

Addressing substance use in patients with intellectual disability: 5 Steps

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Approximately 5% of patients with intellectual disability (ID) have a comorbid substance use disorder (SUD).¹ These patients frequently abuse alcohol, tobacco, and cannabis, but are largely underdiagnosed and undertreated for SUDs. Treatment for SUDs in these patients is critical because substance abuse among patients with ID is associated with developing mood disorders, long-term health consequences, incarceration, and interpersonal instability.¹ To ensure that these often-marginalized patients are adequately assessed and treated for SUDs, consider the following 5 steps.

1. Perform screening tests. Unfortunately, no substance use screening tests are validated specifically for patients with ID. When presented with mainstream screening tools, patients with ID could produce false positives or false negatives for 2 reasons:

- Patients with ID are more likely to respond in the affirmative to screening questions that they do not understand.
- Many screening questionnaires assume that patients possess an amount of knowledge and cognitive ability to abstract information that patients with ID may lack.

Clinicians should therefore adapt screening questions to better match the cognitive and communicative abilities of their patients with ID by simplifying sentences, using graphics, and avoiding negative phrases and confrontation. For example, while all-encompassing, the term “alcohol” may be confusing for some patients. Instead of broadly asking a patient, “Do you drink alcoholic beverages?” it may be necessary to specifically ask, “Do you drink wine?” or “Do you drink beer?” Similarly, it may

be insufficient to ask a patient, “Do you smoke marijuana?” Instead, use colloquial terms (ie, weed, reefer) to ensure that the patient knows which substance you mean. Screening questions can be complemented by ordering urine drug testing and obtaining collateral information from caregivers.²

2. Use approved medications to treat SUDs. Medication-assisted treatment (MAT) is underprescribed for patients with ID. Medication compliance in patients with ID may be a concern; however, many of these patients are compliant with treatment because they often live with family members, in group homes, or in other settings where their medications are administered to them.

Also, be mindful of whether your patient has epilepsy. This condition is common among patients with ID,³ and some MAT can lower the seizure threshold. When starting and titrating MAT, always monitor patients carefully for benefits and adverse effects.⁴

3. Make a thorough assessment before recommending Alcoholics Anonymous or Narcotics Anonymous meetings. While the 12-step recovery model has proven benefits, the typical structure of 12-step meetings is

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Adapt screening questions to the cognitive and communicative abilities of your patient with intellectual disability

not conducive to all patients with ID. Only recommend such meetings to patients who have 60- to 90-minute attention spans and demonstrate the cognitive, communicative, literacy, and social skills to fully engage during the meetings.⁵

4. Employ motivational interviewing.

Many patients with ID have cursory knowledge of the health risks associated with substance abuse, particularly those with mild ID. Motivational interviewing techniques that include health education may help produce favorable outcomes in these patients.⁶

5. Provide ongoing support. Remember that addiction is a chronic disease with a risk of relapse. Provide continuous support

for patients with ID and comorbid SUDs throughout all phases of their recovery, and refer them to addiction specialists, pain specialists, or psychotherapists as appropriate.

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