It Takes Imagination to See Without Sight: Envisioning Inclusivity

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ASAM Annual Conference, April 13-16th, 2023

Disclosure Information

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ASAM Annual Conference, April 2023

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- No Disclosures

Learning Objectives

Upon completion participants will be able to:

(1) Describe the complex interactions of physical disability and the disease of addiction.

(2) Identify barriers impeding recovery and addiction disease management for the physically disabled using an accessibility analytical tool as applied to their health care settings.

(3) Articulate solutions for enhancing accessibility and using integrated care in their physical rehabilitation and addiction treatment programs.

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Review of meeting agenda

What do you see on the agenda for today's session that is of interest to you?

What if the tables were turned?

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Re-imagining

Myths versus reality

Stigma versus open-mindedness

Inclusion and accessibility versus discriminatory restricted access

Inclusion "allows for people with disabilities to take advantage of the benefits of the same health promotion and prevention activities experienced by people who do not have a disability."

(Centers for Disease Control and Prevention, 2020)

Why does this matter???

[Disability Inclusion | CDC]

Who are we referring to…?

Defining disability:

According to the United Nations Convention on the Rights of Persons with Disabilities, people ". . . with disabilities include those who have long-term physical, mental, intellectual or sensory [such as hearing or vision] impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."

http://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf pdf icon

Prevalence data: operationalizing disability

Standard Disability Questions for Population Surveys:

CDC (Centers for Disease Control and Prevention) relies on standard disability measures that include self-assessment/identification as having “serious difficulty” with:

a) hearing (deaf)

b) seeing (even w/ glasses) (blind)

c) concentrating, remembering, making decisions (≥ 5 yr old due to physical, emotional or mental condition) (cognitive)

d) walking/climbing stairs (≥ 5 yrs old) (mobility)

e) dressing/bathing (≥ 5 yrs old) (self-care)

f) doing errands alone (≥ 15 yrs old) due to physical, emotional or mental condition (independence)

http://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf pdf icon

Prevalence of disability

Disability of any type: 24.8% of the population

Behavioral Risk Factor Surveillance System (2020)
Prevalence of 6 disability types:

Hearing	5.7%
Vision	4.9%
Mobility	11.1%
Self-care	3.0%
Independence	6.4%
Cognitive	10.9%

Disability and Health Data System Explore by Location | NCBDDD | CDC

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Vulnerability to a substance use disorder and mental health symptoms by Persons with Disability (PWDs)

56.6% of PWDs reporting anxiety and/or depression
28.7% of Pw/oDs reported anxiety and/or depression

38.8% of PWDs reported new/increased substance use
17.5% of Pw/oDs reported new/increased substance use

30.6% of PWDs reported suicidal ideation
8.3% of Pw/oDs reported suicidal ideation

Chi square values for all <.0001

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http://www.un.org/disabilities/documents/convention/convention_accessible_pdf.pdf pdf icon

Vulnerability to a substance use disorder and mental health symptoms by Persons with Disability (PWDs)

CDC in its Morbidity and Mortality Weekly Report on data collected February – March 2021; summarized the data as follows:

64.1% of PWDs reported adverse mental health or substance use disorder symptoms

36.0% of Pw/oDs reported adverse mental health or substance use disorder symptoms

Substance use to cope with stress or emotions among persons with disabilities was higher than for persons without disabilities, both pre-pandemic (39.7% versus 25.3%, respectively) and past month (40.6% versus 24.5%) both $p<0.001$)

[Mental Health and Substance Use Among Adults with Disabilities During the COVID-19 Pandemic — United States, February–March 2021 | MMWR (cdc.gov)]

Substance misuse by Persons with Disability (PWDs) compared to Persons without Disability (Pw/oDs)

CDC in its Morbidity and Mortality Weekly Report on data collected February–March 2021 on past month use of PWDs vs Pw/oDs respectively for each substance:

	PWDs	Pw/oDs
methamphetamine use:	8.4%	3.4%
nonopioid prescription drug misuse:	4.9%	2.0%
polysubstance use:	16.9%	7.9%
cocaine use:	6.4%	2.2%
prescription or illicit opioid use	9.1%	3.2%

Past-month methamphetamine use increased significantly compared with prepandemic use among all respondents (with disabilities, 45.6% increase, $p<0.001$; without disabilities, 40.6% increase, $p = 0.003$).

Mental Health and Substance Use Among Adults with Disabilities During the COVID-19 Pandemic — United States, February–March 2021 | MMWR (cdc.gov)

Stigma and Stereotypes

A person with all their faculties finds it hard to imagine life without sight, hearing, mobility.

Stereotypes: physical disability is associated with cognitive deficiency, impairments are overgeneralized

Stigma: PWDs (Persons with Disabilities) are avoided, isolated, less likely to be hired or included in societies' opportunities.

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Attitudes toward treatable acute illnesses vs. chronic disabilities

- Nurturing approach versus avoidance of “enabling” and expectation of being self-sufficient
- Addiction as a lifelong disability that requires ongoing supports and management and coping skills
- Coping skills for ongoing disability varies with age/stage in life
- Ageism can deter treatment access

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Physical disability and SUDs

Disabilities and documented high rates of SUDs (substance use disorders) (often as high as 50% of the population):

- Traumatic Brain Injuries (Corrigan and Adams, 2019)
- Spinal Cord Injuries (Lusilla-Palacios & Castellano-Tejedor, 2015, *Adicciones*)
- Visual impairment (Brooks et al., 2014)

25% - 47% w/psychiatric disabilities have co-occurring SUDs documented (Hollen & Ortiz, 2015)

Deaf and hard of hearing tend to have similar SUD rates as hearing population though heavier cannabis use and alcohol use found ((Anderson et al., 2018) (heavy use ≠ SUD; poses high risk)

https://doi.org/10.1016/j.addbeh.2018.10.030

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Challenges to accessing rehabilitation services for persons with a substance use disorder

Service accessibility too often is lacking: physical barriers, lack of sensory accommodations, no cognitive processing adjustments.

Diagnostic/screening tools may not be valid with special populations.

Policy barriers: a substance use disorder diagnosis may preclude admission into rehabilitation programs though the therapy and vocational counseling are essential for recovery.

Training inadequacies: rehabilitation professionals may lack addiction training and addiction specialists may not be trained on disabilities and healthcare accessibility/accommodation solutions.

Through cross-training: stigma can be replaced with knowledge; tools for overcoming barriers can be accessed.

http://dx/doi.org/10.1891/2168-6653.30.3.243

Underrepresentation of PWDs in treatment

- Psychosocial instability: stressors + in adequate supports
- Stigma
- Structural barriers/lack of accommodations*
- Transportation barriers
- Insufficient provider training

Untreated substance use disorder (SUD) compounds work/school problems, family/interpersonal conflict, risk for violence, poverty, injury and other health consequences, and death.

* Perceived (self-reported) accessibility ≠ actual; significant gap

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* Voss et al., 2002

Disability legislation notwithstanding

- Section 504 of the 1973 Rehabilitation Act mandates accessible services
- The Americans with Disabilities Act of 1990, the Americans with Disabilities Amendments Act of 2008, and Section 4302 in the Patient Affordability and Care Act, designate disability as a demographic w/health disparities requiring amelioration.
- Under this Act of 1990, healthcare services, facilities, and equipment must be accessible for people with disabilities, yet accessibility is still lacking in healthcare facilities/services across the country.
- Department of Justice (April 5th 2022 “Guidance” document clarifies ADA protections as applying to persons with a substance use disorder, (e.g., opioid use disorder) prohibiting discrimination

Guidance on Protections for People with Opioid Use Disorder under the Americans with Disabilities Act
by the Department of Justice

- Assistant Attorney General Kristen Clarke of the Justice Department's Civil Rights Division:
- "People who have stopped illegally using drugs should not face discrimination when accessing evidence-based treatment or continuing on their path of recovery. The Justice Department is committed to using federal civil rights laws such as the ADA to safeguard people with opioid use disorder from facing discriminatory barriers as they move forward with their lives." Press release on April 5th, 2022

Justice Department Issues Guidance on Protections for People with Opioid Use Disorder under the Americans with Disabilities Act | OPA | Department of Justice

Integrated care model

Lusk, Koch, and Paul (2016) recommend integrating mental health, substance use disorder treatment, vocational rehabilitation, physical rehabilitation and counseling in comprehensive care service programs.

Vocational rehabilitation counselors would benefit from adopting a recovery-oriented rehabilitation approach, while at the same time offering expertise on implementing accommodations for the disabled and augmenting addiction treatment to include life skills training and vocational preparation/job skills. (Rumrill and Koch, 2022)

http://dx.doi.org/10.1891/2168-6653.30.3.243

http://dx.doi.org/10.1891/JARD-2021-0009

Integration through co-location, trainings, virtual collaborative care

- Provide mental health, medical interventions, addiction treatment, vocational and physical rehabilitation together, co-located or in virtually integrated collaborative programs.
- Create interdisciplinary teams with regular check ins, collaboration and communication.
- Increasingly psychiatric and SUD treatment are integrated with improved outcomes (Drake et al., 2016, Fortuna et al., 2018).
- Cross trainings and interdisciplinary staff meetings are recommended (Rumrill and Koch, 2022).

https://doi.org/10.1093/schbul/sbv110

https://doi.org/10.1111/papt.12143

http://dx/doi.org/10.1891/JARC-2021-0009

Policy changes

- Eliminate eligibility requirement of sustained period of abstinence to access rehab services (Sprong et al., 2022: required by 37% of rehab agencies).
- Failure to provide concurrent treatment and rehabilitation undermines path to recovery through self-sufficient financial means (ideally employment).
- SUDs are chronic, abstinence does not preclude relapse potential.
- Relapse should be expected and recognized as a part of recovery, warranting ongoing integrated care rather than sequential services.
- Motivational interviewing, ongoing relapse prevention, coping supports, medical treatments are needed, rather than discontinuing services when the chronic disease manifests in a flair up – a relapse.

http://dx.doi.org/10.1891/JARC-2021-0009

On boarding and ongoing employment supports enhance recovery

- Vocational rehab team members incorporated on the interdisciplinary treatment team can increasing likelihood of employment:
- job placement assistance
- on-the-job retention supports (short term and long term)

Understanding SUDs as a form of disability opens the door to including vocational rehabilitation services in SUD treatment programs.

Qualified individuals with SUDs are protected from discrimination and entitled to reasonable accommodations, as long as they are not in "active" misuse that compromises on the job functioning, not currently using illegal drugs.

Assistive technologies make reasonable accommodations increasingly realistic, achieving more equitable access to SUD treatment AND employment placement.

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Cross training on pain management and SUD treatment

- Physical rehabilitation, pain management, opioid use disorder, medical, and mental health treatments intersecting in important ways that too often are ignored and result in disjointed, even interfering interventions, avoidable through collaborative care.
- Prevalence of chronic pain in the disabled population increases risk of addiction to opioids; physical rehabilitation is often overlooked as a solution and alternative to opioids.
- Role of buprenorphine and methadone in relation to pain management is a source of confusion in the field of physical rehabilitation.
- Chronic pain was a predictor of retention in our medication-based comprehensive care office-based opioid treatment clinic.

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Chronic pain as a mediator

- How much of the relationship between disability status and substance use is explained by chronic pain?
- In a national study by Reif et al., 2022:
- disability was associated with significantly increased odds of chronic pain (OR = 3.42, $p < 0.001$).
- Their mediation analysis showed that chronic pain accounted for 17%-38% of the association between disability and substance use with the proportion of the explained effect highest for any drug use.

https://doi.org/10.1016/j.dhjo.2022.101290

Rectifying Inequities = Health and Economic Benefits

- The annual economic impact of substance misuse is estimated to be $249 billion for alcohol misuse and $193 billion for illicit drug use. (Surgeon General, 2022)
- Persons with disabilities are overrepresented among the unemployed. (70% of persons with a visual impairment are unemployed.) (APA Fact Sheet on Disability and SES, 2015)
- Addiction treatment access will reduce substance misuse.
- More successful rehabilitation programs will strengthen the US workforce.

Addiction and Substance Misuse Reports and Publications | HHS.gov
factsheet-disability.pdf (apa.org)

Assessing your programs’ accessibility

Using the handout “take a stab” at assessing your program’s accessibility.

When cued, discuss as a group (at your table), your perceived level of inclusion for your programs.

What recommendations might become steps you could imagine taking toward improved inclusion/accessibility and collaborative care that incorporates disability health considerations, rehabilitation care, with your addiction treatment and promotion of recovery?

What is one improvement toward inclusion you can commit to try following this workshop?

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Final Takeaways/Summary

- Disabled persons are especially vulnerable to substance use disorders.
- Barriers to accessibility in addiction treatment programs and in rehabilitation programs (reinforcing silos of care) abound.
- Stigma, stereotypes, lack of cross-training across the fields of addiction, rehabilitation, mental health, pain management potentially diminish our quality of care and health outcomes.
- Improving interdisciplinary diagnostic/screening capabilities, collaborative care, and inclusion by re-imagining our health care service delivery will yield better health outcomes, higher levels of productivity (a stronger economy), and an improved quality of life in our society.

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