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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References

1. Aubin H-J., Luquiens A., Legleye S., Berlin I. Associations between substance use disorders and suicide mortality risk should be adjusted for tobacco use disorder. *Addiction* 2017; **112**: 2066.
2. Bohnert K. M., Ilgen M. A., Louzon S., McCarthy J. F., Katz I. R. Substance use disorders and the risk of suicide mortality among men and women in the US Veterans Health Administration. *Addiction* 2017; **112**: 1193–201.

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

plead for sufficient research capacity and funding to address evidence-based treatment modalities.

Declaration of interests

None.

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References

1. VanDerNagel J. E. L., Kiewik M., de Jong C. A. J., Buitelaar J. K., Didden R., Uges D. R. A. *et al*. Grant application form. Dossier number: 6060600-97-158. ZonMW programma risicogedrag en afhankelijkheid [ZonMW program risk behavior and dependency]; 2008.
2. VanDerNagel J. E. L. Is it just the tip of the iceberg? Substance use and misuse in intellectual disability (SumID). Doctoral thesis, Radboud University Nijmegen, the Netherlands, 2016. Available at: https://www.researchgate.net/publication/308632073_Is_it_just_the_tip_of_the_Iceberg_Substance_use_-and_misuse_in_Intellectual_Disability_SumID (accessed 18 August 2017) (Archived at http://www.webcitation.org/6snyzcwR7).
3. Cockram J., Jackson R., Underwood R. People with an intellectual disability and the criminal justice system. *J Intellect Dev Disabil* 1998; **23**: 41–56.
4. Tort V., Dueñas R., Vicens E., Zabala C., Martinez M., Romero D. M. Intellectual disability and the prison setting. *Rev Esp Sanid Penit* 2016; **18**: 25–32.
5. Fazel S., Bains P., Doll H. Substance abuse and dependence in prisoners: a systematic review. *Addiction* 2006; **101**: 181–91.
6. Bhandari A., van Dooren K., Eastgate G., Lennox N., Kinner S. A. Comparison of social circumstances, substance use and substance-related harm in soon-to-be-released prisoners with and without intellectual disability. *J Intellect Disabil Res* 2015; **59**: 571–9.

THE LESSONS LEARNED FROM THE FENTANYL OVERDOSE CRISES IN BRITISH COLUMBIA, CANADA

Background

Sir: In 2016, more than 900 people in British Columbia (BC), Canada, lost their lives due to unintentional drug overdoses, attributed mainly to illegal drugs mixed with ultrapotent opioids, such as fentanyl groups, which marked an 80% increase compared to the previous year [1,2].

Since 2016, the health authorities and various levels of government in BC have worked together on implementing different methods to control the epidemic [3–7]. There have been some important strategies used in the city of Vancouver which, in our opinion, have been novel in their approach. These strategies included a multi-sectoral approach that involved drug-user community engagement by increasing accessibility, distribution and training in the use of naloxone in addition to early public health crisis declarations, law enforcement engagement, establishment of overdose prevention sites and health-care policy shifts [8,9].

Ways forward

In addition to operating the only legally sanctioned supervised injection facility in North America, Vancouver has benefited from numerous community harm reduction consumption facilities that previous research has shown to have clear benefits [8–12]. Moreover, the harm reduction program in Vancouver has focused on utilizing peer drug user networks [12–14] which has proved to be extremely effective in reducing mortality rates in Vancouver [15–17]. Vancouver is also the only city in North America that has been implementing heroin-assisted treatment [18].

Despite the relative success in controlling the epidemic in Vancouver, the overdose crisis continues to take lives. This could be due to the direct link between the epidemic and the stigmatization and demonization of substance use disorders; a chronic–relapsing medical condition that has traditionally received harsh criticism through its criminalization and massive drug-related incarcerations, rather than supportive health-care evidence-based models. The current drug policies that affect men and women unequally are comparable to the 'discourse of disposal', a social milieu for 'getting rid' of certain segments of society (reflected in policy), such as homosexuals and sex workers [19]. These unjust drug policies are also reinforced by perceived devaluation and discrimination associated with substance use disorders.

Next steps

In our opinion, there is no straight path forward; however, acknowledging the complexities of relapsing nature of addiction as a chronic illness and working with the reality that some people are not willing or ready to stop using drugs is certainly a good start.