

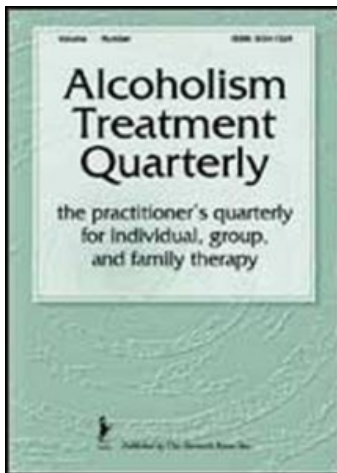
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Physical and Programmatic Accessibility of British Alcohol/Other Drug Treatment Centers

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Recent research from Canada and the United States has found that physical and programmatic access barriers are common in substance abuse treatment facilities and that such barriers directly lead to service denials to select groups of persons with disabilities (PWDs). This pilot study sought to examine such issues in a sample of substance abuse treatment providers in Great Britain. Barriers to both physical and programmatic access were common and were found at rates that generally exceeded those of earlier Canadian and U.S. studies. The vast majority of centers failed to have staff capable of using sign language, nor did they have written materials in Braille or alternate formats for persons with varying cognitive ability. Likewise, physical accessibility was lacking, with most failing to have accessible restrooms and bathing facilities and large numbers did not have accessible entrances and parking. Such extensive barriers to access could effectively prohibit the ability of select PWDs from entering treatment.

KEYWORDS *Persons with disabilities, treatment access, treatment denials, physical accessibility, programmatic accessibility*

Substance use and abuse by persons with disabilities (PWDs) is a significant public health issue. Large percentages of PWDs have addictions concerns,

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face numerous and substantial negative consequences as a result, and are represented in treatment populations in disturbingly low proportions. For example, rates of substance abuse among persons with traumatically acquired physical disabilities have been reported to be as high as 50% to 60% (Kolakowsky-Hayner et al., 2002; McKinley, Kolakowsky, & Kreutzer, 1999; Radnitz & Tirch, 1995; Taylor, Kreutzer, Demm, & Meade, 2003). Rates among persons with persistent mental illness vary by diagnosis, yet are commonly several times that of the general population. Some 20% to 40% of persons with schizophrenia (Barrowclough et al., 2001; Mueser, Bellack, & Blanchard, 1992; Smith & Hucker, 1994), 40% to 60% of those with antisocial personality disorder (Regier et al., 1990), up to 25% of persons with depression (Regier et al., 1990; Weiss, Najavits, & Mirin, 1998), and some 40% of persons with posttraumatic stress disorder (Kessler et al., 1995; Triffleman, 1998) have been found to abuse alcohol and other drugs. Among persons with sensory disabilities, rates of abuse near 50% are common (McCrone, 1994; Nelipovich, Wergin, & Kossick, 1998). Only among persons with developmental disabilities are rates commonly reported below 25%. However, the reported proportions of 12% or more among persons with Autism Spectrum Disorders and mental retardation are nonetheless well above the average for the population as a whole (Burgard, Donohue, Azrin, & Teichner, 2000; McGillicuddy, 2006; Westermeyer, Kemp, & Nugent, 1996).

Obviously, a population with such high rates of addictions is also noteworthy for the use-related negative consequences they incur. For PWDs, the range of such consequences includes those outcomes common to other substance abusers, such as cirrhosis, cancers, and pulmonary disease (Burgard et al., 2000; Corrigan, 1995; Hibbard, Uysal, Kepler, Bogdany, & Silver, 1998; Kolakowsky-Hayner et al., 2002; McKinley et al., 1999). But PWDs also face a number of critical negative consequences as a result of their substance abuse that are largely unique and directly related to their disability status. For example, PWDs who abuse substances are at increased risk for injuries resulting in secondary disability, are less likely to adjust to acquired disability, and are more likely to be unemployed (Drebing et al., 2002; Drubach, Kelly, Winslow, & Flynn, 1993; McKinley et al., 1999; Taylor et al., 2003; Wilber et al., 2002). The likelihood of a number of disability-specific medical problems are also increased among PWDs who abuse substances, including pressure ulcers, urinary tract infections, and seizures (Bombardier, 2000; Bombardier & Rimmel, 1998; Burgard et al., 2000; Hawkins & Heinemann, 1998; Wilber et al., 2002).

As in many Western nations, the number of PWDs in Great Britain is substantial, with recent reports placing the figure at about 12 million persons, or some 22% of the total population (Disability Rights Commission, 2004). Given such numbers and the substantial rates of addiction concerns among PWDs, one might therefore expect the number of PWDs in treatment in the

United Kingdom to be substantial. However, a growing body of research in other nations has found that, with little exception, this is not the case. Although the rate of PWD treatment participation has increased somewhat in the last decade, overall involvement in addiction services is significantly less than would be expected. For example, in the United States, studies have placed the percentage of PWDs in treatment at between 1.5% and 5%, with the majority of these representing only those persons with psychiatric impairments (Cherry, 1993; West, Graham, & Cifu, 2009a). A number of studies in Canada have reported slightly higher rates, from 5% to 10%, but such proportions are not in line with what one would expect based on population estimates and rates of substance abuse (Ogborne & Smart, 1995; Tyas & Rush, 1993; West, Graham, & Cifu, 2009b). To date, no systematic examinations of the presence of PWDs in substance abuse treatment in Great Britain have been undertaken, so comparisons with the United States and Canada cannot be made.

Although a number of possible reasons for such low representation have been explored, mounting evidence suggests that barriers to accessibility could be the most important factor. In a seminal study of treatment center accessibility for persons with spinal cord injury (SCI), Voss, Cesar, Tymus, and Fiedler (2002) found numerous barriers that could effectively bar individuals with SCI and related disabilities from accessing care. For example, 87% of examined facilities had inaccessible restrooms, most had inaccessible interior spaces, and slightly less than half did not have accessible parking. They also found that service providers routinely overestimated the accessibility of their facilities and concluded that most were so plagued by barriers as to be effectively inaccessible to persons with SCI.

West (2007) followed this work with an assessment of accessibility in a national sample of substance abuse treatment providers. Using a self-report survey, respondents were queried not only about the physical accessibility of their facilities, but also about the programmatic accessibility of their services. As was the case in those facilities examined by Voss et al. (2002), substantial numbers of barriers to physical access were found. Some 20% of respondents indicated that they did not have accessible restrooms, about 25% did not have accessible entrances, and 26% of residential centers did not have accessible bathing facilities. Further, programmatic barriers that could inhibit PWD participation were even more common. For example, the majority did not maintain (85%) nor could they produce (95%) materials in Braille or large format, and most (87%) did not have staff capable of using sign language. In a follow-up investigation, West and Graham (in press) extended such findings to treatment centers in Canada, where similar problems with regard to both physical and programmatic accessibility were evidenced. There, inaccessible features, including a lack of accessible parking (21%), curb cuts (44%), restrooms (30%), and elevators for those

in multistoried structures (52%), were common. Programmatic barriers were also noted, including a lack of staff capable of using sign language (81%), a lack of written materials in Braille or alternate formats for use by the visually impaired (98%), and an inability to produce materials in such formats (98%).

Collectively, these studies indicate that programmatic and physical barriers are so common in substance abuse treatment centers as to effectively prohibit access to many PWDs. To date, however, no examination of the accessibility of substance abuse treatment centers in Great Britain has appeared. Therefore it is unknown if the accessibility issues found in the United States and Canada are truly international concerns or merely a reflection of the state of affairs in North America. Because research has demonstrated that for many groups of PWDs inaccessibility directly equates to service denials (West, Graham, & Cifu, 2009d; West, Luck, & Capps, 2007), it is therefore critically important to understand the rates and types of barriers found in British substance abuse treatment facilities. The current research was undertaken to provide just such an examination of physical and programmatic accessibility via a pilot study of a random sample of substance abuse treatment providers from across the United Kingdom.

METHOD

The data for this pilot study were collected via a self-report survey sent to the directors of a stratified random sample of 50 substance abuse treatment agencies from across the United Kingdom, with stratification done by country (i.e., England, Northern Ireland, Scotland, and Wales). The facilities were chosen from the list of such facilities currently maintained by Drugscope. Drugscope is an independent provider of information on substance abuse prevention, intervention, and treatment options available across the United Kingdom and is available via an online and continuously updated Web page. At the time of this survey, the Drugscope searchable database maintained contact information for 1,149 treatment providers.

The survey was implemented using an abbreviated Dillman (1991) method, consisting of two steps. First, each of the 50 locations was sent an initial contact letter that outlined the purpose of the work and alerted them to the forthcoming survey. The letter noted that all responses were voluntary and anonymous. This was followed at 1 week by a survey packet with a postage-paid return envelope. The survey packet contained a cover letter providing essentially the same information as the initial contact letter, the survey (detailed below), and a postage-paid return envelope. Using these methods, a total of 23 completed surveys were obtained, for an overall response rate of 46%. Responders and nonresponders did not differ by primary services orientation (i.e., nonmedical residential, hospital based, or

outpatient) [χ^2 (2, $N = 50$) = 0.21, *ns*] or country of location [χ^2 (2, $N = 50$) = 0.03, *ns*].

The survey was a 55-item self-report device based on prior surveys on similar topics in the United States and Canada (West, 2007; West & Graham, in press; West et al., 2007). The survey requested information about (a) general aspects of the respondent's practice and the clients they served in the 12 months prior to the survey, (b) the physical accessibility of their treatment facility, and (c) programmatic accessibility of their services. Questions were also posed as to the number of PWDs who sought but who were declined services based on accessibility concerns. These questions were analyzed separately and are reported elsewhere (West, Graham, & Cifu, 2009c).

Specifically, with regard to the practice itself, the survey asked about the primary service offered at the facility (i.e., nonmedical residential, hospital based, or outpatient), the number of clinicians working at the center, the total number of clients served in the 12 months prior to the survey, as well as the numbers of clients with developmental disabilities, nonparalytic mobility impairments, sensory disabilities, SCI, and traumatic brain injury (TBI). Seventeen questions were posed with regard to physical accessibility. These included questions about accessible parking spaces, entrances, doors, elevators, fire alarms, toilets, and bathing facilities. Questions were asked as appropriate to each particular respondent. For example, only those respondents located in multistoried buildings were asked about elevators and, in turn, only those reporting an elevator were asked if their lifts were equipped with auditory door/floor alerts. Finally, five questions were asked that addressed programmatic accessibility. These included questions about the ability to make materials in Braille or large format for use by persons with visual impairments, the availability of materials in such formats, the availability of written materials in alternate formats for those with different levels of cognitive ability, the number of staff capable of using signed English or British Sign Language (BSL), and the availability of a TDD/TTY to allow telephone contact with persons with hearing impairments.

To facilitate accuracy, respondents were requested to not rely on their impressions, but to actually inspect, measure, and count features of interest. For example, respondents were instructed to inspect their elevators to see if they were equipped with auditory door/floor alerts to aid persons with visual impairments rather than merely depending on their impressions or recollections. To further help reduce reporting error, specific details and examples were provided for all questions, including, for example, descriptions of the correct placement of handrails in toilet stalls. Descriptive statistics were then used to provide details of the respective availability of programmatic features as well as for those features pertaining to physical access.

RESULTS

Respondent Characteristics

Respondents were located in each of the four countries comprising the United Kingdom, with 15 in England, 1 in Northern Ireland, 6 in Scotland, and 1 in Wales. As noted above, there was no difference between responders and nonresponders with regard to location. The majority of respondents ($n = 14$, 61%) were nonmedical residential providers, followed by outpatient clinics ($n = 8$, 35%) and hospitals ($n = 1$, 4%). Together, these 23 facilities employed a total of 252 clinical staff members ($M = 11$, $SD = 8$) who collectively served a total of 4,684 clients ($M = 221$, $SD = 190$) in the year prior to the survey. Included in this total were 52 PWDs ($M = 2.26$, $SD = 3.49$) representing five broad disability groups (developmental disabilities, nonparalytic physical impairments, sensory disabilities, SCI, and TBI). Total overall PWD participation was therefore about 1.1%.

Programmatic Accessibility

When considering programmatic accessibility, 14 (61%) of the responding facilities had no one on staff who was capable of using signed English or BSL, 8 facilities (35%) had 1 person capable of using BSL, and 1 facility (4%) had a total of 10 staff members who were BSL capable. When considered in terms of the number of overall staff who were BSL capable, 18 of 252 individuals, or some 7%, were able to communicate using BSL. The majority ($n = 19$; 87%) of respondents indicated that they neither had materials in Braille or large print, nor were they capable of producing documents in such formats ($n = 21$; 91%). None of the respondents indicated that they maintained materials in alternate formats for use by persons with varying degrees of cognitive ability such as persons with developmental disabilities or those having had a TBI. Likewise, the majority ($n = 19$; 87%) did not have a TDD/TTY.

Physical Accessibility

Barriers to physical access in these 23 treatment centers were also common. Twenty of the respondents indicated that their facility had on-site parking for client use. However, the majority of these ($n = 16$; 76%) reported that they did not have any accessible parking spaces. Of those facilities with stairs at their entrances ($n = 15$; 65%), 40% ($n = 6$) did not have a ramp or lift to allow persons with mobility impairments to easily access the building. Most ($n = 19$; 83%) failed to have automatic or power-assisted doors to provide ease of access. The majority reported that they did not have fire alarms with visual as well as auditory alerts ($n = 15$; 65%). When considering those

programs located in multistoried buildings ($n = 19$), most ($n = 11$; 58%) did not have an elevator to allow access to higher floors. Among those facilities with elevators ($n = 8$), more than one-third did not have lifts with both visual and auditory door/floor alerts ($n = 3$; 38%). A total of 15 (65%) respondents indicated that they provided transportation for clients either as a means of getting to treatment or as a part of services (e.g., for trips to other service providers or for day-trip recreation activities); of these, 13 (87%) indicated that their transportation was inaccessible to persons using wheelchairs. The majority of respondents also indicated that they did not have accessible restrooms for client use ($n = 13$; 57%). When considering those respondents providing some form of residential care ($n = 13$; 57%), the overwhelming majority did not have accessible baths or showers ($n = 11$; 79%).

DISCUSSION

The purpose of this exploratory research was to determine if accessibility issues that have been shown to exist in other nations were present in substance abuse treatment facilities in the United Kingdom as well. Although limited by its small sample, the current research indicates a similar state of affairs with regard to substance abuse treatment center accessibility in the United Kingdom as in the United States and Canada (West, 2007; West & Graham, in press). Namely, barriers that could potentially limit the ability of PWDs to access treatment were extremely common in this sample. And as was the case in Canada and the United States, these barriers were both of a physical and a programmatic nature. Although the facilities in this initial pilot sample appear to have barriers to access at rates somewhat greater than their transatlantic counterparts, for the most part such barriers were about as prevalent as those reported in earlier investigations. Notable differences between these U.K. facilities and treatment providers in the United States and Canada, however, are evidenced with regard to physical accessibility. Whereas such features as inaccessible parking (20% to 21%), entrances (25% to 36%), and restrooms (20% to 30%) were found at rates of about one-third or less in the United States and Canada, these same elements were found to be inaccessible in considerably greater proportions in the United Kingdom (70%, 40%, and 57%, respectively).

Other aspects of physical accessibility were also notably higher in this U.K. sample than in those earlier studies. Noteworthy among these is the rate of residential centers self-reporting a lack of accessible bathing facilities. More than three-quarters of those respondents providing residential care indicated that they had no accessible bathing options for PWDs. One might surmise that this alone would result in many service denials. Although not considerably different than centers in the United States and Canada, the

rates of programmatic inaccessibility were also substantial. As a result, the impact of such barriers on overall treatment access could be great. Although accommodations could be made to overcome the barriers associated with a lack of Braille and large print materials or a lack of providers trained in sign language, it is difficult to imagine a readily available alternative to materials written at different levels of comprehension for individuals of varying cognitive ability.

A major limitation of this research is its reliance on self-report data. Although efforts were undertaken to aid in reliability, there was no way to ensure that the information obtained was accurate. Further, it is possible that respondents downplayed the number of barriers at their respective locations or, conversely, inflated their interpretations of accessibility as the result of social desirability. If this is the case, the rates of inaccessibility are likely greater than these results would suggest. The possibility of either errors in reporting or the influence of social desirability both reflect the need for future research that collects data via on-site evaluation by individuals trained in accessibility standards. This research is also limited by the small sample such a pilot study affords. To determine if these results are indeed indicative of the treatment community as a whole in Britain, large-scale efforts will need to be made. However, the concordance of these findings with previous research suggests that they are at least relatively accurate.

Even in light of these limitations, this research further demonstrates that accessibility issues are common in substance abuse treatment facilities and advances the need for the field as a whole to systematically address such concerns. Indeed, as research has indicated accessibility to be a problem in other health care settings as well (Bancroft, Lightstone, Simon, Crews, & Baraban, 2006), such issues should be viewed as a common problem needing broad-based attention from the greater public health community. But it is unlikely that accessibility is the lone factor facilitating low PWD treatment participation rates. Additional research is needed to clarify the range of possible factors at play in this undoubtedly complex phenomenon. As the preponderance of research to date has been from the perspective of treatment providers, studies of such issues from the perspective of PWDs is warranted if not overdue. Qualitative studies with groups of PWDs who have addiction concerns as well as those who are in recovery could shed additional light on this issue.

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