Disability Access Project
CALIFORNIA ASSOCIATION OF CADRR ADDICTION RECOVERY RESOURCES

Alcohol, Drugs & Disability

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Accessing Alcohol and Drug Abuse Services for People who are Deaf or Hard of Hearing

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For more information about the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals you can contact Dr. Guthmann at dguthmann@aol.com or go to the program website at www.mncddeaf.org

International Symbol of Access for Hearing Loss

Getting treatment and beginning a program of recovery presents many problems for any individual, but those who are alcoholics or addicts and deaf or hard of hearing face additional barriers to treatment and recovery. At the present time, little data is available to describe the extent of the substance abuse problem with deaf and hard of hearing young people or adults. The majority of the research indicates that deaf and hard of hearing people face at least the same risk of alcoholism and drug abuse as do hearing people (Lane, 1985). Dennis Moore (1991) also points to what he terms "the paucity" of epidemiological data related to the prevalence of substance abuse in the Deaf Community. To date, there have only been two residential school for the deaf studies (Boros, 1981; Isaacs, Buckley & Martin, 1979, Johnson and Lock, 1981) and one state wide study estimating the incidence of substance abuse in the young deaf population.

Barriers to Treatment Services

In addition to the problems of insufficient data to describe the dimensions of the drug abuse problem among deaf and hard of hearing persons, typical treatment and recovery resources pose barriers to these individuals. Deaf and hard of hearing people have unique needs which are often not adequately addressed in a non-specialized substance abuse treatment program because of inadequate accessibility (Rendon, 1992, Whitehouse, Sherman & Kozlowski, 1991; Lane, 1985). The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals has identified the following barriers to treatment and recovery for persons who are deaf or hard of hearing.

1. **Recognition of a problem** - There is a general lack of awareness of the problem of substance abuse within the Deaf Community. This situation is influenced by a lack of appropriate education/prevention curricula and limited access to recent widespread efforts to educate people about alcohol and other drugs through the mass media.
2. **Confidentiality** - Traditionally, the Deaf Community has communicated information about its members very efficiently through person to person contacts. This grapevine-line system of communication within the Deaf Community has kept deaf people informed of community news and concerns. But, individuals in treatment often fear that their treatment experience will become a part of the grapevine information and are therefore reluctant to share their story.
3. **Lack of Resources** - Few resources along the continuum of substance abuse services exist that meet the communication and other cultural needs of deaf and hard of hearing persons. Historically, the array of treatment services available to hearing individuals has not been accessible

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In this issue:

Support for this project is provided by the State of California, Health & Human Services Agency, Department of Alcohol & Drug Programs. Technical assistance and training services are provided at no cost to qualified agencies, and programs.

California Department of Alcohol & Drug Programs

This publication is available upon request in accessible formats including Braille, large print, computer disk, or audiotape as a disability-related reasonable accommodation for people with disabilities.

Disability Access Project:

Mission and Goals

CAARR's specific purpose and goals for technical assistance and trainings under the Disability Access Project is to increase opportunities to, as well as the ability of, people with physical, sensory, and cognitive disabilities to address their alcohol and other drug-related problems by:

Reducing attitudinal, architectural, programmatic, communication and fiscal barriers to accessing appropriate treatment and recovery services for people with disabilities;

Enhancing the cultural and linguistic appropriateness of alcohol and other drug (AOD) treatment and recovery program services for people with disabilities;

Improving the quality, quantity, and outcomes of these services;

Providing trainings and/or technical assistance to state and local AOD agencies statewide and disability agencies statewide.

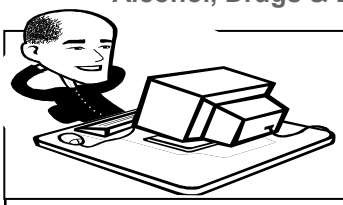
Technical Assistance & Training

CAARR has retained a pool of qualified consultants, many of them people with disabilities in recovery, who can provide technical assistance to alcohol and drug programs, counties, and other individuals and agencies who serve people with disabilities. Examples of technical assistance and trainings provided include:

- Program and policy reviews
- Architectural surveys
- Resource development
- Community forums
- Telephone consultation
- Assistive Technology & Caption Media

The following disability trainings are provided by the CAARR Disability Access Project:

- Disability Awareness and Sensitivity
- Clinical Approaches/Treatment Protocols
- Disability Specific Orientations
- Introduction to Addiction and Recovery for Disability Professionals
- Introduction to Deaf Culture
- Access to Services
- Customized Trainings/Workshops



FROM THE DESK OF BOB OLSON
Project Director

California Association of Addiction Recovery Resources
Disability Access Project

It is estimated that there are approximately 26,000 people in California who are deaf and in need of alcohol or drug abuse intervention and treatment. An additional 439,000 Californians who are hard of hearing may also require intervention and treatment services. These two groups represent the largest underserved population in the alcohol and drug prevention, treatment and recovery settings. Currently, there is only one residential treatment program in California specifically for people who are deaf. This 14 bed facility is managed and staffed by deaf professionals and support personnel who understand not only the cultural aspects of deafness, but also facilitate programs and services in American Sign Language.

This issue of the Alcohol, Drug and Disability Newsletter is focused on services for people who are deaf. Because of the complexity of the topic this issue is somewhat bigger than normal. Dr. Debra Guthmann, a respected professional in the field provides her insight and experiences working with deaf alcohol and drug abusers. The next issue will address accessibility for people who are hard of hearing.

For people who are deaf, effective communications present perhaps the biggest barrier to successful completion of the treatment process. Dr. Daniel Anderson, President Emeritus of Hazelden stresses the importance of effective communications in his book, Perspectives on Treatment, The Minnesota Experience" writing that: *"Perhaps the most mutual element in our programs is the opportunity we give to patients to meet, learn, and grow in small unstructured peer group relationships."* Without the ability to communicate with their peers, people who are deaf miss out on the sharing that is so much an essential component of treatment and ultimately, recovery.

What can we do to overcome these barriers? For people who are deaf accessibility usually means providing interpreters, an expensive and often ineffective proposition in a social model program. Interpreters should, at a minimum, be available for individual one-on-one counseling sessions, lectures and educational sessions, and group therapy meetings. These residents however, miss out on the unstructured peer group relationships that are a vital part of the treatment process.

Certainly, 14 beds is not enough to meet the needs of the Deaf Community and expanding the residential, social model concept of culturally competent (yes, there is a Deaf culture) treatment to central and northern California may be a viable option. But, putting this into practice could be a long, tedious, and slow process.

Cultural competency means recruiting and training Deaf professionals to work in the field of addiction and recovery, and to serve as role models to their peers. This can pay dividends, not only in terms of expanding services, but also by creating a statewide network of Deaf professionals who can reach out to their communities to provide prevention, intervention, treatment and recovery services to this significant cultural minority population in a language that they can understand.

If you or your programs are interested in learning more about Deaf culture give us a call. We have Deaf consultants available to present trainings and workshops throughout California at no cost to you or your agency.

Bob

(Continued from page 1)
for deaf and hard of hearing people. There is also a lack of qualified professionals trained in the areas of substance abuse and deafness. Deaf and hard of hearing individuals, their families or professionals serving them may struggle for lengthy periods of time attempting to locate and access appropriate programming.

4. Enabling - The tendency of family members, friends and even professionals to take care of and protect individuals who are "disabled" or "handicapped" is often played out with deaf and hard of hearing persons. The addition of substance abuse only exacerbates this problem. Often this results in the deaf or hard of hearing individual not being held accountable for his/her behavior. Enabling also sends the unintended message that the deaf or hard of hearing person is not able to take care of him/herself.

Deaf ASL sign for help

5. Funding - Specialized programming to meet the needs of deaf and hard of hearing persons is costly due to the need for specially trained staff, travel costs and the depth and breadth of the client's needs. The process of accessing funding sources may act as a barrier itself to deaf and hard of hearing persons. It is not uncommon for funding agencies to require a number of assessments with various professionals in order for funding to be approved. Again the shortage of appropriately trained professionals in these various fields impacts the accessibility of prerequisite services.

6. Lack of Support in Recovery - Disengaging from old friends may be especially difficult for people who are deaf. Small numbers of deaf people within the community, many of whom use mood altering chemicals leave the recovering person with few positive socializing opportunities. The relatively small number of recovering deaf role models also results in a lack of a sense of support. Also, until recently, alcoholism or drug addiction was often viewed as a moral weakness instead of a chronic disease sometimes contributing to the ostracizing of dependent individuals from the Community.

Communication

In order to access treatment services, the deaf or hard of hearing person must be able to access communication of the treatment process. For many, accessing spoken and written language is a struggle. Concern about accessibility problems related to communication that deaf and hard of hearing people face in entering most treatment programs have been repeatedly documented (Berman, 1990; Lane, 1985; Miller, 1990). It has been found that treatment programs in Illinois, for example, were only minimally compliant in meeting the federal legal mandates as far as accessibility for people with disabilities (Whitehouse, Sherman, Kozlowski, 1991). Similar situations exist in most other states.

For any person who is deaf, communication is a crucial issue. Most deaf people depend on American Sign Language (ASL), a visual language, to communicate (Stokoe, 1981). Because they do not hear language and learn it as hearing children do, they often struggle with English language--written and verbal. Traditional treatment approaches often emphasize the use of reading/writing tasks and "talk therapy" and thus make it difficult for anyone who has language difficulties. Hard of hearing persons face a different set of barriers related to communication in treatment including poor acoustical environment, inadequate lighting, or inability to follow a conversation in a group (Ancelin, 1992).

Communication difficulties also mean that many deaf and hard of hearing persons have had less access to educational information about alcohol and other drugs than their hearing peers. School education/prevention programs and media information often preclude access by deaf people for a variety of reasons including the lack of captioned or signed materials, use of unfamiliar vocabulary and other communication related issues. Often, deaf people receive little or no information about drugs and alcohol or misunderstand the information presented in the media. Historically, few residential (state) schools and almost no mainstream public school programs involve deaf students in alcohol and drug abuse curricula (McCrone, 1982).

Some treatment programs have attempted to resolve the communication issue by using a sign language interpreter and integrating deaf clients into the regular treatment process. Although this is successful for some individuals, many deaf people do not experience treatment in an effective way in this setting. Often, the interpreter is provided only for formal programming and the deaf person misses out on communication with other patients at various times during the day or evening such as free time or meal time. In many instances, there is a shortage of available interpreters so communication is not provided to the client. Deaf and hard of hearing individuals in treatment need more than just interpreting services. It is essential that a full array of services such as education from a qualified teacher of deaf students, direct communication with clinical staff,

captioned or sign video material or innovative treatment approaches be provided. Sometimes, the deaf person is unable or unwilling to establish a bond with treatment staff and patients who do not understand what it means to be deaf or know how to communicate in ASL. For many deaf individuals, this experience could be equated to a hearing individual being placed in a treatment program where Spanish is spoken and an English interpreter is brought in for several hours a day. The difficulty of developing meaningful relationships without fluent communication seems clear.

Lack of awareness or understanding of Deaf Culture on the part of treatment staff or peers can also add to difficulties in a non-specialized program. For example, the experiences of socializing with deaf peers is cherished in Deaf Culture. However, for a deaf person attempting to recover from alcohol and drug abuse, socializing with deaf peers can be problematic when the number may be small and many are using or abusing alcohol and other drugs. Letting go of using friends may mean leaving the Deaf Community, at least for a period of time. While still recommending separation from peers who are using, treatment staff who are knowledgeable about Deaf Culture can appreciate the special difficulty this presents when it leaves the person with few deaf friends, or none at all. The Deaf Club, which serves as the central gathering and socializing place for deaf people, is often supported by the sale of alcohol. Attitudes toward alcohol in the Deaf Community are also important to understand. For example, a study of the attitudes of deaf high school students toward alcohol shows their perception of drunkenness as a "sin" or a sign of character weakness (Sabin, 1988). Understanding of these dynamics is essential on the part of treatment staff. Further, because deafness is considered a low incidence population, deaf people are often geographically isolated from one another. Ninety percent of all deaf people are born to hearing parents and are often the only deaf person in the family. As a result, "Deaf Schools" (state run residential schools for deaf children) become the cultural center and the place where children learn ASL and traditions of the Deaf Community (Padden, 1980).

The following quote sums up the difficulties deaf and hard of hearing persons face once alcohol or other drug problems are identified.

> "Large numbers of deaf alcoholics have been forced to struggle without the help of community agencies. Even within the alcoholism agencies, barriers to treatment exist because the programs have been designed for verbal, hearing clients. Counselors do not understand the psychosocial aspects of deafness or the specific forms of denial that occur, and they do not possess manual communication skills. Agency budgets do not traditionally include funds for sign language interpreters....It is the encounter with confusion and ambivalence found in these situations that have caused deaf alcoholics to avoid agencies, increasing their frustration (and their denial) about being different" (Rendon, 1992).

A Model Program

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (MCDPDHHI) is a specialized program designed to meet the communication and cultural needs of deaf and hard of hearing persons in alcohol and drug abuse treatment. The Program is the recipient of a critical populations grant from the Center for Substance Abuse Treatment. The Program was awarded the initial grant funds in September, 1990, and has received continuous funding since1993. The grant funds enable program staff to provide outreach and training, to modify and develop materials as well as to provide treatment to deaf and hard of hearing persons.

International TTY/TDD Symbol

The MCDPDHHI has developed a Clinical Approaches Manual which describes the philosophy and application of the specialized approaches developed in five and one half years of providing substance abuse treatment services to deaf and hard of hearing persons. The philosophy is based on the Twelve Step program of Alcoholics Anonymous. The manual includes instructions for step work, assignment sheets, examples of client work, behavior management practices, and all other aspects of the program. Within the approaches developed by the program, the principles and concepts of the Twelve Steps are taught and reinforced in a way that has been accessible for deaf and hard of hearing clients.

A videotape explaining each of the Twelve Steps in American Sign Language (with voice and captions) accompanies the Manual. In the approaches described, clients come to recognize that they are powerless over alcohol and/or other drugs and that their

drug use has caused their lives to become unmanageable. Each client explores for him/herself what the impact of that use has been. Upon reaching an understanding of these concepts of powerless and unmanageability, clients are assisted in seeing that there is hope for changing their lives and resources for doing so. Through the program, clients acquire information and skills to make different choices in their lives, including the choice of sobriety. The use of the Twelve Step approach helps to prepare clients to access the most readily available source of support in the form of Alcoholics Anonymous groups.

Being blind cut me off from the world of things
Being deaf cut me off from the world of people
Helen Keller

The program also has developed a number of other specialized materials including Choices curriculum (which provides instruction in decision making and choices); Relapse Prevention Manual; and a prevention videotape entitled "Dreams of Denial". These materials begin to address some of the gaps in the continuum of substance abuse services in the areas of prevention and aftercare.

This program operates on a Twelve Step philosophy and offers patients the opportunity to attend Alcoholics Anonymous, Narcotics Anonymous or other Twelve Step meetings within the hospital as well as in the community. Some meetings are interpreted for deaf people; others consist of all deaf members. Treatment approaches are modified to respect the linguistic and cultural needs of the patients. For example, patients are encouraged to use drawing, role play and communication in sign language as opposed to written work to complete step assignments. Written materials used in the program are modified and video materials are presented with sign, voice and captions. TTY's (which allow deaf people to communicate on the phone), assistive listening devices and decoders for the television are among the special equipment provided for patients. A Clinical Approaches Manual has been developed by the program. This manual describes treatment approaches, philosophy, task rationale, step assignments and educational topics used with deaf and hard of hearing clients in treatment. This manual is intended to assist other service providers who want to replicate the Minnesota Program. Information from the manual is shared in later sections of this paper.

Program staff 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 deaf and hard of hearing clients in their degree of hearing loss, their functioning ability, their communication preferences and their drug use experiences. These factors corroborate 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 American Sign Language. Effective communication is viewed as the most essential tool in providing quality treatment services.

Phases of Treatment--Phase I, Evaluation

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals encompasses three phases. Phase I is the evaluation phase of the program. During Phase I, various assessments are used to gain an understanding of the individual client and his/her use of mood altering chemicals. Typically, assessments include medical background, social history, chemical use history, a clinical assessment and a communication assessment. The communication assessment is an important tool which profiles a client's communication preferences and needs. The results of this assessment allow treatment staff to present information and provide support using the client's own preferred method of communication. During Phase I, clients also complete a drug chart assignment in which they detail the different drugs they have used, a description of their last use and examples of consequences of their use in major life areas such as physical health, legal, family, social, work/school and financial. With few exceptions, drug chart work, and many other assignments are done through drawing. The use of drawing removes the barrier created for many deaf and hard of hearing people by the English language. It also seems to encourage the client to be more in touch with his/her experiences and thus, more in touch with the feelings connected to those experiences.

Phase II--Primary Treatment

Phase II is the primary treatment phase in which clients receive education about the Twelve Steps and complete step work assignments. Ideally, clients will complete steps one through five while in primary treatment. However, the emphasis is for clients to integrate the concepts of the steps into their recovery as opposed to completing the assignments. Step work assignments are modified to meet the needs of the individual client, completed by clients (often through drawing of pictures) and presented in therapeutic groups with staff and peers. Most often, clients pre-

sent their work using American Sign Language. Task rationale for various portions of step assignments help to identify the objectives of each assignment and help to determine if the client has met the objective.

The goal of step one is to help individuals identify the aspects of powerlessness and unmanageability in their lives and to get in touch with their feelings. Giving examples of how their use of alcohol or other drugs has hurt others as well as themselves help to personalize the powerlessness and unmanageability of their own addiction. It is also during step one that a client confronts his/her denial. Following the Alcoholics Anonymous philosophy, the client is asked to admit that drugs/alcohol are more powerful than they are, and that they cannot manage their lives any more. This helps to establish a foundation on which to build a sober life through the subsequent steps.

Courtesy of the Easter Seals Society

A typical step one helps the client to understand the significance of the problem with alcohol and drugs. Again, much of the work is done through the medium of drawing and presented in the client's preferred mode of communication to a group of peers and staff. After the work has been presented, self-related feedback from peers helps the client develop a sense that he/she is not alone, that others have had similar experiences. The client's work is accepted when he/she is able to demonstrate an understanding of the concepts of unmanageability, powerlessness and the effects on self and others. For clients who have not completely understood the concepts, additional assignment(s) may be given to help supply the missing information or understanding. Most of the step one assignments are very similar in the tasks given to clients. Typical modifications of this assignment would involve breaking the assignment down into smaller parts, limiting the scope of the assignment to a period of relapse or expecting a lesser number of examples in each task.

Step two assignments (as well as assignments for the subsequent steps) tend to be more individualized for each client. With the exception of receiving the Step prep and viewing the ASL video about the Step, the assignment is developed by the staff team to meet the individual needs of the client. A list of potential tasks (contained in the Clinical Approaches Manual) provides options for creating the assignment. Again, clients complete the assignment and present it in group, as previously described. The goal of the step two assignment is to allow clients to develop a sense of hope. The assignment helps the client realize that he/she is not alone, that there is a power to sustain him/her in recovery. Since many clients often have had negative or confusing experiences with the concept of God/religion, they are encouraged in step two to identify their own higher power as someone or something--not necessarily God--which they believe to be greater than themselves. Many clients identify their sponsors or an AA/NA group as their higher power. Asking for and accepting help are vital parts of acknowledging and accepting a higher power.

Step three is individualized in the same manner as described above for step two. In this step, the emphasis is on action--safe places the clients can go for sober support, people who can help the client stay sober, and so on. In this step, clients are also asked to begin developing their understanding of higher power. The Serenity Prayer is often used as part of the assigned work of step three. In the treatment setting, it is used to close each therapeutic group session. Clients are encouraged to use the Serenity Prayer as a tool for coping with everyday stresses of living as well as with efforts to maintain sobriety.

As with step two, the Clinical Approaches Manual presents a number of tasks which may be used in creating a step three assignment.

The Clinical Approaches Manual goes on to describe philosophy, task rationale and assignments for each of the steps through step twelve as well as other information about the approaches and assignments. The manual also includes examples of client work.

In addition to step work and group/individual counseling, clients are educated and supported through lectures, educational programs and other activities mentioned above. While alcohol and drug abuse is the primary area of concern, additional problem areas, such as ineffective coping skills and grief/loss issues, receive attention in programming. Throughout the treatment stay, clients are provided with education

related to health concerns commonly associated with substance abuse. Educational lecture topics include HIV/AIDS, sexually transmitted diseases, physical effects of mood altering chemicals, birth control and various types of abuse. Medical testing and consultation is available to all clients.

Beginning in phase I and continuing throughout the client's stay, involvement in Twelve Step meetings is provided as well as education about the programs of Alcoholics Anonymous, Narcotics Anonymous and other Twelve Step groups. A family week experience is provided for clients and their families as appropriate whenever possible. Often, family members are not fluent in sign language and for the first time, through the use of an interpreter, the family explores a variety of issues. If family members are unable to attend, materials and phone contact with staff is available to all family members. An educational component helps school aged clients maintain their schooling while in treatment. The program staff includes a licensed teacher of deaf and hard of hearing students.

Phase III includes an optional extended care program for those clients who need additional support in transitioning back into the community and an aftercare component. For clients who come from other states, staff members attempt to set up a comprehensive aftercare program in the client's home area, offering education and support to service providers there. For local clients, the program offers individual aftercare sessions as well as an aftercare group and connects clients to other local resources such as Twelve Step meetings, a relapse prevention group, therapists fluent in American Sign Language, an interpreter referral center, vocational assistance, halfway houses, sober houses and other sources of assistance and support. Networking with other service providers both locally and nationally is an important activity related to aftercare. Aftercare for clients residing in states other than Minnesota continues to be a challenge. There are limited Twelve Step meetings that currently provide interpreters in major metropolitan areas, let alone rural communities. Shortages of professionals trained to work in this area exist on a national basis. Developing an aftercare plan for out of state clients might be compared to putting together a puzzle--sometimes with many of the pieces missing.

Universal Symbol for Interpreter

Materials developed by the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Persons are available by contacting them at www.mncddeaf.org or by calling toll free 1-800-282-3323 (V/TTY). These materials are also available for loan from the Disability Access Project by calling 916-338-9460 Voice or 916-473-0836 TTY.

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Governor Schwarzenegger Appoints Renée Zito Director of Department of Alcohol and Drug Programs

Governor Arnold Schwarzenegger announced the appointment of Renée Zito as the director of the Department of Alcohol and Drug Programs (ADP) to replace Kathy Jett who was appointed director of the newly reorganized Division of Addiction and Recovery Services within the California Department of Corrections and Rehabilitation (CDCR).

"Alcohol and drug dependency are major public health problems that affect Americans from all walks of life and Renée is perfectly suited to develop and implement programs that encourage those in need to seek treatment and get sober," said Governor Schwarzenegger. "Renée's deep-felt passion for providing assistance to persons who suffer from substance abuse will greatly help the Department of Alcohol and Drug Programs achieve their mission."

Zito has served as the director of programs at Marin Services for Women since 2000, where she oversees and manages the staff for the residential and outpatient programs, housing and education services, as well as the admissions department. From 1994 to 1999, Zito was the executive director of the alcohol and drug treatment center, Hazelden New York. Prior to that, she served as director of Treatment at Smithers Alcoholism Rehabilitation Center of the St. Luke's/Roosevelt Hospital Center from 1986 to 1994. Zito previously taught at the New York State Academy of Addiction Studies and served as an adjunct instructor at Hunter College.

"I have dedicated my entire career to helping people overcome their addictions," said Zito. "I am honored by the Governor's appointment and look forward to using my expertise and knowledge in this area to further serve the people of California."

Zito, 64, of San Francisco, earned a Masters degree in social work from Hunter College and a Bachelor of Arts degree from Fordham University. This position requires Senate confirmation and the compensation is $133,732. Zito is a Democrat.

The California Department of Alcohol and Drug Programs will work closely with the newly re-organized Division of Addiction and Recovery Services within CDCR to create a stronger substance abuse treatment network for in-prison and community-based treatment programs to help reduce recidivism rates among the parole population. ADP provides leadership and policy coordination for the planning, development, implementation and evaluation of a comprehensive statewide system of alcohol and other drug prevention, treatment and recovery services. The Department has approximately 326 permanent staff and oversight responsibilities for an average annual budget of more than $600 million. ADP manages and administers both state and federal monies, including the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, a major source of funding. ADP also manages the Drug Medi-Cal benefit program, which has expanded to more than $115 million yearly.

Refurbished TTYs Available for Sale

The Disability Access Project has an opportunity to purchase approximately 100 Ultratec Superprint TDD/TTYs that have been refurbished by the manufacturer and will make them available to you or your contractors for $100 each, plus shipping. These units normally retail new for about $400-$500.

The Ultratec Superprint is a printing telecommunication device for the deaf (TDD) with direct connect, auto-answer, remote message retrieval, keyboard dialing, and memory dialing features. It has an 8k memory with 9 message buffers to save and send messages, and the TDD Announcer, which is a voice that alerts hearing people to text telephone calls. The Superprint stores up to 26 different phone numbers, and stores and sends personal auto- answer messages. This device directly connects to the telephone line and automatically answers calls with the owner's personal message. It can also be used with a telephone handset.

This is a great opportunity to improve accessibility at a reasonably low cost to your programs and services to people who are deaf, hard of hearing or have a speech disability.

The Disability Access Project can provide free assistance and training to install and train staff on TTY use and etiquette.

If interested, or for more information, contact Bob Olson or Lisa Gish at CAARR, Disability Access Project, 916.338.9460 (Voice), 916.473.0836 (TTY) or e-mail bob@caarr.org.

Resources you can use:

Materials available from the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing
To order any of these titles, print and complete the order form available at www.mncddeaf.org or call The Program at 1-800-282-3323V/TTY

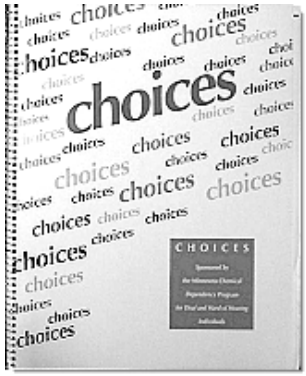
They are also available for loan from the Disability Access Project, 916-338-9460 V or 916-473-0836 TTY and are also available from the Department of Alcohol and Drug Programs Resource Center

Dreams of Denial

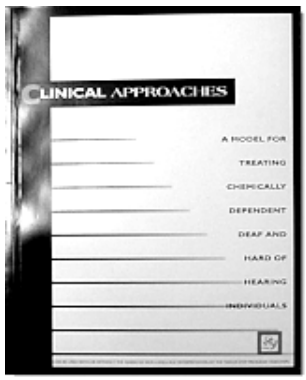
Deaf Actors star in this video developed by the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals. Dreams of Denial covers family issues surrounding substance abuse, relapse, choices, and recovery for the Deaf and Hard of Hearing. An accompanying leader's guide provides curriculum in two formats for use with clients or students. This program is recommended for ages 14 and older. *Signed and Open-Captioned, 23 minutes, VHS, Order Number HIP01 C, $32.95, Leader's Guide included.*

An American Sign Language Interpretation of the Twelve Step Program

This video has twelve segments - each segment is signed and deals with one of the twelve steps of A.A. The video can be used with or without the **"Clinical Approaches"** manual. *Videotape, 55 minutes, Signed and Open-Captioned, Order Number HIP05 C, $24.95.*



Choices
A curriculum developed for educational and treatment settings. The focus of **"Choices"** is on Deaf and Hard of Hearing individuals making appropriate life and recovery choices. This complete educational curriculum includes 17 lesson plan sets covering six major areas including decision-making, risk analysis, and goal setting. **"Choices"** includes facilitator's instructions and masters for handouts as well as overheads. **"Choices"** is recommended for ages 14 and older. *88pp., spiral bound, 8 1/2" X 11", paperback, Order Number HIP02 A, $19.95.*



Clinical Approaches
This manual represents more than five years of work with chemically dependent individuals who are Deaf or Hard of Hearing. The goal of "Clinical Approaches" is to provide a framework to service providers for offering treatment that is sensitive to the communication and cultural needs of Deaf and Hard of Hearing individuals. This manual also reflects a particular sensitivity to client diversity that includes ethnic backgrounds, education, socialization, cultural identity, family history, and mental health status. "Clinical Approaches" is divided into three main sections. Phase I is evaluation. Phase II deals with primary treatment and includes step work, counseling issues, lectures, spirituality groups, family therapy, and other specialty groups. The final section of this manual deals with extended care and aftercare programming. 176 pp., 8 1/2" X 11" paperback, Order No. HIP04 A, $39.95.

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