

## Identifying Substance Abuse Among Clients With Intellectual Disabilities

Contributed by Elspeth M. Slayter, PhD

So, your field placement involves work with clients who have intellectual and/or developmental disabilities (ID/D, formerly mental retardation/developmental disabilities or MR/DD). Perhaps you know that this population has enjoyed increasing levels of freedom and access to community living. But perhaps you didn't know that this increased exposure to community life has led to greater susceptibility to alcohol and drug problems. {mosgoogle right}

Substance abuse in this population can lead not only to increased social isolation after the development of a substance abuse problem and criminal justice involvement, but also to victimization while under the influence, increased cognitive disability, physical impairment, poor impulse control, substance abuse-related medical conditions, and the potential for life-threatening cross-reactions with commonly-prescribed psychotropic medications.

Now, this may seem like a remote possibility, yet clinicians suggest that people with ID/D may have a greater susceptibility to the effects of alcohol and drugs than the general population. Substance abuse treatment providers are often unsure of how to treat this population, as standard approaches may not be appropriate or effective. People with alcohol and drug problems are known to have the potential for higher health care costs and to contribute significantly to national criminal justice costs. Unchecked, this medical problem could cause significant additional cost to state MR/DD agencies, as well as to the Medicaid and Medicare health insurance programs.

We know that nationwide, nearly four million people with ID/D live in non-institutional, community settings today, about 1.5% of the population. Substance abuse may not be the first thing we think of when considering adults with ID/D. Those with mild to moderate ID/D and alcohol and illicit drug problems constitute a marginalized and often poorly supported population. But in 1995, more than 30,000 Americans with ID/D received services for substance abuse issues (Larson, Lakin, Anderson, & Kwak, 2001). So, this issue might affect your clients! Remember, although this is the best estimate of substance abuse in this population, it is probably a low estimate, as it focuses on the receipt of services. Additionally, the literature tells us that people with ID/D face significant barriers to identification of the problem in this population and that there is no scientifically-based approach to treatment that is specifically designed for people with ID/D (Slayter, 2008).

Broad social and cultural views of this population may delimit the scope of how well, and whether, their substance abuse problems are addressed. Denial of the potential for substance abuse among this population may arise from stigma, fear, and discomfort around interacting with people with ID/D or around addressing a substance abuse problem. All these hinderances may in turn limit access to treatment (Slayter & Steenrod, 2009).

Further complicating the issue is the fact that the symptoms of ID/D can themselves mask potential substance abuse problems, making identification difficult, not only by ID/D professionals, but by those in the substance abuse and medical fields as well. Yet, once identified, practitioners are often unclear about best next steps (Slayter & Steenrod, 2009).

Substance abuse in this population raises difficult questions about the civil rights and social responsibilities related to the support and care of people with ID/D. Current frameworks upon which the social service system for people with ID/D rests emphasize self-determination and human rights, a response that evolved because of their historic marginalization (Slayter, 2007). Substance abuse here, however, presents an unusual challenge to self-determination-oriented treatment. The dignity of risk is a term coined by Robert Perske, a disability activist who addressed the overprotection of people with MR during the institutionalization era (Perske, 1972). Perske describes this concept as follows:

Overprotection may appear on the surface to be kind, but it can be really evil. An oversupply can smother people emotionally, squeeze the life out of their hopes and expectations, and strip them of their dignity. Overprotection can keep people from becoming all they could become. Many of our best achievements came the hard way: We took risks, fell flat, suffered, picked ourselves up, and tried again. Sometimes we made it and sometimes we did not. Even so, we were given the chance to try. Persons with special needs need these chances, too. Of course, we are talking about prudent risks. People should not be expected to blindly face challenges that, without a doubt, will explode in their faces. Knowing which chances are prudent and which are not—this is a new skill that needs to be acquired. On the other hand, a risk is really only when it is not known beforehand whether a person can succeed. The real world is not always safe, secure, and predictable, it does not always say "please," "excuse me," or "I'm sorry." Every day we face the possibility of being thrown into situations where we will have to risk everything.... In the past, we found clever ways to build avoidance of risk into the lives of persons living with disabilities. Now we must work equally hard to help find the proper amount of risk these people have the right to take. We have learned that there can be healthy development in risk-taking and there can be crippling indignity in safety! (Perske, 1972)

So, ask yourself to consider these important questions—both as a person and as a social worker with a specific client in mind, perhaps. Do people with ID/D deserve the dignity of risk when it comes to engaging in the abuse of alcohol and illicit drugs? Given that people with ID/D are a vulnerable population, how can the rights of people with ID/D be balanced with the responsibilities of the state to safeguard both their rights as citizens and their safety?

Despite these thorny questions and the challenges associated with identifying substance abuse in this population, there are things you can do. Start by reaching out to colleagues "across the aisle," perhaps your fellow students, who work in substance abuse treatment settings (Slayter, 2008). For now, here is a guide to identifying substance abuse among people with ID/D.

- Frequent intoxication: Do recreational activities center around getting and using substances, as well as recovering from use?
- Atypical social settings: Does the person's immediate peer group suggest that substance abuse may be encouraged? Is the person reluctant to attend social events where substances will not be present?

- Intentional heavy use: Does the person in question use substances along with prescribed medication? Does the person seem to use more than is safe?
- Job problems: Has the person missed work or been late because of use of substances? Does the person blame his/her ID/DD status for work problems?
- Health problems: Does this person have medical problems that are aggravated by repeated substance use? Has this person been victimized while under the influence?
- Problems with significant others: Has a family member or friend expressed concern about this person's substance use? Have important relationships been impaired as a result of substance use?
- Problems with authority/the law: Has the person been visited by police and/or arrested as a result of alcohol or drug-related offenses? Adapted from Owen, P. (1999)

Remember, don't rule out the idea of substance abuse--until you rule it out clinically!

## References

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