Journal on Developmental Disabilities
Le journal sur les handicaps du développement
JoDD

BRIEF REPORT: A Comparison of Clients With a Dual Diagnosis Referred to Specialized Clinical and Crisis-Support Programs

Authors

Stacy E. White,[1]
Yona Lunsky,[1,2]
Clara Ko,[1,2]
Jillian Carlyle,[1]
Trevor Lumb[3]

[1] Dual Diagnosis Program, Centre for Addiction and Mental Health Toronto, ON

[2] University of Toronto Toronto, ON

[3] Griffin Community Support Network Toronto, ON

Correspondence

stacyewhite@yahoo.ca

Keywords

dual diagnosis,
crisis,
specialized clinical services

Abstract

The Dual Diagnosis Program (DDP) at the Centre for Addiction and Mental Health and the Griffin Community Support Network (GCSN) work in partnership to serve individuals with a dual diagnosis in Toronto. The present study compared clients referred to the DDP, a specialized clinical service (n = 51), to those referred to the GCSN, a crisis-support program (n = 51). Client groups differed with respect to service needs, referral sources, place of residence and legal involvement. Similarities included demographics, psychiatric profile, and history of mental health hospitalization. Implications for dual diagnosis service provision and directions for future research are discussed.

The term *dual diagnosis* is used to describe individuals with an intellectual or developmental disability and mental health needs (Ministry of Health and Long-Term Care & Ministry of Community and Social Services, 2008). It is estimated that in Ontario, there are over 125,000 individuals with intellectual disabilities (ID), at least 30% of whom have a dual diagnosis (MOHLTC & MCSS, 2008; Yu & Atkinson, 1993). In Ontario, services for this population are provided by two separate sectors (Ministry of Health and Ministry of Community and Social Services), and have been criticized as fragmented, in that clients and caregivers have trouble seeking services from both sectors at the same time (Lunsky & Puddicombe, 2005; MOHLTC & MCCS, 2008). Even within each sector, the system is difficult to navigate, particularly for service users. The recent Joint Policy Guideline (MOHLTC & MCSS, 2008) stipulates that services for this population should be "integrated, coordinated and operate responsively and proactively both within and across sectors" (p.1). To help create a continuum of dual diagnosis services in Toronto, a partnership was developed in the late 1990s between the Dual Diagnosis Program at the Centre for Addiction and Mental Health and the Griffin Community Support Network.

Description of Programs

Through direct services and referrals to respite, residential safebeds, short-term case management, clinical services and day programming, the Griffin Community Support Network (GCSN) provides "time limited crisis and transitional support to adults 16 years and over with a developmental disability or a dual diagnosis." The Dual Diagnosis Program (DDP) provides assessment, diagnosis, consultation,

education, and training to individuals with a dual diagnosis and their caregivers, through interdisciplinary teams including behaviour therapy, occupational therapy, psychology, psychiatry, nursing and social work.

Description of Clients

A review of studies on individuals with ID accessing crisis-intervention or emergency services for psychiatric or behavioural crises highlights several key characteristics of this group. These clients are often younger adults with milder disabilities (Cowley et al., 2005; Davidson et al., 1999; Gustaffson, 1997). Environmental triggers include the absence of appropriate residential supports (Lunsky, Gracey, & Gelfand, 2008), and some crises may occur because of activities or behaviour requiring legal involvement. Clients utilizing specialized dual diagnosis services are more likely to be young adult males with levels of ID ranging from mild to profound. Research also shows that they are more likely than clients with psychiatric diagnoses without ID to present with externalizing behaviour difficulties as opposed to internalizing problems (Lunsky et al., 2006), and rates of serious mental illness, such as psychotic disorder, tend to be high (Bouras et al., 2003).

Although previous studies have examined the profile of these two related client groups, no studies have yet compared them. Such comparisons are important, if clinical and crisis services are to be linked as part of a continuum of supports for this complex population. In the present study, we aimed to delineate the differences in clients referred to the DDP and GCSN, and to better understand the factors that lead clients to use one service rather than the other.

Method

Participants

The sample comprised 51 clients referred to the DDP and 51 referred to the GCSN, between April and November 2008. Excluded from analyses were clients using both programs simultaneously.

Measures

All client data were collected using the Referral and Intake Form (RIF), a structured interview jointly developed by both organizations (for more information or to obtain the form, contact the authors).. This tool captures current and historical data on clients regarding presenting problems, linkages to other service providers, behavioural risks, diagnoses, medical problems, and other areas. Data in this tool are entered into an Internet-based database shared by the DDP and GCSN.

Procedure

Through a retrospective review of electronic charts, data gathered for each client at the time of referral were analyzed. For this study, data on the following variables were examined: demographics; primary psychiatric diagnosis; level of ID; medication use; place of residence; referral source sector; history of challenging behaviour, forensic involvement, and mental health hospitalization; and primary reasons for referral. This study was approved by the Research Ethics Board at the Centre for Addiction and Mental Health.

Results

Detailed results for chi-square analyses are presented in Table 1. No statistically significant differences were found between client groups in gender distribution, age and marital status; overall, clients in both groups were predominantly male and unmarried, with mean ages of 33.9 (DDP) and 30.4 (GCSN) ($t(100)=1.48$, $p=0.14$). The diagnostic profiles of each client group did not differ significantly. The majority of individuals referred to both services did not have an Axis I disorder recorded at intake. The least common disorders in both groups were anxiety disorders (3.9% DDP, 2.0% GCSN) and autism (3.9% DDP, 5.9 % GCSN), with psychotic disorders as the most common diagnoses (13.7% DDP and GCSN). There was a trend for clients referred to the GCSN to be diagnosed more frequently with Borderline/Mild ID than were those referred to the specialized program. The percentage of clients in each group using at least one psychotropic medication, as well as

Table 1. Chi square comparisons of client characteristics

	DDP % (n)		GCSN % (n)		χ^2
Gender (% male)	52.9	(27)	62.7	(32)	1.005
Marital Status (% single)	82.4	(42)	84.3	(43)	4.704
Primary Psychiatric Diagnoses					8.703
Psychotic Disorder	13.7	(7)	13.7	(7)	
Mood Disorder	9.8	(5)	13.7	(7)	
Anxiety Disorder	3.9	(2)	5.9	(3)	
Substance-related Disorder	–		2.0	(1)	
Autism Spectrum Disorder	3.9	(2)	2.0	(1)	
No Axis I Diagnosis	54.9	(28)	49.0	(25)	
Other/unknown	3.9	(2)	7.8	(4)	
Level of Intellectual Disability					5.676***
Borderline/Mild ID	35.6	(16)	58.0	(29)	
Moderate/Severe ID	31.1	(14)	26.0	(13)	
ID Unknown/Unspecified	33.3	(15)	16.0	(8)	
% using psychotropic medications	51.0	(26)	54.9	(28)	0.157
Referral Source Sectors					15.644*
Community Health	15.7	(8)	2.0	(1)	
Correctional	–		3.9	(2)	
Developmental	49.0	(25)	39.2	(20)	
Family/Self	17.6	(9)	17.6	(9)	
Housing	–		2.0	(1)	
Mental Health	11.8	(6)	11.8	(6)	
Specialized Dual Diagnosis	2.0	(1)	15.7	(8)	
Place of Residence					17.311**
Group home/SIL	33.3	(17)	14.0	(7)	
Boarding/nursing home	5.9	(3)	6.0	(3)	
Family/foster home	39.2	(20)	50.0	(25)	
Other temporary housing	3.9	(2)	24.0	(12)	
Independent	–		2.0	(1)	
Unknown	17.6	(9)	4.0	(2)	
History of challenging behaviour	47.1	(24)	60.8	(31)	1.933
Previous legal involvement	11.8	(6)	27.5	(14)	3.980*
Previous psychiatric hospitalization	29.4	(15)	45.1	(23)	2.684
Primary Reasons for Referral†					
Diagnostic clarification	23.5	(12)	3.9	(2)	11.929**
Assess challenging/aggressive behaviour	41.2	(21)	5.9	(3)	17.654**
Involvement with legal system	–		15.7	(8)	8.681**
Extra staffing needed	–		33.3	(17)	20.400**
Housing support inadequate	2.0	(1)	15.7	(8)	5.971*
Client unattached to service systems	3.9	(2)	17.6	(9)	4.993*
Case management required	9.8	(5)	29.4	(15)	6.220*

* *$p < 0.05$; **$p < 0.01$; *** non-significant trend*

† *Only items for which a significant difference was found are listed*

the mean number of medications, did not differ significantly. Just over half of the clients using each service took psychotropic medications (DDP: 51.0%, GCSN: 54.9%), and used more than 2 medications each (DDP: mean=2.50; GCSN: mean=2.29; $t(52) = 0.66$, $p=0.51$).

A significantly higher proportion of DDP clients lived in supported housing arrangements, such as group homes and Supported Independent Living. GCSN clients were more likely to reside in temporary or more unstable housing, including homeless shelters, transitional homes, safebeds, and correctional facilities. Service sectors from which clients were referred differed somewhat between programs, in that clients referred to the GCSN were significantly more likely to have been referred by other specialized dual diagnosis programs, whereas DDP clients were more frequently referred by community health care providers (including hospitals, general practitioners, and community-based psychiatrists). Although a higher proportion of GCSN clients had previously been involved with the legal system, no significant differences were found with regard to history of challenging behaviour or psychiatric hospitalization. Finally, clients accessing the DDP were significantly more likely to be referred for clinical services, such as diagnostic clarification and behavioural assessment, whereas clients using the GCSN were more often referred for reasons reflecting a need for increased supports, or services to intervene in an environmentally-based problem, including inadequate housing support, involvement with the legal system, and a need for case management.

Discussion

Clients using the specialized clinical and crisis-support programs differed in many respects, such as service needs, referral sources, place of residence, history of forensic involvement, and perhaps level of ID. Individuals using the GCSN were more likely to be referred by other specialized dual diagnosis program.

Our expectation that referral reasons for GCSN clients would be more crisis based and that the residential settings of these clients would be more likely to be unstable or at risk was confirmed. One explanation for differences in referral sources is that health care providers may be more comfortable and familiar with referring clients to other hospital-based services (such as the DDP), but less familiar with community-based resources (such as the GCSN). If this is the case, further education of health professionals on crisis services may be warranted.

It is interesting to note that GCSN clients were more likely to have both unstable housing and previous forensic involvement, as these experiences may be causally linked. Individuals needing housing and social support may more often engage in activity leading to legal involvement, perhaps out of perceived necessity, which may, in turn, lead to a crisis situation. Alternatively, users and non-users of crisis-support programs may be equally likely to be involved in potentially illegal activity; however, supported individuals may be deemed less risky by law enforcement officials and/or be less likely to be charged with an offence. As suggested by Holland, Clare, & Mukhopadhyay (2002), appropriate social support for individuals with ID, along with clinical intervention, may lower the risk for offending behaviour.

In general, the profile of clients using the crisis service is consistent with the literature describing individuals with ID who experience crises. The profile of clients referred to dual diagnosis services also matches what has been reported in the literature. It is interesting, however, that the two groups are quite similar with regard to gender distribution, age, psychotropic medication use, presence of psychiatric disorders, and history of challenging behaviour and mental health hospitalization. This leads us to ask why these two comparable groups do not access more similar services. It appears that individuals who are better supported and in more stable situations are those who are directed towards dual diagnosis clinical services. In contrast, less supported individuals may not access clinical services, even though they would likely also benefit from them.

These findings further highlight the need for a collaborative approach to service provision for this population. We are concerned that clients and caregivers in crisis may not seek clinical services once their immediate needs are met

and they are no longer in an acute crisis situation. If this occurs and underlying mental health issues go unaddressed, one might argue that this can contribute to future episodes of crisis. More research on clients' pathway to crisis and to service is needed.

This is a preliminary study based on information collected over only a six-month period. Future research comparing client characteristics should include a larger sample referred over a longer time frame. It would also be beneficial to examine the profile of clients accessing both services simultaneously, and to study whether crisis clients do ultimately access clinical services when their crisis resolves. It is important for crisis and clinical service agencies to know that despite different approaches, the two types of programs serve similar clients; this knowledge may help to strengthen and better integrate the services they each provide.

References

Bouras, N., Cowley, A., Holt, G., Newton, J.T., & Sturmey, P. (2003). Referral trends of people with intellectual disabilities and psychiatric disorders. *Journal of Intellectual Disability Research*, *47*(6), 439–446.

Cowley, A., Newton, J., Sturmey, P, Bouras, N., & Holt, G. (2005). Psychiatric inpatient admissions of adults with intellectual disabilities: Predictive factors. *American Journal on Mental Retardation, 110*, 216–225.

Davidson, P.W., Houser, K.D., Cain, N.N., Sloane-Reeves, J., Quijano, L., Matons, L., Giesow, V., & Ladrigan, P.M. (1999). Characteristics of older adults with intellectual disabilities referred for crisis intervention. *Journal of Intellectual Disability Research*, *43*(1), 38–46.

Griffin Community Support Network (GCSN) http://www.griffin-centre.org/programs_tss.asp

Gustaffson, C. (1997). The prevalence of people with intellectual disability admitted to general hospital psychiatric units: Level of handicap, psychiatric diagnoses and care utilization. *Journal of Intellectual Disability Research, 41*(6), 519–526.

Holland, T., Clare, I.C.H., & Mukhopadhyay, T. (2002). Prevalence of 'criminal offending' by men and women with intellectual disability and the characteristics of 'offenders': Implications for research and service development. Journal of Intellectual Disability Research, *46*(1), 6–20.

Lunsky, Y., Bradley, E., Durbin, J., Koegl, C., Canrinus, M., & Goering, P., (2006). The clinical profile and service needs of hospitalized adults with mental retardation and a psychiatric diagnosis. *Psychiatric Services*, *57*(1), 77–83.

Lunsky, Y., Gracey, C., & Gelfand, S. (2008). Emergency psychiatric services for individuals with intellectual disabilities: Perspectives of hospital staff. *Intellectual and Developmental Disabilities*, *46*(6) 446–455.

Lunsky, Y., & Puddicombe, J. (2005). *Dual diagnosis in Ontario's speciality (psychiatric) hospitals: Qualitative findings and recommendations* (Phase II Summary report). Toronto, ON: Centre for Addiction and Mental Health.

Ministry of Health and Long-Term Care & Ministry of Community and Social Services. (2008). Joint policy guideline for the provision of community mental health and developmental services for adults with a dual diagnosis. Queen's Printer for Ontario.

Yu, D., & Atkinson, L. (1993). Developmental disability with and without psychiatric involvement: Prevalence estimates for Ontario. *Journal on Developmental Disabilities*, *2*(1), 1–6.