

## **Aggression and Dual Diagnosis: Implications for Ontario's Developmental Services**

*Jennifer Puddicombe and Yona Lunsky*

### **Abstract**

*Aggression in people with a dual diagnosis is very challenging for service providers in community and clinical settings. The purpose of this paper is to review concerns expressed by community service providers and hospital staff regarding aggression displayed by the adults with developmental disabilities that they support. Findings are based on input received during province-wide focus groups on dual diagnosis in Ontario's psychiatric hospitals. The two most significant themes that emerged regarding aggression were: client aggression frequently leads to hospitalization, and, once in hospital, aggression prevents clients from being transferred back to community-based services. This paper concludes with participants' recommendations for the potential role of developmental services in dealing with aggression.*

Adults with developmental disabilities are three to four times more likely to have a mental illness compared to other adults (Borthwick-Duffy, 1994; Reiss, 1990). The presence of both a developmental disability and a mental illness diagnosis in the same person is referred to as "dual diagnosis." Individuals with a dual diagnosis often have complex needs and are particularly challenging to serve in both the mental health and developmental systems. For example, a key finding from Phase I of a three-year study on dual diagnosis in Ontario's psychiatric hospitals (see Lunsky et al., 2003) was that individuals with a dual diagnosis receiving inpatient or outpatient services were rated as more aggressive than their counterparts without developmental disabilities receiving similar services. The study also found that patients with a dual diagnosis who were aggressive were harder to serve, had longer lengths of stay, and had greater problems accessing and/or maintaining appropriate community placements than other psychiatric patients (Lunsky et al., in press).

For individuals who have developmental disabilities and limited communication skills, aggression to self and to others (also referred to as "challenging behaviour") is often considered to be a form of non-verbal communication (Repa & Walker, 1983; Talkington, 1971). Unfortunately, aggressive clients can be demanding and sometimes frightening for those who care for them. This article focuses on concerns expressed by community service providers and hospital staff regarding serious aggression displayed by the adults with developmental disabilities that they serve. It also addresses how aggressive clients impact psychiatric hospital and community services, and concludes with some recommendations for how developmental services could better serve such individuals.

### **Method**

For Phase II of a three-phase project on Dual Diagnosis in the Provincial Psychiatric Hospitals, a series of round-table discussions/focus groups were held between November 2004 and February 2005 in Ontario's nine tertiary level care psychiatric hospitals located in: 1) Brockville, 2) Hamilton, 3) Kingston, 4) London, 5) North Bay, 6) Penetanguishene, 7) Toronto, 8) Thunder Bay and 9) Whitby. Following a presentation summarizing findings from Phase I of this study, two members of the research team conducted interviews and facilitated focus group discussions. The purpose of Phase II was to get feedback from, and to discover the most critical concerns of, relevant stakeholders regarding how to better serve individuals with dual diagnosis who use tertiary care services. A total of 156 participants from across the province attended these discussions/interviews, including representatives from the Ministry of Health and Long Term Care, representatives from the Ministry of Community and Social Services, parents, hospital staff (including middle or senior management), as well as community service providers from both the developmental and mental health sectors.

### **Results**

Of the many themes that emerged through content analyses, issues regarding aggression were overwhelmingly mentioned by stakeholders across Ontario as being a major challenge to serving individuals with a dual diagnosis. This section focuses on two of the main themes relating to aggression, which were summarized nicely by one participant: "Aggression is the main ticket into hospital and the main barrier to getting out."

Aggression leads to hospitalization: Although not common in all individuals with developmental disabilities (Emerson et al., 2001), aggression was reported by focus group participants as being the primary reason for referral to hospital-based services from the community (see also Davidson, 1994; Edelstein & Glenwick, 1997). Participants noted that clients who got referred to hospital were not able to manage in the community because of the following reasons:

- 1) Lack of training for direct care staff on how to handle aggression and how to prevent it (see also Feldman et al., 2004).
- 2) Restrictive government guidelines (that are sometimes difficult to interpret) on how aggression should be managed in the community. Community staff reported that, because of these guidelines, they have limited options to deal with aggressive clients: they cannot contain a person in a locked room, they cannot use mechanical or physical restraints, and they only have limited access to chemical restraints.
- 3) Inadequate staff support, including low staff-to-client ratios, resulting in clients not being supported safely and frequent staff burnout (see also Rose et al., 2004).
- 4) Clients and caregivers have limited access to specialized clinical services in the community. There is such a long waitlist for services that by the time appropriate services become available, the aggression has become so severe that family or staff are completely burnt out and can no longer continue supporting the individual.

Because of these barriers to managing aggression, community agencies may resort to calling police or going to the emergency room when clients become aggressive, and many clients end up in hospital. At this stage, because caregivers are burnt out and there is a minimal commitment from local hospitals to follow up with clients after discharge, agencies may refuse to take back individuals who are still at risk for displaying aggression. When this is the case, local hospitals often transfer these individuals to tertiary care facilities that are "better-equipped" to deal with them.

Aggression is a barrier to getting out of hospital: Stakeholders expressed concern over the discrepancy between aggression-management practices of hospitals and community agencies, and how the different models of care make transitions of aggressive clients from hospital to community services quite difficult: Once an aggressive patient gets admitted to hospital, he or

she may be treated in a very different manner than is typically the case in the community. Many hospital programs do not have access to clinicians with expertise in behavioural strategies and dual diagnosis. In addition, aggression is managed in the hospital according to a "medical model," which tends to be more reactive in nature than preventative (e.g., by understanding the function of a patient's aggression and modifying the environment accordingly). When faced with individuals who display aggression to self or others, hospital staff can choose to place the patient in a "locked seclusion" room or in mechanical restraints, or may administer chemical restraint. Community settings are not allowed to employ these "restraint options" when faced with supporting the same individual. Thus, an individual who displays aggression in hospital may be safely managed, but with methods that are not transferable to the community.

Because the community is not set up to deal with all hospitalized clients who display aggression, and cannot always offer high enough levels of support to safely manage aggression, community providers are often unwilling to accept patients with a history of aggression being discharged from hospitals. As one participant put it, "Even agencies that are supposed to serve the dually diagnosed are resistant to serve them when there is aggression." As a result, patients end up staying in hospital much longer than is necessary because there is no place for them to go. Stakeholders refer to these patients as "bed blockers," because their unnecessarily long admissions create a shortage of acute care beds for new patients, and this blockage creates a "logjam" in the whole system.

## **Discussion**

Regional focus groups held across Ontario with hospital and community stakeholders revealed major concerns regarding aggression in adults with a dual diagnosis and listed barriers to managing aggressive individuals that lead to them being hospitalized and that prevent them from returning to the community. Focus group participants noted that there were an alarming number of patients in tertiary level settings who were ready to be discharged, but who remained in hospital because they were not welcome in the community, frequently because aggression was an issue (see also Saeed et al., 2003; Watts et al., 2000). Stakeholders suggested several recommendations that addressed how to better meet the needs of individuals with aggression. We summarize recommendations here that apply specifically to developmental services (for a full list of recommendations, see Lunsky et al., in preparation).

1. Direct care staff in the developmental sector need to feel better supported, including being able to access clinical expertise, when dealing with aggressive clients. When a client in the community is presenting with aggression, services must be available immediately to support that person and his/her care providers. Such services must include comprehensive assessments with a behavioural and medical component, along with follow-up behavioural interventions that are time-intensive when necessary.
2. Staff members in the developmental sector require additional training on how to manage aggression safely and effectively. Community settings must be safe, and guidelines on how to manage aggressive behaviour must be clear.
3. Developmental services should be allowed and encouraged to work cooperatively with staff and patients in hospital, both to help the hospital develop a model of care that is transferable to community settings, and to help clients develop and transfer new skills in coping with frustration once out of hospital.
4. The developmental sector needs to take a more preventative approach, including educating families and staff on how to predict and prevent aggression, providing clients with opportunities for participation in fulfilling activities, and teaching clients alternate forms of communication to express their needs.

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### Correspondence

Jennifer Puddicombe  
Centre for Addiction and Mental Health  
1001 Queen Street West  
Toronto, Ontario  
M6J 1H4  
[Jennifer\\_Puddicombe@camh.net](mailto:Jennifer_Puddicombe@camh.net)