Letters to the Editor

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ASSOCIATIONS BETWEEN SUBSTANCE USE DISORDERS AND SUICIDE MORTALITY RISK SHOULD BE ADJUSTED FOR TOBACCO USE DISORDER

In January 2014, Bohnert *et al.* [1] reported in *Addiction* an excess risk of death by suicide in individuals diagnosed with tobacco use disorder. Their findings derived from a cohort of the US Veterans Health Administration (VHA) records and included all individuals who received VHA services in fiscal year (FY) 2005 and who were alive at the beginning of FY 2006 (n = 4 863 086). In an unadjusted, bivariate model, tobacco use disorder was associated significantly with an increased risk of suicide [hazard ratio (HR) = 1.88; 95% confidence interval (CI) = 1.76–2.02). After adjustment for a number of confounders—including substance use disorders—the association, although attenuated, remained significant (HR = 1.36; 95% CI = 1.27–1.46). This paper added strong evidence to the already well-demonstrated increased independent risk of suicide death among smokers [2–5].

The reading of the recent paper of Bohnert *et al.* [6] in the same journal triggered some level of surprise. The authors, reportedly using the same database of individuals who received VHA services in FY 2005 and who were alive at the beginning of FY 2006 (n = 4 863 086), aimed to estimate associations between substance use disorders and suicide. The authors specified HRs between each alcohol, cocaine, cannabis, opioid, amphetamine, psychostimulant and sedatives use disorders, but not tobacco use disorder and death by suicide, in unadjusted and adjusted models. In the adjusted models, adjustment was made for many possible confounders (age, Charlson comorbidity index, co-occurring psychiatric conditions such as depression, schizophrenia, bipolar disorder, post-traumatic stress disorder and other anxiety disorders) but, astonishingly, not for tobacco use disorder or smoking.

Thus, the authors demonstrated in 2014 [1] that tobacco use disorder was associated significantly with suicide mortality after adjusting for substance use disorders. The 2017 paper by the same authors [2] using the same database seems to ignore their own previous finding.

Declarations of interest

None.

Keywords Cohort, epidemiology, methods, psychiatric disorders, smoking, substance use, suicide, tobacco use.

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RESPONSE TO AUBIN *ET AL.* (2017)

We appreciate the comments on our paper by Aubin and colleagues [1], and agree that tobacco use disorder is a potentially important risk factor for suicide. Nonetheless, given preliminary evidence suggesting potential male–female differences with respect to other substance use disorders (SUDs) and the risk of suicide, the primary objectives of our most recent paper [2] were to estimate and compare other SUD-suicide associations between men and women in the US Veterans Health Administration (VHA). Within the paper, we acknowledged that incomplete adjustment for confounding factors, measured or unmeasured, was a potential study limitation. We elaborated further that,

due to power constraints, we were unable to account for co-occurring SUD diagnoses, which includes tobacco use disorder. Nonetheless, in order to address the specific concerns about tobacco, we ran model 3 including tobacco use disorder, and findings were only modestly attenuated and broadly consistent with the prior model 3 findings; the hazard ratios (HRs) estimating suicide risk associated with any current SUD were 1.5 [95% confidence interval (CI) = 1.4–1.6] for men and 1.9 (95% CI = 1.2–2.8) for women. Overall, it is important to acknowledge that this study was undertaken to identify markers of risk for suicide (e.g. to inform providers and health systems), not to necessarily make causal inferences about mechanisms of risk.

Declaration of interests

None.

Keywords Drug use disorders, risk, substance use disorders, suicide, tobacco use disorder, veterans.

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INTELLECTUALLY DISABLED AND ADDICTED: A CALL FOR EVIDENCE BASED TAILOR-MADE INTERVENTIONS

At the start of our project, substance use disorders (SUD) among adults with intellectual disabilities (ID) and knowledge on SUD in individuals with ID was limited [1]. In recent years, epidemiological studies have emerged, indicating that this population may be larger than thought initially. In our study [2] (n = 407, 97%) on SUD almost all individuals with ID had used alcohol and tobacco at least once in their lives, and 50% of them had used at least one illicit substance. The judicial system shows that there is an over-representation of this group [3]. Data from several prison populations showed higher ID levels than in the community (between 10 and 70%), especially among prisoners with psychiatric disorders [4]. It is estimated that a high percentage of SUD is present among prisoners with ID [5].

However, little is known about evidence-based interventions for SUD in individuals with ID. There are several reasons for the gap between epidemiological knowledge and treatment modalities. First, this group is frequently denied access to the full range of available services, including prevention, (early) intervention and aftercare. Secondly, when individuals with ID are admitted to substance treatment they are often unable to benefit from mainstream interventions, due to their limited vocabulary, poor development of memory function and difficulties discriminating between relevant and irrelevant information. They experience problems with planning and attention, have impaired abstract reasoning and low self-insight. Furthermore, group-based programmes are difficult for people with ID to participate in because they are often too abstract, proceed too fast or require adequate social skills. Therefore, a great need exists for effective, tailor-made treatment strategies designed for these patients.

In order to bridge the gap between our epidemiological knowledge and treatment modalities, we conducted a review of the literature on obstacles for SUD treatment for individuals with ID, and the opinions of authors regarding the adaptation of treatment programmes. We found only six studies, including two randomized studies, that provide data regarding a treatment modality, covering a total of 148 participants world-wide. The overall conclusions of these reviewed studies are that the substance-related knowledge increased, but failed to impact substance-related attitudes, intention to stop using or the substance use itself. The interventions are often too short and do not take into account the complex nature of SUD in ID. We conclude that almost no new insights were presented between 1980 and 2015.

This provides food for thought that the lack of adequate treatment modalities might lead to societal exclusion, and even criminalization, of this group [6]. This leads to an extremely problematic situation, as there is apparently lack of attention from scholars, clinical agencies, donors and governmental-funded bodies to invest in the development and adaptation of evidence-based treatment modalities for this group.

The co-occurrence of SUD and ID thus calls for scientific collaboration between addiction care and intellectual disability services. By illustrating the gap of research, we aim to spark future research and we will take the initiative to collaborate with the clinical and research community to combine the effort of researching SUD and ID. Further, we