SOUTHERN NETWORK
OF SPECIALIZED CARE

Understanding Special Needs Offenders who have a Dual Diagnosis

3rd Edition

June 2013

SOUTHERN NETWORK OF SPECIALIZED CARE

July 2013

Dear Colleagues:

The SNSC understands that as duties continue to change and develop, professionals within the Criminal Justice System (CJS) are often expected to provide supports and services with people who could be identified as having a Dual Diagnosis. The SNSC has compiled this resource to share knowledge and insight about people who have a Dual Diagnosis and some of the strategies that have been proven effective in providing care and supports within a CJS environment.

The first edition of Understanding the Offender with a Dual Diagnosis was developed as a result of requests for information from the Elgin Middlesex Detention Centre in London, ON. It is the hope of the SNSC that the information provided in this, the third edition, will continue to enhance your understanding and knowledge as you endeavour to provide services for these complex people.

Regards,

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Chapter 1 : Who Are Special Needs Offenders?

Special Needs Offenders are "those who are mentally ill and/or developmentally disabled persons or persons with special needs who are in conflict with the law." [1]

Special Needs Offenders (SNO) are among the groups of people that are in a particularly vulnerable position in detention centres and prisons and are in need of additional care and protection. More and more frequently, police and corrections officers are expected to provide direct support for special needs offenders.[2]

It is often assumed that special needs offenders make up a small percentage of the general offender population. However, for a number of reasons, their proportions in detention centres and prisons have been growing in recent years.[3]

A person who has an intellectual disability/dual diagnosis frequently has specific vulnerabilities in the criminal justice system, which cause challenges for themselves, the police, courts, and corrections workers as they move through the system.

"People with developmental disabilities represent 2-3% of the general population, but they represent 2-10% of the prison population (Baroff, 1996; Denkowski & Denkowski, 1985; Smith, Algozzine, Schmid, & Hennly, 1990), and the statistics are higher for juvenile and jails."[4]

Vulnerabilities include:

- More susceptible to being the "fall guy" or doing something illegal to impress someone else;
- When questioned by police, they may not understand the questions asked or their rights;
- More likely to confess to crimes they did not commit;
- Past experiences lead them to believe that if they agree people will usually leave them alone;
- More often held in custody during pre-trial due to an inability to follow recognizance orders;
- Fixed income, lost family ties or limited social supports often mean they remain in custody because of the difficulty in securing surety;
- If the person is supported by a community-based agency, the agency cannot act as surety for the person;

[1] Howlett, M. (2005). The Mental Health Commission of Canada – the Way Forward, 4.

[2] **The International Institute on Special Needs Offenders and Policy Research (Canada) 2012**

[3] Mr. Howard Sapers Correctional Investigator of Canada and Dr. Ivan Zinger, Office of the Correctional Investigator, Appearance before the Standing Committee on Public Safety and National Security, June 2, 2009

[4] Griffiths, D., Taillon-Wasmond, P., & Smith, D. (Eds.). (2002). Offenders who have a developmental disability. In Dual Diagnosis: An Introduction to Mental Health Needs of Persons with Developmental Disabilities . Sudbury, ON.: Habilitative Mental Health Resource Network.

- Usually depend on ODSP (Ontario Disability Support Plan) and depending on the offence they are not always eligible to obtain legal aid in Ontario courts;
- Typically do not understand criminal proceedings;
- Can be taken advantage of in jail; can be victimized sexually, physically, financially and verbally;
- More likely to be disciplined and/or isolated for not understanding and following institutional rules;
- Have difficulty following institutional hierarchy and following social cues;
- Frustration/fear/anxiety can manifest as challenging behaviour that can lead to additional charges, longer sentences, the use of segregation and a need for higher security.

Research indicates that people, who have intellectual disabilities, including autism, will have *up to seven times more contacts with police* than a member of the general public.[5]

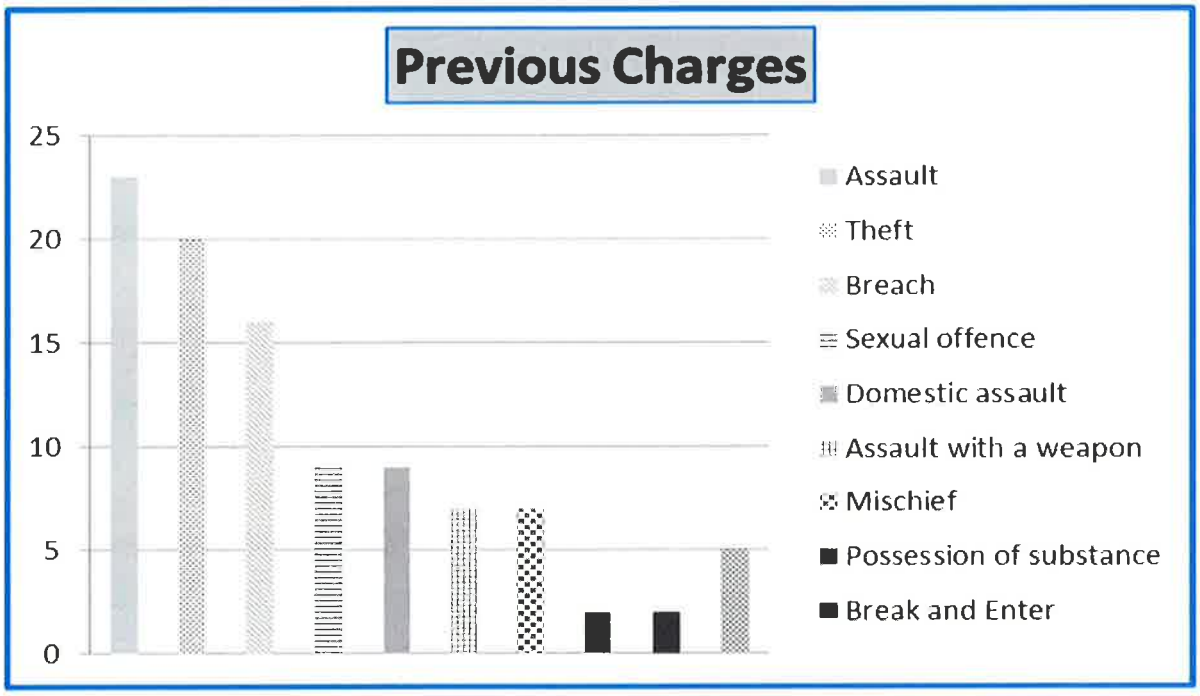
Profile of the Dually Diagnosed Offender [6]
Statistics gathered from the Dual Diagnosis Justice Case Managers from the South West Region for the period of April 1, 2012 to December 30, 2012

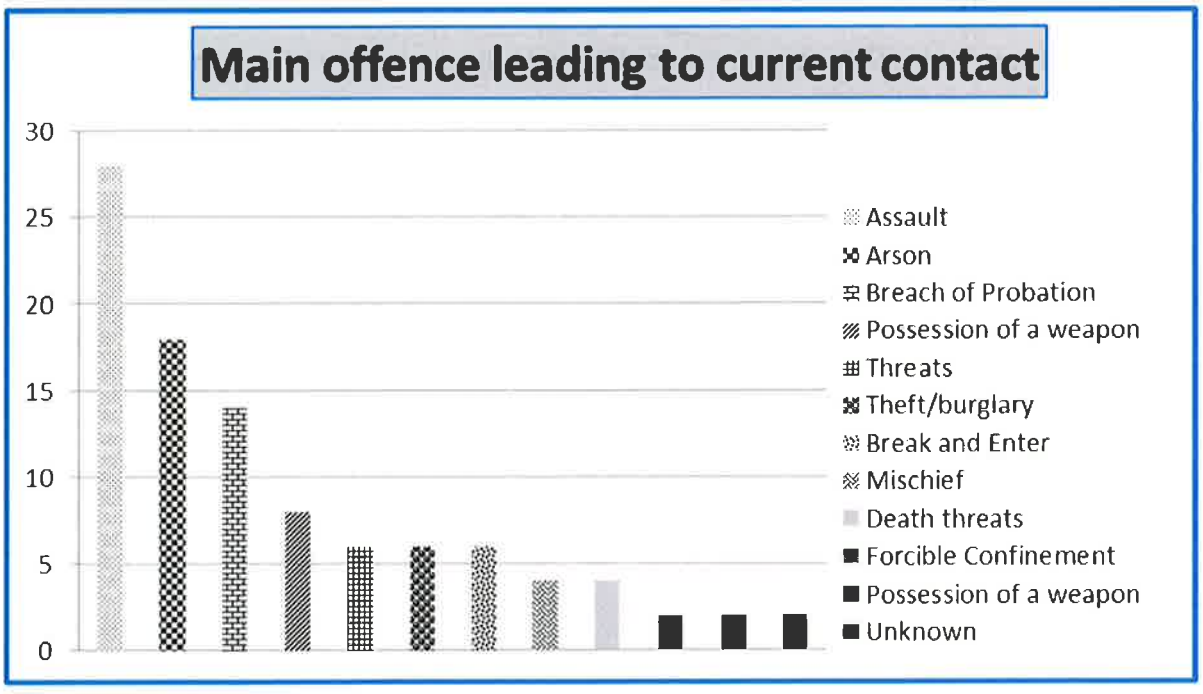
Total Cases to end of Q3 for 2012/2013 = 38

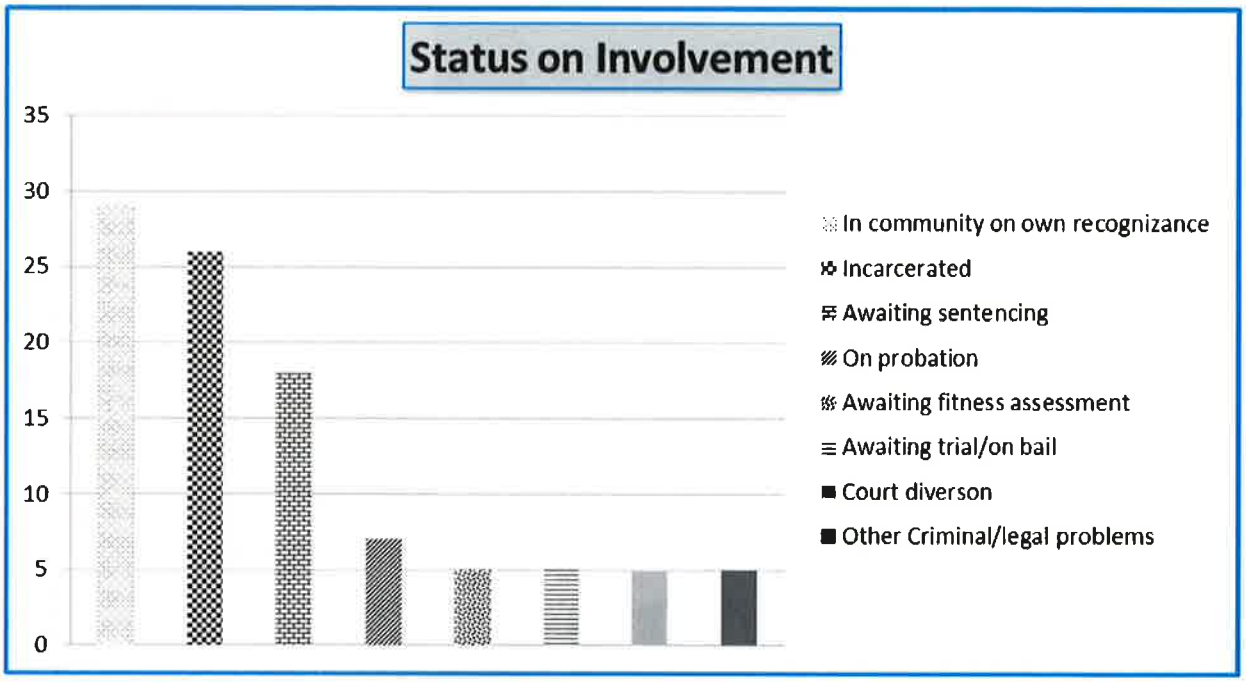
Previous Charges: Of the 38, 25 (66%) had previous charges before the police involvement that lead to contact with the DDJCM.

Total number of previous charges = 44

[5] Curry, K., Posluszny, M. and Krasha, S. (1993). Training criminal justice personnel to recognize offenders with disabilities. Washington, D.C.: Office of Special Education and Rehabilitative Services News in Print.
[6] Regional Support Associates, Dual Diagnosis Justice Case Management Program. 2012.


Previous Charges
25
20
15
10
5
0
Assault
Theft
Breach
Sexual offence
Domestic assault
Assault with a weapon
Mischief
Possession of substance
Break and Enter


Main offence leading to current contact
30
25
20
15
10
5
0
Assault
Arson
Breach of Probation
Possession of a weapon
Threats
Theft/burglary
Break and Enter
Mischief
Death threats
Forcible Confinement
Possession of a weapon
Unknown



Number of Days in Jail

Of the 38 served in 2012, 19 spent more than one day in custody (detention).
Total # of days in jail = 191
Average length of stay = 10.5 days

The Special Needs Unit at Elgin Middlesex Detention Centre has noted that the involvement of Dual Diagnosis Justice Case Managers leads to shorted stays in detention.

Resolution

At end of reporting period, resolution had been reached for 8 of the 38. The remaining 30 clients were awaiting resolution at the end of the reporting period.
Outcome:
Diversion – 3
Probation/parole – 3
Sentence – 2

Identifying a Person Who Has a Dual Diagnosis

In Ontario, the term dual diagnosis is a term applied to a person who has an intellectual disability and mental health need and/or challenging behaviours.

The term "challenging behaviour" is used to describe behaviour that interferes with a person's daily life. [7]

There are no indicators that will, with 100% accuracy, help lead to the conclusion that a person has an intellectual disability/dual diagnosis. However, there are a number of signs that are reasonably accurate to indicate a person likely may have an intellectual disability/dual diagnosis. Many of these signs can be investigated by observing the person, gathering information directly from the person, or through their files and include:

- The person may have very little understanding of the sub-culture within the correctional facility and tend to take longer to adapt than a general offender.
- The person may lack insight into common language used, the hierarchy, and how "things work".
- Many special needs offenders often do not want to be identified as having a disability or mental health needs. The person may be reluctant or refuse to answer questions about their past, education, employment or daily living histories. SNOs have the ability to understand the labels that make them different and more vulnerable in the general inmate population.
- Lack of, inappropriately timed, or inappropriate amounts of eye contact.

Questions that may assist in concluding a person has an intellectual disability/dual diagnosis:

- Did the person attend special education classes in school?
- Has the person repeated more than one grade in school?
- Did the person ever work in a sheltered workshop or is their work history stable with some paid employment experience?
- Has the person ever had paid staff supporting them or have they ever lived in a group home? Do they have a case manager in the community?
  Has the person ever been told they have a developmental disability/intellectual disability or learning disability? Have they been told they have a diagnosis of a mental health problem?
- Is the person able to tell time on a watch or a clock with hands (not digital)?
- Does the person have an excessive need to be accepted by others?

[7] Joint Policy Guidelines for the Provision of community Mental Health and Developmental Services for Adults with a Dual Diagnosis (2008). *Building the Path to Home: Links to Sustainable Housing for People with Dual Diagnosis.* Toronto, ON: Centre for Addiction and Mental Health.

Chapter 1 : Who Are Special Needs Offenders?

Corrections officers may observe some of the following behaviours from special needs offenders that general population prisoners typically do not display:

- Excessive crying.
- Persistent conversation on specific topics.
- Disorganized conversation.
- Pacing and hand ringing that appears ritualistic.
- Trouble adapting to any changes.
- Verbal communication inconsistent with visible emotions; for example, laughing when they are expressing regret.

Together with other indicators, such as challenges with communication or impulsive behaviour, it may mean the person has a disability, not that they are being disrespectful.

- Increased property destruction compared to the general population inmate.
- Self-injurious behaviour such as pulling at their hair, hitting themselves, biting their own arms, hands.
- Isolating themselves from others.
- Refusing meals or hoarding food.
- Dramatic changes in weight.
- Limited insight into reasons why they have offended or acted out.
- Limited insight into consequences of behaviour – both specific to their own and in general.
- Slow at processing information. The person may pause a long time before answering questions, following through with requests made of them, or carrying on a conversation. This can be interpreted as defiance or refusal but is generally the time it takes the person to understand the question/request and form an appropriate response.
- Poor impulse control.
- Poor understanding of others personal space – may appear to be crowding the person, stand too close to them or touch when it is not appropriate.
- Increased prevalence of poor hygiene.

NB: The current diagnostic term "developmental disability" is still found in much research, literature and service system work. However, this manual uses the term "intellectual disability", which will be the updated diagnostic/clinical term for developmental disability with the introduction of the DSM V in 2013. The term "dual diagnosis" refers to people who have both an intellectual disability and/or a mental health need/challenging behaviour.

Chapter 2 : Challenges in the Criminal Justice System

"The criminal justice system is designed to provide secure containment of prisoners, and to maintain order with a hope that the punitive procedures will produce an inhibiting effect on criminal behaviour. However, as Gardner et al. (1990) suggest, this premise is based on the belief that the offender has an alternative prosocial behaviour that he or she can select to use after release. This assumption may be faulty when referring to persons with developmental disabilities. A skill development approach to habilitation is required if there is to be effective change in the behaviour post incarceration (Gardner et al., 1998)."[1]

Studies have shown that people who have intellectual disabilities face a higher prevalence of psychosocial or psychiatric disabilities than the general population and they will therefore need greater access to appropriate treatment such as behavioural therapy, speech therapy, occupational therapy and physiotherapy.[2]

Special needs offenders can present and experience significant challenges within the Criminal Justice System (CJS):

1) Offenders who have intellectual disabilities may find it difficult to follow facility rules for a variety of reasons. Often they do not have the ability to understand implied social rules or recall and follow the more concrete rules of a facility and are more inclined to break rules more often than others. This may be observed as disruptive behaviour, aggression or violence. In correctional facilities, inability or refusal to follow rules is often addressed with punitive measures such as removal of privileges, restraint or isolation.

2) In correctional facilities, misconduct offenses should be documented and frequent disciplinary offenses can create an accumulation of misconduct reports. For an offender who has difficulty understanding and following the rules; this can have a negative impact on success in seeking parole.

[1] Griffiths, D., Stravrakaki, C., & Summers, J., (Eds.). (2002). Dual Diagnosis: An Introduction to the mental health needs of persons with developmental disabilities. Sudbury, ON.: Habilitative Mental Health Resource Network.
[2] Rickford, D. and Kimmett, E., (2005).Troubled Inside: Responding to the Mental Health Needs of Men in Prison. London, U.K.: Prison Reform Trust.

3) Corrections officers are in a position to be able to observe and recognize patterns of offender behaviour and can often detect behaviour that is "out of the norm". Without specific training in identifying intellectual disabilities or dual diagnosis in offenders, there is little opportunity to effectively offer recommendations and suggestions when creating plans for people. Therefore, providing training for corrections officers on the signs and indicators of intellectual disabilities and mental health needs enhances the ability of corrections officers to respond appropriately to these offenders.[3]

4) Special needs offenders are at increased risk of harm because they are vulnerable to abuse, exploitation, manipulation, misunderstanding of what is expected of them, and inability to benefit from most existing treatment programs within correctional facilities.

5) Existing treatment programs often depend on group work or strong receptive language skills. Programs in the CJS are often not designed for the special needs offender or for people who have cognitive issues or challenges. People with these challenges experience great difficulty understanding or benefitting from these types of programs.

6) The average length of stay in custody is frequently less than 35 days. This time period is often too short to provide effective treatment programming, particularly if the offender requires longer than average time to complete a program.[4]

[3] Handbook on Prisoners with special needs. CRIMINAL JUSTICE HANDBOOK SERIES UNITED NATIONS PUBLICATION. ISBN 978-92-1-130272-1.

[4] Endicott, O.R., (1991). Persons with Intellectual Disability who are Incarcerated for Criminal Offenses: A Literature Review. Ottawa, ON: Correction Services Canada.

Chapter 3 : What is an Intellectual Disability?

The term "intellectual disability" is the diagnostic term/clinical term for what was formerly diagnosed as a developmental disability. The term "developmental disability" is still used appropriately in many legislative and medical contexts. For the purposes of this manual, intellectual disability is used to reflect current clinical usage.

In Ontario, legislation describes a person with a developmental disability (intellectual disability) as someone who has:
"significant limitations in cognitive functioning and adaptive functioning and those limitations...

a) originated before the person reached 18 years of age;
b) are likely to be life-long in nature; and
c) affect areas of major life activity, such as personal care, language skills, learning abilities, the capacity to live independently as an adult or any other prescribed activity. 2008, c. 14, s. 3 (1)".

- Adaptive functioning refers to a person's capacity to gain personal independence, based on the person's ability to learn and apply conceptual, social and practical skills in his or her everyday life;
- Cognitive functioning refers to a person's intellectual capacity, including the capacity to reason, organize, plan, make judgments and identify consequences. 2008, c. 14, s. 3(2).[1]

This definition means that a person who has an intellectual disability is someone who may have trouble reasoning, planning, organizing, making judgements and identifying the consequences of their behaviour. They also have difficulty learning and applying concepts and social and practical skills needed for daily living.[2]

Previous clinical terminology may be used in older clinical reports. Some of the clinical terms used to describe an intellectual disability are:

- developmentally delayed
- mentally retarded
- retarded
- developmentally handicapped
- mentally challenged
- developmentally challenged
- challenged

[1] Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act (2010). Retrieved from http://www.e-laws.gov.on.ca/html/source/regs/english/2010/elaws_src_regs_r10299_e.htm
[2] Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act (2010). Retrieved from http://www.e-laws.gov.on.ca/html/source/regs/english/2010/elaws_src_regs_r10299_e.htm

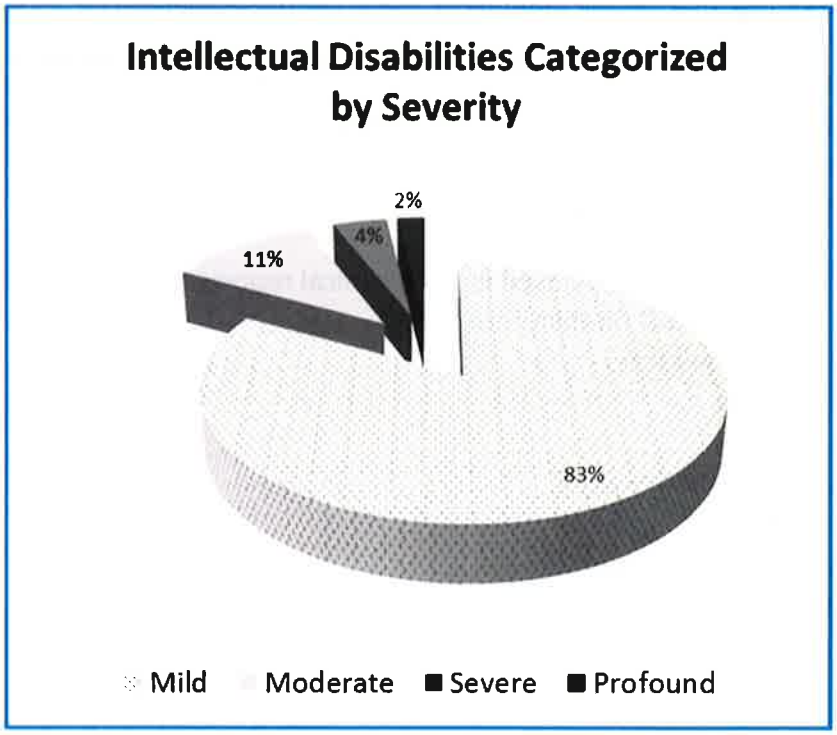
Chapter 3 : What is an Intellectual Disability?

There are many slang terms that are used inappropriately to describe or refer to a person who has an intellectual disability. Some of these include:

- retarded
- a retard
- disabled
- moron
- imbecile
- idiot
- "on the short bus"
- simpleton
- dimwitted

In the same way that it is not appropriate to refer to people as their race, religion, sexual orientation, etc., it is not acceptable to refer to people as their disability or with terms that they find offensive and disrespectful.

Intellectual disabilities are categorized according to severity as follows:



Mild: 80 – 85% of people with ID • IQ 50-70 • Slower than normal development in all areas • Unusual physiology rare • Can learn practical skills • Ability to learn literacy skills • Can conform socially • Can learn daily tasks	**Moderate: 10 – 12 % of people with ID** • IQ-35-49 • Noticeable delays, particularly speech • May have unusual physiology • Can learn simple communication • Can learn simple health and safety skills • Can participate in some self-care • Can perform supervised tasks • Can travel alone to familiar places
Severe: 3-4% of people with ID • IQ 20-34 • Significant delays in some areas • May walk late • Limited expressive communication skills • Can learn daily routines and repetitive activities • May learn simple self-care • Need direction and supervision socially	**Profound: 1-2% of people with ID** • IQ <20 • Significant delays in all areas • Congenital abnormalities present • Need close supervision • Requires attendant care • May respond to regular physical and social activity • Not able to do self-care

Note that 80 to 85% of people who have an intellectual disability fall into the mild range of disability. Additionally, it can be very difficult to identify the presence of a mild intellectual disability. [4]

[3] Youth in Transition Toolkit (2010). Southern Network of Specialized Care. Retrieved from http://www.community-networks.ca/uploads/Common/YITTool%20Kit%20CONTENTS%20FINAL%20%20March%201%202011.pdf

[4] Youth in Transition Toolkit (2010). Southern Network of Specialized Care. Retrieved from http://www.community-networks.ca/uploads/Common/YITTool%20Kit%20CONTENTS%20FINAL%20%20March%201%202011.pdf

Chapter 3 : What is an Intellectual Disability?

Some things that may indicate a person has an intellectual disability:
The answers the person gives to the following questions may help provide clarity into whether or not the person may have an intellectual disability:

- Does the person communicate in short sentences?
- Does the person seem to be able to do things you later discover he or she really can't do?
- Does the person have trouble generalizing (applying general information to more than one specific context)?
- Does the person seem to learn more slowly than expected for someone who does not have a disability?
- Does the person have trouble with abstract thinking (e.g. understanding how two things are similar)?
- Does the person do better on concrete and structured tasks (e.g. when directions are very specific and broken into steps)?
- Does the person have memory problems?
- Does the person have trouble solving problems?
- Does the person show poor judgment?
- Does the person have trouble understanding "why" questions?
- Is the person good at picking up non-verbal social cues?
- Is it difficult to get a true idea of what the person is capable of, or what he or she understands in a conversation?[5]

Adaptive Functioning

Adaptive skills are the skills necessary for daily living.

Three skill types make up adaptive functioning:

1. Conceptual skills—language and literacy; money, time, and number concepts; and self-direction.

2. Social skills—interpersonal skills, social responsibility, self-esteem, gullibility, naïveté (i.e., wariness), social problem solving, and the ability to follow rules/obey laws and to avoid being victimized.

3. Practical skills—activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, use of the telephone.

[5] Dual Diagnosis Implementation Committee of Toronto (2006). Building the Path to Home: Links to Sustainable Housing for People who have Dual Diagnosis. Toronto, ON: Centre for Addiction and Mental Health.

Someone who has an intellectual disability may have skill deficits as a result of problems with adaptive functioning. These deficits may show in the following ways:

- Can the person tell time on an analogue watch (a watch with an hour hand and a minute hand)? Show the person a watch and ask what time it says. A person who has an intellectual disability may find this difficult.
- Does the person travel alone on buses or the subway? Do they travel by themselves? What routes do they take? (Get the person to describe it).
- What is their favourite TV show? (Often, the person may choose children's or young teen's programming because of the high visual / low verbal content.)
- Does the person look after their own money? Do they pay the bills? Which bills do they pay? How do they pay them?
- Ask how much familiar items cost. Then less familiar, more expensive items, "How much does a car cost?" "How much does a house cost?" (Often, the person will not be able to estimate well). The person may not be able to distinguish between the cost of familiar items but not larger, significantly more expensive items.
- Does the person have a job? Did they ever have a job? What did they do? (i.e., competitive employment, sheltered workshop, co-op program through school)?

They may not have any obvious physical appearance of disability. Cognitive difficulties, however, may not be noticeable unless a person spends a significant period of time interacting with them. The person may also demonstrate a "cloak of competence" which means they are able to present as if they do not have an intellectual disability.

The term "cloak of competence" means a person appears to understand more than they actually do. Special needs offenders use overcompensation, often verbally, to distract from their cognitive disabilities in attempts to avoid bullying or victimization. When the person is involved in more complex conversation, their disability is more apparent.

A person with an intellectual disability/dual diagnosis can also display what are known as **"splinter skills".** For example, a person may have a large vocabulary that they use in everyday conversation. However, their real understanding of the words they use is low or non-existent. The skill in retaining and using words in context is called a splinter skill. These skills can help to convince others that the person is more skilled than they actually are.

The difficulty with cloak of competence and splinter skills is that they can give the impression the person understands the scope and importance of a situation when they really don't. They may agree to things that they don't understand and are not able to cope with situations that arise.

Recognizing a Mental Illness

Mental illness can cause disturbance in thoughts, feelings and perceptions that may impact day-to-day functioning. It can happen any time in a person's life.

Symptoms of mental illness can impact a person's daily routine and ability to perform at their usual level. Mental health issues are common. Studies indicate that in any given year, one in every five Canadian adults under age 65 will have a mental health problem.[6]

While there is significant advancement in diagnosis of and understanding of people who experienced mental illness, stigma and discrimination can still contribute to people with mental health issues keeping them a secret or avoiding diagnosis.[7]

Mental illness is not always classified as serious. A serious mental illness (SMI) is diagnosed on the basis of three criteria:

1. Duration (length)
2. Distress (misery, upset, stress)
3. Diagnosis (identification)

In mental health services, it is more challenging to get services and supports if you have a mild to moderate mental illness. Services prioritize supports for people who have a serious mental illness.

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[6] Offord, D.R., Boyle, M.H., Campbell, D., Goering, P., Lin, E., Wong, M., & Racine, Y.A. (1996). One-year prevalence of psychiatric disorder in Ontarians 15 to 64 years of age. *Canadian Journal of Psychiatry*. 41 (9): 559-63.

[7] Canadian Collaborative Mental Health Initiative (2006). Working together towards recovery: Consumers, families, caregivers, and service providers. Mississauga, ON.

Signs a Person May Have a Mental Illness:

- Increased anxiety, panic or fright
- Hearing, seeing, feeling imaginary things (hearing voices is not the same as talking to oneself for company or to reduce anxiety)
- Need for instant fulfillment / gratification
- Unusual sleep patterns (insomnia or lengthy periods of sleep)
- False beliefs (delusional thinking or paranoia)
- Decline in personal hygiene
- Inappropriate expressive reactions
- Family history of mental illness
- A functional or behavioural change
- Excessive reactivity / moodiness
- Heightened emotional sensitivity
- Accelerated speech patterns
- Lingering sadness
- Self-isolation
- Memory problems (worsening memory or change in memory)
- Changes in appetite (loss of weight or increase in weight)
- Self-injurious behaviour
- Suicidal ideation

What is a Dual Diagnosis?

The presence of both a mental illness and an intellectual disability is referred to as a dual diagnosis.

> ***People who have developmental disabilities have the same potential to develop a full range of psychiatric disorders as the general population. Therefore, it is important to understand how signs and symptoms of mental illnesses may look different in people who have a developmental disability to be able to support them in getting accurate diagnosis and proper treatment. ****[8]

People who have a dual diagnosis and are functioning within the "mild" range of intellectual disability have typically not had traditional developmental services or mental health supports available to them or have not sought them; possibly to avoid stigma, a need to express independence or a need to be socially included.

[8] British Columbia Ministry of Health Services (2007). Family Physician Guide: For Depression, Anxiety Disorders, Early Psychosis, and Substance Use Disorders. Victoria, BC.

These characteristics and tendencies create great difficulty for identification by Corrections Officers, Special Needs Units in Correctional Facilities and Mental Health Services.

In Ontario, the term dual diagnosis is a term applied to a person who has a developmental disability and mental health need and/or challenging behaviours.

Recognizing Mental Health Problems in a Person Who Has an Intellectual Disability
Indicators that someone with an intellectual disability might be experiencing mental health problems:[9]

- Overly dependent given his or her abilities
- Overly independent given his or her abilities
- Change is really hard for the person
- Lacks peers and friends
- Impulsive
- Withdrawn
- Person is aggressive physically or verbally
- The person has trouble with anger
- Irritability
- Socially and/or sexually inappropriate behaviour
- May not accept/believe they have an intellectual disability
- Appears higher functioning than he or she really is
- Has been diagnosed with a mental illness
- Self-injurious behaviour
- Change in sleep patterns
- Appetite changes
- Changes in energy level
- Anxious/fearful
- Confusion or disorientation
- Hears voices when no one is present (This is not the same as talking to oneself for company or to reduce anxiety).
- Family problems interfere with the person's ability to function
- Family history of intellectual disability, mental illness or both [10]

[9] *Dual Diagnosis Implementation Committee of Toronto (2006). Building the Path to Home: Links to Sustainable Housing for People who have Dual Diagnosis. Toronto: Centre for Addiction and Mental Health.

[10] Dual Diagnosis Implementation Committee of Toronto (2006). Building the Path to Home: Links to Sustainable Housing for People who have Dual Diagnosis. Toronto, ON: Centre for Addiction and Mental Health.

Chapter 4 : Strategies for Interacting with a Special Needs Offender

If you suspect or know through assessment/diagnosis that a person has an intellectual disability/dual diagnosis, there are a number of tips to assist with interactions that help build more positive rapport and increase corrections officers' effectiveness in working with these special needs offenders.

- When possible, find a place to communicate with the person where there are few distractions.

- Take extra time to explain expectations and make sure you have the person's attention when doing so.

- Do not use jargon or slang when communicating. Be direct and use straight forward language.

- Speak slowly and clearly. Use clear, precise language. Many people with intellectual disabilities/dual diagnosis have difficulty understanding abstract communication or concepts; ideas and expressions of speech can be very difficult for them to understand.

- Be very specific when giving directions to the person. Explain clearly or show them what you want them to do. You may even need to explain how they can complete the request you have made. If the person is able to read, try to write things down for them in case they have difficulty retaining information or following verbal direction.

- Use visual cues that help the person understand what you are saying. Visual cues help them interpret the words that are spoken.

- When giving directions/orders to the person, try not to give more than one or two at a time. A person who has ID may only be able to process limited amounts of information at a time. If this is the case, they may be overwhelmed by more than one instruction; completing only one item on the list of instructions or none at all.

- Allow the person some time to process information and act on it. A person who has an intellectual disability/dual diagnosis will need extra time to understand what is being asked of them before they can act on it.

- Ask the person to tell you what they think you are asking. They should be encouraged to use their own words so you can check their understanding. People who have intellectual disabilities/dual diagnosis may indicate they understand and be able to echo the words someone has used, but be unable to communicate understanding or context using their own words. By asking them what they have understood using their own words, it is easier to get a clear picture of their actual understanding.

- Use open questions to get more than a "yes" or "no" answer. The person may feel the need to "please the questioner" and may answer in the way they think they should.

- Be aware of your body language. Make sure your verbal message and your body language are consistent. For example, if you are saying you are not upset, but your arms are crossed over your chest and your face is closed, these two messages can be interpreted differently. The verbal and non-verbal messages need to be consistent. [1]

[1] Spence, D. & Hughes, J. (2003). An Instructor Manual for Training Staff Who Work With People Who Have Mental Health Needs and A Developmental Disability. Behaviour Management Services York and Simcoe.

Chapter 5 : Dual Diagnosis Justice Case Management

As a part of the overall court support service enhancement initiatives in the province in 2006, the role of the Dual Diagnosis Justice Case Manager (DDJCM) was placed into the Court Support and Court Diversion Services within the Province of Ontario. Funding for twelve (12) full time positions was provided by the Ministry of Health and Long Term Care for the Ministry of Community and Social Services to administer.

There are 23 Dual Diagnosis Justice Case Managers located across the province working in full and part time roles. Three of these positions are located in Ontario's Southwest within the Southern Network of Specialized Care Region.

Dual Diagnosis Justice Case Management (DDJCM) is a court and community-based support service for people who have an intellectual disability and a mental health need and have been, or are currently involved in the justice system. This program is available to adults over age 18.

The goal for services by the DDJCM is to reduce the number of people with a dual diagnosis who formally enter the criminal justice system and/or decrease their time spent in a correctional facility.

A key responsibility of the position is to identify, assess, and facilitate planning options and supports at key intervention points within the court system.

Key components of the DDJCM Role are:

- **Consultation:**
    - Assist Mental Health Court Support personnel by providing support in the area of dual diagnosis and acting as a single point of contact in navigating MCSS funded services and supports.
    - Assist Defense and Crown by assessing individuals in custody at court that are suspected of having a dual diagnosis.
    - Provide education to individuals, defense, crown, families, court support personnel, special constables, police and judiciary regarding aspects and behaviours and needs of the dually diagnosed individual and any community-based options for them.

- **Court Support:**
    - Working collaboratively with the Crown and Defense Attorneys, the DDJCM works to prepare an Individual Support Plan to address the needs of both the client and the Crown. In doing so, best attempts are made to advocate for a noncustodial disposition (i.e., no jail or detention) so that the client can access community-based programs that address the client's needs, and avoid further contact with the law, avoid a criminal record, and avoid recidivism when possible.

- When non-custodial dispositions are not an option for the person, the DDJCM will build a case to advocate for a shorter sentence, or at times, a longer sentence that will entitle the client for a jail-based treatment program within the Ministry of Community Safety and Correctional Services.

- **Release from Custody Planning:** The DDJCM partners with the various correctional facilities and assists the release from custody planners and social workers to develop appropriate discharge plans. The DDJCM acts as a contact in accessing MCSS funded services and supports. They assist with transitioning clients being released back into the community to ensure follow through with discharge plans. The DDJCM can provide education to correctional officers on best practices for working with "Dually Diagnosed – Special Needs Offenders".

- **Case Management:** The DDJCM works to ensure all parties involved with the individual are kept up to date and have current information regarding court proceedings. They assist clients to obtain appropriate documentation to access community services, i.e., Health Card, SIN card, Birth Certificate, etc. They can help ensure links are made to longer term community and regional supports upon clients' discharge from the DDJCM program; and ensure referrals are made on the client's behalf for appropriate assessments, i.e., psychological, psychiatric, etc.

- **Diversion:** The DDJCM will make application to the Crown for Diversion when a dually diagnosed client commits a minor/low level offence. They will monitor and encourage compliance with diversion and treatment measures if and when diversion is granted. They also provide open communications with the courts regarding progress made by the diversion client and obstacles that have affected the diversion plan.

In carrying out this role, the Dual Diagnosis Justice Case Managers have noted some of the challenges they encounter:

- Absence of a confirmed diagnosis of either an intellectual disability, mental health issue, or both complicates accessing services needed
- Long wait lists for developmental services needed because capacity for community services is currently full in many organizations
- No community case management services for complex cases
- Large geographic territory covered by each is time consuming and can take away from capacity to be involved in more cases

In the Southern Region, there are 3 Dual Diagnosis Justice Case Managers that are mandated to carry out these key objectives. The DDJCMs are located in Hamilton/Niagara, London/Middlesex, and Windsor/Essex and cover the courts across the entire Southern Region.

Chapter 5 : Dual Diagnosis Justice Case Management

Dual Diagnosis Justice Case Management Services in your region can be accessed as follows:

Hamilton/Niagara/Haldimand/Norfolk/Brant
DDJCM – DSO in the Hamilton-Niagara Region
Hamilton 905-297-5604
Niagara 289-477-5305

To contact DDJCMs in the geographic areas below, call them in their offices at Regional Support Associates (RSA). RSA is a group of Specialized Clinicians who provide a wide range of services to people who have intellectual disabilities.

London/Middlesex
Elgin/Oxford
Grey/Bruce
Huron/Perth
Chatham/Kent
Sarnia/Lambton
Windsor/Essex

Phone: 1-800-640-4108
Fax: 519-421-4249

To connect with the DSO for services provincially:

http://www.dsontario.ca/

Chapter 6: Fetal Alcohol Spectrum Disorder (FASD)

Fetal Alcohol Spectrum Disorder (FASD) is a term used to describe a range of disabilities caused by pre-natal exposure to alcohol. Most commonly recognized diagnoses within this spectrum are:

1. Fetal Alcohol Syndrome (FAS) and;
2. Partial Fetal Alcohol Syndrome (pFAS).

Together they represent about **15%** of those affected by pre-natal exposure to alcohol. These people typically have:

- Three characteristic facial features
- Central nervous system damage or permanent brain damage
- Growth impairment

Many doctors are only familiar with these two forms of FASD. However, the remaining ***85%*** of those actually affected fall under the category of Alcohol Related Neurodevelopment Disorder (ARND).

People with Alcohol Related Neurodevelopmental Disorder have brain damage but no facial features or growth impairment that is typically associated with FASD. It is impossible to tell from looking at them that they have a disability.[1]

This makes FASD an invisible disability most of the time.

As a result, people who have FASD are largely misdiagnosed or go unrecognized altogether; receiving inappropriate, ineffective support and intervention. Most often brain damage is never detected.

Behaviour is incorrectly considered to be willful.

The prevalence of FASD is ***at least*** 1 in every 100 live births. This makes FASD one of the leading causes of disability in North America. 10% will have an IQ of 70 or below, which also makes FASD one of the leading causes of intellectual delay (as historically defined). [2]

[1] Malbin, D. V. (2004). Fetal alcohol spectrum disorder (FASD) and the role of family court judges in improving outcomes for children and families, 55.
[2] Public Health Agency of Canada (2005). Fetal Alcohol Spectrum Disorder (FASD).

Chapter 6: Fetal Alcohol Spectrum Disorder (FASD)

To caregivers and professionals, people with ARND (Alcohol Related Neurodevelopmental Disorder) often seem more capable than they actually are. This is a complicating factor when a person who has ARND comes into contact with the Criminal Justice System.

While each person impacted by FASD is unique, brain damage typically results in various dysfunctional behavioural symptoms commonly found with this disability including:

- problems with interpersonal skills and reading social cues
- impulsive actions along with a lack of inhibitions
- poor understanding of boundaries and ownership
- struggles with regulating emotions
- rigid and inflexible behaviour patterns
- being easily influenced and overly trusting
- individuals act younger than they are chronologically (often half their chronological age)
- sleep problems and being overly active
- sensory sensitivity
- trouble learning or memory problems
- trouble making good decisions
- making the same mistake repeatedly (not learning from previous experiences or consequences)
- lying and/or stealing

FASD is ORGANIC BRAIN DAMAGE caused by pre-natal exposure to alcohol. It is NOT a mental health or behavioural issue.

These behavioural symptoms lead to the secondary disabilities of FASD and have lifelong impacts on all sectors of community service provision.

The secondary characteristics of FASD include:

- mental health problems
- disrupted school experience
- trouble with the law
- confinement for treatment or mental health
- addictions
- inappropriate sexual behavior
- social isolation
- victimization
- risk taking activities
- unplanned pregnancy
- problems with employment
- withdrawal
- problems living independently
- Homelessness [4]

Chapter 6: Fetal Alcohol Spectrum Disorder (FASD)

FASD and the Criminal Justice System (CJS)

There are some patterns in offenses and behaviour that can indicate a special needs offender may have Fetal Alcohol Spectrum Disorder:

- repetitive but non-escalating pattern of repeat offenses over short and long term periods
- offences exacerbated by drugs and alcohol
- warnings, probation or prison time do not act as deterrents for future offences
- often numerous charges for same offence
- appears to have no remorse
- will talk the talk but unable to walk the walk without support

The criminal justice system is designed to be corrective in nature. Punishment is one aspect of the CJS, whereas sentencing must consider other factors such as deterrence, separation of offenders for the protection and reparation for society, assisting in rehabilitation and acknowledgement of harm. Offenders with FASD will not be deterred by incarceration because their ability to generalize or transfer learned skills from one situation and apply them to another is severely impaired by FASD.

The criminal justice system can experience the following challenges when working with a person who has FASD:

- An unreliable memory results in changes to "the story".
- They will agree to leading questions.
- Impairment to executive function impacts judgement and reasoning which impacts the ability to determine the intent of the person's behaviour. Executive functioning
- manages such processes as planning, working memory, attention, problem solving, verbal reasoning, inhibition, mental flexibility, task switching, and initiation and monitoring of actions.
- Poor planning capacity means the person is more likely to commit offences of opportunity and impulse, i.e. shoplifting, break and entering, car theft, etc.
- The person cannot anticipate consequences and has limited problem solving skills to resolve disputes or talk themselves out of trouble.
- People who have FASD are highly suggestible, willing to please, are usually the last ones to notice that things are going wrong, and are the first ones to get caught.

[4] Streissguth, A.P., Barr, H.M., Kogan, J., & Bookstein, F.L. (1996). Understanding the occurrence of secondary disabilities in clients with fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE): Final report to the Centers for Disease Control and Prevention on Grant No. RO4/CCR008515 (Tech. Report No. 96-06). Seattle: University of Washington, Fetal Alcohol and Drug Unit.

Support Strategies in a Corrections Facility

- **Typical punishment or reward programs will be unsuccessful with people who have FASD.**
- **People who have FASD need structure and routine. Support the development of this, whenever possible, with caregivers or service providers.**
- **The person needs significant support with understanding communication: verbal and non-verbal. Understanding what is said, or receptive language, is most difficult. Communication should be as concrete as possible. Use visual cues to support the verbal message.**
- **Sensory disorders are very common in people who have FASD. Busy, bright, loud environments, such as in detention centres, court waiting areas, and correctional facilities may cause the person stress; possibly leading to oppositional or acting out behaviour. When communicating with the person, try to find a place or time with fewer distractions.**
- **Identify the person's strengths. Focus on these to help build a rapport while reinforcing their self-esteem, skills and confidence.**
- **Early identification that a person has been affected by FASD is critical. Early identification can be challenging with limited diagnostic services in Ontario and pre-screening tools still in development. However, positive developments have been happening as there is now a screening tool approved for use with youth.** [5]

[5] Advancing Effective Intervention Practices in Fetal Alcohol Spectrum Disorder (2010). FASD Ontario Network of Expertise.

Tips for Police from Police

- Know the facts about FASD and try not to use persons with FASD as Confidential Informants (CI).
- People with FASD appear intelligent and are in many ways. Use an interview to determine what they may really know.
- Remember sensory issues. Ensure there is limited stimulation in the interview room.
- Identify and acknowledge the person's strengths.
- Provide visual cues to help the person with communication whenever possible.
- Remember the person has poor social skills. They may "get in your face" (close talkers). This is not meant to be confrontational. It really is just poor social skills.
- Slow down. Don't quickly move from one question to another.
- Give exact directions. Write them down for the person. Show them a map instead of giving directions. Failure to follow directions may not be intentional.
- The person will likely not show remorse. They are not being disrespectful. It is part of having FASD.
- Remember mental health issues.
- Remember the dysmaturity (acting younger than their actual age) when dealing with sexual 'offences'. A person with FASD is, maturity wise, roughly half their chronological age, and may be more innocent/naive than they appear.
- Understand chronic anger, fatigue, frustration, avoidance....understand them and then help create solutions.
- Know and visit local youth residential facilities in your area so you can get to know the clients. Build rapport with youth to assist later. Be a mentor.
- Give good support to caregivers. Be part of the solution to reduce the number of hours you spend charging repeat offenders.
- Create an action plan to avoid trouble situations.
- Get a risk assessment completed through the Behavioural Unit to assist with first response from police. People who have FASD pick up bad habits in jail. Use alternative measures to redirect people away from the court system and into proper environments.

Tips provided in consultation with: Detective Constable Dylan Langille, Middlesex County Crime Unit, 823 Exeter Road, London, VNET 506 6945

Chapter 7 : Autism Spectrum Disorder (ASD)

Autism Spectrum Disorder (ASD) is a complex condition that affects normal brain development and impacts a person's social relationships, communication, interests and behaviour. When most people talk about the autism spectrum disorders (ASDs), they are referring to the most common ones on the spectrum:

- Autism
- Asperger's Syndrome
- Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS)

The term "spectrum" is used to describe the vast differences in severity and symptoms that people can experience. The actual diagnosis within the spectrum of disorders is based on:

- Number and particular kinds of symptoms
- Severity – mild to severe
- Age of onset
- Levels of functioning
- Challenges with social interactions [1]

Autism Spectrum Disorder (ASD) impacts normal brain development leaving most individuals with communication problems, difficulty with typical social interactions and a tendency to repeat specific patterns of behaviour.

In Canada, there is no national government monitoring system to provide accurate statistics on the prevalence of ASDs despite it being one of the most common forms of neurological disorder or severe intellectual disability in childhood.

The Centers for Disease Control (CDC) in the United States released new data from multiple communities in 2012 reporting that the prevalence rate of ASD in the United States was 1 in 88 based on combined data from fourteen monitoring sites between 2000–2008. We can anticipate that the prevalence in Canada is similar. [2]

[1] Autism Canada (2012). Retrieved from http://www.autismcanada.org/aboutautism/index.html

[2] Autism Society of Canada (2012). Retrieved from www.autismsocietycanada.ca/index.php?option=com_content&view=article&id=55&Itemid=85&lang=en

Chapter 7 : Autism Spectrum Disorder (ASD)

People who have ASD, including those with Asperger's syndrome, share a difficulty in making sense of the world around them and often display challenges with social interaction, communication and abstract thinking. All people who have been diagnosed with Autism Spectrum Disorder demonstrate some of the following challenges in varying degrees:

- Difficulty with Social Relationships
    - Not responding to their names when called
    - Appearing not to listen when spoken to
    - Inability to display/interpret situation appropriate facial expressions
    - Avoiding eye contact
    - Not responding to affection and sometimes treating people as if they were inanimate objects
    - Difficulty identifying boundaries of others

- Deficits in communication / language – difficulties using and understanding verbal and non-verbal language are exceedingly common in people who have ASD. **They include:**
    - Delayed or absent development of spoken language
    - Responses to the communications of others (e.g. won't look)
    - Difficulty starting a conversation or keeping it going
    - Pronoun confusion (i.e., I vs. You)
    - Stereotypical and repetitive use of language (i.e., using lines from a favourite movie to communicate)
    - Idiosyncratic use of words and phrases (i.e., always salutes and says "Yes sir" when given a direction)
    - Abnormalities in volume, pitch, tone, rate, and rhythm of speech

- Perseveration of interests and activities – typically with a narrow range of interests. People may also engage in repetitive, stereotyped body movements such as hand flicking, spinning or rocking. Perseverations might extend to food.
- Dependence on routine.
- Atypical sleeping, toileting and eating routines.
- Abnormal responses to sensory stimulation – many people who have ASDs have unexpected reactions to stimuli. People may have hypersensitivity (cannot tolerate touch, can hear the sound of a light buzzing, can be fascinated with how a spinning object looks, etc.) or hyposensitivity (can appear deaf, extremely high pain tolerance). [3]

[3] Autism Society of Canada (2012). Retrieved from http://www.autismcanada.org/aboutautism/characteristics.html

Indicators that a Person May Have an Autism Spectrum Disorder

1. The person may avoid eye contact even if you change your location to be in the person's line of sight.
2. The person may not have verbal communication skills or may have limited vocabulary and point or use gestures.
3. The person's speech may be monotone without expected changes in tone.
4. The person may repeat exactly what is said to them, whether or not they have been asked.
5. The person may engage in repetitive physical actions, such as hand flapping, finger flicking, or whirling objects.
6. The person may rock back and forth, pace or engage in self-abuse. These outbursts can be an expected response to fear, confusion, or frustration.
7. Atypical gait when walking or running.
8. The person may not respond to or responds inappropriately to verbal communication or sounds.
9. The person may not understand body language or recognize command presence, i.e., a police or corrections uniform.
10. The person may be dressed inappropriately for the weather.
11. The person may not ask for help or show any indications of pain, even though injury seems apparent.
12. The person may wear medical alert tags or possess other written material indicating they have an autism spectrum disorder. [4]

[4] Children's Hospital and Health System (2009). Autism Spectrum Disorders: A Special Needs Subject Response Guide for Police. Milwaukee, Wisconsin.

Tips for Positive Interactions with People who have an Autism Spectrum Disorder

1. Allow the person to acclimatize to the new environment; they made need to wander and touch objects as long as it is safe to do so.
2. Don't expect eye contact and don't force it on them.
3. Do not interfere with self-rocking, hand-flapping, twirling, etc. This self-stimulatory behaviour, "stimming", helps the person stay calm and in control.
4. Model the behaviours you want to see.
5. Personal space is subjective. Be prepared for the person to invade your personal space as they may have a different sense of personal space.
6. Keep communication brief, clear and literal. Try to frame the demand/request in terms of what the person needs to do as opposed to what they need to stop doing. i.e., give the direction "Stand by the door" instead of "Stop pacing around the room."
7. Give extra time to allow the person to answer or comply after a command or question.
8. Tell the person the rules: the formal and the informal rules. People who have ASD are often taught to rely on and respect rules. Routine and rules can be natural strengths for people who have ASD when they understand what the routines and rules are.
9. Avoid sarcasm, jokes or teasing.
10. Try to reduce outside stimulation when possible.
11. Pain compliance will not work reliably, either because the person does not perceive the pain the same way most people do, or they cannot make the connection between your actions and the pain. [5]

[5] Children's Hospital and Health System (2009). Autism Spectrum Disorders: A Special Needs Subject Response Guide for Police Officers. Milwaukee, Wisconsin.

Chapter 8 : Acquired Brain Injury (ABI)

Many offenders are living with acquired brain injury (ABI) and related problems that complicate their management and treatment while in correctional facilities.

A traumatic brain injury can be defined as a blow or jolt to the head or a penetrating head injury that disrupts the function of the brain. [1]

The Canadian definition describes brain injury as:

"Brain Injury occurs suddenly, without warning. In an instant, life is changed, forever. Every day we participate in activities that produce endless risks for sustaining a brain injury; events include a car accident while driving to the grocery store, a fall from a bike, or a blow to the head."[2]

Available research suggests that brain damage specific to the frontal and temporal lobes of the brain is associated with an increase in the potential for aggressive, violent and criminal behaviour. Some people who have frontal lobe damage **may:**

- Have short attention spans,
- Have difficulty regulating emotional responses and inhibiting impulses,
- Have difficulty switching behaviour when necessary and empathising with others,
- Have poor recognition of the full impact of their behaviour on others,
- Have a lessened capacity to self-correct, learn and think flexibly.

These deficits mean that when a person who has frontal lobe and temporal lobe damage engages in behaviour, they are likely to repeat such behaviour. Brain damage does not make this behaviour inevitable, but more likely. [3]

[1] Faul, M., Xu, L., Wald, M.M., Coronado, V.G. (2010). Traumatic brain injury in the United States: emergency department visits, hospitalizations, and deaths. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

[2] Brain Injury Association of Canada (2013). What is Brain Injury. Retrieved from http://biac-aclc.ca/what-is-it/

[3] Hawkins, K.A., Throbst, K.K.,(2000). Frontal Lobe Dysfunction and Aggression. *Conceptual Issues and Research Findings.* Yale University School of Medicine, 5 (2): 147–157.

Chapter 8 : Acquired Brain Injury (ABI)

Acquired Brain Injury (ABI) and the Criminal Justice System

Within the correctional setting, an acquired brain injury can contribute to situations that lead to disciplinary action toward the person. The following are some common acquired brain injury problems and strategies for management within a corrections environment.

- Attention deficits may make it difficult for the person with an acquired brain injury to focus on a required task or respond to directions given by a corrections officer. Either situation may be misinterpreted, thus leading to an impression of deliberate defiance on the part of the person.

Strategies for Interaction:

  - Ask the person to repeat what you have said using their own words. This will confirm that he or she has heard and understood your directions.
  - Encourage the person to write down steps for the task.
  - Allow extra time for the task to be done.
  - Clear or reduce environmental distractions.

- Memory deficits can make it difficult to understand or remember rules or directions, which may lead to disciplinary actions by corrections staff.

Strategies for Interaction:

  - Explain rules or directions slowly, step-by-step.
  - Ask the person to repeat the steps and encourage him or her to write down the information.
  - Provide examples and ask the person to provide his or her own.
  - Teach the person to ask questions when he or she doesn't understand.

- Slowed verbal and physical responses may be interpreted by corrections officers as uncooperative behavior.

Strategies for Interaction

  - Give directions, or ask questions, slowly; repeat if necessary.
  - Allow the person additional time to respond.
  - Irritability or anger may be difficult for the person to control. This can lead to an incident with another person or corrections officer. Such incidents can lead to further injury for the person with an acquired brain injury and others.
  - Avoid arguing with the person.
  - Try re-phrasing the problem; breaking it down into parts.
  - Reinforce positive behaviours.

- Uninhibited or impulsive behaviour, including unacceptable sexual behaviour, may provoke other people in the corrections facility or result in disciplinary action by corrections officers.

Strategies for Interaction:

- Tell the person calmly that the behaviour is unacceptable.
- Seek assistance from professionals in mental health services, developmental services, or acquired brain injury [4]

[4] Traumatic Brain Injury: A Guide for Criminal Justice Professionals. (2013). United States Centres for Disease Control and Prevention. Retrieved from http://www.brainline.org/content/2010/03/traumatic-brain-injury-a-guide-for-criminal-justice-professionals_page3.html

Chapter 9 : Substance Abuse

"The closure of all institutions for people who have intellectual disabilities/dual diagnosis was intended to ensure that all people had the right to the same patterns of life that mirrors other members of society around them. This brings people with intellectual disabilities/dual diagnosis into contact with all aspects of normal life, including habits and behaviors from which they were previously protected, including substance use and inevitably substance abuse"[1]

Among people who have intellectual disabilities and use alcohol and illicit drugs there is a higher rate for them to develop substance abuse problems. [2]

People who have intellectual disabilities/dual diagnosis and are substance abusers share some common traits: [3]

- They tend to start drinking alcohol later than their peers who do not have intellectual disabilities.
- They are less likely to seek help for their substance abuse problem. When they do, resources for treatment of substance abuse in people who have intellectual disabilities are very difficult to find.
- They tend to be at greater physical risk from the substance abuse as they are more likely to be taking prescription medications for other medical conditions such as seizures, metabolic disorders and mental health issues.

Among people who have a dual diagnosis, there is vulnerability toward dependence on drug and alcohol abuse (concurrent disorders). This vulnerability can be a result of:

- Impaired communication and interpersonal skills that can make it difficult for people who have a dual diagnosis to develop strong social networks. If the group with whom they are attempting to fit in engages in drug and alcohol use, the person may want to fit with the group and engage as well.

[1] Quintero, M. (2011). Substance abuse in people with Intellectual Disabilities. *Social Work Today*, 11 (4):26.

[2] Slayter, E.M. (2010). Medicaid-covered alcohol and drug treatment use among people with intellectual disabilities: evidence of disparities. *AAIDD*, 48 (5):361-374.

[3] Quintero, M. (2011). Substance abuse in people with Intellectual Disabilities. *Social Work Today*, 11 (4):26.