

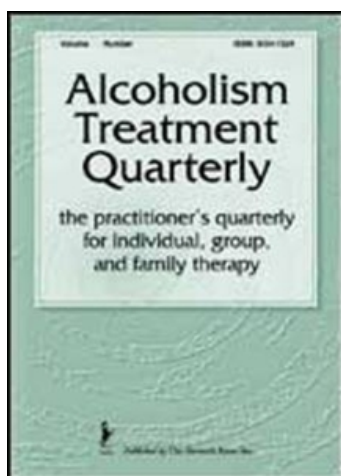
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Rates and Correlates of Alcohol/Other Drug Treatment Denials for People With Disabilities in the United Kingdom

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Previous research with U.S. samples has demonstrated that barriers to physical access directly result in service denials to persons with disabilities (PWDs) seeking substance abuse treatment. To date, however, such findings are limited to samples from the United States and only with regard to persons with physical disabilities. The present research sought to examine such issues in Great Britain and to further the scope of study by assessing the impact of programmatic barriers on the ability of individuals with developmental and sensory disabilities to access care. Results indicate that service denials to PWDs with physical disabilities are common, with 60% to 75% of respondents indicating that they had declined services to PWDs. Programmatic barriers resulted in service declines to persons with developmental disabilities (33%) but not to individuals with sensory disabilities. This research further indicates that physical access barriers result in treatment denials to persons with physical disabilities and that programmatic barriers may result in similar declines to persons of select disability groups.

KEYWORDS *Persons with disabilities, substance abuse treatment, treatment denials, treatment access*

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Persons with disabilities (PWDs) are, as a group, some of the heaviest users of alcohol and illicit drugs, whether compared to the population as a whole or to other subgroups. Available research indicates that PWDs abuse and are addicted to substances at rates that generally far exceed those of persons without disabilities. Persons with psychiatric disabilities have abuse rates ranging from 15% to 40% (Barrowclough et al., 2001; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Triffleman, 1998; Weiss, Najavits, & Mirin, 1998). Individuals with physical disabilities have rates of abuse as high as 50% to 65% (Bombardier, Rimmele, & Zintel, 2002; Corrigan, 1995; Kolakowsky-Hayner et al., 2002; McKinley, Kolakowsky, & Kreutzer, 1999; Radnitz & Tirch, 1995; Taylor, Kreutzer, Demm, & Meade, 2003). Among persons with visual and auditory disabilities, such rates range from 40% to 50% (McCrone, 1994; Nelipovich, Wergin, & Kossick, 1998). The lowest rates of abuse among PWDs appear for those individuals with developmental disabilities, such as mental retardation (MR) and autism, yet their rates of 12% to 14% generally exceed those of the general population (Burgard, Donohue, Azrin, & Teichner, 2000; McGillicuddy, 2006; Westermeyer, Kemp, & Nugent, 1996).

Further, the impact substance abuse has on PWDs in terms of both the number and severity of negative consequences is also notable. PWDs face the same sequelae of health, legal, and social problems as a result of their use as their nondisabled counterparts, as well as a host of unique consequences related to disability. As is the case with all substance abusers, PWDs with addiction concerns experience high rates of cancers, ulcers, and cirrhosis, and are more likely to be the victims of crime and to be unemployed (Burgard et al., 2000; Kolakowsky-Hayner et al., 2002; Moore & Li, 1994). Unique considerations include delays in adjusting to acquired disability, a variety of disability-related health conditions, and increases in the likelihood of acquiring secondary disabilities (Bombardier, 2000; Bombardier & Rimmele, 1998; Burgard et al., 2000; Drubach, Kelly, Winslow, & Flynn, 1993; Hawkins & Heinemann, 1998; Kolakowsky-Hayner et al., 2002; McKinley et al., 1999; Tate, 1993; Taylor et al., 2003; Wilber et al., 2002). In sum, PWDs abuse alcohol and illicit drugs at high rates and experience numerous generic and unique negative consequences as a result of such use. As such, they are a group that could benefit from substance abuse treatment.

Despite such high rates of abuse and the fact that large numbers of PWDs reside in most Western nations, their presence in substance abuse treatment are notably small. Research over the last decade has estimated the presence of PWDs in treatment to be no more than 2% to 10%, substantially less than population and abuse rates would suggest. More than a decade ago, Cherry (1993) examined the rates of PWDs in treatment in California and found that roughly 1.5% of clients currently engaged in services were disabled. More recently, West, Graham, and Cifu (2009a) reported a national examination of the rates of PWDs in treatment in the United States and found that only about 5% of individuals receiving services in 1 year had a disability.

Similar rates have been noted in Canada, where PWD treatment participation has been found to vary from about 5% to 10% (Ogborne & Smart, 1995; Tyas & Rush, 1993). Again, these are rates well below those that would be expected based on the number of PWDs in the respective areas of these investigations and the rates of substance abuse by such groups.

While the underrepresentation of PWDs in substance abuse treatment is likely a multifactorial issue, a growing body of research has developed indicating the presence of physical access barriers to be a likely primary cause. Voss, Cesar, Tymus, and Fiedler (2002) first reported that barriers to PWD access to substance abuse treatment were common, findings that were replicated by West and colleagues in numerous studies in the United States and other nations (West, 2007; West & Graham, in press; West, Graham, & Cifu, 2009b). Collectively these studies demonstrated that from 20% to more than 50% of facilities have numerous physical and programmatic barriers that could inhibit PWD treatment participation. Subsequent investigations directly linked such accessibility concerns to treatment denials for a variety of groups of PWDs. West, Luck, and Capps (2007) found that physical barriers resulted in 61% of treatment providers declining services to individuals with spinal cord injury (SCI) and 44% declining services to individuals with traumatic brain injury (TBI). In sum, 55% of individuals with SCI and 42% of individuals with TBI were unable to acquire substance abuse treatment due to physical inaccessibility. Such results were confirmed in a related study that extended such findings to other groups of PWDs (West, Graham, & Cifu, 2009c). Similar denial rates were made by service providers to individuals with SCI (69%) and TBI (73%), and such barriers to access also prompted providers to decline services to individuals with multiple sclerosis (MS; 91%), muscular dystrophy (MD; 67%), and individuals with other mobility impairments (68%) as well. Such denials resulted in 67% of persons with SCI, 68% of those with TBI, 87% of individuals with MS, 75% of those with MD, and some 65% of those with other mobility impairments being deprived of treatment.

To date, however, the impact of barriers has only been explored in the United States. Although accessibility concerns have been noted in Canada (West & Graham, in press) and the United Kingdom (West et al., 2009a), the impact of such barriers in these other nations is currently unknown. Further, the examinations to date have only been with barriers that are physical in nature. Although a variety of programmatic barriers such as a lack of Braille or other alternate format materials and sign language interpreters have been noted, the impact of such barriers on the ability of PWDs to receive treatment is unknown. We conducted the following research to address these issues in a sample of substance abuse treatment providers in the United Kingdom. The purpose of the research was to determine the impact of barriers on the ability of providers to serve and on the ability of PWDs to obtain substance abuse treatment. Further, we sought to determine the impact not only of physical barriers, but programmatic barriers as well. To that end, we piloted a survey

to a sample of 50 treatment providers in the United Kingdom to determine the impact of both physical and programmatic barriers on the ability of individuals with developmental disabilities, nonparalytic physical disabilities, sensory disabilities including blindness, deafness, and deaf-blindness, SCI, and TBI to receive treatment.

METHODS

The data for this pilot study were collected via a self-report survey sent to a stratified random sample of 50 substance abuse treatment providers in the United Kingdom. Stratification was based on the country level (i.e., England, Northern Ireland, Scotland, and Wales). The sample was chosen from the continually updated list of substance abuse treatment providers maintained online by the independent organization Drugscope, which maintained contact information for some 1,149 at the time of the survey. Surveys were directed to the director of each facility and were mailed using an abbreviated two-step Dillman (1991) method. Specifically, all 50 directors were sent an initial contact letter noting that they were selected to receive the survey, providing a brief outline of the purpose of the research, and informing them that their responses would be anonymous. This was followed at 1 week by a survey packet containing a cover letter detailing the same basic information as the first contact letter, a survey (description below), and a postage-paid return envelope.

A total of 23 completed surveys were received, for an overall return rate of 46%. A comparison of responding and nonresponding facilities on known demographics evidenced no differences based on primary services orientation (i.e., nonmedical residential, hospital based, or outpatient) [$\chi^2(2, N = 50) = 0.21, ns$], or country of location [$\chi^2(2, N = 50) = 0.03, ns$]. As noted in our previous research (West et al., 2009b), the respondents largely reflected nonmedical residential providers (61%), followed by outpatient (35%) and hospital-based treatment services. In the year prior to the survey they collectively provided treatment to some 4,684 clients ($M = 221, SD = 190$) via a combined staff of 252 ($M = 11, SD = 8$) clinicians.

The survey itself was a 55-item device developed from prior research examining substance abuse treatment and disability issues (West, 2007; West & Graham, in press; West, Luck, & Capps, 2007). The purpose of the survey was twofold. In addition to collecting general demographic information about each of the respective facilities, the survey sought information about physical and programmatic barriers to access that could inhibit the ability of PWDs from participating in substance abuse treatment as well as the number of PWDs who sought treatment and who may or may not have been declined services due to the presence of such barriers. Data from those questions regarding barriers have been detailed elsewhere (West et al., 2009b). For the

current study, focus was placed on those questions regarding respondent facility characteristics and rates of PWD treatment seeking and acceptance or denial.

In particular, with regard to facility demographics, we inquired about the primary services orientation of the center (i.e., nonmedical residential, hospital-based, or outpatient) and the number of staff members employed to provide direct clinical care. For PWD treatment rates, we asked about the numbers of individuals with any one of five disabilities (developmental disabilities, nonparalytic physical impairments, sensory disabilities, SCI, and TBD) who sought services from these providers and the numbers who received treatment and those who were denied services due to the inability of the respondents to provide services based solely on the presence of either physical or programmatic barriers to access. Data were to reflect the year prior to the survey. In an effort to ensure that reports were as accurate as possible, all respondents were asked to check for such information in existing case files and other center records and not to rely on memory or the subjective impressions of their staff.

Data Analysis Plan

The data analysis plan involved three components. First, descriptive statistics were used to determine the numbers of various PWDs seeking treatment and the numbers and percentages of such individuals who were declined services based on the physical inaccessibility of the respondent's treatment center. This afforded an examination of treatment denials from the standpoint of the number of potential clients with disabilities thus impacted by barriers to accessibility. Second, descriptive statistics were also used in an analysis of service denials from the perspective of the number of centers declining services regardless of the number of PWDs who sought treatment. Thus we calculated the number and percentage of providers in the sample who were approached by any number of individuals with one of the five disabilities of interest and in total, as well as the number and percentage of those who declined treatment due to accessibility concerns. Finally, we conducted six analysis of variance (ANOVA) tests to determine if denials of service were related to the primary services offered by the respondents. In this analysis, services orientation (i.e., nonmedical residential, hospital-based, or outpatient) was used as the predictor variable. The outcome variables were created by grouping respondents according to their tendency to decline services to PWDs. Respondents were categorized as (1) "always declined," when they self-reported that they had declined services to all PWDs presenting for treatment; (2) "partial decline," when they reportedly declined services to some but not all PWDs; and (3) "never decline," when they indicated that they never refused to provide services due to accessibility concerns. Upon such classification, we conducted the six ANOVAs with services orientation

as the sole predictor variable and the treatment decline categories of each of the five disability groups (developmental disabilities, nonparalytic physical impairments, sensory disabilities, SCI, and TBI) as dependent variables. In each case, the assumption of equal variance was assessed using of Levene's test and was found to be valid. When significant main effects were noted, post hoc examinations using the Bonferroni method to control for Type I error were made to discern potential group differences.

RESULTS

The 23 responding facilities in this pilot study were approached by a total of 96 individuals with one of the five disabilities of interest during the year prior to the survey and provided services to 52. A total of 44 (46%) were denied services due to accessibility concerns. Treatment denial rates varied considerably based on disability type. A total of 44 persons with developmental disabilities sought substance abuse treatment and 31 (71%) of these individuals were denied services due to self-described programmatic barriers to access. Fourteen individuals with nonparalytic physical disabilities sought treatment services and four of these persons (29%) were unable to receive services due to physical access barriers. When considering persons with sensory disabilities, there were no service denials due to accessibility concerns. In total, 24 individuals with sensory disabilities both sought and received services. Some 5 individuals with SCI sought services from these providers and, of these, 3 (60%) were denied treatment. Similar denial rates were evidenced for persons with TBI, where 9 such individuals sought treatment and 6 (67%) were denied services due to inaccessibility. Rates by disability group and for all PWDs by primary service orientation can be found in Table 1.

When viewed from the perspective of the number of treatment providers who declined services due to accessibility issues, similarly high rates were found. Overall denial rates ranged from 0 to 75%. When considering persons with developmental disabilities, 6 providers indicated that they were approached by at least one individual with such an impairment, and of these, 2, or roughly 33%, declined to provide services based on the inaccessibility of their program materials and methods. A total of 6 respondents were also approached for services by individuals with nonparalytic physical disabilities, and of these 4 (67%) declined to provide services due to physical barriers. When considering individuals with sensory impairments, 8 respondents indicated that someone who was blind, deaf, or deaf-blind sought their treatment services. All 8 of the providers indicated that they did, in fact, serve these clients. Four respondents indicated that they were approached for services by an individual with an SCI in the last year. Of these, 3 (75%) were unable to provide services due to physical barriers in their treatment facility. Finally, 5 respondents indicated they were approached by at least one individual

TABLE 1 Overall Treatment Declines by Disability Type and Services Orientation*

Characteristic	Disability Group	<i>n</i> Seeking Services	<i>n</i> Denied Services	% Denied Services
Primary Services Orientation				
Hospital-based	Developmental	0	0	—
	Nonparalytic	0	0	—
	Sensory	0	0	—
	SCI	0	0	—
	TBI	1	0	0
	Total	1	0	0
Nonmedical Residential	Developmental	8	1	13
	Nonparalytic	6	2	33
	Sensory	13	0	0
	SCI	4	3	75
	TBI	7	5	71
	Total	38	11	29
Outpatient	Developmental	36	30	83
	Nonparalytic	8	2	25
	Sensory	11	0	0
	SCI	1	0	0
	TBI	1	1	100
	Total	57	33	58
Total	Developmental	44	31	71
	Nonparalytic	14	4	29
	Sensory	24	0	0
	SCI	5	3	60
	TBI	9	6	67
	Total	96	44	46

*The *ns* in this table represent the number of PWDs within each category.

with a TBI seeking services and, of these, 3 declined services (60%) due to inaccessibility. Rates for all disability groups by affiliation and primary service orientation can be found in Table 2.

Finally, the six ANOVAs that sought to determine if the primary services orientation (nonmedical residential, hospital based, or outpatient) was associated with treatment declines for any of the five disability categories were all nonsignificant. Treatment denials were equally as likely to occur for all PWD groups regardless of the type of service provider from which they sought treatment.

DISCUSSION

Overall, the service denial rates due to accessibility concerns in this U.K. sample were similar to those found in reports with U.S. samples (West et al., 2009a; West et al., 2007). As noted above, when considering those groups for

TABLE 2 Overall Treatment Declines by Provider Characteristics*

Characteristic	Disability Group	<i>n</i> ** Approached	<i>n</i> Declining Services	% Declining Services
Primary Services Orientation				
Hospital-based	Developmental	0	0	—
	Nonparalytic	0	0	—
	Sensory	0	0	—
	SCI	0	0	—
	TBI	1	0	0
	Total	1	0	0
Nonmedical Residential	Developmental	2	1	50
	Nonparalytic	2	2	100
	Sensory	8	0	0
	SCI	3	3	100
	TBI	3	2	67
	Total	18	8	44
Outpatient	Developmental	4	1	25
	Nonparalytic	4	2	50
	Sensory	0	0	—
	SCI	1	0	0
	TBI	1	1	100
	Total	10	4	40
Total	Developmental	6	2	33
	Nonparalytic	6	4	67
	Sensory	8	0	0
	SCI	4	3	75
	TBI	5	3	60
	Total	29	12	41

*The *ns* in this table represent the numbers of respondents who were approached by a PWD but who made any service declines based on physical accessibility concerns.

**Includes respondents who denied some or all individuals within each particular disability category.

whom comparison data are available, treatment denials rates in the United States range from 55% to 67% for persons with SCI and 42% to 68% for persons with TBI. The 60% and 67% rates for SCI and TBI, respectively, for this U.K. sample fall within the same range and are therefore quite comparable. The same is true when considering the number of facilities that denied services. In the United States, between 61% and 69% of centers denied services to persons with SCI due to accessibility concerns, and between 44% and 73% did so for persons with TBI. Although the obtained rate when considering SCI in this U.K. sample was somewhat greater, at 75%, the 60% decline rate when considering TBI was again within the same range as in the United States. Such numbers further indicate that accessibility issues inhibit PWD treatment participation in substantial ways and that such issues are not a problem limited to the United States.

Whereas studies in the United States have focused solely on physical disabilities, the current work expanded the focus to include persons with developmental and sensory disabilities as well. The inclusion of these two groups provides additional insights into accessibility issues, as the potential barriers were not limited to physical features, but programmatic components as well. Based on studies noting that programmatic features of treatment programs are as prone to barriers as their physical spaces (West & Graham, in press; West et al., 2009b), we anticipated that both groups would demonstrate denial rates similar to those of groups of persons with physical disabilities. Surprisingly, this was not the case for those individuals with sensory disabilities. Some 71% of persons with developmental disabilities experienced service declines, with one-third of treatment providers making such declines. Although the number of providers declining services was somewhat small, the percentage of individuals receiving a service decline was similar for persons with SCI, TBI, multiple sclerosis (MS), and muscular dystrophy (MD), as noted in other research (West et al., 2007; West et al., 2009c). However, there were no service exclusions for persons with sensory disabilities. This was unexpected given the high rates of programmatic accessibility concerns in the United Kingdom (West et al., 2009b) in terms of the availability of large format and Braille documents and sign language-capable staff. The respondents most likely found alternate means of accommodating these clients. The ability to make such accommodations for persons with developmental disabilities was apparently not as readily achieved. The small sample of this pilot investigation prevented the exploration of the intersecting effects of presence and types of barriers and their overall impact on service denials. Future research is needed to both identify barriers and note their precise impact on client access to care.

Although it is encouraging that the respondents of the current study indicated that they readily accepted all potential clients with sensory disabilities, the rates of service denials to the other disability groups represented in this research are as great as those in previous research and should be viewed as serious detriments to public health. When viewed from the standpoint of individual treatment facilities, the rate of declines due to accessibility concerns ranged from a low of 29% (for clients with nonparalytic physical disabilities) to a high of 71% (for clients with developmental disabilities). Alternately, when viewed from the perspective of the number of clients who were declined services due to accessibility concerns, the number of declines was even more notable, although again the exception of persons with sensory disabilities should be noted. When considering clients with developmental disabilities, paraplegia and quadriplegia, and nonparalytic physical impairments, the percentage of treatment declines ranged from a low of 33% (for persons with developmental disabilities) to a high of 75% (for persons with SCI). Obviously, aside from consideration of sensory disabilities, these are sizable denial rates and cause for concern. Having from

one-third to three-quarters of facilities self-determine that their programs or facilities are inaccessible to various groups of PWDs is unacceptable. Likewise, denial rates of slightly less than 33% to more than 70% must be quite disheartening to PWDs seeking freedom from substance abuse. Given the necessary nexus of an individual's desire to attempt treatment and the availability of services at any given time, critical opportunities for intervention are doubtless being lost.

As a small-scale pilot study, this effort is not without its limitations. The small sample size limits the generalizations that can be made, and the findings may not represent the whole of addiction treatment providers in the United Kingdom. The fact that denial rates for this group are similar to those of studies conducted in the United States somewhat assuages these concerns, but, as this is the first examination of such issues in the United Kingdom, concerns over the representative nature of these findings are founded. Future research with larger samples is needed to overcome this limitation. The self-report nature of this research also draws doubt on the conclusions. It is unlikely that the respondents kept complete information on the disability status of all applicants, so the data here are, at best, an estimate, despite our attempts to obtain completely accurate data. It is possible that respondents did not wish to note the full extent of their service denials. However, such an implication would suggest that denial rates are more dramatic than these findings indicate. An examination of service attempts and related denials in a sample of PWDs would aid in overcoming such limitations and would help to validate these findings.

Even in light of such limitations, this research further indicates the impact accessibility has on PWD treatment participation and demonstrates that such issues are an international concern. Although largely limited to data from small-scale studies, mounting evidence from the United Kingdom and the United States indicates that such denials are common and evidenced for persons with a variety of impairments. Further, such denials are not limited to those associated with physical accessibility concerns; groups of PWDs such as those persons with developmental disabilities are also being denied services due to programmatic barriers.

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