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OXFORD HOUSE: DEAF-AFFIRMATIVE SUPPORT FOR SUBSTANCE ABUSE RECOVERY

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DEAF INDIVIDUALS seeking substance abuse recovery are less likely to have access to treatment and aftercare services because of a lack of culturally and linguistically specific programs and insufficient information about existing services. Previous research indicates that Oxford House, a network of resident-run recovery homes, serves a diverse group of individuals in recovery. However, research has not addressed the experiences of Deaf Oxford House residents. The present study found no significant differences between Deaf and hearing men living in Oxford House in terms of sense of community and abstinence self-efficacy. However, while most of the hearing participants were employed, none of the Deaf Oxford House members were. The study's findings indicate that Oxford House may be a promising Deaf-affirmative alternative for individuals seeking recovery from substance abuse. However, since Oxford Houses are self-supporting, Oxford Houses designed for the Deaf community may face unique economic challenges.

Abuse or misuse of alcohol and other drugs affects a significant number of Americans and is related to a variety of negative outcomes for affected individuals and the larger society (Gmel & Rehm, 2003; Office of National Drug Control Policy, 2004; Substance Abuse and Mental Health Services Administration, 2003). Only a handful of studies have attempted to document the prevalence of problematic substance use among Deaf individuals. These studies have found that substance-related problems are as common in the Deaf community as they are among the hearing population (Lipton & Goldstein, 1997). In addition, access to treatment

for Deaf individuals remains a critical issue (Guthmann & Blozis, 2001; Lipton & Goldstein, 1997; Vernon, 1995).

The most commonly encountered problem when services are provided to Deaf individuals who abuse substances is inadequate communication. That is, there are not enough substance abuse counselors who are proficient in American Sign Language (ASL) or signed English (Guthmann & Blozis, 2001; Leigh, Corbett, Gutman, & Morere, 1996). In addition, because of communication barriers, substance abuse education and prevention efforts have not yet reached many in the Deaf community. Therefore, there is a

lack of awareness of the problem of substance abuse and available treatment programs among a large part of the Deaf population (Guthmann & Sandberg, 2003). When information about treatment services reaches the Deaf community, services may still be inaccessible because of stigmatization of substance abuse, mistrust of hearing service providers, and a lack of culturally and linguistically appropriate services (Guthmann & Blozis, 2001; Guthmann & Sandberg, 2003; Lipton & Goldstein, 1997). Those who do seek treatment frequently encounter a lack of specialized treatment programs that adequately address the specific needs of the Deaf community (Guthmann & Blozis, 2001; Leigh et al., 1996; Vernon, 1995). Additionally, there are few culturally and linguistically appropriate aftercare programs; many 12-step groups such as Alcoholics Anonymous and Narcotics Anonymous also lack the resources to provide sign language interpreters for Deaf members (Guthmann & Sandberg, 2003).

A vital step in the recovery process is to reduce contact with former substance-using friends and develop relationships with individuals who support abstinence (Brewer, Catalano, Haggerty, Gainey, & Fleming, 1998). This may be especially difficult for Deaf individuals, who likely have limited access to 12-step groups and other such support programs (Guthmann & Blozis, 2001). Thus, many Deaf individuals who complete substance abuse treatment may find it more difficult to develop social networks that support long-term abstinence.

Since the early 1990s, a research team at DePaul University, in Chicago, has conducted a series of studies involving Oxford House, a residential recovery program founded in the mid-1970s (Jason, Davis, Ferrari, & Bishop, 2001). Since its inception, Oxford House has grown into an interna-

tional network of more than 1,200 homes serving thousands of individuals attempting to recover from substance addictions in the United States, Canada, and Australia. Oxford Houses are single-sex dwellings, though some allow residents' minor children to live with them.

Each Oxford House operates democratically, with a majority of at least 80% required for decisions regarding membership and most other house policies. Professionals are not involved with the houses, and residents must follow three simple rules: They must pay rent, abstain from using alcohol and drugs, and avoid disruptive behavior. Violation of these rules results in eviction from the house. Unlike other residential substance abuse treatment programs, Oxford House has no prescribed length of stay for residents, who strive to support each other's efforts to maintain abstinence, find employment, and attend treatment and 12-step meetings (*Oxford House Manual*, 2000). Research indicates that Oxford House residents are more likely to maintain long-term abstinence and employment than individuals in more traditional aftercare programs (Jason, Olson, Ferrari, & LoSasso, 2006). Additionally, Oxford House seems to help a wide range of people in recovery, including individuals diagnosed with psychiatric disorders and those involved with the criminal justice system (Jason et al., 2001; Majer, Jason, Ferrari, & North, 2002)

Oxford Houses in different parts of the United States serve Deaf individuals. Typically, staff from treatment programs for the Deaf community consult with local Oxford House leaders to develop these houses. House members attend 12-step meetings and participate in local Oxford House chapter meetings, which are interpreted by volunteers. A few sign language houses also have been developed.

In the present study, we attempted to explore the characteristics of Deaf Oxford House residents. On the basis of a review of the literature, we hypothesized that there would be no significant differences in history of substance use (alcohol, cocaine, or heroin) between Deaf and hearing Oxford House residents. In addition, on the basis of Oxford Houses' acceptance of individuals from diverse cultural groups, we expected no differences in sense of community between Deaf and hearing Oxford House residents. However, we hypothesized that because of a lack of access to supportive outside programs, Deaf Oxford House residents would have less confidence in their ability to maintain sobriety than hearing Oxford House residents.

Method

Participants

We recruited 10 Deaf men and 10 hearing men, matched for age, ethnicity, and time spent in Oxford House, for the present study. Three of the Deaf participants were recruited from Oxford Houses where they were the only Deaf member; 7 were recruited from an Oxford House designed specifically for the Deaf community. Hearing participants were recruited from various Oxford Houses throughout the United States, as part of a larger national study of Oxford House. All participants reported using both alcohol and illicit drugs. Data on participants' marital status and ethnicity are provided in Table 1.

Measures

The Addiction Severity Index (McLellan et al., 1992) is a widely used measure of recent and lifetime substance use and related medical, psychological, family and social, employment, and legal problems. McLellan and colleagues determined that the ASI composites, which measure the extent of problems

Table 1
Personal Characteristics of the Sample

	Deaf (n = 10)	Hearing (n = 10)
Ethnicity		
European American	6	6
African American	3	3
Hispanic/Latino	1	1
Marital status		
Married	0	1
Separated or divorced	3	4
Never married	2	5
Status not provided	5	0
N = 20.		

over the preceding 30 days concerning alcohol and drug use, as well as problems of a psychiatric, medical, social, employment-related, or legal nature, were internally consistent (alphas > .70) and demonstrated temporal stability (retest reliability > .83). For the present study, the ASI was used to gather demographic information and lifetime substance use data.

The Perceived Sense of Community Scale (Bishop, Chertok, & Jason, 1997) is a 30-item, 3-factor scale (mission, reciprocal responsibility, and disharmony) that has been administered to Oxford House residents in previous studies. Bishop and colleagues found this scale to be internally consistent and to correlate with measures of perceived social support. For the present study, Cronbach's alpha was .95 for the Deaf sample and .96 for the hearing sample.

The Alcohol Abstinence Self-Efficacy Scale (DiClemente, Carbonari, Montgomery, & Hughes, 1994) measures confidence that alcohol use can be avoided when one is in a setting that might lead to relapse. DiClemente and colleagues found the AASE to be a reliable measure that correlated with levels of substance use during treatment. For the present study, the AASE was modified to assess both drug and al-

cohol abstinence self-efficacy by adding the word *drugs* to each question. Cronbach's alpha was .98 for the Deaf sample and .96 for the hearing sample.

Procedure

Participants were recruited through letters sent to Oxford House presidents followed by telephone calls and house visits by research staff. In each case, research team members explained the nature, purpose, and goals of the study and remained in the house while participants completed paper-and-pencil measures. The staff member who administered the measures to the Deaf participants had some knowledge of ASL but was not a trained interpreter.

Results

Means and standard deviations for the demographic variables age, years of

education, months in Oxford House, and months of sobriety are presented in Table 2. Independent sample *t* tests revealed that there were no significant differences between the Deaf and hearing participants in terms of any of these four variables. Employment information indicated that none of the 10 Deaf participants were employed, while 8 of the hearing participants reported that they were working. Differences in employment status between the Deaf and hearing samples were found to be statistically significant, $X^2(1, 20) = 13.33, p < .01$. Additionally, among the Deaf participants, 5 reported receiving Social Security Disability Insurance (SSDI) benefits, 3 reported receiving no income, 1 said he received unemployment benefits, and 1 reported receiving financial support from family. One of the 2 unemployed hearing individuals received unemployment benefits, and the other received SSDI. Participants who were unemployed reported participating in volunteer activities in their communities.

The means and standard deviations for years of substance use, sense of community, and abstinence self-efficacy are presented in Table 3. As predicted, there were no significant differences between Deaf and hearing participants in years of substance use (alcohol, cocaine, or heroin). Additionally, there were no significant differences in either sense of community or abstinence self-efficacy between Deaf and hearing participants.

Table 2
Means and Standard Deviations for Demographic Variables

Variable	Deaf		Hearing	
	M	SD	M	SD
Age (years)	37.23	6.83	36.43	5.92
Years of education	11.22	3.15	12.81	1.63
Months of sobriety	21.78	20.94	37.83	20.39
Months in Oxford House	6.83	7.85	7.13	7.33

Table 3
Means and Standard Deviations for Substance Use–Related Variables

Variable	Deaf		Hearing	
	M	SD	M	SD
Alcohol use (years)	16.63	10.27	13.56	8.26
Cocaine use (years)	11.50	10.54	7.22	10.03
Heroin use (years)	5.63	10.42	1.11	1.96
Sense of community	107.00	22.73	109.45	19.98
Abstinent self-efficacy	82.80	20.57	72.30	20.21

Discussion

There have been few studies documenting the needs and treatment experiences of Deaf individuals in substance abuse recovery. The purpose of the present study was to explore differences between recovering Deaf and hearing Oxford House members. The two samples were successfully matched in terms of age, years of education, and length of time in Oxford House. No significant differences were found between the two samples in months of sobriety, but Deaf Oxford House members were less likely to be employed than their hearing counterparts.

No significant differences were found between Deaf and hearing participants in years of alcohol, cocaine, or heroin use prior to entering Oxford House. These results were expected, based on findings in the literature (Lipton & Goldstein, 1997). There were no significant differences between Deaf and hearing participants in sense of community in Oxford House or abstinence self-efficacy. These findings indicate that Deaf individuals find support for their recovery in Oxford House and that this support may contribute to abstinence self-efficacy. As DiClemente and colleagues (1994) have reported, abstinence self-efficacy predicts long-term abstinence from drugs and alcohol. The present study's findings suggest that Oxford Houses designed for the Deaf may provide an effective alternative for

Deaf individuals seeking to recover from drug and alcohol abuse.

Differences in employment status between Deaf and hearing participants found in the present study are consistent with previous findings indicating that Deaf individuals find it more difficult than hearing individuals to secure employment (Guthmann & Blozis, 2001). Individuals with histories of substance abuse also encounter barriers to employment (Platt, 1995; Zanis, 2004). In the present study, half of the Deaf participants reported receiving SSDI benefits. However, 3 of 10 Deaf individuals reported not having a source of income, and another participant reported family members as his only source of income. Because Oxford Houses are self-supporting and depend on members' ability to pay rent, houses designed specifically for members of the Deaf community may face unique economic challenges.

Future research will need to explore further the employment status of Deaf Oxford House members and its impact on recovery. Barriers to employment among Deaf individuals in recovery also need to be explored. Variables that may be related to inability to find employment (e.g., work history, criminal involvement) could not be explored in the present study because many of the Deaf participants' responses to relevant questions on the ASI were missing. Thus, the self-administered ASI employed in the

present study may not be an appropriate measure to use with Deaf individuals. Additionally, barriers that may be unique to Deaf individuals in recovery, such as experiences of discrimination and a lack of job skills, were not explored.

Limitations of the present study include the small sample size and the absence of women in the sample. Another limitation is that we were not able to collect follow-up data on Deaf participants' length of stay in Oxford House and their success at maintaining abstinence over a longer period of time. Nonetheless, the results of the present study suggest that ongoing investigations of the experiences of Deaf individuals in Oxford House may add to the literature on effective substance abuse recovery programs for this underserved group.

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