment. (Guthmann, 1998). Most assessors are unfamiliar with how to work with D/deaf people and are even less likely to be fluent in ASL. Those who have some awareness of the needs of D/deaf people may use a sign language interpreter for the assessment process. Although this is an appropriate accommodation, problems of interpreter availability, interpreter qualifications and the costs involved often complicate the process. The addition of a third party to an interview will change the dynamics and may impact the validity of the assessment. The limited availability of properly qualified interpreters is also a factor that continues to be a problem throughout the United States. There are few interpreter training programs focusing on specialized substance abuse vocabulary, much of which is unfamiliar to the client. For example, the concept of what “blackout” means may need to be explained in addition to (or instead of) using the actual term. When concepts and/or vocabulary are unfamiliar to the client, the validity of the assessment may be compromised (Guthmann & Sandberg, 1995). The uses of self-report paper-and-pen or computerized tools, both heavily dependent on knowledge of English

language, are also inappropriate for this population. All of these factors lead to a high possibility of inaccurate assessment data.

Because this population is considered “low incidence” (less than 1% of the overall population), and because there are few professionals trained to assess individuals for substance abuse problems, successful community-based treatment may be unrealistic. Regional programs for this population seems to be a more logical approach. Research has found that people who are D/deaf or hard of hearing do not have ready access to appropriate alcohol and other drug information. When problems do exist, treatment professionals lack the training required to meet the needs of these clients (Guthmann, 1995). Alcohol and other drug abuse prevention materials do not take into account the cultural, language, or communication differences faced by people who have hearing losses.

A treatment program serving D/d people should be accessible by phone. The program staff should be familiar with phone communication options and should have a TTY (also referred to as a TDD), which enables a person to type and send messages over the telephone. In California, when the 15 treatment providers listed in the state alcohol and drug agency's directory as having a TTY were contacted, 12 of them either answered the phone by voice, did not answer the phone or hung up when they heard the TTY tones. In Texas, Region III, 19 counties have phone numbers listed under the Texas Commission on Alcohol and Drug Abuse (TCADA), however; no facilities listed a TTY number for D/deaf people to use when in need of treatment. This shows the need for ongoing training about phone communication with D/deaf people. Relay services involve the use of communication assistants who utilize TTY's to facilitate communication. New technology involves the use of a computer “web cam” which allows for a signed message translated by an interpreter.

Mainstream versus Specialized Treatment Programs

Assuming the D/deaf and hard of hearing individual negotiates the barriers mentioned above, a treatment referral will most likely be either to a mainstream program (a generic program) or to a specialized program designed especially for persons with a hearing loss.

Mainstream programs attempt to deal with communication barriers by using a sign language interpreter while specialized programs have staff who are able to communicate directly in sign language with the client. Although mainstream programs are successful for some individuals, many D/deaf people do not experience treatment in an effective way in this setting. Because of costs, the interpreter is often provided only for formal programming. The D/deaf person misses the opportunity to communicate with other patients at other times of the day. A shortage of qualified interpreters further limits communication opportunities for the D/deaf client. It is well known that the bulk of treatment occurs outside the formal group and 1:1 setting and clients need to have the ability to converse with their peers in treatment. In addition, with little if any communication while in treatment, D/deaf patients have no trust or rapport for the professionals trying to assist them. Because many D/deaf people experience reading and writing difficulties with the English language, the assignments and guidelines given to them increase their treatment barriers. This group will experience the same challenges as any other group struggling to learn English as a second language.

Beyond interpreting services, D/deaf and hard of hearing individuals in treatment may need other accommodations to full access treatment. These could include culturally appropriate treatment approaches, signed or captioned videos, and the opportunity to complete assignments other than in written English. There is a lack of educational materials available for D/deaf clients related to substance abuse written at an appropriate reading level. Serewicz (ADAW 1996) explains, "Think of all the abstract concepts involved in treatment and D/deaf people are very concrete; plus, many of them have severe experiential deficits."

People who are late deafened, grew up using the oral methods of communicating, are hard of hearing and do not use sign language, or those who do not identify with Deaf Culture may all be appropriate for mainstream settings. This population is actually larger than the population which uses sign language (Minnesota Chemical Dependency Treatment Program for Deaf and Hard of Hearing Individuals, 1996). These individuals will generally prefer to be served by programs for the general population alongside clients who can hear. The types of accommodations they need generally include things like good lighting, amplification, slowed or repeated spoken conversation, oral

interpreting, captioning, use of computer technology and/or individual attention. In these cases, a program may want to use a laptop computer with someone inputting the information and sitting next to the client who is able to read the screen or if the technology is available, Computer Assisted Realtime Transcription (CART) services. CART services utilize a court reporter who types everything that is said into a stenography machine which then converts the information into a computer and it is read by the client on a monitor or laptop screen.

Some people who are D/deaf and use sign language as their primary means of communication may also be referred to mainstream programs. One situation where this would constitute an appropriate referral is in the case of a D/deaf person working in the social services/health care field. Due to the possibility of encountering his/her own clients, the D/deaf professional may want to avoid specialized treatment settings and opt for a mainstream program. In this instance, the treatment provider would be providing interpreters. It is important for treatment providers to understand the parameters within which interpreters work. If an interpreting assignment (e.g., interpreting for a group) is two hours or less, an interpreter will usually take the assignment alone. S/he will probably need a break at some point during the two hours, however; interpreting is tiring, and an interpreter's effectiveness diminishes over time. Well-placed breaks or hiring two interpreters for assignments more than two-hours will greatly reduce fatigue and enhance performance.

In addition to the cost factors, receiving treatment through indirect communication with an interpreter presents additional challenges. There is the problem with potential confidentiality violations, as can happen when the interpreter may be someone known to the D/deaf client. If the D/deaf client is in a mainstream program, it is essential that the sign language interpreters have training related to confidentiality, alcohol use, substance abuse and the street term names for drugs. There are few training programs on a national basis that offer substance abuse and mental health related interpreter training, which makes finding qualified interpreters even more challenging.

Some mainstream programs have had clients with minimal language skills and it is difficult for the most skilled interpreter to be sure what the client is communicating. In these cases, an Intermediary Interpreter has been used by some programs to help facilitate

effective communication. An Intermediary Interpreter is a Certified Interpreter who is culturally D/deaf and their first language is ASL. The information is gestured from the D/deaf client to the Intermediary Interpreter who then signs to the Sign Language Interpreter who voices what is being stated. Even though it is understood that most mainstream treatment programs do not have funds to afford accommodations for one interpreter, much less an intermediary interpreter, to be present for all groups, one-to-one therapy sessions and free time, it is a method of communication to be aware of when the need arises.

An example of a mainstream treatment program that successfully used an intermediary interpreter was when there were fourteen individuals who were D/deaf with substance abuse issues in a facility at the same time. The psychologist and counselor had been frustrated for several months because of the inability of the professional sign language interpreters to correctly voice the D/deaf client's statements during the group sessions. They contacted an agency nearby that contracted with interpreters and asked them for advice. The agency had an intermediary interpreter who was Deaf and they sent one to the facility to assist the professional sign language interpreters. The intermediary interpreter was able to assess the professional's voicing skills and noticed that they were unable to accurately voice for two or three D/deaf individuals. The intermediary interpreter bridged this gap by signing in English what the D/deaf participants were saying and allowing the professional interpreters to appropriately voice the D/deaf participants information. At the same time the intermediary interpreter was able to assess the quality of the professional sign language interpreters and provide feedback to the psychologist and counselor. The feedback given was focused on issues of skill mastery and vocabulary needed for working in a chemical dependency treatment program.

For the most part, people who are D/deaf and identify with themselves as part of the Deaf Community will prefer a specialized treatment program. Specialized treatment components are sensitive to specific cultural, language, and communications issues and include staff fluent in sign language and knowledgeable about Deaf Culture. These clients feel more comfortable in a specialized treatment facility where they can communicate with others in their own language (ASL) and have peers with the same cultural values. Specialized treatment facilities may also provide clients access to other

D/deaf recovering people who can serve as role models.

One example of a model specialized treatment program for D/deaf and hard of hearing individuals is The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (MCDPDHII). This program is designed to meet the communication and cultural needs of D/deaf and hard of hearing persons in chemical dependency treatment. Staff members are fluent in ASL as well as knowledgeable and sensitive to Deaf Culture. The program includes individual and group therapy, education offerings, spirituality group, grief group, recreational therapy, men's/women's groups, participation in accessible Twelve Step groups, comprehensive assessment services and aftercare planning. The Program was the recipient of a critical populations grant from the Center for Substance Abuse Treatment as well as training grants through the Office of Special Education and Rehabilitation Services.

The Program operates on a Twelve Step philosophy using treatment approaches that are modified to respect the linguistic and cultural needs of the clients. As opposed to the traditional emphasis on reading and writing, clients are encouraged to use a variety of methods including the use of drawing, role-play, and communication using a variety of sign language systems. Any written material used in the Program is modified and video materials are developed and presented using sign language, voice and captioning. TTY's, assistive listening devices, flashing light signals, decoders and other technological help to make the treatment setting accessible to D/deaf and hard of hearing clients.

Program staff members give top priority to viewing each client as unique and strive to meet treatment needs in an individualized, therapeutic manner. Attention is given to client diversity with respect to ethnic background, education, socialization, cultural identity, family history and mental health status. In addition, staff members recognize variation in D/deaf and hard of hearing clients with regard to the degree of hearing loss, their functioning ability, their communication preferences and their drug use experiences. These factors substantiate the benefits of a flexible approach. The Program recognizes the importance of all clinical staff being knowledgeable about a variety of communication methods and being fluent in ASL. Effective communication and cultural understanding are viewed as the most essential tools in providing quality treatment services.

Careful consideration should be given when making treatment referral decisions for

people who have a hearing loss. Although each person deserves individual consideration, some general principles can help to guide referral decisions about mainstream versus specialized programs.

Aftercare and Recovery

Even for those D/deaf people who are able to find and complete treatment, barriers remain to their ongoing recovery. Recovery resources such as counseling, outpatient services or support groups offer limited accessibility to D/deaf persons. Even Alcoholics Anonymous and other Twelve Step groups, the mainstay of recovery for many hearing people, struggle to be accessible to D/deaf people. Twelve Step sponsors who provide mentoring and support for those new to recovery are seldom able to effectively communicate with D/deaf recovering people. Within the group of recovering persons, few D/deaf role models are available to support those who are new to recovery. A common suggestion in recovery is to avoid old acquaintances and environments associated with chemical use. Most hearing people in recovery have choices and options of places to go and people to see. They can realistically develop new friendships in the recovering community. In contrast, many D/deaf people in recovery are isolated and have a limited circle of sober, D/deaf friends. The Deaf Community being a strong social network often looks at substance abuse issues as a sign of weakness. The probability of admitting such a problem is difficult since many members of the Deaf community tend to believe it is not a problem. Some of the social and sports events within the Deaf community involve activities that typically involve the use of alcohol or individuals using other substances. This makes it difficult for one who is trying to stay sober, however; these D/deaf individuals are left isolated without communication within their social community if they do not attend those functions. Some communities have attempted to set up alcohol free events to assist community members in having more “sober” options for socialization. There is a need for ongoing education to be provided to Deaf community members related to substance abuse.

For those D/deaf individuals who have completed treatment, recovery is an important part of the process. To assist with access to aftercare, some states have set aside funds to assist in the provision of interpreters for Twelve Step meetings. Since a

part of recovery is the ability to find a sponsor and there are not enough individuals fluent in ASL to be one, some hearing sponsors have utilized computers for communication purposes as well as the “web cams” discussed earlier in this article. As technology continues to be more available on a national basis in more states and rural areas, more creative options for aftercare will be available for D/deaf individuals.

Conclusion

Attempts must be made to identify the segments of the D/deaf population, which are not being successfully treated for their substance abuse. To identify the segments of D/deaf people with substance abuse issues it is important to fully understand the lives of D/deaf people and their experiences. D/deaf people frequently feel like outsiders in the hearing world and being an addict makes them feel more like one. If we have a better understanding of the cultural experiences and socialization needs of the D/deaf and hard of hearing population, we can help bridge the gap by developing assessment, treatment and aftercare programs that better meet the needs of this population.

Full accessibility is required for successful treatment. It is strongly recommended that D/deaf individuals who utilize ASL or other sign language systems have specialized treatment and aftercare programs available to them. It is imperative that this population have access to D/deaf role models, counselors or psychologists who are either D/deaf or hearing and fluent in sign language. It is also important that when possible, D/deaf people be placed with other D/deaf or hard of hearing individuals who share common experiences and can identify with each other. Providing treatment to D/deaf and hard of hearing individuals in a specialized setting can eliminate some of the enabling which occurs from professionals who are not experienced in working with this population. If D/deaf individuals are in a mainstream program for treatment, it is essential that they have trained interpreters available for as many of the daily treatment components as possible. Mainstream treatment providers should ensure that D/deaf clients have full access regardless of their preferred mode of communication. If there are no fluent signing hearing or D/deaf staff then the emphasis when possible should be on having D/deaf role models involved in various aspects of the treatment program. If a D/deaf client does not use sign language, utilize a lap top computer, oral interpreter or CART.

BIOGRAPHY

Debra Guthmann, Ed.D is currently the Director of Pupil Personnel Services at the California School for the Deaf, Fremont and current Project Director for The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, where she oversees a variety of training and grant projects. Dr. Guthmann has authored numerous articles focusing on chemical dependency and ethical issues pertaining to Deaf and Hard of Hearing individuals and been involved with over 150 national and international presentations. Dr. Guthmann has written book chapters focusing on substance abuse and treatment models to use within the Deaf and Hard of Hearing population, culturally affirmative substance abuse treatment when working with Deaf and Hard of Hearing clients and dual relationships within the Deaf Community. Dr Guthmann is the past President and current board member for the National Association on Alcohol, Drugs and Disability (NAADD) and past President and current Treasurer of the American Deafness and Rehabilitation Association (ADARA) which is one of the largest organizations for professionals serving Deaf and Hard of Hearing Individuals. She also serves on a number of boards including the Rehabilitation, Research and Training Center focusing on Substance Abuse and Disabilities located at Wright State University in Dayton Ohio, California Department of Rehabilitation's Deaf and Hard of Hearing Advisory Committee and San Francisco State University's Rehabilitation Counseling Training Program

Vicki M. Graham, BS, Level III Intermediary Interpreter is coordinator of student services and D/deaf and hard of hearing service specialist at the Office of Disability Accommodations at the University of North Texas, TX and former case manager, training coordinator and intermediary interpreter for Texas, Missouri and Illinois rehabilitation treatment programs and agencies. Ms. Graham is a culturally D/deaf woman of D/deaf parents. She was educated in both a school for the Deaf and mainstreamed public schools. Ms. Graham has twenty-five years of experience working with the Deaf Community providing conferences, inservice presentations, workshops, outreach and training programs regarding TTY access, ASL and other sign languages, Deaf Culture and how to accommodate clients successfully at universities, hospitals, emergency facilities, mental health and other agencies as well as treatment centers regarding substance abuse with D/deaf and hard of hearing individuals nationally. Ms. Graham has served as an Advisory Board member to Waubonsee Interpreter Training Project and John A. Logan Interpreter Preparation Program and was past President for Southern Illinois Registry of Interpreters for the D/deaf.

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Glossary

American Sign Language (ASL) - A visual language using gestures, facial expression, body movements, and finger spelling for letters in individual words. It is a recognized language with its own grammar, syntax, and vocabulary.

Assistive Listening Devices (ALD) – These are hearing aids or amplification systems designed to improve hearing in difficult listening situations. These devices amplify desired sounds (signals) and minimize undesired sounds (background noise). Some systems use a microphone with a cord to reach the desired sound source and other systems use a cordless microphone for convenience.

Personal FM system - This is a system that helps reduce background noise. The speaker wears a compact transmitter and microphone, while the consumer uses a portable receiver and earphones that attach to hearing aids, headphones or custom earmolds.

Group FM System. –This is used with a hearing aid or other ALD in a group, large room or auditorium setting where using only a hearing aid may be difficult. The message is broadcast directly from the microphone that the speaker is wearing to the consumer and this helps eliminate background noise.

Infrared and/ Loop Systems – These devices use an infrared or loop system to assist deaf or hard of hearing people hear sounds more clearly by reducing or cutting out background noise. If the equipment is available, these systems can be used to assist deaf

or hard of hearing people hear better during meetings that occur in an office or conference room. The system can also be used to pick up sound from televisions, or radios. In a theatre, a loop can help a person hear sounds from a play or movie more clearly.

Closed Captioning – This is used for D/deaf and hard of hearing individuals who can't hear the television but can read the words across the bottom of the screen much like subtitles in a foreign film.

TTY/TDD (teletypewriter or telecommunication device for the Deaf) – This device allows a D/deaf or hard of hearing person to make a telephone call directly to another person with the same type of device.

Amplified Phones – These phones have a volume control on the receiver and increase the volume of the phone so the person can hear more clearly.

CART (Computer Aided Real-Time Transcription) – A trained court reporter using a stenotype machine, computer, and real-time translation software to create the text with a delay of less than one second to provide this service. This is unlike real-time captioning (text over pictures) as it only produces text that is displayed on a monitor.

D/deaf Persons - Those who have a severe or profound hearing loss or who's residual hearing is so minimal that they may not use speech for communication. The degree of hearing loss will vary with each client, as will the ability to use auditory and visual cues to understand spoken communication.

D/deaf Culture/Community - Deaf people who have the same values, beliefs, norms, traditions and strong cultural social network and are typically identified in writing with higher case "D."

Hard of Hearing - Individuals who have some residual hearing but are not completely D/deaf. Some of these clients may also depend on lip reading an oral interpreter, a sign language interpreter or CART to understand much of what is said.

Late Deafened Adult – People who lose their hearing typically in their adult years after functioning auditorally. In these situations a previous hearing loss is possible and the hearing loss can progress rapidly.

Oral Interpreter – This person provides communication access in various situations so the D/deaf or hard of hearing person involved may have equal access to resources. They do not use sign language or gestures for communication, but a system that incorporates speech and lip reading only.

Qualified Sign Language or Intermediary Interpreter/Transliterator – This person provides communication access in various situations so the D/deaf or hard of hearing

person involved may have equal access to input and output and can take advantage of the same resources. Interpreters transmit all auditory input into a visual form, and vice-versa. These individuals are trained and certified by the Registry of Interpreters for the Deaf or the National Association of the Deaf and are familiar with vocabulary and concepts related to substance abuse. An Intermediary Interpreter is a D/deaf person while a sign language interpreter is a hearing person, however, both follow the same guidelines.

Pre-lingual Deafness – Deafness occurring before language is developed.

Post-lingual Deafness – Deafness occurring after language has been developed.

Relay Calls – If there is no available access to a TTY/TDD, each state has a phone number to call to access the relay service. Staff call the Relay Service phone number and speak through a third party operator to access an individual who is D/deaf or hard of hearing. (Treatment facilities should be equipped with TTY direct lines and lighting devices to alert the client if the phone is ringing, someone knocking at the door or in case of fire.)