This article was downloaded by: [Rick Csiernik] On: 11 May 2013, At: 05:57 Publisher: Routledge Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Journal of Social Work Practice in the Addictions

Publication details, including instructions for authors and subscription information: <u>http://www.tandfonline.com/loi/wswp20</u>

Examining the Intersection of Addiction and Issues of Ability in Canada

Rick Csiernik MSW PhD^a & Melissa Brideau BSW^b ^a School of Social Work, Kings University College at Western University, London, Ontario, Canada ^b Social Worker and Advocate, London Employment Help Centre, London, Ontario, Canada Published online: 10 May 2013.

To cite this article: Rick Csiernik MSW PhD & Melissa Brideau BSW (2013): Examining the Intersection of Addiction and Issues of Ability in Canada, Journal of Social Work Practice in the Addictions, 13:2, 163-178

To link to this article: <u>http://dx.doi.org/10.1080/1533256X.2013.783368</u>

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: <u>http://www.tandfonline.com/page/terms-and-conditions</u>

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae, and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand, or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.



Examining the Intersection of Addiction and Issues of Ability in Canada

RICK CSIERNIK, MSW, PHD

Professor, School of Social Work, Kings University College at Western University, London, Ontario, Canada

MELISSA BRIDEAU, BSW

Social Worker and Advocate, London Employment Help Centre, London, Ontario, Canada

Nearly 2 million Canadians report some form of ability issue. Levels of addiction among these individuals are upward of 60% greater than within the general Canadian population, yet they have significantly lower rates of treatment participation. Lower rates of treatment are due to a variety of reasons, including physical, attitudinal, and programming barriers that are often insurmountable for individuals living with disabilities who wish to access substance abuse treatment. Three areas of ability issues that overlap with addiction are examined in detail—traumatic injury, including brain and spinal cord injury; sensory disabilities that include those living with visual and hearing limitations; and mobility impairments—to highlight gaps in the current treatment continuum in Canada.

KEYWORDS addiction, Canada, disability, mobility impairments, sensory limitations, traumatic injury, treatment barriers

Over the past decade, two intersecting topics have gained increased attention in the social work profession: addiction issues, whereby professionals have advocated that substance use is a multifaceted process, not only affected by physical and psychological factors but also by environmental and societal factors (Csiernik, 2011; Csiernik & Rowe, 2010), and ability issues (Smart

Received May 20, 2012; revised August 9, 2012; accepted September 10, 2012.

Address correspondence to Rick Csiernik, School of Social Work, Kings University College, 266 Epworth Avenue, London, Ontario N6A 2M3, Canada. E-mail: rcsierni@uwo.ca

& Smart, 2007; West, Graham, & Cifu, 2009a, 2009b, 2009c, 2009d, 2009e). Currently, an increasing number of social work professionals are helping to change perceptions about the experience of living with an ability issue and contributing to efforts to reduce the isolation and oppression of those living with disabilities by providing professional education and awareness regarding the many barriers they contend with on a daily basis (Barnes & Mercer, 2010; Priestley, 2001).

Recent legislative changes in Canada, such as the Accessibility for Ontarians with Disabilities Act (2011), have been designed with the goal of eliminating barriers commonly experienced by many individuals in the areas of physical accessibility, mobility, customer service, transportation, and employment, as well as information and communication (Ontario Ministry of Community & Social Services, 2011). In addition, research such as the Participation and Activity Limitations Survey developed by Statistics Canada (2006), which had a specific focus on issues of mobility, has provided data on the number of Canadians living with a wide range of disabilities. These studies indicate that the rates of disclosed disability have increased across all provinces with nearly 2 million (6.1%) Canadians reporting some form of ability issue. However, despite the notable progress that has been made in both the disability and addiction fields, there remain significant gaps in both research and in the treatment continuum in instances where the two intersect. Between 1990 and 2011, only 40 peer-reviewed articles were found in the literature pertaining to the intersection of addiction and disability. The purpose of this article is to examine the intersection of addiction with issues of ability in Canada focusing specifically on brain and spinal injury sensory disabilities and mobility impairments.

In conducting this examination of the literature, we found very disparate information pertaining to different types of ability issues. This was very much influenced by which disciplines had taken a leadership role in investigating the intersection of substance use and disability. In the area of traumatic injury, which begins this article, the influence of emergency and rehabilitative medicine is evident in the quantitative focus on initiation and maintenance of substance use behavior. In contrast, the middle section on sensory disability and the final section on mobility impairment are more descriptive, examining issues of discrimination and barriers or access to treatment, reflecting the influence of counseling professionals in this area of inquiry.

BRAIN AND SPINAL INJURY AND SUBSTANCE USE

Traumatic injury in the rehabilitation literature is an umbrella term used to describe a number of disabling conditions that are acquired as a result of an accident or disease (Bombardier & Turner, 2010). Although there are various forms of traumatic injury, the most prominent are those pertaining to brain

and spinal cord injuries. The Ontario Brain Injury Association (2011) stated that there are currently 1.3 million (4.0%) Canadians living with the effects of an acquired brain injury, and it is estimated that within the province of Ontario alone, more than 18,000 individuals will suffer from a brain injury in a year. The Canadian Paraplegic Association (2011) reported that there are more than 86,000 (0.3%) Canadians living with spinal cord injuries, with approximately 4,300 new cases reported each year.

Survivors of brain and spinal cord injuries experience a number of challenges related to not only the physical effects of the injury, but also the impact on their psychological, social, and emotional levels of functioning (Bombardier & Turner, 2010; Kreutzer, Witol, & Marwitz, 1996; Smedema & Ebener, 2010). Along with this are the attitudinal responses that individuals are at fault for these forms of injury because of their actions, and thus are not deserving of the costly rehabilitative services and required home and workplace modifications (Boros, 1989). In response, some research indicates that many individuals use alcohol or drugs to reduce the feelings of anxiety, stress, anger, and isolation that are often associated with sustaining such injuries, even if they were not regular users prior to the incident (Elliott, Kurylo, Chen, & Hicken, 2002; Saunders & Krause, 2011; Smedema & Ebener, 2010), whereas other research suggests that more than half of traumatic injury survivors had traumatic issues related to their substance use and abuse (Smedema & Ebner, 2010; West et al., 2009d). The literature focuses on three areas of intersection between traumatic injury and substances: preinjury substance use, substance use at the time of injury, and postinjury substance use. Each area has a multitude of implications that rehabilitation professionals must take into consideration to assist those contending with the effects of brain and spinal cord injury and coexisting substance use issues.

Preinjury Substance Use

Research into preinjury substance abuse among those with brain and spinal cord injury remains limited, yet it has become evident that the rate of preinjury substance use experienced by both of these groups is alarmingly high. The first substantive cross-sectional examination (Schiller, Lucas, Ward, & Peregoy, 2012) of preinjury substance use among individuals admitted to a Level 1 trauma center who had experienced a traumatic brain injury (TBI) or spinal cord injury (SCI) found a greater regular use of alcohol than among the general population (51%), with 81% of those with TBI and 93% with SCI reporting regular use of alcohol prior to their injury. The General Health and History Questionnaire, including descriptive information pertaining to alcohol and drug use, was completed by patients, family members, or both during the patient's rehabilitation stay. Forty-two percent of patients with TBI and 57% of those with SCI were classified as heavy drinkers (five or more standard drinks in a day for a man and four or more standard drinks in a day

for a woman), substantively greater than the general population level of just under 20%. Abstinence in the year before injury was reported by only 19% of those living with TBI and only 4% of those with SCI. Illicit drug use was reported by 30% of the participants with TBI and approximately one third of participants with SCI (Kolakowsky-Hayner et al., 1999).

Bombardier, Rimmele, and Zintel (2002) assessed the alcohol and drug use patterns of 142 patients with TBI at an inpatient rehabilitation program by examining alcohol and drug use and dependency, lifetime alcohol-related problems, readiness to change, preferred change strategies, blood alcohol levels, and toxicology tests, as well as what the authors termed "attributions regarding the cause of injury," whereby subjects were asked to rate the extent to which they felt alcohol or drug use contributed to the cause of their injury. Results revealed that 59% of participants met the criteria for at-risk drinkers, and 34% reported preinjury illicit drug use.

Additional research also suggests that preinjury substance use might be associated with poorer outcomes for those living with brain and spinal cord injury. For example, individuals living with TBI who have a history of alcohol abuse might be at an increased risk of experiencing emotional and behavioral problems as well as suffering a recurrent brain injury (Bombardier & Turner, 2010; Kolakowsky-Hayner et al., 1999). Similarly, individuals living with SCIs who abused alcohol prior to their injury have been shown to have higher rates of depression and suicide (Bombardier & Turner, 2010). Thus, by obtaining information related to preinjury substance use, rehabilitation professionals might be better equipped to help individuals achieve optimal recovery.

Substance Use at the Time of the Injury

Although several studies have documented the rates of pre- and postinjury substance use among those living with TBI and SCI, fewer studies have examined the prevalence of substance use at the time of injury for this population. It has been estimated that as many as 36% to 51% of TBIs occurred while individuals were intoxicated (Ponsford, Whelan-Goodinson, & Bahar-Fuchs, 2007). Kreutzer, Witol, and Marwitz (1996) found that of 51 patients with TBI, 32 (57.1%) had positive blood alcohol levels on admission to hospital, with half of them meeting the criteria for intoxication.

Similar to the findings on TBI, studies between 1981 and 1995 on individuals with SCI found them to have high rates of substance use at the time of injury, with estimates of alcohol or drug intoxication ranging from 17% to 62%. The higher rates of substance use have been found in the more recent of these studies, most likely due to more physicians looking at the use of psychoactive drugs as part of their postaccident assessment (Kolakowsky-Hayner et al., 1999; Tate, Forchheimer, Krause, Meade, & Bombardier, 2004). However, due to the limited literature in this area, it is difficult to discern

whether or not substance use at the time of injury affects postinjury outcome. Whereas some studies reveal that there is a correlation between substance use at the time of injury and poorer recovery outcomes, others have found no significant relationship between these two variables (Corrigan, 1995). Thus, additional research is required to ascertain the relationship between intoxication at the time of injury and postinjury outcomes.

Postinjury Substance Use

Studies examining postinjury substance use of those living with TBI and SCI demonstrate that a number of individuals are contending with serious substance abuse issues (Bombardier & Turner, 2010; Elliott et al., 2002; Kolakowsky-Hayner et al., 1999; Kolakowsky-Hayner et al., 2002; Ponsford et al., 2007; Taylor, Kreutzer, Demm, & Meade, 2003). Kolakowsky-Havner et al. (2002), in a cross-sectional study, compared the postinjury substance use patterns among 30 individuals living with SCI with 30 individuals with TBI. The majority of those who consumed alcohol postinjury were either moderate (up to one drink per day for women and two drinks per day for men) or heavy drinkers. Moderate drinkers with a SCI reported drinking on average once or twice per week (23.3%), and those contending with the effects of TBI reported drinking two to three times per month (33.3%). In contrast, heavy drinkers living with SCI were more likely to report drinking on a daily basis (16.7%), and individuals with TBI reported drinking three to four times per week (10%). Thus, the ongoing use of alcohol postinjury is a critical factor to be cognizant of when engaging the client in rehabilitation, both physical and psychosocial.

In addition, several studies documenting postinjury substance use indicate that although substance use does decline in the first year following injury, 2- and 3-year follow-ups show that substance use often returned to preinjury rates (Bombardier, Temkin, Machamer, & Dikmen, 2003; Kolakowsky-Hayner et al., 1999; Ponsford et al., 2007; Tate et al., 2004). Of further concern is that postinjury recovery can be significantly impacted by the use of psychoactive substances, including the risk of reinjury, seizures, increased frustration and aggressiveness, decreased life satisfaction, and an increased risk for depression and suicide (Bombardier & Turner, 2010; DeLambo, Chandras, Homa, & Chandras, 2009; Kolakowsky-Hayner et al., 2002; Smedema & Ebener, 2010).

In addition, using drugs after a TBI can greatly exacerbate the effects of such injuries, as individuals might experience a number of other challenges in relation to their coping and problem-solving abilities and social skills. Common side effects of TBI, such as deficits in memory, fatigue, and height-ened sensitivity to stimulation, can intensify with the use of substances and impede rehabilitation efforts (DeLambo et al., 2009). Thus, although rehabilitation professionals typically have little education and training with regard to

addiction issues, these professionals have a unique opportunity and responsibility to offer assistance to those with coexisting substance use issues.

SENSORY DISABILITIES

Individuals Living With Low Vision or Blindness

According to the Statistics Canada (2006) Participation and Activity Limitation Survey, there are more than 600,000 (1.9%) Canadians living with a visual impairment. Visual impairment can be thought of on a continuum ranging from modest low vision to total blindness (Jutai et al., 2005). Although there has been increased awareness regarding the specific needs of this population, research suggests that average substance use within this group is greater than in the general population (Koch, Nelipovich, & Sneed, 2002; Koch, Shearer, & Nelipovich, 2004; Nelipovich, Wergin, & Kossick, 1998).

Professionals have long recognized the negative effects of stereotyping and discrimination on the lives of those with visual impairments. However, professionals in both the disability and addiction fields need to understand that those who are visually challenged might experience various psychosocial effects. These could be directly related to one's substance use or occur as a result of the negative public and professional attitudes toward those individuals who are visually challenged and experiencing issues with substance use. This includes viewing the individual as incapable, incompetent, and lacking intelligence because of the disability (Room, 2005). Individuals contending with such issues face additional stigma that can increase their resistance to working with helping professionals. Some might be hesitant to disclose substance use, as by doing so they might make themselves ineligible for needed services (Koch et al., 2002; Koch et al., 2004).

Individuals living with the effects of low vision or blindness and a coexisting substance use have never fit into any specialized service delivery system. Professionals from both the disability and addiction fields are typically unable to provide comprehensive services because they have not been educated or prepared to deal with these co-occurring conditions. The lack of formal education and cross-training of professionals thus becomes another barrier for clients who face both a visual challenge and a substance abuse issue. Such compartmentalized thinking further defines a person in terms of his or her disability, rather than as an individual with interrelated and integrated abilities and disabilities (Koch et al., 2002; Koch et al., 2004).

Individuals with visual impairments experience a multitude of barriers when trying to obtain appropriate supports from substance abuse treatment programs. Too often treatment programs have policies and procedures that neglect to take into account the unique needs of those with visual impairments with the "one size fits all" approach. For example, substance abuse treatment programs typically provide participants with educational materials or written exercises designed to increase one's understanding of the nature of substance use. For those with visual challenges, however, this approach presents a significant barrier, as this information is rarely provided in alternate formats, such as an audio version, Braille, large print, or via a computer using assistive technologies (Koch et al., 2002; Koch et al., 2004). Such barriers impede an individual's therapeutic process because the client might not get the opportunity to participate in crucial components of substance abuse treatment. In addition, the common, empirically supported (Flores, 1983; Loughran, 2009) use of group therapy can create problems for those with visual impairments, as some find it difficult to track the flow of conversation and miss out on many of the visual cues that are an integral part of the group therapy process (Sales, 2000). Further, treatment agency protocols can create systemic barriers for the visually impaired. This can include issues as simple as a lack of proper screening and referral procedures that allow visually impaired clients into programs that require reading activities without providing Braille translations.

Professionals might find it difficult to work in collaboration with other agencies to determine the most effective and appropriate intervention due to the fact that there is often a lack of written case management procedures and specific processes for providing services to this unique population. Consequently, confusion could arise between the ability and addiction fields as to whether one's substance abuse is considered to be the primary issue or a symptom of a coexisting ability issue. The lack of communication and collaboration across disciplines comes at a high cost to the individuals who are trying to access services, as they are shuffled through the addiction and disability service delivery systems only to experience unmet needs and unsuccessful treatment strategies (Koch et al., 2002; Koch et al., 2004).

Finally, it is equally important to remove any architectural barriers that might interfere with a person's ability to access appropriate substance abuse treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 1998). For instance, it is important in addiction treatment facilities to keep all pathways clear, raise low-hanging lights, use large size fonts on all signs, and include Braille on elevator buttons. It is also crucial for individuals working at such agencies to ensure that verbal announcements are made instead of only using the traditional method of postings on bulletin boards. In addition, efforts should be made to aid those individuals who require assistance in orienting themselves with the layout of a building or room by explaining where doors, furniture, and other important features are located (SAMHSA, 1998).

Individuals Who Are Deaf or Hard of Hearing

In Canada, there are currently more than 700,000 (2.2%) people who are either deaf or hard of hearing (Statistics Canada, 2006). According to the

Canadian Hearing Society, the term *deaf* is usually used to describe those individuals with a severe to profound hearing loss who primarily depend on visual means of communication, which can include the use of sign language, speech reading, and reading and writing (Canadian Association of the Deaf, 2007; Canadian Hearing Society, 2008). In contrast, the term *hard of hearing* is used to describe those individuals who are able to communicate through the use of spoken language. Individuals who are hard of hearing can understand varying degrees of spoken language either with or without the use of assistive devices such as hearing aids. It is also important to note that although this terminology is often used to describe the extent of one's disability, hearing loss occurs on a continuum ranging from moderate to severe (Canadian Hearing Society, 2008).

Little is known about the exact numbers of Canadians who are deaf or hard of hearing and contending with coexisting substance use issues, as these individuals are often isolated and hidden within deaf communities due to communication barriers. There is also a lack of understanding that deaf culture is in a fact a unique culture (Moore & McAweeney, 2006). The uniqueness begins with the fact that deaf culture does not directly relate to the foundation skills of the counseling professions: hearing and speaking. Rather, it is sign language that unites members of this community.

The use of sign language influences psychosocial development in the same way that spoken language influences hearing culture as a creator of civilization, a transmitter of information, and the primary means to present one's self-image to others. It is important to understand that many individuals who are deaf not only have a sensory disability, but they are also part of a unique and distinct culture (Lipton & Goldstein, 1997). Additionally, being part of the deaf culture entails limited exposure to discussions regarding substance use, decreased access to formal prevention programs, and often enabling behaviors by those around the individual who feel that substance use is a justified method of coping given the disability-related challenges that the individual might experience on a daily basis.

Concerns also arise as those who are deaf or hard of hearing often have limited access to informal support networks of family and close friends, which can further the isolation and oppression already experienced by many individuals. As a result of this isolation, there is increased emotional distress. For some, there might be a struggle to connect even in such a fundamental way as the inability of young people who are deaf to communicate with their parents about basic needs, let alone contentious issues like drug use (Berman, Streja, & Guthmann, 2010; Titus & White, 2008). It is imperative that professionals be aware of such factors to begin to address specific barriers that impede an individual's access to substance abuse treatment.

Rendon (1992) was among the first to give voice to members of the deaf community in the United States and their experience with addiction: I came to realize that I had a problem with drugs and alcohol just after turning 30. I had been using since I was 18—daily usage which I considered a normal part of my lifestyle. . . . I was missing work at an alarming rate. . . . My supervisor gave me a verbal warning . . . as a last resort, I went to an employment counselor. The counselor . . . told me I had alcohol-related problems whether I thought so or not and that it was nothing to be ashamed of. . . . The first four and half years, I was slipping and falling all over the place. In and out of therapy, 12 step programs, hospitals, jails and near brushes with death. Being deaf created special problems. Each and every time I went to a 12 step meeting, I had to make a telephone call to arrange for interpreters. . . . It is hard not to feel the unfairness of things, knowing there are 800 different 12-step meetings per week in the Bay Area, and I can't choose any in my own neighborhood because they have no sign language interpretation. (Rendon, 1992, p. 104)

For any individual struggling with the effects of addiction, beginning substance abuse treatment is a very daunting and challenging task. However, as the preceding quote illustrates, this task is made increasingly difficult for those who are deaf or hard of hearing, as many people often face significant communication barriers (Alexander, DiNitto, & Tidblom, 2005; Guthmann & Blozis, 2001; Guthmann & Graham, 2004; Guthmann & Sandberg, 1998; Lipton & Goldstein, 1997; Moore & McAweeney, 2006; Titus & Guthmann, 2010; Titus & White, 2008). Individuals typically experience the first of many barriers when trying to obtain an assessment, as there are no formalized assessment tools designed to meet the unique needs of this population (Guthmann & Graham, 2004; Guthmann & Sandberg, 1998). Due to a lack of cross-training, substance abuse professionals are unfamiliar with how to effectively work with members of the deaf and hard of hearing community and might be even less familiar with alternate modes of communication such as American Sign Language (ASL).

Unfortunately, this lack of professional preparation only leads to further obstacles, as substance use is already a difficult issue for many to discuss (Guthmann & Graham, 2004). Although sign language interpreters might be seen as an appropriate means of reducing barriers, studies suggest that problems could still arise when using this method of communication (Guthmann & Graham, 2004). For example, Alexander et al. (2005) asked 26 deaf individuals about their understanding of two widely used screening tests: the CAGE and the AUDIT. Interviews were conducted by examining each assessment tool sentence by sentence while having an interpreter sign so that participants could understand and respond to the questions being asked. The results indicated only 4 out of the 26 participants involved in the study had a clear understanding of both screening tests. In addition, the researchers found that there were a number of critical words identified on these screening tests, such as *hangover* and *blackout*, that had several different signs to

convey their meaning, which only served to further contribute to the confusion and frustration experienced by participants. As a result, the validity of these assessment tools was compromised.

Additional issues that can be encountered when relying on the use of interpreters include challenges such as locating qualified interpreters, contending with interpreter availability, and finding interpreters who know the unique signs and slang related to drug culture. Furthermore, when using an interpreter for individual work, the clinician must carefully consider the impact of adding a third party to the situation, as this will inevitably affect the dynamics of the clinician-client relationship (Guthmann & Graham, 2004; Guthmann & Sandberg, 1998). In contrast, if a treatment provider wishes to use an interpreter for group therapy, there are other critical factors that must be considered, including the fact that interpreting is very tiring and the interpreter's effectiveness will decrease over time. In these situations it is essential to plan breaks to ensure that the interpreter can maintain the level of skill needed to keep track of what everyone in the group is saying, or depending on group size and length of session, hiring two interpreters to ensure effective communication and interactions among all members of the group (Guthmann & Graham, 2004).

These issues are slowly being addressed as a specific substance abuse screen in ASL is currently under development. In addition, the recent implementation of a web-based 12-step meeting run by recovered deaf substance users allows participants to see and interact with one another on the computer screen (Titus & Guthmann, 2010).

MOBILITY IMPAIRMENT

There are more than 200,000 (0.6%) Canadians living with mobility impairments (Statistics Canada, 2006). The term *mobility impairment* is used when discussing individuals who have difficulty using their extremities, or those individuals who demonstrate a lack of strength to walk, grasp, or lift objects. As a result, the use of devices such as a wheelchair, crutches, cane, or walker might be required to assist with mobility. Although spinal cord injuries, which were previously discussed, do overlap with issues of mobility, there are many other factors that lead to mobility impairments, including disease, congenital disorder, and non-spinal-cord injuries and accidents (Colorado State University, 2010).

Due to increased awareness and recent legislative changes, attempts have been made to reduce many of the barriers commonly experienced by this population on a daily basis. However, as with other groups discussed earlier, many barriers remain for those with mobility challenges who are attempting to access appropriate treatment for substance use issues, as evident in the low rate of treatment participation among this group. For example West et al. (2009e) found that within the province of Ontario, treatment providers indicated that although they had served 235 individuals with various disabilities over a 1-year period, this was a small percentage of the population estimated to be living with such disabilities. In addition, they had only assisted a total of six with mobility impairments (five with TBI and one with SCI) within the year prior to the survey.

This low rate of participation in treatment is primarily due to the fact that many treatment centers are often inaccessible to those with mobility impairments. Voss, Cesar, Tymus, and Fiedler (2002) assessed the perceptions of managers at various substance abuse treatment centers regarding physical accessibility for those with SCI. In a telephone interview, 30 of the 32 facilities surveyed reported that they were wheelchair accessible; however, an on-site follow up visit to 15 of the facilities revealed significant differences between what was perceived by the managers to be accessible and the legislative guidelines designed to reduce barriers for those with mobility impairments During the visit several components of each treatment facility, including both the exterior and interior of the building, as well as policies and procedures, were examined to determine the overall accessibility of these programs to those with mobility impairments. Inspection by qualified experts revealed that only nine out of the 15 sites surveyed had an entrance door that met the width guidelines to accommodate individuals in wheelchairs, and only two had washroom facilities that met the appropriate guidelines. In terms of overall accessibility, whereas 93% of staff indicated in a phone survey that their facility was physically accessible to those with mobility impairments, on-site surveys showed that only 13% of the facilities actually met all accessibility requirements. What is not evident from the study is if hospital-based substance use disorder treatment programs and SAMHSA-funded programs provided better physical accessibility than did community-based or private treatment programs.

West, Luck, and Capps (2007) examined the impact of physical inaccessibility of various substance abuse treatment programs in the mid-Atlantic region of the United States. They found that only 13% of the treatment professionals participating in the study had been approached for services by individuals with an SCI. However, of those, only 39% indicated that they were able to provide services to this population due to inaccessibility of their treatment service. Similarly, 50 (36%) of the respondents revealed that they had been previously approached by those with TBI seeking substance abuse treatment, and 22 (44%) were unable to provide services to this population.

West et al.'s (2009d) study of those living with other types of mobility impairments found treatment denial rates due to those impairments ranging from 67% for those with muscular dystrophy to rates as high as 91% for individuals with multiple sclerosis. Of particular interest was the fact that whereas previous studies have indicated that there was no association between the number of service refusals and type of treatment, results of this

study suggest that those seeking treatment in outpatient settings experience fewer service refusals compared to those seeking treatment in residential treatment programs. This difference is attributed to the nature of outpatient services and the interactions that treatment providers have when working with those living with physical disabilities. For example, whereas outpatient service providers must ensure that all waiting areas and meeting rooms are accessible, those working in residential settings might find it increasingly difficult to accommodate individuals with physical disabilities, as they could often experience multiple barriers related to bathing, sleeping, eating, and recreational activities that are an essential part of one's daily routines.

FUTURE DIRECTIONS

It is evident that we know too little about the intersection of addiction and disability. The limited empirical data that do exist in this area indicate that those with disabilities use psychoactive substances at a greater rate than those in the general population (Kolakowsky-Hayner et al., 1999; Schiller et al., 2012), but the numbers remain for the most part vague and thus more precise prevalence rates are needed. Of the existing research studies, only a few articles have been authored by social workers and this is clearly an area where the profession needs to become more active and study not only the expressed, but more important, the felt need of this population.

This review has served to highlight a significant gap in the addictions treatment continuum for those with ability issues and coexisting substance use problems. Individuals with ability issues continue to face a multitude of attitudinal, programming, and environmental barriers when attempting to access appropriate substance abuse treatment. Restrictions to programs, lack of appropriate substance abuse screening tools, and misunderstandings of what it means for a service to be truly accessible underscore that greater cooperation is required between professionals working in the area of disability and those in the addiction treatment. Without identifying the unique needs of each individual and making appropriate referrals, those with ability and coexisting substance use issues risk getting "lost" in the very systems that many depend on for adequate treatment, guidance, and support. As a result, individuals become a part of a vicious cycle of unmet needs and unsuccessful treatment strategies, which only serves to further perpetuate the isolation and oppression that is already experienced by members of this population.

It is therefore crucial for all staff to receive adequate cross-training to increase professional preparation and competency to serve this population. Strengthening relationships and creating a professional dialogue can pave the way for the critical examination of current policies and procedures to more effectively meet the needs of this group. For example, substance abuse treatment programs that espouse total abstinence might inadvertently exclude those with disabilities from participating in treatment as they might need to take medications for their other conditions. In addition, it is important for treatment facilities to explore the benefits of utilizing assistive technologies and the assistance of skilled professionals, such as personal support workers, to remove environmental and programmatic barriers.

In 2010, an extensive national consultation was conducted by the Canadian Centre on Substance Abuse (2010) in conjunction with the National Advisory Group on Workforce Development, resulting in the development of technical and behavioral competencies for addiction counselors. These guidelines for best practice in the field of addiction counseling in Canada did not contain a single competency directly related to individuals with disabilities. Thus, it is also paramount that postsecondary institutions include a focus on this unaddressed issue of oppression in a range of academic disciplines including, but not limited to, social work, disabilities studies, health sciences, psychology and, of course, addiction studies. As awareness and professional preparation increases, it will, in turn, become increasingly imperative for policymakers to take note and develop more up-to-date legislation to ensure that those with ability issues and addictions are no longer ignored, but instead are given equal access to comprehensive treatment options, support, and guidance that reflects each individual's unique needs and goals.

Further, future research studies will need to explore the firsthand experiences of those who have been forced to endure the many attitudinal, programming, and environmental barriers when attempting to access services within the addiction treatment continuum. Other than Rendon (1992), it is rare to hear the voices of people with intersecting issues of addiction and ability issues in the literature, as little has been formally documented regarding the impact of these barriers on the experiences of those with disabilities. Until this too is addressed, this group will remain an oppressed subpopulation within the larger marginalized world of addicted individuals.

REFERENCES

Alexander, T., DiNitto, D., & Tidblom, I. (2005). Screening for alcohol and other drug use problems among the deaf. *Alcoholism Treatment Quarterly*, *23*(1), 63–78.

Barnes, C., & Mercer, G. (2010). *Exploring disability*. Cambridge, UK: Polity Press. Berman, B. A., Streja, L., & Guthmann, D. S. (2010). Alcohol and other substance

use among deaf and hard of hearing youth. *Journal of Drug Education*, 40(2), 99–124.

- Bombardier, C. H., Rimmele, C., & Zintel, H. (2002). The magnitude and correlates of alcohol and drug use before traumatic brain injury. *Archives of Physical Medicine & Rebabilitation*, 83, 1765–1773.
- Bombardier, C. H., Temkin, N. R., Machamer, J., & Dikmen, S. S. (2003). The natural history of drinking and alcohol-related problems after traumatic brain injury. *Archives of Physical Medicine & Rehabilitation*, 84, 185–191.

- Bombardier, C. H., & Turner, A. (2010). Alcohol and other drug use in traumatic disability. In R. Frank, M. Rosenthal, & B. Caplan (Eds.), *Handbook of rehabilitation psychology* (2nd ed., pp. 241–258). Washington, DC: American Psychological Association.
- Boros, A. (1989). *Alcohol and the physically impaired*. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.
- Canadian Association of the Deaf. (2007). *Definition of "deaf."* Retrieved from http://www.cad.ca/definition_of_deaf.php
- Canadian Centre on Substance Abuse. (2010). *Competencies for Canada's substance abuse workforce*. Ottawa, Canada: Canadian Centre on Substance Abuse.
- Canadian Hearing Society. (2008). *Get connected to deaf, deafened and bard of bearing people: A guide for service providers and businesses*. Retrieved from http://www.psncorp.com/Downloads/CHS:Guide_To_Service_Providers_And_Businesses.pdf
- Canadian Paraplegic Association. (2011). *Spinal cord injury Canada*. Retrieved from https://www.canparaplegic.org/resources/sci_facts
- Colorado State University. (2010). *The access project: Mobility impairments definition*. Retrieved from http://accessproject.colostate.edu/disability/modules/MI/ tut_MI.cfm
- Corrigan, J. (1995). Substance abuse as a mediating factor in outcome from traumatic brain injury. *Archives of Physical Medicine & Rehabilitation*, *76*, 302–309.
- Corrigan, J., Rust, E., & Lamb-Hart, G. (1995). The nature and extent of substance abuse problems in persons with traumatic brain injury. *Journal of Head Trauma*, *10*(3), 29–46.
- Csiernik, R. (2011). *Substance use and abuse: Everything matters*. Toronto, Canada: Canadian Scholars' Press.
- Csiernik, R., & Rowe, W. (Eds.). (2010). Responding to the oppression of addiction: Canadian social work perspectives (2nd ed.). Toronto, Canada: Canadian Scholars' Press.
- DeLambo, D. A., Chandras, K. V., Homa, D., & Chandras, S. V. (2009). Traumatic brain injuries and substance abuse: Implications for rehabilitation professionals. Retrieved from counselingoutfitters.com/vistas/vistas09/DeLambo-Chandras-Homa-Chandras2.doc
- Elliott, T., Kurylo, M., Chen, Y., & Hicken, B. (2002). Alcohol abuse history and adjustment following spinal cord injury. *Rehabilitation Psychology*, 47(3), 278–290.
- Flores, P. (1983). Group therapy for alcoholics. New York, NY: Haworth.
- Guthmann, D., & Blozis, S. A. (2001). Unique issues faced by deaf individuals entering substance abuse treatment and following discharge. *American Annals of the Deaf*, 146, 294–303.
- Guthmann, D., & Graham, V. (2004). Substance abuse: A hidden problem within the deaf and hard of hearing communities. *Journal of Teaching in the Addictions*, *3*(1), 49–64.
- Guthmann, D., & Sandberg, K. (1998). Assessing substance abuse problems in deaf and hard of hearing individuals. *American Annals of the Deaf*, *143*, 14–21.
- Jutai, J., Hooper, P., Cooper, L., Hutnik, C., Sheidow, T., Tingely, D., & Russell-Minda, E. (2005). *Vision rehabilitation: Evidence-based review*. London, Canada: CNIB Baker Foundation for Vision Research.

- Koch, S. D., Nelipovich, M., & Sneed, Z. (2002). Alcohol and other drug abuse as coexisting disabilities: Considerations for counselors serving individuals who are blind or visually impaired. *Review: Rehabilitation and Education for Blindness* and Visual Impairment, 33(4), 151–159.
- Koch, S. D., Shearer, B., & Nelipovich, M. (2004). Service delivery for persons with blindness or visual impairment and addiction as coexisting disabilities: Implications for addiction science education. *Journal of Teaching in the Addictions*, 3(1), 21–48.
- Kolakowsky-Hayner, S., Gourley, E., Kreutzer, J., Marwitz, J., Cifu, D., & Mckinley,
 W. (1999). Pre-injury substance abuse among persons with brain injury and persons with spinal cord injury. *Brain Injury*, 13, 571–581.
- Kolakowsky-Hayner, S., Gourley, E., Kreutzer, J., Marwitz, J., Meade, M., & Cifu, D. (2002). Post-injury substance abuse among persons with brain and persons with spinal cord injury. *Brain Injury*, 16, 583–592.
- Kreutzer, J., Witol, A., & Marwitz, J. (1996). Alcohol and drug use among young persons with traumatic brain injury. *Journal of Learning Disabilities*, 29, 643–651.
- Lipton, D. S., & Goldstein, M. F. (1997). Measuring substance use among the deaf. Journal of Drug Issues, 27, 733–754.
- Loughran, H. (2009). Group work in the context of alcohol treatment. *Journal of Teaching in the Addictions*, 8(1/2), 125–141.
- Moore, D., & McAweeney, M. (2006). Demographic characteristics and rates of progress of deaf and hard of hearing persons receiving substance abuse treatment. *American Annals of the Deaf*, *151*, 508–512.
- Nelipovich, M., Wergin, C., & Kossick, R. (1998). The macro model: Making substance abuse services accessible to people who are visually impaired. *Journal* of Visual Impairment and Blindness, 92, 567–570.
- Ontario Brain Injury Association. (2011). *About OBIA*. Retrieved from http://www. obia.ca/index.php/about
- Ontario Ministry of Community & Social Services. (2011). Accessibility for Ontarians With Disabilities Act. Retrieved from http://www.e-laws.gov.on.ca/ html/source/regs/english/201/elaws_src_regs_r11191_e.htm
- Ponsford, J., Whelan-Goodinson, R., & Bahar-Fuchs, A. (2007). Alcohol and drug use following traumatic brain injury: A prospective study. *Brain Injury*, 21, 1385–1392.
- Priestley, M. (2001). *Disability and the life course: Global perspectives*. Cambridge, UK: Cambridge University Press.
- Rendon, M. E. (1992). Deaf culture and alcohol and substance abuse. *Journal of Substance Abuse Treatment*, 9(2), 103–110.
- Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drugs and Alcohol Review*, *24*(2), 143–155.
- Sales, A. (2000). Substance abuse and disability (ERIC Document Reproduction Services No. ED 440352). Retrieved from http://www.eric.ed.gov/PDFS/ ED440352.pdf
- Saunders, L. L., & Krause, J. S. (2011). Psychological factors affecting alcohol use after spinal cord injury. *Spinal Cord*, 49, 637–642.
- Schiller, J., Lucas, J., Ward, W., & Peregoy, J. (2012). Summary health statistics for U.S. adults: National Health Interview Survey, 2010. Atlanta, GA: National Center for Health Statistics.

- Smart, J. F., & Smart, D. W. (2007). Models of disability: Implications for the counseling profession. In A. Dell Orlo & P. Power (Eds.), *Psychological and social impact of illness and disability* (5th ed., pp. 75–100). New York, NY: Springer.
- Smedema, S. M., & Ebener, D. (2010). Substance abuse and psychosocial adaption to physical disability: Analysis of the literature and future directions. *Disability* and Rehabilitation, 32, 1311–1319.
- Statistics Canada. (2006). *Participation and activity limitations survey*. Ottawa, Canada: Author.
- Substance Abuse and Mental Health Services Administration. (1998). Substance use disorder treatment for people with physical and cognitive disabilities (PMID 22514835, SMA 98–3249). Rockville, MD: U.S. Center for Substance Abuse Treatment.
- Tate, D., Forchheimer, M., Krause, J., Meade, M., & Bombardier, C. (2004). Patterns of alcohol and substance use and abuse in persons with spinal cord injury: Risk factors and correlates. *Archives of Physical Medicine & Rehabilitation*, 85, 1837–1847.
- Taylor, L., Kreutzer, J., Demm, S., & Meade, M. (2003). Traumatic brain injury and substance abuse: A review and analysis of the literature. *Neuropsychological Rehabilitation*, 13(1/2), 165–188.
- Titus, J. C., & Guthmann, D. (2010). Addressing the black hole in substance abuse treatment for deaf and hard of hearing individuals: Technology to the rescue. *Journal of the American Deafness and Rehabilitation Association*, 43(2), 92–100.
- Titus, J. C., & White, W. L. (2008). Substance use among youths who are deaf and hard of hearing. *Student Assistance Journal*, 20(3), 14–18.
- Voss, C. P., Cesar, K. W., Tymus, T., & Fiedler, I. G. (2002). Perceived versus actual accessibility of substance abuse treatment facilities. *Topics in Spinal Cord Injury Rebabilitation*, 7(3), 47–55.
- West, S., Graham, C., & Cifu, D. (2009a). Alcohol and other drug problems and persons with disabilities: A new light on an often overlooked problem. *Alcoholism Treatment Quarterly*, 27, 238–241.
- West, S., Graham, C., & Cifu, D. (2009b). Physical and programmatic accessibility of British alcohol/other drug treatment centers. *Alcoholism Treatment Quarterly*, 27, 294–304.
- West, S., Graham, C., & Cifu, D. (2009c). Prevalence of persons with disabilities in alcohol/other drug treatment in the United States. *Alcoholism Treatment Quarterly*, 27, 242–252.
- West, S., Graham, C., & Cifu, D. (2009d). Rates of alcohol/other drug treatment denials to persons with physical disabilities: Accessibility concerns. *Alcoholism Treatment Quarterly*, 27, 305–316.
- West, S., Graham, C., & Cifu, D. (2009e). Rates of persons with disabilities in alcohol/other drug treatment in Canada. *Alcoholism Treatment Quarterly*, 27, 253–264.
- West, S., Luck, R., & Capps, F. (2007). Physical inaccessibility negatively impacts the treatment participation of persons with disabilities. *Addictive Behaviors*, 32, 1494–1497.