Dual Disorders: Mild Intellectual Disability and Substance Abuse

A.B. Hammink, J. VanDerNagel, and D. van de Mheen

Contents

15.1 Mild Intellectual Disability .................................................. 206
  15.1.1 Case 1: Peter .................................................. 207
15.2 Prevalence and Determinants of Substance Abuse Among People with Mild Intellectual Disability .................................................. 208
  15.2.1 Substance Use and Substance Abuse in Intellectual Disability Settings .................................................. 209
  15.2.2 Triple Diagnosis: Mild Intellectual Disability, Substance Abuse, and Psychiatric Problems .................................................. 209
  15.2.3 Case 2: Claire .................................................. 210
  15.2.4 Substance Abusers with Mild Intellectual Disability in Forensic Settings .................................................. 211
15.3 Screening for Mild Intellectual Disability in (Addiction) Care .................................................. 211
15.4 Recognition and Screening of Substance Abuse in People with Mild Intellectual Disability .................................................. 212
15.5 Treatment of Substance Abuse in People with Mild Intellectual Disability .................................................. 215
  15.5.1 Problems in Standard Care .................................................. 215
  15.5.2 Ways to Adapt Treatment to the Needs of Those with Mild Intellectual Disability .................................................. 215
  15.5.3 Inpatient Addiction Treatment .................................................. 217
  15.5.4 Case 3: Sandra .................................................. 218
  15.5.5 Specialized Inpatient Treatment .................................................. 218
15.6 Future Directions .................................................. 219

References .................................................. 219

A.B. Hammink (✉) • D. van de Mheen
IVO Addiction Research Institute, Rotterdam, The Netherlands
e-mail: hammink@ivo.nl; vandemheen@ivo.nl

J. VanDerNagel
Tactus Addiction Research Institute, Enschede, The Netherlands
e-mail: J.vandernagel@Tactus.nl

© Springer-Verlag Berlin Heidelberg 2015
G. Dom, F. Moggi (eds.), Co-occurring Addictive and Psychiatric Disorders,
DOI 10.1007/978-3-642-45375-5_15
Abstract

In European countries, there is an increasing awareness that substance abuse also occurs among people with a mild intellectual disability (MID). Individuals with MID often do not fit within the traditional (addiction) treatment systems and subsequently treatment outcomes can be poor. To improve outcome and treatment retention, programmes should be adapted to the specific needs and competences of these patients. This chapter describes substance abuse among people with MID from a European perspective. It aims at providing information and practical tools for both screening and treatment interventions.

15.1 Mild Intellectual Disability

An intellectual disability (ID) is defined by three aspects: significant cognitive deficits; a significant impairment in adaptive behaviour; and onset before the age of 18 (APA 2013). Adaptive behaviour can be impaired in different areas, such as communication, personal hygiene, independent living, social and relational skills, participation in society, autonomy, health and safety, applied knowledge, leisure, and work. An IQ between 50/55 and 70 is generally considered a mild intellectual disability (MID), an IQ between 70/75 and 85 is considered a borderline intellectual disability (BID) (APA 2013). Since persons with both mild ID and borderline ID encounter similar problems regarding substance use and substance use treatment, in this chapter, the term “mild intellectual disability” (MID) will be used for both MID and BID.

As can be concluded from the definition of MID, the difficulties of persons with MID are not limited to the cognitive domain and their academic performance. Some problems that are often seen in persons with MID are (VanDerNagel et al. 2013b):

- Cognitive deficits, which can be evidenced in a less structured way of information processing, difficulties with abstract thinking, a less well-functioning memory, a limited attention span, a limited insight in causality of behaviour, and less mental flexibility
- Delayed social and/or emotional development and psychological maturation
- Limitations in social adaptation. People with MID are more vulnerable in their social-emotional development, may experience difficulties in overseeing complex social situations and are less able to cope with the practical aspects of daily life
- Lack of self-control and a greater degree of impulsivity
- Low socio economic status (SES). Many persons with MID live in underprivileged neighbourhoods, have low incomes and limited access to (paid) work
- Co morbid psychiatric disorders. Apart from other developmental disabilities such as ADHD and ASS, examples are psychosis and mood disorders (see Sect. 15.2.2)
- Co-occurring behavioural disorders. Examples of problem behaviour are oppositional behaviour; aggressive or violent behaviour, suicidal behaviour and auto mutilation
- Somatic co morbidity, such as hearing and vision deficiencies, motor problems, and epilepsy
These examples illustrate the numerous and complex challenges that people with MID face. Many of their difficulties, and even their MID itself often go unrecognized (both by themselves and by professionals). The discrepancy between chronological age, level of cognitive development and level of social emotional development evidenced by these individuals poses additional difficulties, both for themselves, their families and those who care for them, as the case-example of Peter (see below) illustrates. People with MID therefore often need specific care and treatment services, including both long term and intensive counselling.

15.1.1 Case 1: Peter

Peter (51 years old, married with 2 teenage daughters) started working at the age of 14. He was “not fit for school, more of a practical guy”, worked as a hired help at a transportation company, and at age 21 got a commercial driver’s licence. Since then, he has been employed as a truck driver. He enjoyed his work on long haul projects, driving bulk-goods from Rotterdam harbour to all parts of Europe. Being a truck driver, he stuck to his bosses rule of “a beer or two max a day”, during his long weeks from home. During the occasional week off at home, he tended to drink somewhat more. During this time he could increasingly more often be found in the pub. At one point his company underwent reorganization and Peter was assigned to parcel delivery service. To plan his deliveries all over the Netherlands, Peter had to work with an electronic route manager. In the new situation he had to work a tight schedule. This was too much for Peter: he encountered numerous problems with the device, ran late and got more, and more frustrated and annoyed (as did his customers). After 2 weeks of trying to fulfil his new assignment, he went on sick leave. Bored at home, he spent more and more time in the pub, drinking until the point of obliviousness. When he had to visit the doctor to get a sick note, he was referred to a counsellor because of his drinking. During the intake, it became clear that Peter struggled to adapt not only to his new working conditions, but also to his role in his family, now that he spent more time at home. Drinking seemed Peters “solution” to ease his anxiety and stress. Peter was referred for psychological evaluation, during which it became clear that Peter could neither read nor write. He tested in the mild to borderline IQ range, with a verbal IQ of 74, and a performance IQ of 69. Only after this test did Peter reveal that as a child, he attended a “school for retarded children”.

As the case of Peter illustrates, it may not immediately become clear during treatment that a person has MID. Though many persons with MID can benefit from social services for those with ID (such as sheltered living, sheltered working, or community-based services), a large majority (especially those with borderline ID) does not receive specialized help. In fact, many individuals with MID do not see themselves as being “handicapped” and may therefore refuse specialized services themselves. Others may have had some specialized care in the past, but then terminated the service, often because of a need of more autonomy and independence. Most countries currently have policies that encourage more inclusive
societal or community-based care. This allows many people with MID to live a "normal" life, albeit with a little help. Thus, the fact that a patient holds a job or lives with a family of his own, does not preclude him from having an MID.

15.2 Prevalence and Determinants of Substance Abuse Among People with Mild Intellectual Disability

MID is a common disability in all European countries, but no prevalence rates on a European level are available. In the Netherlands (a population of almost 17 million people) for example, it is estimated that 120,000 people have an intellectual disability (IQ lower than 70), of which 60,000 people have a mild intellectual disability (IQ between 50 and 70). Approximately two million people have a borderline intellectual disability (IQ between 70 and 85) (Ras et al. 2010). In the last decade, it has become clear that substance use is prevalent among those with MID, and that this concerns all types of substances including illicit drugs (To et al. 2014; VanDerNagel et al. 2011a).

Prevalence estimates for MID substance abusers in Europe suggest lower rates of alcohol and drug use and similar rates of smoking when compared to corresponding rates for the general population. In general, it is estimated that 3% of all people with ID have problems with alcohol or drug use. However, several methodological issues limit the generalizability of international study findings regarding prevalence rates to a large MID population. Methodological reasons also complicate comparisons across countries, and between studies and subgroups. For instance, substance abuse is more common among people with MID and especially BID than among those with a moderate and severe intellectual disability (McGillicuddy 2006).

Well known risk factors of substance abuse, such as low socioeconomic status, problems with social contacts, behavioural and psychiatric problems, coping skill deficiencies, work-related problems, and financial problems are more often seen among people with MID than among their peers without MID (Hamminck and Schrijvers 2012). Substance abuse among MID is also associated with co-occurring severe behavioural problems and/or psychiatric problems (Caroll Chapman and Wu 2012; Didden et al. 2009). Additional determinants of increased substance abuse are inadequate coping skills, struggling with feelings of loneliness, stigmatization, and limited social skills. Furthermore, the desire to fit in and be socially include is an important reason for using substances and could therefore be seen as a risk factor of substance abuse (Caroll Chapman and Wu 2012). Substance abuse in any population is associated with severe physiological, psychological, and social problems. The consequences of substance use among people with MID may be more severe because of higher levels of somatic and psychiatric co-morbidity (McGillicuddy 2006), prescribed medication and social factors including difficulty accessing appropriate treatment (Slayter 2010), work-related problems and social interaction problems.
15.2.1 Substance Use and Substance Abuse in Intellectual Disability Settings

In many European countries, changes in health-care systems have led to a greater degree of deinstitutionalisation and integration of people with MID in the community. It could be that these changes lead to an increased vulnerability of substance abuse among people with MID. However, substance use and abuse is common in all subgroups of MID, including those in residential care (VanDerNagel et al. 2011a). The use of psychoactive substances (other than prescribed drugs) may in itself be a problem for ID settings, as some institutions have regulations against using substances. Other settings allow use of (some) substances, mostly limited to alcohol and tobacco, provided that staff members and other patients are not confronted with excessive use or negative consequences. Although these rules may provide support for some patients to stay clear of substance use, others might not be deterred. In ID services that ban (all or some) substance use, the substance use may go underground, or clients might use within their own quarters or outside the facility, and refrain from asking help when substance use poses problems. Several ID-facilities across Europe recognize this risk, and have started programmes to promote early identification and—if needed—adequate referral to substance treatment facilities. For instance, several ID facilities in the Netherlands and Flanders have implemented the use of the SUMID-Q, a Dutch instrument used to screen for and assess substance use (risk) among patients with ID (see Sect. 15.4). Unfortunately, such programmes are not widely implemented yet.

15.2.2 Triple Diagnosis: Mild Intellectual Disability, Substance Abuse, and Psychiatric Problems

Co-occurring psychiatric problems are an additional risk factor for substance abuse among people with MID. At the European level, little is known about prevalence rates of MID substance users with co-morbid psychiatric problems. In a Dutch sample of 185 MID individuals admitted to substance abuse treatment facilities, 42% had a co-occurring behavioural or emotional problem (Didden et al. 2009). In a sample of 115 MID adults seeking mental health services in London, 8% were current substance abusers and 15% had a history of substance abuse (Chaplin et al. 2011). These numbers suggest a need to incorporate the comprehensive assessment of substance abuse and psychiatric disorders into treatment plans for people with MID in mental health or psychiatric settings. Not in the least because triple diagnosis is often combined with problems in other areas such as housing, work, and social relationships.

The assessment of co-occurring psychiatric problems in those with MID and substance use disorder poses additional challenges to mental health care professionals for a variety of reasons. First, it requires knowledge of three fields of (mental) health care (addiction, general psychiatry and ID care). Though several countries (e.g. the UK) have excellent mental health services for those with MID, these services often do not include addiction services. Second, there is a lack of appropriate diagnostic
instruments and assessment methods for psychiatric conditions among those with MID. Third, psychiatric conditions may present differently among those with MID, and especially when there is co-occurring substance abuse.

15.2.3 Case 2: Claire

Claire is a 21 years young woman with trisomy 21 (Down’s syndrome). At the age of 18 she moved to a community-based training house, to learn skills needed to live on her own. Shortly after this move, she experienced a depressive episode. This was attributed to the changes in lifestyle and demands associated with these changes and successfully treated with cognitive behavioural therapy in combination with temazepam prescribed by her GP because of her sleeping problems. After this major episode, Claire has generally been doing well. With some help of the ID service staff, she started working as an aid at a food court. Here she enjoyed serving customers and meeting new people. In the last year or so, she started to “hang out” with some of the local youth after work. After a while, she even joined this group on Friday night outings. At first the staff members applauded this, since making friends had always been difficult for Claire. However, after six months, there were some concerns. Claire was late in returning to the house several times and disregarded house rules regarding alcohol use and smoking. She also started talking rudely to the staff, claiming that she “was entitled to make her own choices”. Even more concerns arose when Claire asked her older sister if she had ever tried ecstasy pills or speed. Fortunately, Claire also remained interested in improving her adaptive skills. Although she was always a bit anxious about living on her own, she seemed to consider this to be a serious option in the last few months. She even planned to get her drivers’ licence, which appeared impossible, as Claire has difficulties negotiating busy traffic even when on foot. One Saturday, things went wrong. Claire, who had been partying the night before, was irritated by the sounds of her housemates and picked a fight. She ended up assaulting a staff member who tried to intervene, and kept yelling that she was to make her own choices. Even her parents were unable to calm her down. Even though the yelling stopped, Claire stayed restless, very talkative, and full of plans of how she wanted to change her life by moving out instantaneously, getting a better paid job and finding someone to start a family of her own. Nobody slept well that night, including Claire, who kept packing and unpacking her suitcase. The next day, Claire agreed to talk to a person of specialized mental health services, and eventually was admitted with a tentative diagnosis of “drug induced psychosis or mood disorder”. Only when her irritability, grandiose and racing thoughts, sleeplessness, and restlessness did not subside after several weeks, did she receive the diagnosis of Bipolar I disorder.

The case of Claire illustrates how symptoms can be interpreted as being signs of psychological development, a struggle with discrepancy between abilities and social demands, a part of substance (induced) disorder, psychiatric illness, or a combination of these. This diagnostic puzzle can be further complicated by prolonged and progressed psychiatric illness, severe social problems (marginalization), forensic issues, medical conditions, etc. Therefore, a full assessment needs to be made, preferably by (a team of) clinicians with specific skills in working with
this group. In order to diagnose psychiatric disorders in people with MID, a healthcare professional can use the Diagnostic Manual-Intellectual Disability (DM-ID, Fletcher et al. 2007), an adapted version of the DSM-IV. The DM-IDII is currently being developed as an adapted version of the DSM-5.

As for the treatment of triple diagnosis, strategies for integrated treatment of dual diagnosis generally apply, as long as adaptations are made to better suit the needs of those with MID (see Sect. 15.5.2). Pharmacotherapy can often be necessary, but attention has to be paid to severe or unexpected side effects, as these seem to be more common among those with MID. For instance, benzodiazepines may lead to paradoxical agitation, or conversely, to severe drowsiness. Patients with MID may benefit from psychological treatment, including CBT and EMDR as well. In addition to the treatment of the patient’s symptoms, psychoeducation of family and professional caregivers is essential, as is developing a relapse prevention plan in collaboration with these parties.

15.2.4 Substance Abusers with Mild Intellectual Disability in Forensic Settings

Substance abuse and forensic problems seem to be associated for MID substance abusers as well. However, little is known about the prevalence of MID substance abusers in forensic settings on a European level. In a Belgian sample of detained substance abusers, 50% had MID (Vandevelde et al. 2005). These patients had more additional problems than detained substance abusers without MID, such as family issues and psychological problems. Another comparison, in this case between Dutch delinquent adolescents with and without MID showed that 56% of the delinquent adolescents with MID used alcohol and 46% used drugs compared to 27% and 4% among non-delinquent adolescents with MID (VanDerNagel and Kea 2013). Professionals in forensic settings may find it difficult to identify MID, substance abuse, or both. This makes providing sufficient care and preventing recidivism a challenging task.

In the Netherlands, an intervention called “Stay-away Plus” (Den Ouden et al. 2011) was developed specifically for adolescents with MID and substance abuse problems in the juvenile system. Characteristics of this intervention are a slower work pace than the regular Stay-away intervention, more room for explanation and repetition, more use of visual tools and less writing assignments. Increasing social control and avoiding risk situations are important goals, alongside increasing self-control. Another important characteristic is the involvement of an older or counsellor to ensure generalisation towards external situations and external control or boundaries.

15.3 Screening for Mild Intellectual Disability in (Addiction) Care

For professionals in addiction care, mental health care and forensic care, it can be difficult to recognize MID. Screening for MID in these settings is important, but in most European countries validated screening instruments are lacking. An example
of a valid screening instrument, developed in the UK, is the Child and Adolescent Intellectual Disability Screening Questionnaire (CAIDS-Q). Another screening instrument, that can be used among people aged 13 and older, is the Hayes Ability Screening Index (HASI, Hayes 2000). This instrument has been translated into several languages, including Dutch and Norwegian. If available screening instruments are not (yet) in use, professionals must be alert for signs that might indicate MID, such as (Didden et al. 2013):

- Unfinished primary school, grade retention, history of special education
- Limited or absent social network
- Use of simple language, incorrect use of more complex expressions, or prototypical use of standard phrases (“parroting” others expressions)
- Difficulties with comprehending language, as can become apparent when asked to summarize the conversation
- Reading and calculating difficulties (especially multiplying)
- Difficulties in remembering what was being said
- Uncomfortable attitude towards difficult questions

An IQ-test can be used to determine MID, but psychiatric co-morbidity, cognitive damage due to frequent substance use, acquired brain injury or intoxication during performance of the test need to be taken into consideration during interpreting the results of this test. It is recommended to perform the IQ-test when a patient with MID and substance abuse is stable and sober for several (at least two) weeks, and if necessary repeat the test after a year. A full IQ-test is preferred over a shortened version or a screener.

The life course of a patient can further clarify whether cognitive or learning disabilities were present before the age of 18, before substance use, or can show that there was trauma that led to acquired brain injury. Neuropsychological tests could indicate whether there is damage due to substance abuse, such as attention deficits, disordered executive functioning (for example the ability to plan things ahead and impulse control), short-term memory, and orientation problems. Furthermore, verbal IQ seems to be less easily affected by substance abuse than does performance IQ.

15.4 Recognition and Screening of Substance Abuse in People with Mild Intellectual Disability

It is important to detect substance use in patients with MID in an early stage to estimate the risks and prevent development of problematic use. Most MID substance abusers start using substances in early to late adolescence. This means that professionals in special education schools or related settings need to be alert for signs of early substance use to prevent the development of problematic use (Caroll Chapman and Wu 2012). Many signs of substance use can also occur in people with MID that do not use substances. However, often signs of (problematic) use are behavioural changes or deterioration of physical functioning compared to the
period prior to (the increase of) substance use. Signs and signals of substance abuse can be divided into the following categories (VanDerNagel et al. 2013b):

- Physical signs (e.g. weight changes, increase in falls, poor physical condition)
- Psychological signs (e.g. mood swings, difficulty concentrating, deviant behaviour, aggression, disinhibition, peculiar behaviour, and fluctuating behaviour) without a clear cause
- Social signs (e.g. leaving school early, truancy, negligence of appointments, changing social environment, social isolation, police contacts)

No single symptom is "proof" of substance use and the signs and potential signals of substance use should be interpreted in the light of the general behavioural pattern of the person of interest.

In the MID population, signs and symptoms of substance use are often not recognized at all, or are misattributed to other factors such as physical or psychiatric conditions. It is only after the substance use problems have progressed, that (with benefit of hindsight), earlier symptoms are recognized as symptoms of substance (ab)use (Sturme et al. 2003). Hence, there is a need for tools for screening and early identification. Unfortunately, screening and assessment of substance use in people with MID is hindered by a lack of suitable questionnaires (McGillicuddy 2006; VanDerNagel et al. 2011a). Widely used instruments that are validated for the general population (e.g. CAGE, MAST, AUDIT/DUDIT) require a basic level of knowledge, conceptual understanding, the ability to reflect on one's own behaviour, or an adequate memory that people with MID may lack. For instance, some patients use slang for the substances they use, and not recognize alternative terminology, or the fact that the term "drugs" applies to their use as well. Also, questions such as "how often do you drink to remediate symptoms of withdrawal" requires adequate memory and skills to relate causes and effects that persons with MID may lack. The fact that some questions may be too complex may not become clear during interviewing, as some persons with MID are (highly) suggestible, and may say "yes" or "no" according to their interpretation of what the interviewer wants to hear. To add to these problems related to structured questionnaires, some patients may tend to be secretive about their use, even when this is not in their best interest. All of these issues may lead to invalid responses when persons with MID are interviewed with unsuitable instruments (VanDerNagel et al. 2013a).

For this reason, VanDerNagel et al. (2011) developed a Dutch screening instrument, the Substance Use in Individuals with Mild Intellectual Disability-Questionnaire (SUMID-Q, Box 15.1) (VanDerNagel et al. 2011b). As far as we know, this is the only screening instrument as of yet available in Europe, which was specifically designed for the MID population.
Box 15.1. Steps of SUMID-Q

The SUMID-Q consists of several steps (VanDerNagel et al. 2011b):

Before step 1: Establish a good working relationship and be willing to discuss substance use in an open, empathetic way. Maintain this neutral stance and an inquisitive attitude during the whole interview.

Step 1: Talk about psychoactive substances in general

- Assess patient’s familiarity with substances and his terminology (use pictures, starting with more common substances such as smoking and alcohol). Use the patient’s terminology in the remainder of the interview, do not further enquire about substances the patient does not seem to be familiar with.
- Assess patient’s further knowledge of and attitude towards each type of substance.

During this phase, remain interested in the patients opinion, do not correct or confront him/her unless you are asked for your opinion (if so, briefly present your point of view without elaborating or starting a discussion).

Step 2: Talk about other persons substance use in general

- For instance, discuss other person’s substance use (substance use among peers, staff, family members: “Does your father/mother/sister/friend/caregiver use…?”)

Step 3: Enquire about patient’s own experiences with substance use

- Ask about life time use (“Did you ever use... yourself?”, if so: “How old were you?”)

During this step, remain neutral. Try to be interested without being inquisitive. Accept whatever answer was given, without questioning its validity.

Step 4: Further inquire about the use of this type of substance to assess

- Patterns of use (frequency, quantity)
- Circumstances (alone/with others, at home or somewhere else)
- Effects (positive and negative)

In this phase it remains important to keep a genuine interest in the client’s story. Focusing on the “how” “what” “when” “with whom” “to what effect” helps to do so. Try to avoid “why” questions.

Repeat steps 2–4 for other types of substances.
15.5 Treatment of Substance Abuse in People with Mild Intellectual Disability

Ideally, addiction care, intellectual disability services, and—when applicable—psychiatric and/or forensic services work closely together in the treatment of MID substance abusers with or without co-occurring psychiatric or behavioural problems. Unfortunately, this is far from reality. In daily practice, care and treatment for those with dual (MID and addiction), triple (MID, addiction; and psychiatric, behavioural or forensic problems) is scattered across services. Apart from collaboration issues, knowledge regarding intellectual disability (in addiction care or forensic settings) or substance abuse (in intellectual disability settings) is lacking. Therefore, those with MID (whether it is identified as MID or not) who are referred for addiction care often receive "standard care".

15.5.1 Problems in Standard Care

Unfortunately, addiction treatment protocols are often not suited to the needs of persons with MID. Problems may arrive as early as the referral; many persons with MID will not seek help, do not know where to go or a letter with scheduled appointment may remain unopened. During the initial assessment, similar problems may arise as during screening (see Sect. 15.4). Further, many persons with MID cannot voice their needs and problems, which can be mistaken for lack of motivation or no need for help. Treatment protocols, in addiction are often quite verbal, require reading skills and the capacity to do exercises at home. Many persons with MID lack skills needed for these actions.

Furthermore, many patients with MID have previous experiences with addiction treatment in which they have failed (for instance, because the programme was too difficult for them) and are not confident that a new attempt will succeed. Existing treatment programmes are not designed for people with MID, they often make a great appeal to the self-sufficiency of patients with MID. In general, it is important to embed treatment of substance use within the environment of the patient with MID. A patient can successfully complete a treatment in an institutional setting, but then be unable to apply the achieved skills in their own home environment (generalisation).

15.5.2 Ways to Adapt Treatment to the Needs of Those with Mild Intellectual Disability

To better suit the needs of those with MID, several adaptations can be made to standard treatment protocols and procedures. These adaptations concern treatment content, but even more so treatment length and the way that the content is presented and communicated (VanDerNagel et al. 2013b). Ideally, information about the cognitive level, communication skills, developmental level and co-morbidity is
collected before treatment starts. Developmental level in particular, rather than biological age or first impression needs to be taken into account when interviewing the patient. Treatment sessions must be planned according to the patient’s needs. Most patients with MID benefit more from multiple shorter sessions, than from one single lengthy session. It is also preferable to keep waiting times in crowded waiting rooms as short as possible. Confrontation with other substance abusers may induce anxiety or lead to undesirable social interactions (VanDerNagel et al. 2013b).

The first step to successful treatment is establishing a good working relationship. This requires more effort from the therapist than with patients without MID (Sturme et al. 2003). Many persons with MID are tense when confronted with a new therapist and will need some time before they feel at ease. It is often helpful when a mentor (from ID services) or a trusted family member can be present during sessions. Offering a cup of coffee, explaining the goals of the session, engaging in some “small talk” and taking a more supportive, positive stance may help the patient to feel comfortable with the new situation. During communication with the patient, it is preferable to use short sentences, avoid difficult wording, abstract concepts and complex phrases. It may be helpful to use pictures and (fake) props (e.g. beer bottles, washing soap as fake cocaine, herbs for cannabis) to (literally) show which substances are discussed. Communication with a patient with MID should be as precise and concrete as possible, asking one question at a time and not presenting too much information at once (Sturme et al. 2003).

To check understanding and promote retention, it may be helpful to ask the patient to summarize what was discussed. When collateral information is needed, permission needs to be asked to address the person who accompanies the patient (this is generally granted). Main focus of the therapy should be to help the patient find solutions instead of emphasizing (or denying) problems. Further, positive feedback rather than confronting techniques or lectures should be used. With some help, most patients are able to fill out a (simplified) registration form, provided that filling out is practised during sessions. An analysis of the function of substance use as well as strong points, interests and social support factors of a patient generally helps to find new perspectives. Talking about the fact that relapse is not failure in and of itself often reduces both pressure and fear of trying to change (VanDerNagel et al. 2013b).

A number of existing treatment models and methods can be used for patients with MID, in some cases with several adjustments. First, motivational interviewing shows promising results in some small-N studies among those with MID (Mendel and Hipkins 2002; Treutelman et al. 2013) and can easily be modified to the needs of patients with MID (Frielink and Embregts 2013). Second, cognitive–behavioural therapy (CBT) is widely used in ID care, and as preliminary studies show, CBT-based interventions for substance use can be adapted to persons with ID (De Haan et al. 2012; VanDerNagel and Kiewik nd). A CBT based group intervention was successfully piloted in the Netherlands (Den Ouden et al. 2012). In both individual and group CBT interventions for MID, there is more focus on practising skills, rather than understanding behaviour. Also, these interventions were markedly longer, since people with MID generally require more time to learn new skills.
Third, self-help groups can be very supportive for persons with MID (Stumey et al. 2003). In self-help groups, people with similar problems meet each other. Participants benefit from each other’s experiences in solving problems or making them manageable. A well-known self-help group around the world is Alcoholics Anonymous (AA). Many of these self-help groups use the Twelve Steps Programme, which is aimed at abstinence. This programme was developed for alcoholics, but is used for other addictions as well. In Germany, there are some AA-meetings for people with special needs (e.g. MID). Focusing in other ways on the betterment of the MID patient’s personal relations is also worthwhile, as a supportive environment often is prerequisite to staying clear from substances. Third parties can also play an essential role in implementing new skills in daily situations.

Regarding pharmacological treatment of people with MID, similar criteria apply as for people without MID. However, some people with MID are more sensitive to side effects, so careful monitoring is necessary. Clear instructions—both to patient and caregiver—accompanied by a clear written instruction of dosage, usage and risks are necessary. Use of aversive drugs can be risky in those with limited understanding of the consequences of combining these drugs with alcohol.

Unfortunately, there are also some pitfalls in working with persons with both MID and substance use problems. Commonly made errors are i.e. mistaking the incapacity to adhere to treatment requirements (e.g. to do certain exercises) for lack of motivation, assuming the patient will tell the therapist when something is unclear, focussing on big (often abstract or seemingly unreachable) goals rather than short time successes, and assuming the patient can apply newly learnt skills in other situations (this generally takes a lot of practice) (VanDerNagel et al. 2013b). Furthermore, based on experience in clinical practice, follow up after reaching goals is often too short.

### 15.5.3 Inpatient Addiction Treatment

Though some clinics seem to be reluctant to admit patients with MID, indications for inpatient treatment are basically similar to those without MID. People with MID may benefit from a therapeutic setting, with 24/7 support, medical attention etc. Often, in acute clinical care (e.g. detoxification or short term admittance) advantages outweigh disadvantages (for those with a proper indication). In these short-term inpatient wards, focus often is on medical care and stabilization, rather than on psychological or group treatment. Prolonged clinical care, especially when group therapy is a major part of the therapy plan, generally needs more adaptations for those with MID (VanDerNagel et al. 2013b). However, downsides of admission to inpatient treatment are that leaving the home environment can be stressful and in some cases traumatizing for a patient with MID. Furthermore, because the treatment programme is not adjusted to the patient’s needs or his MID is not acknowledged by the care professionals, the chance of overburdening a patient is present during inpatient treatment.
15.5.4 Case 3: Sandra

The first time Sandra (23 years, IQ about 60, ADD and cannabis use disorder) was admitted, she was reluctant to go. Though she agreed that “back home things did not work out”, she was scared to meet other people (of course, when asked, she would deny this) and was convinced she could not be helped in reducing her cannabis intake. Unfortunately, her expectations became true. It was only upon admittance that it became clear that she was to share a room with another patient. Janet seemed nice enough, but she was much older and could not stop talking and asking Sandra questions. Then it became clear that Sandra had to quit smoking cannabis instantly, without any medication to reduce withdrawal symptoms, or to remediate the sleeping problems she had since early childhood. And finally, to her horror, Sandra had to participate in group therapy, and participate in cleaning the ward, setting the table etcetera. Sandra’s shy and aloof attitude was addressed in a group meeting by one of the staff members. This was too much: Sandra ran out and discharged herself only days after admittance.

A year later, Sandra’s problems had only gotten worse, despite prolonged outpatient treatment. Her parents (with whom she was still living) were getting desperate, and pushed for another attempt of inpatient detoxification. Sandra of course, was even more reluctant than before. This time however, Sandra and her case manager visited the clinic before admittance, and met with one of the senior nurses. She showed Sandra the ward, and asked her what she remembered from the last time. Sandra proudly showed that she still knew were the kitchen, bathrooms, and recreation area were. Only during this tour Sandra found out that there were also private rooms. With a little help from her case manager, she could explain why such a room would help her to get the rest she needed. When hearing about Sandra’s sleeping problems, the nurse proposed that Sandra would sleep close to the nurses’ quarters, so that she would not feel alone at night. During group sessions and meals, Sandra could be seated next to the staff as well, if she would like that. Finally, the nurse reassured Sandra that medication for withdrawal symptoms and sleeping problems need not be a problem. Eventually, Sandra decided to give it a go, and a 2 week inpatient detoxification was agreed upon. Sandra was admitted Friday afternoon, after several patients had left for a weekend at home. This allowed her a few quiet days to get used to being in the clinic. Two weeks later, Sandra was proud to have completed her inpatient treatment as planned.

15.5.5 Specialized Inpatient Treatment

In the Netherlands, a small number of addiction treatment services or ID treatment services offer specialised treatment programmes for patients with MID and substance abuse programmes. Similar programmes may exist in other European countries. These programmes are characterised by an integrated approach that focuses on the treatment of substance abuse and functioning of the patient in different areas, such as leisure time, guiding patients to daily activities or work,
keeping an appropriate day- and night rhythm, strengthening adaptive skills and building a social network. Another part of this type of treatment is restoring contact with family members. Admission in an inpatient treatment centre starts off with detoxification. In most cases, detoxification of patients with MID and addictive behaviour can be done in a regular detoxification unit, because clinical programmes during detoxification generally are not primarily aimed at changing behaviour and gaining insight. Also, there are few group activities during detoxification and mainly individual counselling is provided. First observations can be made during this phase, which can provide a basis for future diagnostics. In mainstream addiction treatment, group therapy is one of the main types of treatment. This group therapy has a tendency to overburden a patient with MID because of the assumed high level of social and emotional skills. Be this as it may, some patients with MID are able to function successfully in group therapy.

15.6 Future Directions

On a European level, attention towards substance abuse (and co-occurring psychiatric disorders) among people with MID is increasing. This chapter has shown that the screening on substance abuse in ID services or of MID in forensic or psychiatric services remains important. Further, more research is needed on treatment of dual and triple diagnosis in people with MID. Commonly used treatments methods, such as motivational interviewing, cognitive behavioural therapy and pharmacotherapy, can be used with people with MID, as long as the methods are modified towards the needs of people with MID. To offer a successful treatment, it is necessary to collaborate with all relevant services that are involved with the patient with MID (e.g. ID services, mental health services, forensic services, addiction care). Further, treatment needs to be embedded in a trajectory that focuses on the daily routine of people with MID, such as daily activities, job, social network, and skills to cope with adverse events. Because of the gaps and shortcomings in current research, collaboration on a European level regarding substance abuse among people with MID is desirable.

References

VanDerNagel J, Kiewik M (nd) CGT-plus, cognitieve gedragstherapie voor verslaving bij mensen met een lichte verstandelijke beperking. Amersfoort
VanDerNagel J, Kiewik M, Van Dijk M, De Jong C, Didden R (2011b) Handleiding SumID-Q. Meetinstrument voor het in kaart brengen van middelengebruik bij mensen met een lichte verstandelijke beperking. Tactus, Deventer
VanDerNagel J, Kemna L, Didden R (2013a) Substance use among persons with mild intellectual disability: approaches to screening and interviewing. The NADD Bulletin 16(5)