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UK DRUG POLICY COMMISSION

# The Impact Of Drugs on Different Minority Groups: A Review Of The UK Literature

## Part 3: Disabled people

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# Executive summary

The Office for Public Management (OPM) was commissioned by the UK Drug Policy Commission (UKDPC) to conduct a review of the literature relating to a range of aspects of drug use among people with disabilities. This review forms part of a wider programme of work undertaken by the UKDPC, the aim of which was to provide an overview of what is known about the differing needs and challenges associated with drug use among diverse minority communities within the UK. This research was funded by the Home Office.

UKDPC's specific objectives for the review were to provide an overview of the evidence relating to people with disabilities on the following issues:

1. The extent and nature of drug use
2. The need for and access to prevention and treatment programmes
3. Interaction with the police and criminal justice system as a result of drug-related enforcement activity and drug markets.

Representatives from the UKDPC and OPM review team recognised from the outset that there is likely to be a dearth of literature relevant to all three objectives and numerous gaps in the evidence. In order to redress this, a second element of this review includes a review of data sources held at the UK Data Archive in order to identify datasets that record both disability and drug use. Appendix 1 provides an overview of these datasets. OPM and UKDPC agreed that mental health would be excluded as a disability type for this review. This was because the number of references obtained in the early searches that included this term was vast and it would not be possible within the scope of this project to provide an in-depth analysis that would do justice to the complex nature of the associations between mental health and drug use. Additionally, in order to make the search process manageable, the following specific disabilities were searched for: learning difficulties; hearing impairments; visual impairments; speech, language and communication impairments; and mobility/physical impairments.

The literature search, review and synthesis were informed by good practice guidelines issued by government agencies and universities (Government Social Research, undated; EPPI-Centre, 2007; Hartley, 2004). These have been developed with the specific aim of facilitating the synthesis of diverse material to inform

the evidence-based policy and practice movement within the UK. The search was conducted in partnership with search specialist Alan Gomersall, Deputy Director of the Centre for Evidence-Based Policy and Practice (CEBPP). The review as conducted over a number of stages and literature was identified from a series of database searches, and by advisory group members and other experts. Following the sifting process, 13 items were included for review.

The review found that sample sizes within individual studies were relatively small, and that participants are often researched through ‘proxies’ such as nurses or social workers. Additionally, some of the studies reviewed are themselves reviews of existing data, and sometimes provide no information about the methodologies used in relation to those sources cited. Where reviews of existing evidence do reflect on the quality of their source material, some find it to be methodologically poor, with limitations including: small sample sizes, lack of reliable and viable measurement tools, studies undertaken in hospitals where the person’s access to alcohol and drugs is limited, lack of control groups, lack of generalisability and no long-term follow-up. Comparisons between studies are also difficult to make since operational definitions of ‘use’ and ‘misuse’ differ. A clear demographic breakdown of disabled research participants is also often lacking. **Caution should therefore be used when interpreting findings.**

## **KEY FINDINGS**

### ***Objective 1: The extent and nature of drug use***

The most recent and reliable source that provides data on the prevalence of drug use among people with disabilities is Hoare’s report on the findings from 2008/09 British Crime Survey (2009). Those respondents that did not have a long-standing illness or disability (LSID) were slightly more likely to use class A drugs (3.9%), stimulant drugs (4.7%) and any drugs (10.3%) in the last year than those that did have an LSID (Class A drugs: 2.4%; stimulant drugs: 3%; any drugs: 8.5%). However, these differences were not statistically significant and thus probably arise from the different age distributions of these two populations.

Hoare also reported that levels of use of two or more and three or more drugs were similar for those respondents with LSIDs and those with no LSIDs. Patterns of use over the last year among those respondents with an LSID were also similar to patterns of use among those without an LSID, with cannabis being the most commonly used drug (LSID: 6.8%; no LSID: 8.1%), followed by cocaine powder (LSID: 1.9%; no LSID: 3.2%).

While several of the other studies reviewed comment on prevalence and the ‘extent of the problem’, they also suggest that there are methodological limitations on

existing data. For example, Huxley et al. (2005) reference a study by McGillicuddy and Blane (1999) based on 122 community-based individuals (sample details not provided), which found that the majority reported no drug or alcohol use at all, with alcohol and illicit drug use reported by 39% and 4%, respectively. However, there is no indication of whether these figures represent lifetime use or current use.

Research conducted by FMR (2002), on behalf of the Greater Glasgow NHS Board, with a sample of 89 people with visual and/or hearing impairments found that only ten respondents (11%) reported having used illicit drugs. The authors of the study note that the respondents to this survey included a significantly larger proportion of older people than younger people.

The briefing paper produced in 2004 by the Drug and Alcohol Education and Prevention Team for Alcohol Concern and DrugScope, argues it is evident that there is a population of people with hearing impairments (albeit a minority) who misuse substances to a problematic extent. “Some might imagine young deaf people are not likely to get involved in drugs,” they begin, “but this simply is not the case.” The paper cites Cox and Jackson’s 1998 survey of 11–24-year-old people with profound hearing impairments. Their study found that eight in ten of the young people in their sample had been offered drugs at some time and that 54% had taken up drugs offers. However, it is worth noting that this relates to lifetime use, rather than current or regular use.

Taggart et al. (2008) suggest that with regards to people with learning disabilities, the known statistics may be an underestimation, as a large proportion of people with learning disabilities are thought to be unknown to learning disability services. They reference a study by Whittaker (2004), which suggested that about 1–2% of people in the general population will have learning disabilities (meaning an IQ of approximately 70 or below, and also low social skills), yet the actual number of people known to ‘learning disability services’ is lower than these estimates. It is reported that between 0.23% and 0.29% of the population is in contact with learning disability services, and it is likely that most of those not engaged are those with ‘borderline to mild learning disabilities’ and living independently in the community. Taggart et al. suggest this may be a subgroup of people “at greater risk of developing a substance-related disorder” (2008: 13).

With regards to reasons for substance misuse, the literature highlights isolation, exclusion and ‘social distance’ as potential factors in the experience of substance misuse among people with disabilities. Valentine et al. (2003), quoted in Drug and Alcohol Education and Prevention Team (2004: 2), reported that young people with hearing impairments find it difficult to participate in school culture, particularly in secondary schools, because of different modes of communication, learning

strategies and culture. They found high levels of distress, isolation and bullying and experiences of persistent exclusion from school culture, particularly in mainstream secondary schools. Work by McCrone (2003) (also quoted in Drug and Alcohol Education and Prevention Team, 2004) suggested that some young people with hearing impairments who took illicit drugs are self-medicating for pain due to communication frustrations, academic failure, family problems, loneliness, anger and pessimism.

The impact of isolation and social pressure on drug misuse appear to be two sides of the same coin, with the latter more keenly felt as a result of experiencing the former. Across the literature about people with hearing impairments and people with learning disabilities, it is suggested that drugs or alcohol are used as a means of identification with and acceptance by non-disabled contemporaries, a way of 'fitting in'.

The review by COI Communications (2004) considers how mental health, learning disability and poverty can compound the negative experiences of people with hearing impairments regarding alcohol and drug misuse. The study refers to this group's higher susceptibility to mental health problems and the recognised links between mental health problems and drug and alcohol misuse, and to Home Office data that links poverty and social exclusion to increased risk of problematic drug use in the general population.

Across the literature, lack of information and communication challenges are also prominent as issues aggravating drug and alcohol misuse, both in terms of people with hearing impairments and those with disabilities. Authors point out that deafness creates barriers to audible sources of information, such as television and radio, and lower literacy levels among British Sign Language (BSL)-users mean that access to information in print may be restricted (COI Communications, 2004: 17). For example, the Alcohol Concern and DrugScope briefing comments that the words 'stoned' and 'poppers' are not signs learned in most BSL classes (Drug and Alcohol Education and Prevention Team, 2004: 2).

It is important to note that the findings of the literature emphasise alcohol as the main substance misused by those disabled people involved in research studies. In Taggart et al.'s 2004 study about people with intellectual disabilities, for instance, alcohol was the most commonly reported substance, being misused by all 41 participants, as identified by the 'community of informants'. Other substances that the participants were reported to be using, along with the alcohol,



included cannabis ( $n = 4$ ), ecstasy ( $n = 3$ ), ‘prescribed medications’ ( $n = 2$ ) and amphetamines ( $n = 1$ ).

There is evidence to suggest that some people suffering from long-term illness or disability use cannabis medicinally. A report on scientific and medical evidence on cannabis by the Select Committee on Science and Technology (1997–1998) reports that a survey conducted by the newspaper *Disability Now* in 1997 among its readers with disabilities revealed that of 200 respondents who reported using cannabis for medical reasons, 40 were taking cannabis for multiple sclerosis, 40 for spinal injury, 35 for back pain, 27 for arthritis and 64 for other conditions.<sup>1</sup>

### ***Objective 2: The need for and access to prevention and treatment programmes***

Research conducted by FMR (2002) with a sample of 89 respondents with visual and/or hearing impairments explored their knowledge of drugs and drugs services and their access to drug-related information. The findings indicate that awareness of the names of drugs ranged from eight respondents having heard of Temgesic,<sup>2</sup> 35 saying that they had heard of crack cocaine and around 62 saying they had heard of cannabis. As mentioned earlier, the fact that this sample included a disproportionately high number of both older respondents and people with hearing impairments means that levels of awareness are likely to be higher among the wider population.

The same survey also asked respondents about the sources of information they would consult if they wanted to know more about drug and alcohol services. The most common sources of information quoted were family and friends (23 respondents), followed closely by a doctor (21 respondents). However, those with visual impairment were most likely to turn to a doctor. Finally, the survey also asked respondents the extent to which they were aware of specific services aimed at people with alcohol or drug problems. Approximately three-quarters of respondents that answered this question (59 out of 81) were unaware of any such services, with levels of awareness lowest among those with both hearing and visual impairment.

Several studies at least touch on the weaknesses of current practice in drug treatment and prevention for people with disabilities, and from those findings some broad conclusions about what constitutes good practice could be extrapolated. However, there is little discussion of specific good practice examples.

The alcohol and drug service professionals interviewed by McLaughlin et al. reported that they used their standardized assessment schedule to assess their

<sup>1</sup> The numbers add up to more than 200 as some people may have reported taking cannabis for more than one condition.

<sup>2</sup> Temgesic is an opioid prescription painkiller.

intellectual disability clients, the only real divergence being their language (i.e. more 'user friendly' words). Overall, the authors report, "a strong theme that emerged from the AD [alcohol and drug] services professionals was that they all agreed that their services did not effectively address the needs of this population" (McLaughlin et al., 2007: 137).

The study by Taggart et al. (2007) involving research with ten substance misusers with learning disabilities found that respondents would appreciate discussing their substance-related problems on a one-to-one basis, as well as greater family involvement in treatment. Additionally, the research conducted by FMR (2002) with people with visual and/or hearing impairments found that opinions were mixed about whether alcohol and drug services should be specifically dedicated to these groups or whether mainstream services with special resources for these groups were better, with people with hearing impairments preferring the former.

With regards to good practice in drug education and information provision, guidelines published by the National Institute for Health and Clinical Excellence (NICE) (2007) on psychosocial interventions for drug misuse stress that person-centred care means that all information that service users are given should be accessible to people with additional needs, such as physical, sensory or learning disabilities. The briefing paper *Drug Education for Young Deaf People* (Drug and Alcohol Education and Prevention Team, 2004) reported that young people with hearing impairments want drug education and information that is clear, not patronising, easy to assimilate, direct, visual and with not too much content. In its review, COI Communications (2004) recommends that information is made more readily accessible to people with hearing impairments through the provision of plain language information packs and posters, BSL videos and Open i broadcasts.

A project by Hutchinson and Geddes (1998) (reported in Drug and Alcohol Education and Prevention Team, 2004) demonstrated the need for drug awareness teaching resources tailored specifically to children with hearing impairments. They observed that the drug education being taught in schools relies heavily on oral communication, which can create problems for this group. The authors point out, for instance, that the generic sign for drugs is of injecting in the arm, and suggest that this can result in this group of young people having a very general understanding of drugs. Young people with hearing impairments also have 'slang' or regional signs to denote drugs which practitioners may not be aware of.

The National Treatment Agency (NTA) (2007) has published guidelines on needs assessments, which include supplementary guidance notes for diversity legislation. With regards to the Disability Discrimination Act 1995, the NTA highlights a number of required actions to ensure that the physical space occupied by drug treatment

services is accessible to people with disabilities and lists a number of recommended actions to improve communication with clients with disabilities.

Taggart et al. refer to a report by ARAC (2002) that few learning disability, and also mainstream addiction, service providers have clear written policies and procedures for co-working with people with learning disabilities. Consequently, the authors suggest, both types of service providers “have reported a number of difficulties in recognizing and meeting the complex needs of this population” (Taggart et al., 2004: 7).

In a review published some years later, Taggart et al. restate the point, arguing that “many people with learning disabilities fall between mainstream addiction and learning disability services” (Taggart et al., 2008: 11) due to a lack of integrated service provision between drug and alcohol misuse services and learning disability services. Indeed, within the study conducted by McLaughlin et al (2007), all the 13 professionals interviewed highlighted that no integrated service existed for people with learning disabilities with alcohol or drug misuse problems, reporting that there was “little if any collaboration being undertaken”.

### ***Objective 3: Interaction with the police and criminal justice system***

The studies report nothing relating to interaction with the police and criminal justice system.

### **GAPS IDENTIFIED AND CONCLUSIONS**

- As discussed, the most reliable data on drug use among people with an LSID is the British Crime Survey. However, this gives no indication of how drug use varies across disability types.
- The literature reviewed appears to focus primarily on people with learning disabilities and hearing impairments. These studies tend to have small sample sizes, or people with disabilities are researched through ‘proxies’. Additionally, other types of disabilities are seldom or rarely discussed.
- Taggart et al. argue in their 2008 study that studies based on more robust methods are needed, conducted using both objective and subjective forms of measurement alongside appropriate follow-up. They argue that samples need to be of ‘an appropriate size’, with a matched control group, to enable generalisations to be made. They suggest that such studies could focus on developing proactive preventative programmes aimed at young people with learning disabilities, and so promote safe practice in drinking and halting illicit drug use (Taggart et al., 2008: 16).

# 1. Introduction

The Office for Public Management (OPM) was commissioned by the UK Drug Policy Commission (UKDPC) to conduct a review of the literature relating to a range of aspects of drug use among people with disabilities. This review forms part of a wider programme of work being undertaken by the UKDPC, the aim of which is to provide an overview of what is known about the differing needs and challenges associated with drug use among diverse minority communities within the UK. This research is funded by the Home Office.

UKDPC's specific objectives for the review were to provide an overview of the evidence relating to people with disabilities on the following issues:

1. The extent and nature of drug use
2. The need for and access to prevention and treatment programmes
3. Interaction with the police and criminal justice system as a result of drug-related enforcement activity and drug markets.

The UKDPC and OPM review team recognised from the outset that the nature of the population under study had a number of implications for the literature review:

- there was likely to be a dearth of literature relevant to all three objectives and numerous gaps in the evidence;
- there was likely to be a paucity of good quality relevant material, particularly robust quantitative studies;
- there was likely to be more coverage of some disability groups than others (e.g. mental health);
- findings from studies derived from particular localities and regions might not necessarily be applicable at the national level; and
- methods used and quality of data generated were likely to vary considerably.

To help address these factors, a second element of this review included a review of data sources held at the UK Data Archive, which enabled us to identify datasets that recorded both disability and drug use and that could be exploited to provide additional information. An overview of these datasets is included in Appendix 1. OPM and UKDPC agreed as well to exclude mental health from the types of disability covered in the review. This decision was taken because the number of references

obtained in the early searches that included this term was vast. We decided that it would not be possible within the scope of this project to provide an in-depth analysis that would do justice to the complex nature of the associations between mental health and drug use.

To make the search process manageable the following specific disabilities were searched for:

- learning difficulties;
- hearing impairment;
- visual impairment;
- speech, language and communication impairment; and
- mobility/physical impairment.

This literature review is designed to ‘map out the terrain’. We adopted a strategic approach to the available literature, honing in on particular areas that had the greatest potential to yield valuable insights and learning to inform UKDPC’s policy and planning work.

The rest of this report is structured as follows:

Chapter 2 describes the methods used for searching, securing and reviewing the material. It also provides an overview of the main characteristics of the reviewed literature in terms of methods used, types of literature or study and the quality of the literature. Challenges relating to methodologies, terminology, data analysis and reporting are also discussed.

Chapter 3 presents the findings against each objective. It should be noted that the amount and types of evidence available and relevant to the different objectives varied. Any gaps in research evidence that we identified during the course of the review are also presented in this section.

Finally, chapter 4 presents conclusions and draws together the key themes.

## 2. Method and overview of material included

### LITERATURE SEARCH AND REVIEW PROCESS

Our approach to the literature search, review and synthesis has been informed by good practice guidelines issued by government agencies and universities (Government Social Research, undated; EPPI-Centre, 2007; Hartley, 2004). These have been developed with the specific aim of synthesising diverse material to inform the evidence-based policy and practice movement within the UK.

In recognition of the importance of qualified search specialists in enhancing the quality of reviews (Wade et al., 2006), we worked with search specialist Alan Gomersall, Deputy Director of the Centre for Evidence-Based Policy and Practice (CEBPP). Alan provided expert advice and support as we developed our search strategies. The stages of the review process were as follows:

#### 1. Initial and revised search of databases

Representatives from the UKDPC and OPM worked in partnership to develop the approach towards database searches. We agreed that it needed to be underpinned by an iterative process of progressive and informed filtering. Initial searches were broad and allowed us to ascertain the broad contours of the terrain and identify the extent and type of relevant literature available on the different databases. It also helped us to ensure that none of the critical items were missed. Each subsequent search was based on decisions informed by the findings of preceding searches and guided by the overall objectives of the review.

The initial broad search terms were developed in accordance with the aims and objectives of the project and compiled by OPM and our literature search expert at CEBPP with contributions from UKDPC. A full list of search terms used can be found in Appendix 2.

Our search expert conducted a total of nine searches across six databases. The outputs from the initial searches fed into the refinement of search terms. Four general search strategies were used at this stage:

- **Broad search strategy:** For example, (disabled, handicap) + (drug, substance, narcotic) + (use, abuse, misuse).

- **Search strategy with 'NOT' clause:** (disabled, hearing impaired, learning difficulty, visual impairment etc.) + (drug, substance, narcotic) + (use, abuse, misuse) + NOT (mental health).
- **Search strategy with 'NOT' clause 2:** (disabled, hearing impaired, learning difficulty, visual impairment etc.) + (drug, substance, narcotic) + (use, abuse, misuse) + NOT (mental health) + NOT (America, China, South Africa, Japan etc.).
- **Search strategy with 'NOT' and 'INCLUSION' clause:** (disabled, hearing impaired, learning difficulty, visual impairment etc.) + (drug, substance, narcotic) + (use, abuse, misuse) + NOT (mental health) + NOT (America, China, South Africa, Japan etc.) + AND (England, Wales, Scotland, United Kingdom, Leicester, Bradford etc.).
- **General Simple Search Strategy:** For example, (hearing impaired, learning difficulty) + (drug).

We conducted a number of trial searches using the broad search strategy. These yielded an extremely long list of results, which included a great deal of irrelevant material and a substantial quantity of material on mental health. UKDPC and OPM agreed that including specific disabilities as search terms would be a more effective way of identifying relevant material. We therefore added the following disabilities and impairments to our list of search terms: learning difficulties; hearing impairment; visual impairment; speech, language and communication impairment; mobility/physical impairment.

At the same time, we added a 'NOT' clause to exclude material related to mental health. In some cases, this still resulted in a long list of international material so a second 'NOT' clause was added. This helped us to filter the results further and make the results list more manageable to sift.

Together with the CEBPP, we developed our search strategy further by adding 'INCLUSION' or 'AND' clauses, which specified a range of regions, cities and areas across the UK. This helped to filter the results further. In general, searches were done using the strategies that our partner, based on his experience and expertise, felt would yield the best results from each particular database.

The search systems of a small number of databases (e.g. DrugScope) would only allow very simple searches, using one or two search terms. In these cases, our partner used a number of combinations of terms to ensure that the search process was exhaustive. Additionally, in the case of DrugScope, numerous reading lists published by the organisation were also consulted to identify relevant literature.

We shared all material identified with the UKDPC. As expected, there was a significant dearth of empirical material identified. Appendix 3 shows the databases



that were searched, the specific search strategies that were used and the results obtained.

The search and reviewing process was designed to be robust, and every effort has been made to ensure that no relevant item has been omitted. At this early stage, we did not filter results on the basis of their quality. We agreed with UKDPC that decisions about the appropriate quality standards to use should come at a later stage in the process, once we had a better understanding of the extent and quality of the material available and following further discussions about the purpose and audience for the review.

## **2. Website searches**

In light of the limited number of items identified, OPM and UKDPC agreed that it would be helpful to search the websites of organisations and charities representing people with disabilities. Twelve websites were searched in full, but no relevant documents were identified. The list of websites searched can be found in Appendix 4.

## **3. Input from experts**

Consultation with experts can be an effective way of identifying relevant material, including grey literature and very recent material that might not yet be included on bibliographic databases. Experts can also often provide a good indication of the importance of various sources of material and of different individual items. Their input is particularly valuable when their expertise covers a range of areas relevant to the objectives.

Our original proposal was to consult with a number of experts, including practitioners, academics, policymakers and representatives from community groups. However, since a project advisory group was in the process of being set up to comment and advise on the design, progress and outputs of the project, it was agreed that we would draw on the expertise of members of this group. Their knowledge would contribute significantly to the identification of valuable additional materials. The group comprises ten experts from a range of different backgrounds. In addition to these advisory group members, seven other experts were also contacted in order to identify relevant literature. A full list of advisory group members and experts consulted with can be found in Appendix 5.

## **4. Defining inclusion and exclusion criteria**

Following the broader search, we developed a set of inclusion and exclusion criteria against which to generate a shortlist of relevant material to be included in the detailed document review.



We did not feel it was appropriate to set inclusion and exclusion standards prior to carrying out the initial searches. We wished to ensure that the standards we did develop were informed by our initial searches, which yielded helpful clues about the relative distribution of various sources of material and their likely content and quality. In searching and reviewing less well-researched areas, imposing objective inclusion or exclusion standards prior to any search being carried out can mean that potentially useful material is excluded. It can also mean that too little or too much literature is included in the review (Government Social Research, undated).

The eventual set of inclusion criteria was agreed in consultation with UKDPC and included:

- Focus on project aims.
- Published between 1999 and 2009.<sup>3</sup>
- About people with disabilities (excluding mental health problems) in the UK.

### 5. Review of evidence against quality standards

UKDPC and OPM agreed that the limited amount of empirical data identified meant that using very stringent quality standards to exclude literature was likely to leave us with only a few documents to review. We decided against eliminating materials on the basis of quality in advance of review. Instead, OPM reviewed the full shortlist of literature identified and assessed each document against the agreed quality standards. This meant that we could interpret and present the findings alongside appropriate caveats about the quality of the data. These quality assessments and caveats are included throughout the report.

Material that met the inclusion standards was read and reviewed in full. To facilitate a systematic extraction of relevant information, a data extraction sheets (DES) was designed so that identification of relevant evidence was consistent and directed towards answering the review questions. The DES was designed in collaboration with UKDPC. A copy of the blank DES is provided in Appendix 6.

Different quality standards were used to assess the reliability and validity of the different studies. The choice to vary quality standards was made in recognition of the wider debates around appropriateness of standards in relation to different types of studies.<sup>4</sup>

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<sup>3</sup> This criterion was relaxed after initial searches due to the paucity of material identified.

<sup>4</sup> However, there can be different preferences across different policy fields, see Nutley et al. (2007), Oakley et al. (2005), Bambra (2005), Attree and Milton (2006), Popay et al. (1998), Spencer et al. (2003).

We agreed in consultation with UKDPC that the quantitative studies would be assessed using US Census Bureau standards (13 standards) (US Census Bureau, 2006) on the minimal information to accompany any report of survey or census data. The majority of qualitative studies were small local-level studies, so we agreed with UK DPC that a set of five simple standards recommended by the Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre) (University of London, Institute of Education) was most appropriate for this review. The full list of quality standards can be found in Appendix 7.

The quantitative studies reviewed were scored out of 13 and assigned ratings of low, medium or high quality based on comparative scoring. The qualitative studies reviewed were scored out of 5 and also assigned ratings of low, medium and high quality.

These rating categories were defined by considering the relative weight of the quality standards. A number of standards refer to very basic information that tends to accompany all studies and does not in fact shed very much light on the quality of the study. For quantitative studies this basic information includes:

- organisational sponsor of a survey;
- organisation that conducted the survey;
- wording of the questions asked.

For the qualitative studies the basic information includes:

- aims clearly stated;
- context clearly stated.

Standards relating to this basic information in qualitative and quantitative studies were given less weight when defining the rating categories of low, medium and high.

The more significant standards are those that shed light on the quality of the study and are also less likely to be discussed or addressed in study reports. For the quantitative studies these include:

- discussion of the statistical precision of the results;
- description of estimation procedures;
- discussion of non-sampling errors;
- discussion of methods employed to ensure data quality.

For the qualitative studies the more significant standards include attempts to establish reliability and clear description of sampling and research methods.

This approach helped to ensure that studies that met only the less significant standards were not assigned an inflated rating and that studies that met the more significant standards received an appropriate rating.

## 6. Final synthesis

The reviewed material was subjected to broad content analysis, with key themes and associations drawn out.

### OVERVIEW OF MATERIAL INCLUDED

This review draws on 13 documents, with the following focus:

Focus of study	Number of documents with this focus
People with learning/intellectual disability	5
People who are hearing impaired	2
People who are hearing and/or visually impaired	1
Cannabis use by people with a range of long-standing illnesses or disabilities (LSIDs)	2
2008/09 British Crime Survey (BCS), which includes prevalence data on those with an LSID	1
Guidelines on treatment services and needs assessments	2

These 13 studies explore the prevalence of substance misuse among the group defined as relevant to this review; reasons for particular patterns of misuse; the extent to which existing service provision meets the needs of these particular groups; and the barriers and challenges faced by these groups when accessing prevention and treatment services.

As discussed above, quantitative studies were assessed against a number of quality standards and assigned a score out of 13 as well as categories of 'low', 'medium' and 'high' quality. Of the three quantitative studies assessed, one was of high quality, one of medium and one of low. Four studies made use of qualitative methodologies of which two were of medium quality and two were of high quality. Finally, one study was secondary research, which was of medium quality.

The full list of material reviewed with individual quality ratings can be found in Appendix 8.

### **LIMITATIONS OF METHODS AND DATA**

A number of challenges relating to data and methods were identified. These included:

- Learning-disabled study participants are often researched through ‘proxies’, such as nurses or social workers.
- Sample sizes within individual studies are relatively small.
- Comparisons between studies are difficult to make if operational definitions of ‘use’ and ‘misuse’ differ. A clear demographic breakdown of disabled research participants is also often lacking.
- There is underestimation of prevalence rates among disabled populations, due to significant proportions of some impairment groups being unknown to the relevant services.
- Some of the studies reviewed are themselves reviews of existing data, and sometimes provide no information about the methodologies used by the sources cited.
- Where reviews of existing evidence do reflect on the quality of their source material, some find it to be methodologically poor, with limitations including: small sample sizes, lack of reliable and viable measurement tools, studies undertaken in hospitals where the person’s access to alcohol and drugs is limited, lack of control groups, lack of generalisability and no long-term follow-up (Taggart et al., 2008: 16).

### **TERMINOLOGY**

Throughout this report, we use the word ‘drugs’ to refer to illicit drugs. That is, controlled substances that are classified as Class A, B or C. Where prescription drugs are being used ‘off-prescription’ – that is, not for the prescribed purposes – this is made explicit.

In the limited literature included in this review there is considerable variability in terminology used to refer to drug use/misuse. These include:

- substance abuse;
- substance misuse;
- problematic drug use;
- chemical dependency.

Additionally, some of the literature uses the term ‘disability’ and some the term ‘impairment’.

As far as possible we have reported findings using the terminology that is used in each report. Beyond this, we have used language that is consistent with the aims and objectives of the review.

Finally, although alcohol use was not the focus of this review, it is often reported on with drug use in the literature. Where this is so we have reported these findings.

### 3. Research findings

#### EXTENT AND NATURE OF DRUG USE

##### *Prevalence of drug use*

The most recent and reliable source of data on the prevalence of drug use among people with disabilities is Hoare’s report on the findings from the 2008/09 British Crime Survey (BCS) (Hoare, 2009). As Table 1 indicates, among 16–59-year-olds, respondents who did not have a long-standing illnesses or disability (LSID) were slightly more likely to use Class A drugs, stimulant drugs and any drugs in the last year than those who did have an LSID (this relates to both those whose condition limits their activities and those for whom it does not). However, this difference was not statistically significant, implying that the variation is most probably due to variances in age distribution of the two populations, with the sample of people with an LSID almost certainly having a higher average age. Additionally, the prevalence of use of Class A drugs, stimulant drugs and any drugs in the last year is very similar for people with an LSID that limits daily activities and people with an LSID that **does not** limit daily activities.

**Table 1: Prevalence of last year use of Class A drug, stimulant drug or any drug for those with/without an LSID (2008/09 BCS)**

	Last year prevalence: %		
	Any Class A drug	Any stimulant drug <sup>5</sup>	Any drug <sup>6</sup>
LSID	2.4	3.0	8.5
LSID (limits activities)	2.6	3.0	8.8
LSID (does not limit activities)	2.3	3.0	8.0
No LSID	3.9	4.7	10.3

Table 2 indicates levels of use in the last year for specific drug types. The patterns of use in the last year for any particular drug are similar for those respondents with an LSID and respondents without an LSID. For example, across both groups, levels of

<sup>5</sup> Any stimulant drug use includes cocaine powder, crack cocaine, ecstasy, amyl nitrite, amphetamines and methamphetamine.

<sup>6</sup> Any drug use includes methamphetamine since 2008/09.

cannabis use are highest (LSID: 6.8%; no LSID: 8.1%), followed by cocaine powder (LSID: 1.9%; no LSID: 3.2%) and ecstasy (LSID: 1.1%; no LSID: 2%).

**Table 2: Prevalence of last year use of specific drugs for those with/without an LSID (2008/09 BCS)**

	Last year prevalence: %						
	Cocaine powder	Ecstasy	Hallucinogens	Amphetamines	Cannabis	Ketamine	Amyl nitrite
LSID	1.9	1.1	0.2	0.9	6.8	0.1	0.9
LSID (limits activities)	1.9	0.8	0.2	1	6.9	0.1	0.8
LSID (does not limit activities)	1.8	1.4	0.2	0.7	6.6	0	1.1
No LSID	3.2	2.0	0.7	1.3	8.1	0.7	1.5

The 2008/09 BCS also explored levels of poly-drug use among those with an LSID. Table 3 illustrates the proportion of respondents with and without an LSID that reported using multiple drugs in the last year.

**Table 3: Prevalence of poly-drug use in the last year by those with/without an LSID (2008/09 BCS)**

	Last year prevalence: %				
	One illicit drug	Two illicit drugs	Three or more illicit drugs	One stimulant drug	Two or more stimulant drugs
LSID	68	14	18	54	46
LSID (limits activities)	67	15	18	59	41
LSID (does not limit activities)	69	11	20	–	–
No LSID	59	20	21	55	45

‘–’ in tables indicates zero.

The proportion of respondents who had used two or more stimulant drugs was similar for those with an LSID (46%) and without an LSID (45%). Levels of use of three or more illicit drugs are also quite similar for both groups (LSID: 18%; non LSID: 21%). A number of small differences were observed in the use of one and two illicit drugs over the last year. However, these differences should be treated with caution because of the different age distribution of these two populations. The authors report that their logistic regression analysis demonstrated that having/not having an LSID was not significantly associated with poly-drug use and that the differences remarked on above are not statistically significant.

Respondents with an LSID appeared to be more likely than those without an LSID to use just one illicit drug (68% and 59%, respectively). Conversely, respondents without an LSID were more likely than those with an LSID to use two illicit drugs (20% and 14%, respectively). It should be noted that these differences need to be interpreted with caution.

Several of the other studies reviewed also comment on prevalence and the 'extent of the problem' and, like Hoare, the authors of these studies also suggest that there are methodological limitations on the data. For example, sample sizes are often small, and people with disabilities are often researched through 'proxies', such as nurses and social workers.

A study by McLaughlin et al. was based on evidence from a small pool of 13 'community informants', who were practitioners within either intellectual disability (ID) services or alcohol and drug (AD) services. Each informant had on their caseload at least one ID service user with substance misuse problems (McLaughlin et al., 2007: 136). This means that there were potentially as few as 13 people with learning disabilities misusing alcohol/drugs represented within the study.

One professional interviewed by McLaughlin et al. thought that prevalence rates among people with intellectual disabilities may be higher than case numbers suggested, considering:

- the number of users with borderline or mild intellectual disability not known to services; and
- that some AD service professionals felt that the service users they were in contact with may have had an intellectual disability.

It is important to note that all those in this sample reported that alcohol was the main substance they used, and that only "a small number" reported using illicit substances such as cannabis and ecstasy and some reported overusing prescribed medications.



*“There are only five AD service teams in this geographic region of the UK, it can be observed that only three of these teams identified four people with intellectual disabilities: two AD service teams did not respond” (McLaughlin et al., 2007: 139)*

*“... this low response rate of four people with intellectual disabilities using these AD services may actually indicate that very few people use such mainstream AD services or, on the other hand, it may highlight the difficulties that these staff have in recognising people with intellectual disabilities within mainstream services” (McLaughlin et al., 2007: 140)*

McConkey et al. (2006) (cited in McLaughlin et al., 2007) reported that approximately 16,000 people with intellectual disabilities were known to ID services within one geographic region<sup>7</sup> of the UK and estimated that another 16,000 people were not known to services: those not known to services are most likely to have a mild/ border-line intellectual disability and living with family or independently.

Huxley et al. (2005), in their discussion paper on the need for integrated services, reference two studies conducted since 1999 which seek to estimate prevalence of drug use among people with learning disabilities. One of these, by McGillicuddy and Blane (1999), which was based on 122 community-based individuals (sample details not provided), found that the majority reported no drug or alcohol use at all, with alcohol and illicit drug use reported by 39% and 4%, respectively. However, the study gives no indication of whether these figures represent lifetime use or current use. Taggart et al. (2008), in their review of a number of studies, conclude that people with learning disabilities use and misuse illicit drugs at relatively low rates.

A lower quality research study conducted by FMR (2002) on behalf of the Greater Glasgow NHS Board, with a sample of 89 people (recruited through agencies such as Deaf Connections and RNID) with visual and/or hearing impairments, found that only ten respondents reported having used illicit drugs:

- Four people with hearing impairment, one person with a visual impairment and one person with a partial visual impairment had tried cannabis. Only one person with a hearing impairment (male, 16–24 years) was currently using cannabis.
- One person with a hearing impairment and one with a partial visual impairment had used amphetamines.
- One person with a hearing impairment and one person with hearing and visual impairments had used temazepam off-prescription.
- One person with a hearing impairment and one with a partial visual impairment had used LSD.

<sup>7</sup> Geographic region was not identified.

The authors of the study note that respondents to this survey included a larger number of older respondents (45–65 years: 25 respondents; 65+: 37 respondents) compared to younger respondents (16–24 years: 7 respondents). The sample also includes more people with hearing impairments (54 out of 89) than with visual impairments.

A Central Office of Information (COI) scoping study (COI Communications, 2004) on drug misuse and people with a hearing impairment looks at a survey commissioned by the British Deaf Association (BDA) and carried out by the Cox & Jackson Consultancy.<sup>8</sup> The survey addressed young people with hearing impairments, and the sample consisted of 214 people aged 11–24 years. The authors report that a large majority of this sample claimed to have tried illicit drugs, with just under half saying they had tried them in the three months before the survey. The authors compare this with findings from the 2002/03 BCS, in which 28% of all 16–24-year-olds said they had taken any illicit drugs in the past year. The Cox & Jackson data appears to show that use of illicit drugs among this sample of young people with hearing impairments is higher than among the general population. In terms of exposure to drugs, the BDA survey found that children with hearing impairments who attended special schools were less likely to have access or exposure to drugs than those who were attending a mainstream school. However, the authors of the COI scoping study have reservations about the sample and methodology of the Cox & Jackson research.

Taggart et al. (2008) suggest that known statistics on drug use by people with learning disabilities may be an underestimation, as a large proportion of this population is thought to be unknown to learning disability services. They reference a study by Whittaker (2004), which suggested that 1–2% of people in the general population will have learning disabilities (meaning an IQ of approximately 70 or below, and also social skill deficits) yet the actual number of people known to ‘learning disability services’ is lower than these estimates. Taggart et al. quote literature (Whittaker and Porter, 2002) that indicates that between 0.23% and 0.29% of this population is in contact with learning disability services, most of those not engaged probably are with ‘borderline to mild learning disabilities’ and living independently in the community. The authors suggest this may be a subgroup of people “at greater risk of developing a substance-related disorder” as living independently can expose them to greater social pressures (explored further in the next section) which can lead to greater alcohol or illicit drug use as a coping mechanism (Taggart et al., 2008: 13).

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<sup>8</sup> *Drugs in the Deaf Community* – summary of key findings of a survey carried out by Cox & Jackson Consultancy for the British Deaf Association (1998)

In a 2005 study, Huxley et al. (2005) also argue that prevalence rates for drug use from studies in the US are likely to underestimate the true rates of drug use by people with learning disabilities, and refer to the “inherent problems in self-reporting studies, a lack of standardised methods to investigate substance misuse and difficulties in obtaining people’s consent to screen for drug use” (Huxley et al., 2005: 15). The authors’ conclusion is that, based on the limited research available, there is a population of people with learning disabilities (albeit a minority) who misuse substances to a problematic extent.

The briefing paper produced in 2004 for Alcohol Concern and DrugScope draws similar conclusions about drug use among young people with hearing impairments: “Some might imagine young deaf people are not likely to get involved in drugs,” they begin, “but this simply is not the case” (Drug and Alcohol Education and Prevention Team, 2004: 1–2). The paper cites Cox & Jackson’s 1998 survey of people aged 11–24 with hearing impairments. This study found that that eight in ten of the young people in their sample had been offered drugs at some time, and that 54% had taken up drugs offers, with cannabis being the most commonly used drug. The research also found that these young people “may be more likely to have tried or started taking drugs when aged 14–16”. However, it is worth noting that these findings are not related to current or problematic use, but instead to offers of drugs and whether or not these offers were ever taken up (lifetime use).

The briefing paper also cites Cox & Jackson as arguing that only when viewed on a national perspective does the scale of drug use by deaf people become apparent, due to the fact that this is a scattered community with only small numbers in any given locality.

#### ***Substance type and frequency***

It is worth emphasising that the studies reviewed consistently find that alcohol is the main substance used by disabled people. For example, in Taggart et al.’s study of people with intellectual disabilities (2004), alcohol was the most commonly reported substance misused by all 41 participants, as identified by the ‘community of informants’. Other substances that participants were reported to be using together with alcohol included cannabis ( $n = 4$ ), ecstasy ( $n = 3$ ), ‘prescribed medications’ ( $n = 2$ ) and amphetamines ( $n = 1$ ). One participant was also described as addicted to gambling machines. The same study examined frequency of substance misuse, and found that within a seven-day period, twelve respondents reported misuse at weekends (over two to three nights); eight respondents reported misuse every three to four days; and eight respondents reported misuse as a weekly habit. The study does not highlight which cases refer to drug use, however, and restates that the main substance misused was alcohol.

### ***Reasons for substance use***

As outlined in the introduction, there is significant variability in the terminology used to refer to drug use/misuse. As far as possible we have reported findings using the terminology that is used in each report.

#### **Isolation**

The literature highlights isolation, exclusion and ‘social distance’ as potential factors influencing illicit drug use among people with disabilities. The COI study quotes Royal National Institute for the Deaf (RNID) research among people with hearing impairments (RNID, 1999), which states that:

- 71% feel isolated because of their hearing loss;
- 39% avoid meeting new people;
- 59% believe hearing people think they are stupid; and
- 20% have been the victim of abusive language or gestures.

Valentine et al. (2003), quoted in Drug and Alcohol Education and Prevention Team (2004: 2), reported that young people with hearing impairments find it difficult to participate in school life, particularly in secondary schools, because of different modes of communication, learning strategies and culture. They found high levels of distress, isolation and bullying and experiences of persistent exclusion from school culture, particularly in mainstream secondary schools.

Work by McCrone (2003) (also quoted in Drug and Alcohol Education and Prevention Team, 2004) suggests that some young people with hearing impairments who took illicit drugs were self-medicating for pain due to communication frustrations, academic failure, family problems, loneliness, anger and pessimism. This study also suggests that because families and their communities can ‘over protect’ these young people, they might deny drug use and its associated problems. This can result in drugs issues not being discussed openly, which in turn can limit opportunities for these young people to receive drugs education, which can inhibit acknowledgement of a drug problem and hence preclude them seeking advice and support. Raising similar points, two small-scale 2007 studies, by Baker (quoted in Taggart et al., 2008) and by Taggart et al. (2007), report that the people with learning disabilities consulted with used a combination of alcohol, illicit drugs and prescribed medications. These are used to “self-medicate against life’s negative experiences” as a result of “psychological trauma” (such as bereavement, rape, physical and psychological abuse, deterioration of their mental health) and “social distance from the community” (for example being bullied or exploited, lack of companionship, loneliness, isolation) (Taggart et al., 2007: 9).

The theme of isolation as a factor encouraging substance misuse is prominent in Taggart et al.'s small-scale research with ten individuals with learning disabilities. The authors reported that “many of the informants spoke of their lack of companionship, of having no friends, whether non-disabled or disabled, and the loneliness of living by oneself”. Here the impact described was in terms of alcohol consumption rather than illicit drug use. While some respondents spoke about drinking in their own homes, alone or with partners, for others it was a means of finding company, by drinking in bars, clubs and on the streets. “In hindsight,” the authors reported, “these so-called friends were actually exploiting the individuals for their own gain, either for money to buy drink and/ or food, or in some cases, sexually” (Taggart et al., 2007: 4–5).

#### **Social pressures and seeking acceptance**

The research reviewed suggests that isolation and social pressure can be two sides of the same coin, with the latter more keenly felt as a result of experiencing the former. Much of the literature about people with hearing impairments and people with learning disabilities finds that drugs or alcohol are used as a means of identification with and acceptance by non-disabled contemporaries, a way of ‘fitting in’. The RNID (1999) research cited in the COI study (COI Communications, 2004) refers to the negative perceptions of deafness that continue to be common among hearing people and argues that this can affect the self-esteem of those with hearing impairments, so increasing their susceptibility to substance abuse disorders. The COI study also proposes that people with hearing impairments may also use drugs to deal with anger or frustration experienced as a result of difficulties in communicating with the hearing world. Some of these hearing-impaired people experience feelings of low self-esteem and of helplessness, and have difficulty adapting to their deafness, with substance misuse “a way of numbing these feelings” (COI Communications, 2004: 17).

#### **Multiple disadvantage**

The COI review (COI Communications, 2004) considers how mental health, poverty and learning disabilities can compound the negative experiences of people with hearing impairments (the review reports a higher incidence of mental health problems among those with hearing impairments). This in turn can contribute to drug and alcohol misuse. The study refers to this group's higher susceptibility to mental health problems, and the recognised links between mental health problems and drug and alcohol misuse; to the “impressionability and vulnerability” of some people with learning disabilities who may have a lower level of understanding about the dangers or health implications of drug and alcohol misuse; and to Home Office data that links poverty and social exclusion to an increased risk of problematic drug use in the general population. With regard to the latter point, the COI review

references a survey conducted by RNID in 2002,<sup>9</sup> which illustrated that the rate of unemployment for people with partial or profound hearing impairments, standing then at 19%, was four times that of the general population.

### **Lack of information and communication challenges**

Across the literature, lack of information and communication challenges are also prominent factors aggravating drug and alcohol misuse for people with hearing impairments and for those with other types of disabilities. Authors find that deafness creates barriers to audible sources of information, such as television and radio, and lower literacy levels among British Sign Language (BSL)-users mean that access to information in print may be restricted, and that there is a lack of information for BSL-users on drugs and alcohol (COI Communications, 2004: 17). The Alcohol Concern and DrugScope briefing paper comments, for instance, that the words ‘stoned’ and ‘poppers’ are not signs learned in most BSL classes (Drug and Alcohol Education and Prevention Team, 2004: 2).

The briefing also suggests that carers might not have the appropriate vocabulary or level of knowledge themselves to be able to provide relevant and factual information about drugs (Drug and Alcohol Education and Prevention Team, 2004: 2). The COI review goes on to argue, however, that “once deaf people start to become aware of services and/or sources of accessible information, because of the closeness of the deaf community, word should travel fast and members of the community are likely to help increase awareness among themselves” (COI Communications, 2004: 17).

### ***Medicinal use of cannabis***

There is evidence to suggest that some people suffering from long-term illness or disability use cannabis medicinally. A study by the Select Committee on Science and Technology (1997-1998), looking at the scientific and medical evidence on cannabis, reports the findings of a survey conducted by the newspaper *Disability Now* in 1997. The survey of disabled readers found that of 200 respondents, 40 people were taking cannabis for multiple sclerosis, 40 for spinal injury, 35 for back pain, 27 for arthritis and 64 for other conditions.<sup>10</sup>

The Select Committee report also notes that 35,000 out of a total of 85,000 patients suffering from multiple sclerosis are members of the Multiple Sclerosis Society, with the Society reporting that more than 1% of these patients, and possibly as many as 3–4%, use cannabis for the relief of symptoms such as fatigue, balance problems and muscle weakness.

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<sup>9</sup> Bradshaw, W. *The Employment Situation and Experiences of Deaf and Hard of Hearing People*, RNID (2002).

<sup>10</sup> The numbers add up to more than 200 as some people may have reported taking cannabis for more than one condition



A bulletin published by the International Association for Cannabinoid Medicines (IACM) in 2005 quotes a large-scale UK-wide survey on the medical use of cannabis, conducted from 1998 to 2002.<sup>11</sup> The survey found that cannabis was used by a considerable percentage<sup>12</sup> of patients and that medicinal cannabis use was associated with younger age, males and those with previous recreational use of cannabis. More than a third of medicinal cannabis users (35%) reported using it six or seven days a week. The percentages of condition-specific cannabis users were reported as follows:

- 25% of patients with chronic pain used cannabis medicinally;
- 22% of patients with multiple sclerosis used cannabis medicinally;
- 22% of patients with depression used cannabis medicinally;
- 21% of patients with arthritis used cannabis medicinally; and
- 19% of patients with neuropathy used cannabis medicinally.

### **NEED FOR AND ACCESS TO PREVENTION AND TREATMENT PROGRAMMES**

#### ***Knowledge about drugs and drugs services***

Research conducted by FMR (2002) with a sample of 89 respondents with visual and/or hearing impairments found that awareness of the names of drugs ranged from eight respondents having heard of Temgesic, 35 saying that they had heard of crack cocaine and around 62 saying they had heard of cannabis. Generally speaking, respondents with visual impairments had a higher awareness of drugs than those with hearing impairments. It should be noted that nine respondents reported having heard of Semeron, a bogus drug which was included to test over-reporting, a very large proportion compared to the number of people that endorse bogus drugs in other surveys, such as the BCS (closer to five respondents out of a sample of several thousand). This and other methodological and sampling limitations should be taken into account when interpreting these findings.

The same survey also asked respondents about the sources of information they would consult if they wanted to know more about drug and alcohol services. As Table 4 indicates, the most common sources of information quoted were family and friends (23 respondents) followed closely by a doctor (21 respondents). However, those with visual impairment were most likely to turn to a doctor.

<sup>11</sup> Ware, M.A., et al. The medicinal use of cannabis in the UK: Results of a nationwide survey, *International Journal of Clinical Practice*, March 2005.

<sup>12</sup> Exact percentage not provided.

**Table 4: Sources of information about drug and alcohol services**

Sources of information	Number of respondents			Total
	Hearing impairment	Visual impairment	Hearing/ visual impairment	
Friends or family members	20	1	2	23
Doctor	11	8	2	21
Citizens' Advice Bureau	3	1	0	4
Helplines	6	3	0	9
Social Work Department	8	3	0	11
Internet	14	2	0	16
Other	21	8	5	34
Base	63	17	9	89

Finally, the survey asked respondents the extent to which they were aware of specific services aimed at people with alcohol or drug problems. Approximately three-quarters (59 out of 81) of respondents who answered this question were unaware of any such services, with levels of awareness lowest among those with both hearing and visual impairment.

### ***Good practice in drug treatment and prevention***

Several studies touch on the weaknesses of current practice in drug treatment and prevention for people with disabilities, and from this some broad conclusions about what constitutes good practice could be extrapolated. However, there is little discussion of specific good practice examples.

The alcohol and drug service professionals interviewed by McLaughlin et al. reported that they used their standardised assessment schedule to assess their intellectual disability clients, with adjustments made only to language used (i.e. more 'user friendly' words). The professionals working within intellectual disability services reported using no specific alcohol/drug assessment framework. The authors report "a strong theme that emerged from the AD [alcohol and drug] services professionals was that they all agreed that their services did not effectively address the needs of this population" (McLaughlin et al., 2007: 137).



The study by Taggart et al. involving research with ten substance misusers with learning disabilities offers some of the most interesting findings around this question. Respondents reported that they could benefit from (Taggart et al., 2007: 7):

- discussing their substance-related problems and life circumstances on a one-to-one basis rather than in group sessions, which could be intimidating;
- the availability of a wider network of friendships in which the person could engage in various recreational or diversionary pursuits which would widen the person's social support network; and
- greater family support and involvement in the person's treatment package.

The research conducted by FMR (2002) with a sample of 89 respondents with visual and/or hearing impairments found that opinions were mixed about whether alcohol and drug services should be dedicated specifically to people with hearing or visual impairments or whether mainstream services with special resources for these groups were better, with 21 respondents (out of 78 who answered the question) preferring the former and 28 the latter. The authors also report that participants in a focus group for people with hearing impairments expressed a preference for dedicated services. They thought that more people would feel comfortable and confident about using these services. There were also a significant number of 'don't know' responses to the survey across impairment groups (29 in total).

#### **Information and education for people with disabilities**

Guidelines published by the National Institute for Health and Clinical Excellence (NICE) (2007) on psychosocial interventions for drug misuse stress that person-centred care means that all information given to service users should be accessible to people with additional needs, such as physical, sensory or learning disabilities.

The Alcohol Concern and DrugScope briefing paper *Drug Education for Young Deaf People* (Drug and Alcohol Education and Prevention Team, 2004) is the document with the greatest focus on education as a means of discouraging substance misuse among disabled people, focusing specifically on young people with hearing impairments. In their consultations with practitioners (note this was not directly with young people themselves), respondents reported that young people with hearing impairments want drug education and information that is:

- clear;
- not patronising;
- easy to assimilate;
- fairly direct;
- visual; and
- not too content-heavy.

The study found that most drug education resources are aimed at pupils within mainstream education and often need to be adapted for use with young people with hearing impairments. A project by Hutchinson and Geddes (1998) (reported in the briefing paper) demonstrated the need for drug awareness teaching resources tailored specifically to children with hearing impairments. They observed that drug education in schools relies heavily on oral communication, which can create problems for this group. The authors point out, for instance, that the generic sign for drugs is of injecting in the arm, and suggest that this can result in this group of young people having a very general understanding of drugs. Young people with hearing impairments also have 'slang' or regional signs to denote drugs and practitioners might not be aware of these (Drug and Alcohol Education and Prevention Team 2004: 6).

On the basis of these points, the authors argue that professional development for teaching staff can be useful in raising their awareness about the need for a more specialized approach to drug education for young people with hearing impairments (Drug and Alcohol Education and Prevention Team, 2004:9). For the young people themselves, the briefing paper suggests that developing skills and understanding to manage drug related situations should be a central aim.

The briefing paper also highlights the need for parents and carers to be involved in their children's drug education so they too are more aware of how to access help and support – a need that may be particularly great where communication between deaf youngsters and their families is more difficult.

On this topic of conveying information, Huxley et al. reference work by Burgard in 2000 to emphasise that "some individuals [with learning disabilities] have very real deficits in their ability to take in and retain information ... and adhere to treatment regimes". Reflecting this, drug misuse treatment "tends to be more behavioural, less confrontational, more directive and more likely to involve the client's family" (Huxley et al., 2005: 17).

Davidson, Miller and Kenneth (2004) cited in the COI review (2004) recommend an approach to substance misuse services for people with hearing impairments, in which primary care services are made accessible to this community for low to moderate cases of drugs use disorders, with more serious or complex cases being referred to and treated by specialist regional teams. These specialist regional teams, Davidson et al. argue, would be useful for making links between the relevant statutory and voluntary organisations and would avoid the need for local teams to dedicate large amounts of resources to a small minority of people. At the same time, the needs of a geographically disparate minority could be met by regional teams, which could become providers/enablers of substance use screening, prevention and treatment services for people with hearing impairments.

In its review, the COI recommends that information is made more readily accessible to people with hearing impairments in the following ways (COI Communications, 2004: 35):

- a plain language information pack about drug misuse for young people;
- a BSL video (with subtitling and plain language voiceover) on drug and alcohol misuse in general, distributed to the Open i distribution list and to Drug Action Teams (DATs) and other frontline services;
- Since Open i is broadcast on a number of digital and freeview channels, the authors also suggest promoting the availability of the drugs video to these outlets with a view to getting them broadcast for free – or at least promote its availability; and
- promotion of specially tailored information materials through plain language posters (for use by local services, with space for contact details to be added locally). These could promote information materials, including the ‘Talk to Frank’ site, and advertise local drug advice services.

Considering the studies that make up their 2008 review, Taggart et al. report that a number of interventions have been offered to people with learning disabilities who have misused alcohol and illicit drugs, and that overall the results appear promising. The interventions cited range from medication, support groups and education to behavioural programmes and staff education. However, while the authors conclude that these studies have been informative, they are felt to provide “little more than descriptive accounts of either mainstream or modified interventions” and the methodological quality of many of those studies is felt to be questionable (Taggart et al. 2008: 16).

### ***Access to drug treatment and prevention programmes***

The NTA has published guidelines on needs assessment, which include supplementary guidance notes for diversity legislation. With regards to the Disability Discrimination Act 1995, the NTA highlights a number of required actions to ensure that the physical space occupied by drug treatment services is accessible to people with disabilities (NTA, 2007: 5):

*“Where a physical feature makes it impossible or unreasonably difficult for disabled customers to make use of a service offered to the public, service providers have to take measures (where reasonable) to:*

- *Remove the feature, or*
- *Alter it so it no longer has that effect, or*
- *Provide a reasonable means of avoiding the feature, or*
- *Provide a reasonable alternative method of making the service available to disabled people”.*

The NTA (2007) also identifies a number of recommended actions in order to ensure equal access:

- Employing a designated person or persons as a disability services advisor
- Looking at how staff interact with disabled people
- Helping everyone to improve their communication with disabled people
- Access audits on NHS buildings used to improve physical access (and potentially on the buildings of other DAT commissioned services)
- Reviewing procedures and routine practices which can be as disabling as buildings.

The research conducted by FMR (2002) with a sample of 89 respondents with visual and/or hearing impairment asked the respondents to indicate what resources they would personally need in order to access an alcohol or drug treatment service. As Table 5 illustrates, staff with BSL skills, BSL interpreters, text phones and improved lighting for lip reading were the resources most cited as necessary. Among respondents with visual impairments large print documents were the preferred resource (5 out of 10 respondents).

**Table 5: Resources cited as necessary by respondents with hearing and/or visual impairment**

Resources needed	Number of respondents			
	Hearing impairment	Visual impairment	Hearing/ visual impairment	Total
Induction loop systems	10	0	3	13
Text phones	29	0	0	29
Good lighting (for lip reading)	23	3	2	28
All information provided in minimum font size 18pt	2	5	1	8
Staff with BSL skills	39	0	2	41
BSL interpreters provided as required	29	0	1	30
Other	2	3	1	6
Base	60	10	6	76

In 1994, Campbell et al. (quoted in Taggart et al., 2004: 10) identified five barriers to treatment for chemical dependency among people with learning disabilities.

- Existing mainstream treatment models might need to be substantially adapted in view of their emphasis on insight, which the authors suspect is not always possible for people with learning disabilities.
- People with learning disabilities might lack the necessary skills to cope with and benefit from group-based therapies used for their non-disabled peers.
- The emphasis on effecting positive life changes might not reflect the real choices available to most people with a learning disability.
- Alcohol counsellors (including ‘dual diagnosis workers’) do not receive training in working with people with learning disabilities as part of their general training and might base their assessments and interventions on stereotypes or inaccuracies.
- There is a low level of integration between services for people with a learning disability and mainstream addiction.

The literature also highlights the barriers that people with hearing impairments can face in accessing support, with most drug support services aimed at the hearing population. The Alcohol Concern/DrugScope discussion paper reflects on research that finds young people with hearing impairments “face genuine communication problems, which means that they can be cut loose from assurance and support services such as counselling, sex education, peer education and professional support” (Drug and Alcohol Education and Prevention Team, 2004: 8).

Huxley et al. (2005) quote statistics from the National Drug Treatment Monitoring System in England for 2001/02 that show that almost one in four (73%) of problem drug users accessing drug treatment services was a heroin user.<sup>13</sup> They also refer to a study by Burgard et al. (2000),<sup>14</sup> which suggests that people with learning disabilities tend to use substances such as alcohol and cannabis rather than ‘hard’ drugs. The substance choice for people with learning disabilities might be an important factor in them not accessing substance misuse services.

Taggart et al. (2004) refer to a report by ARAC (2002) that few learning disability or mainstream addiction service providers have clear written policies and procedures for co-working with people with learning disabilities. Consequently, the authors suggest, both types of service providers “have reported a number of difficulties in recognizing and meeting the complex needs of this population” (Taggart et al., 2004: 7).

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<sup>13</sup> This number is 66% based on 2006/07 NDTMS data.

<sup>14</sup> This study was based in the USA.

In a later review, Taggart et al. restate the point, arguing that “many people with learning disabilities fall between mainstream addiction and learning disability services” due to a lack of integrated service provision between drug and alcohol misuse services and learning disability services (Taggart et al., 2008: 11). All of the 13 professionals interviewed as part of the research conducted by McLaughlin et al. highlighted that no integrated service existed for people with learning disabilities with alcohol or drug misuse problems, reporting that there was “little if any collaboration being undertaken”. The authors argue that the services available were based on a ‘reactionary’ model, for example at a time of crisis, rather than a ‘proactive’ preventative model. All the professionals in the study reported that the way forward was through the development of a “joint approach between intellectual disability and addiction services” (McLaughlin et al., 2007: 142).

The BDA provides some counselling about alcohol and drug misuse for people using mainstream services, where resources are very limited, but the COI has been unable to identify any other specialist services for people with hearing impairments relating to drug or alcohol misuse (COI Communications, 2004: 20).

#### **INTERACTION WITH THE POLICE AND CRIMINAL JUSTICE SYSTEM**

The studies reviewed report nothing relating to interaction with the police and criminal justice system.

#### **GAPS IDENTIFIED**

- As discussed, the most reliable data on drug use among people with an LSID is the British Crime Survey. However, this gives no indication of how drug use varies across disability types.
- The literature reviewed appears to focus primarily on people with learning disabilities and hearing impairments. These studies tend to have small sample sizes, or people with disabilities are researched through ‘proxies’. Additionally, other types of disabilities are seldom or rarely discussed.
- Taggart et al. argue in their 2008 study that studies based on more robust methods are needed, conducted using both objective and subjective forms of measurement alongside appropriate follow-up. They argue that samples need to be of ‘an appropriate size’, with a matched control group, to enable generalisations to be made. They suggest that such studies could focus on developing proactive preventative programmes aimed at young people with learning disabilities, and so promote safe practice in drinking and halting illicit drug use (Taggart et al., 2008: 16).

## 4. Conclusions

This review has highlighted a number of areas in which further research into the use of drugs, including alcohol, by disabled people would be valuable. (It is important to note that levels of alcohol use appear higher than use of illicit drugs, as is the case for the wider population.)

One of the most fundamental areas is gaining a more accurate picture of the size, profile and needs of this population. It is not possible at present to identify with any accuracy the prevalence or patterns of use among people with particular types of impairment. As we noted in the introduction, estimated prevalence rates are likely to be low. Many of the existing studies have methodological shortcomings, and comparison across studies is made difficult by, for example, inconsistencies in sample definitions.

That said, however, the evidence reviewed does suggest a number of areas that might benefit from greater attention from policymakers, including those in health, education and community and local government as well as those with specific responsibility for drug policy.

Some of the particular difficulties faced by people with learning disabilities relate to service provision. Gaining a better understanding of why such low numbers of learning disabled people present to alcohol and drugs services would help to ensure that the right steps are taken both to raise the quality of those services and to improve the communication about them. At present, it seems that staff training should be improved to enable service providers to recognise people with intellectual disabilities who are already using mainstream services, hence helping to ensure that support is properly tailored. Understanding more about how to make those services accessible to people with learning disabilities – and with other forms of impairment – also seems valuable.

The review by Taggart et al. (2008), though of limited methodological rigour, suggests some ways in which interventions offered to people with learning disabilities might be developed in order to meet their needs more effectively. A more rigorous evaluation of some of these might help to fill out this initial picture of some of the ways in which services could be improved – or perhaps entirely rethought.



The evidence suggests that ensuring services are tailored at a local level to cater to the needs of particular groups is also important. Studies suggest that disabled people have different views on whether properly accessible mainstream services or dedicated services would best meet their needs. A mix of approaches, developed on the basis of a local needs assessment, seems most appropriate. The proper integration of drug and alcohol services and learning disability services is also critical. This might go some way to shifting the focus from crisis intervention to a preventive approach.

The implications of the findings from the review about the routes by which young disabled people learn about drugs require some thought and consideration. The study by Cox & Jackson Consultancy for the BDA, (cited in Drug and Alcohol Education and Prevention Team, 2004) again of limited methodological security, suggests that use of illicit drugs by young people with hearing impairments is higher than it is among the general population. Those attending mainstream schools tend to have more exposure and access to drugs than those in special schools. Ensuring that drugs education in mainstream schools is not only accessible to these young people, but also takes into account their wider cultural context and language use, is therefore very important. It is particularly important that drugs policies and education in schools is developed in collaboration with the young people themselves and with their parents.

This is well illustrated by the Hutchinson and Geddes (1998) study (reported in Drug and Alcohol Education and Prevention Team, 2004), which refers to the messages that might be conveyed by the use of the generic 'injecting' sign and the use by young people with hearing impairments of slang or regional signs to denote drugs. Training teachers to enable them to meet the needs of disabled young people and ensuring that they are provided with the necessary resources are important.

Some of the factors that make people more susceptible to drug use are likely to impact with more force and be more widely experienced by disabled people. Social isolation, exclusion from social or employment opportunities, bullying in schools and out, and frustration as a consequence of the failure of mainstream services to meet their needs – and not just those focused on drug use – are likely to impact on disabled people's susceptibility to drug use. One study suggests that young people were self-medicating to escape the pain associated with difficulties at school associated with their hearing impairments.

Two particular levers seem to be available at present that could be used to address the issues noted above. Outcomes-based commissioning in health and children's services requires commissioners to understand the needs of their local populations, the nature of provision in their area and how this meets existing needs, and to use



the commissioning process as a way of shaping local markets and monitoring providers' performance. Commissioners might use these powers to ensure that services are better integrated, staff are properly trained, policies are implemented and services are shaped around achieving the best outcomes for those who use them.

Public services are subject to a number of general and specific duties that might also be used as levers to improve service provision and, in particular, to engage disabled people in shaping policies and services. The Local Government and Public Involvement in Health Act 2007 came into force in April 2009 and guidance on its implementation states that: "Appropriate engagement and empowerment should be embedded as standard practice throughout authorities, central to service delivery, policy and decision making." The introduction of the disability equality duty into the Disability Discrimination Act (amended 2005) makes a number of requirements of public bodies and applies to all the functions of every public authority and could be used in relation to drugs services. The Equality Act 2010, also sets a new standard for those who provide public services to treat everyone, with dignity and respect. Ensuring that public bodies understand the implications of this legislation for any alcohol and drug services they provide, and that they have the support and resources they need to fulfil their requirements effectively, could also be of value.

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# Appendix 1. UK Data Archive datasets

Abbreviation	Full Title	Key variables	Sample size (disability/illness, limiting)	Region	Year
SN5784	Scottish Crime and Victimization Survey, 2006	Whether respondent has any long-standing illness, health problem or disability, First drug taken, age took first drug, methods of drug taking, drugs taken most often in last month	968 (9.7%)	Scotland	2006
SN6332	Comparing Love and Domestic Violence in Heterosexual and Same Sex Relationships, 2005-2006	Disability, your alcohol/drug use	89 (11.1%)	UK	2005-2006
SN5269	Mental Health of Children and Young People in Great Britain, 2004	Generalised learning disability, have you used these drugs in past year/month, have you ever had treatment because you were taking drugs, would you know where to get more information about drugs	161 (0.8742)	Great Britain	2004
SN5202	Health Education Population Survey, 2004	Whether have any long-standing illness, disability, or infirmity, ever used (drugs), attitudes towards drugs (all use of drugs is wrong, its okay to use soft drugs like cannabis etc)	653 (36.6%)	Scotland	2004

Abbreviation	Full Title	Key variables	Sample size (disability/illness, limiting)	Region	Year
SN5339	Poverty and Social Exclusion in Northern Ireland, 2002-2003	Any long-term illness, health problem or disability, alcohol or drug use, how severe is alcohol or drug use	956 (30.8%)	Northern Ireland	2002-2003
SN4735	Continuous Household Survey, 2002-2003	Have long-standing illness, disability or infirmity, which substances have use you used in last 12 months/4 weeks, how old were you when first tried drugs	1809 (33.63%)	Northern Ireland	2002-2003
SN5834	Young People's Behaviour and Attitudes Survey, 2003	Any long-standing illness or disability, what age when first offered drugs, who were you with/where were you last time took drugs, knowledge about drugs, education about drugs	1124 (15.6%)	Northern Ireland	2003
SN5760	Growing Up in Scotland: Sweeps 1 to 3, 2005-2008	Disability/illness that is limiting, out of work disability/illness, receive disability living allowance, taken any of the drugs listed in the last 12 months	271 (6%)	Scotland	2005-2008

# Appendix 2. Search terms used

## BROAD SEARCH TERMS

<b>Group 1:</b> Drug (s) Substance Narcotic (s)	<b>Group 3:</b> <i>(This group of terms is likely to be picked up by searching for Group 1 and Group 2 terms)</i> Preval (ent, ence) Pattern (s) Behaviour (s)
<b>Group 2:</b> Use (abuse, misuse) Problem (s) Addict (s, ion, ed) Depend (ence) Habit	<b>Group 4:</b> Ethnic (ity) Race Minorit (y, ies) Asian Afr (ican, o) Carribbean Europe (an)

## Appendix 3. Database search results

	Databases searched	Search date	Search terms	Search date range	Items identified	Items exported by searcher	Comments
1	SPP	22/10/09	((disab* or learning difficult* or hearing impair*) and (drug or substance or narcotic*) and (abuse or misuse)) not mental*)	1999 - 2009	96	62	A few resource packs on drug education for young people with special educational needs Approximately 5 - 7 relevant articles on substance abuse and people with learning disabilities, intellectual disabilities or special education needs Some international material
2	Drugscope	22/10/09	disabled; deaf, hearing, learning disabilities, special education needs	1999 - 2009	19	19	A few drug education packs for people working with deaf people with misuse problems Some international material Some policy material
3	CommunityWise	22/10/09	((disab* or learning difficult* or hearing impair*) and (drug or substance or narcotic*) and (abuse or misuse)) not mental*)	No date limit	79	15	Varied articles on substance abuse – nothing on disabled groups



	Databases searched	Search date	Search terms	Search date range	Items identified	Items exported by searcher	Comments
4	Embase	22/10/09	(((((disab* or learning) adj difficult*) or deaf* or hearing) adj impair*) and (drug or substance or narcotic*) and (abuse or misuse)) not ((((((mental* or America* or china or United) adj states) or south) adj Africa) or japan* or usa or far) adj east))	1999 - 2009	27	3	Article on screening for substance misuse amongst deaf people; on deafness as a result of drug use
5	HMIC	22/10/09	(((((disab* or learning difficult* or hearing impair*) and (drug or substance or narcotic*) and (abuse or misuse)) not mental*))	1999 - 2009	7	2	1 relevant article – duplicate from SPP search
6	SPP, HMIC	27/10/09	(((((visual or mobility or communication) and impairment) or speech or language) and ((drug or substance or narcotic*) and (abuse or misuse)) and (england or wales or scotland or united kingdom or Leicester or Bradford or London or liverpool or birmingham))	1999 - 2009	10	2	Irrelevant
8	Embase Medline	27/10/09	(((((visual or mobility or communication) and impairment) or speech or language) and ((drug or substance or narcotic*) and (abuse or misuse)) and (england or wales or scotland or united kingdom or Leicester or Bradford or London or liverpool or birmingham))	1999 - 2009	0	0	Nothing relevant
9	Drugscope	3/11/09	Impairment, visual, blind, speech, language, communication, physical, mobility	1999 - 2009			Nothing relevant Some international material

## Appendix 4. Website searches

### Websites searched:

- Action for Blind people
- Deafblind UK
- RNIB
- National autistic society
- British deaf association
- Hearing concern
- Afasic
- British Dyslexia Association
- Mencap
- Association for Spina Bifida and Hydrocephalus
- Scope
- Sense

# Appendix 5. Advisory group members/experts consulted with

## Advisory group members

Haleh Afshar (chair), UKDPC Commissioner  
Paul Turnbull, Institute for Criminal Policy Research, Kings College London  
Karim Murji , Faculty of Social Sciences, The Open University  
Annette Dale Pereira, UKDPC Commissioner  
Kate Davies, Assistant Director Strategy, Equality and Diversity – NCTPCT / UCLAN  
Kath Browne, University of Brighton  
Lawrence Taggart, School of Nursing, University of Ulster  
Harry Sumnall, Centre for Public Health, Liverpool John Moores University  
Howard Meltzer, University of Leicester  
Sara Skodbo, Principal Researcher, CDAR, Home Office

## Other experts consulted with:

Gordon Hay, Senior Research Fellow, Centre for Drug Misuse Research, University of Glasgow  
Mike Ashton, Drug and Alcohol Findings, London  
Monty Moncrieff, Hungerford Drug Project, Turning Point, London  
Jane Fountain, Professor of Substance Use Research, International School for Communities, Rights and Inclusion (ISCRI), University of Central Lancashire  
Gareth Hewitt, Head of Substance Misuse, Strategy Implementation & Finance Team, WAG  
Sandie Saunders, Strategy and Commissioning Manager, Drugs and Alcohol, Bolton  
Home Office Equalities Forum

## Appendix 6. Data extraction sheet

*Note page numbers in brackets when referencing*

*Record findings by disability group*

<b>Title</b>	
<b>Author(s)</b>	
<b>Date published</b>	
<b>ID Number</b> (from spreadsheet)	
Date document analysed by OPM	
<b>Content Overview</b> (from abstract)	
<b>Methodology</b> – consider the research questions/ hypotheses posed; the research design; the sampling strategy (including sample size and response rates in quantitative research); the nature and quality of the fieldwork; the process of analysis; and the nature and robustness of findings.	
<b>Quality Assessment</b> (TBD)	
<b>Sector background of published document</b> – (e.g. academic discipline, health, policy guidance, think tank, research centre, charity etc)	

<p><b>Sample group(s) discussed, e.g.</b></p> <p>disability</p> <p>ethnic group</p> <p>age</p> <p>gender</p> <p>sexuality</p> <p>faith</p> <p>nationality or national background</p>	
<p>Geographical focus</p>	
<p>Evidence/information relating to <b>Review 5a: Prevalence and patterns of drug use within different disability groups</b></p>	
<p><b>Prevalence</b> – Quantitative (or qualitative) evidence about:</p> <p>the number/percentage of people with drug misuse problems across different disability groups</p> <p>change over time</p> <p>comparisons across groups</p> <p><i>(Record findings by disability group)</i></p>	
<p><b>Patterns:</b> Quantitative or qualitative evidence about disability groups' drug use across: e.g.,</p> <p>drug types,</p> <p>drug use methods</p> <p>regions,</p> <p>gender,</p> <p>deprivation/socio-economic class</p> <p>frequency of use,</p> <p>length of time of use</p> <p>reasons for use etc</p> <p>Also note change over time and comparison across groups</p> <p><i>(Record findings by disability group)</i></p>	

Evidence/information relating to <b>Review 5b: Disability groups need for and access to prevention and treatment programmes</b>	
<p><b>Good practice in drug treatment and prevention:</b></p> <p>Drug prevention and treatment needs of disability groups</p> <p>What works in drug treatment and prevention for disability groups</p> <p>Can include: Evaluations/reviews of effectiveness of specific disability programmes or general programmes that are working well with disability groups</p> <p><i>(Record findings by disability group)</i></p>	
<p><b>Access to drug treatment and prevention programmes:</b></p> <p>Experiences of accessing drug treatment/prevention programmes</p> <p>Extent and types of targeted drug treatment and prevention programmes for disability groups</p> <p><i>(Record findings by disability group)</i></p>	
Evidence/information relating to <b>Review 5c: Disability groups interaction with the police and criminal justice system</b>	
<p><b>Prevalence/Impact of drug enforcement activity</b> on disability groups:</p> <p>stop and search,</p> <p>arrest,</p> <p>sentencing,</p> <p>other enforcement activities</p> <p><i>(Record findings by disability group)</i></p>	
<b>Research gaps identified</b>	
<b>Policy implications identified</b>	
<b>Key conclusions of study</b>	
<b>Additional references to obtain</b> <i>(add to spreadsheet)</i>	

# Appendix 7. Quality standards for review

## **1. Census Bureau Standard: Minimal Information to Accompany any Report of Survey or Census Data**

1. The organizational sponsor(s) of a survey;
2. The organization(s) that conducted it;
3. The wording of questions asked and description of derived measures that are the subject of the report;
4. A definition of the population under study, and a description of the sampling frame used to identify this population;
5. A description of the sample design;
6. The size of sample, and disposition of sample cases (e.g., numbers of interviewed cases, ineligible cases, and nonresponding cases);
7. If applicable, information on eligibility criteria and screening procedures;
8. A discussion of the statistical precision of the results, at least for the major estimates.  
This could include estimates of sampling variances, standard errors, or coefficients of variation, or presentation of confidence intervals;
9. Description of estimation procedures, including weighting, editing, and imputation methods;
10. If applicable, clear indication of which results are based on parts of the sample, rather than on the total sample;
11. Method and dates of data collection;
12. Discussion of nonsampling errors that may (or are known to) affect the data; and
13. Discussion of methods employed to ensure data quality.

## **2. EPPI Centre – Qualitative research quality standards**

1. Aims clearly stated
2. Context of study clearly described
3. Sample clearly described
4. Methods clearly described
5. Attempts to establish reliability and/or validity of data analysis

## Appendix 8. Material reviewed

- Quantitative methodologies quality assessment categories: **Low: >0 and ≤8; Medium: >8 and ≤11; High: >11**
- Qualitative and secondary methodologies quality assessment categories: **Low: >0 and ≤3; Medium: >3 and ≤4; High: >4**

Number	Author	Title	Published by	Date	Sample	Quality assessment score
1	Select Committee on Science and Technology	Cannabis: The scientific and medical evidence	House of Lords	1997-1998	NA	NA
2	FMR	Final Report November 2002 : Drug and alcohol issues affecting those with a sensory impairment in Greater Glasgow	Commissioned by North Greater Glasgow NHS Board	2002	N=89 Hearing impairment = 63 Visual impairments = 17 Both impairments = 9	Qual: 4; Medium
3	COI Communications	Drug misuse and people with hearing impairment: stage 1	COI Communications.	2004	NA	NA
4	Taggart et al.	An Exploration Of Substance Misuse In People With Learning Disabilities Living Within Northern Ireland	Commissioned by the Review of Mental Health and Learning Disability, Northern Ireland.	2004	N=41 individuals with learning disabilities m=21, f=20	Quant: 9.5, Medium
5	Drug and Alcohol Education and Prevention Team.	Drug education for young deaf people: a briefing paper for practitioners working with young deaf people.	London: DEPIS, 2004.	2004	NA	NA



Number	Author	Title	Published by	Date	Sample	Quality assessment score
6	Huxley et al.	Substance misuse and the need for integrated services	Learning Disability Practice. Vol 8 No 6 pp14-17	2005	NA	NA
7	IACM bulletin	Bulletin March 2005	International Association for Cannabinoid Medicine	2005	NA	NA
8	Taggart et al.	Listening to people with intellectual disabilities who misuse alcohol and drugs	Health and Social Care in the Community. 15(4), July 2007, pp.360-368.	2007	N=10 people with intellectual disabilities	Qual: 5; High
9	McLaughlin D.F. et al.	The experiences of professionals who care for people with intellectual disability who have substance-related problems.	Journal of Substance Misuse. 12(2), April 2007, pp.133-143.	2007	N= 13 practitioners within intellectual disability services or alcohol and drug services	Qual: 4.5; High
10	NTA	Supplementary guidance notes on diversity legislation	NTA	2007	NA	NA
11	NICE	Guidelines: Drug Misuse: Psychosocial interventions	NICE	2007	NA	NA
12	Taggart et al.	Alcohol and illicit drug misuse in people with learning disabilities: implications for research and service development.	Advances in Mental Health and Learning Disabilities. 2(1), March 2008, pp.11-21.	2008	NA	Secondary: 3.5; Medium
13	Hoare, J.	British Crime Survey: Drug Misuse Declared: Findings from the 2008/09 British Crime Survey	Home Office	2009	N=5013 people with long standing illness or disability Limits activities=3231 Does not limit activity=1782	Quant: 11.5; High