Alcohol, tobacco and cannabis use: Do students with mild-intellectual disability mimic students in the general population?

Dibia Liz Pacoricona Alfaro, Virginie Ehlinger, Stanislas Spilka, Jim Ross, Mariane Sentenac, Emmanuelle Godeau

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A B S T R A C T

Education policies encourage inclusion of students with mild-intellectual disability (mild-ID) in community/school life. However, such policies potentially increase exposure to substance use.

This article examines tobacco, alcohol and cannabis use among French students enrolled in special units for students with disabilities (ULIS) at mainstream junior high schools compared to those of general population of the equivalent age; and explores factors associated with substance use among ULIS students, known to present mostly mild-ID.

In 2014, a questionnaire adapted from the international HBSC/WHO study was administered to 700 ULIS students (mean-age 14.2). Comparative data were gathered from 7023 junior high-school students (mean-age 13.6) in the general population.

Among students <14 years-old, tobacco and alcohol use rates were similar between ULIS and general population. For students ≥14, alcohol use remained comparable, while tobacco and cannabis use were higher in general population.

Among ULIS students, low perceived health/life satisfaction, divorced/separated parents and high perceived academic demands were associated with tobacco use. Bullying, not liking school very much and attending schools outside a deprived area were associated with alcohol use. Having had sexual intercourse and not perceiving one's health as excellent were associated with cannabis use. Having dated was associated with using all three substances.

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What this paper adds?

Overall, students with mild-ID are increasingly mainstreamed educationally. Yet, an under-explored aspect of inclusion is offering those students the opportunity to participate in school-based health surveys using accessible procedures so their views may be heard alongside those of students in the general population.

* Corresponding author. Permanent address: Rectorat de Toulouse 75 rue Saint Roch - CS 87703 31077 TOULOUSE cedex 4, France.
E-mail address: Emmanuelle.Godeau@ac-toulouse.fr (E. Godeau).

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Especially for students with mild-ID, self-reported questionnaires with assured anonymity seem to be the best way to collect information on sensitive topics such as risk behaviors. A high level of perceived anonymity minimizes socially desirable responses. We used a group-administered paper-and-pencil questionnaire because a significant body of evidence demonstrates that if data are gathered anonymously, respondents will report their behaviors and attitudes with a greater degree of candor; and, as a result, their responses will be more valid. A major strength of our study is the comparability of methods used for special units and general population students, with adaptations to take into account cognitive limitations of students with mild-ID, thereby allowing collection of comparable data from large samples in both settings. The fact that adolescents are surveyed during the time period when they are most likely to initiate substance use minimizes recall bias. Hence, observation of these early experiences becomes more accurate, especially among students with mild-ID.

The inclusion of students with mild-ID alongside those in the general population enables a more comprehensive description of substance use in this age group. A better understanding of the similarities and differences between students from the general population and those with mild-ID will potentially guide policies and practices adapted to the latter.

1. Introduction

Inclusive education is recognized widely as a principle for promoting equal opportunities for people with disabilities in educational environments and more broadly in society (UNICEF, 2012; World Health Organization, 2011). Inclusive policies operating internationally encourage enrollment of a growing proportion of children with various types of disabilities in mainstream schools and, ideally, within mainstream classrooms (Blanc, Bondonneau & Choisnard, 2011; McLeskey, Landers, Williamson & Hoppey, 2010).

Within France, the act of 11th February 2005 on equal rights and opportunities, participation and citizenship of people with disabilities1 recognizes the rights of all children with disabilities to attend the closest school to their homes. Currently in France, the majority of students with mild-intellectual disabilities (mild-ID) are enrolled collectively in special units within mainstream schools, because it is assumed that they could not follow all subjects due to their degree of disability (Le Laidier & Prouchandy, 2012). Such classrooms or special units are called Unité Localisée pour l’Inclusion Scolaire or ULIS. These ULIS group relatively small numbers of students (10 to 12), most of whom have mild-ID, sometimes combined with another disability. At junior high school, for example, approximately three quarters of students in ULIS presented mild-ID during the school-year we conducted our survey (Ministère de l’Éducation Nationale, 2014). The ULIS are comparable to “self-contained classrooms” for students with disabilities in the United States in that, while they are grouped together for homeroom and some subjects, many students leave the unit to take one or more classes with students in the general population. The ULIS are coordinated by a specialized teacher and methods are adapted to the students’ capacities. Students in ULIS have to be enrolled in regular classes according to their personalized education plan.2 Although a greater amount of interaction with other adolescents represents an unquestionable benefit for students with intellectual disability (ID), this potentially also means greater exposure to risks such as use of substances.

Adolescence is when the consumption of substances typically begins, with the prospect this adolescent experiment will transform into a lifelong behavior. Some substances, such as tobacco and alcohol, are widely considered licit even if their use may be illegal for minors. Other substances, such as cannabis, historically have been considered illicit for the general population, though laws have begun to change, and enforcement varies widely. Given the well-known potential consequences of early licit and illicit substance use (DeWit, Adlaf, Offord & Ogborn, 2000; DeWit, Hance, Offord & Ogborn, 2000; Jha et al., 2013; Liang & Chirizths, 2015; Moss, Chen & Yi, 2014), numerous policies have been implemented to delay the onset or prevent entirely the consumption of substances during adolescence. Like many other countries, France over the past 15 years has implemented pricing policies, banned sales to minors, banned use of substances in schools, banned public advertisements, and implemented general prevention campaigns and prevention programs in schools (Díaz Gómez, Lermenier & Milhet, 2013). However, prevention policies often are not adapted to the limitations of students with ID.

Previous studies provide conflicting evidence on differences in substance use between students with ID and the general student population. For example, several studies showed higher smoking rates among adolescents with ID compared to the general student population (Blum, Kelly & Ireland, 2001; Emerson & Turnbull, 2005; Kalyva, 2007; Kepper, Monshouwer, van Dorsseelaer & Vollebergh, 2011). Other studies have shown that alcohol use was similar between groups (Maag, Irvin, Reid, & Vasa, 1994), or lower among adolescents with ID over the past year and month (Gress & Boss, 1996). Regarding cannabis use, Kepper (Kepper et al., 2011) reported similar rates in lifetime prevalence between adolescents with ID and their non-disabled counterparts, but Gress (Gress & Boss, 1996) found lower rates of use for last year and last month among students with ID compared to mainstream. Besides, most studies of adolescents with ID are limited by small sample sizes (Emerson & Turnbull, 2005; Kalyva, 2007). In any case, there has been a glaring gap in epidemiological data about the magnitude of substance use among young people with ID in France because such students historically were excluded from large nationally representative surveys. While the characteristics of adolescent substance use and associated risk factors have been widely examined and described for the general population (Fisher, Miles, Austin, Camargo & Colditz, 2007; Hibell et al., 2012; Jovic et al., 2014; Jovic et al., 2015; Malmberg et al., 2010; Spilka et al., 2015), this is not the case among adolescents with ID.

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1 Act No. 2005–102 of 11 February 2005
2 Equivalent to the Individualized Educational Plan in the United States

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