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The California Mental Health Planning Council is currently considering the capacity of California's public mental health system to meet the service needs of individuals experiencing an acute psychiatric crisis. In 1978, the California Legislature established the community residential treatment system as an alternative to institutional care. Crisis residential treatment is specifically intended to be an alternative to hospitalization for individuals experiencing an acute psychiatric crisis requiring temporary removal from their home environment. The enclosed article offers a definition of the crisis residential treatment setting, describes the role of crisis residential treatment in a system of care, identifies and describes the characteristics of three types of crisis residential treatment programs, and describes a program of the Progress Foundation called La Posada.

Alternatives to psychiatric hospitalization include such programs as La Posada in San Francisco—a cost-effective model of crisis residential treatment that combines crisis intervention with therapy.

Crisis Residential Treatment: An Alternative to Hospitalization

Steven Fields, Gilbert K. Weisman

The United States is moving from a system that is heavily reliant on hospital services to one that favors outpatient care. However, as Kiesler (1982) observes, the pace of change in the official mental health policy has not been matched by changes in the incentives favoring hospitalization. These have begun recently, so there has been little support for the development of alternatives.

Nonetheless, in the past three decades, several successful model programs have been developed as alternatives to psychiatric hospitalization (Mosher and Menn, 1982). These models have ranged from home-based approaches with outreach teams (Stein and Test, 1979) to such experimental services as the Soteria Project, a residential program that originally offered crisis services without the use of medications (Mosher and Menn, 1982). Kiesler (1982) summarizes the findings of ten of the most significant studies of alternatives to inpatient treatment; the populations served were varied, and suicidal patients were excluded from some settings. More than one-third of patients were excluded in some studies, and 20 to 53 percent were ultimately admitted to a hospital. Still, he concludes, "There is not an instance in this array of studies in which hospitalization had any positive impact on the average patient which exceeded that of the alternative care . . . In almost every case, the alternative care had more positive outcomes" (Keisler, 1982, pp. 357–358).

Stroul (1991) describes a remarkable growth of various types of crisis residential (CR) services since the mid 1980s. These services range from low-staff models, such as crisis apartments and foster-family homes, to highly medical settings with an institutional flavor. By far the most frequent is a group home with intensive staffing. Most recently, there has been a resurgence of interest in the development of CR services as part of an overall crisis response system,

thus addressing the problem of how best to manage utilization of psychiatric inpatient care. This level of care is viewed as an effective way to respond to the challenges of managed care in the behavioral health field. Effectiveness is enhanced when CR programs operate within a system that includes twenty-four–hour crisis telephone services, walk-in services, and mobile crisis outreach capability (Stroul, 1987).

Critics of crisis residential treatment (CRT) contend that this service level is primarily for clients who are not severely ill, and the populations served by CRT settings are not the same as those receiving inpatient care (Stroul, 1987). Because most programs serve only voluntary clients, they may not have an appreciable effect on inpatient utilization. Critics also contend that CRT programs should not be serving individuals who require a high degree of containment as well as the services of a professional staff. There has been concern that the relatively low cost of alternative facilities is achieved through inadequate staffing, both in numbers and in the training or credentials of the staff, thus compromising the care of severely ill clients.

Another concern is that community opposition to the siting of facilities may be heightened by proposals that include crisis programs for less stable patients. It is difficult enough to locate housing for transitional programs without the added complication of serving persons in more acute crises. Often, the alternative staffing patterns and the open nature of the facilities serve to increase community concerns about safety and privacy.

Finally, organizations or agencies considering the development of CRT programs must consider the problem of liability. Alternative settings are susceptible to severe criticism and legal action if there is an incident within the program or the community surrounding the facility. Without national standards of accreditation or certification of such facilities, organizations developing such settings do not have the same guidance and protection from risk that is afforded by compliance with the regulatory standards that govern more traditional settings.

Definition of Crisis Residential Treatment Settings

For the purposes of this chapter, CRT settings will be defined as normalized residential settings that serve small groups of clients, usually no more than sixteen. Whether conducted in individual apartments or houses, these programs follow a noninstitutional, social rehabilitation model. This approach adapts techniques first developed in halfway houses more than thirty years ago to enhance independent functioning. These techniques are applied in short-term, crisis-oriented settings (Weisman, 1985).

Role of Crisis Residential Treatment

Crisis residential services have taken several forms, including outreach to clients' homes, group homes, and foster-family care settings, as pioneered by Paul Polak in southwest Denver in the 1970s. As Stroul (1987) points out, CRT

settings can range from highly institutional environments to very normalized, home-like settings.

Whatever the modality, the role of the crisis residential service in a system of care is threefold: to divert individuals from unnecessary hospitalization or to shorten their hospital stay; to stabilize the crisis without requiring inpatient care; and to develop, with the client, a support system that will sustain the client following discharge from the CRT setting.

CRT services can provide effective interventions in a wide array of psychiatric emergencies. There is virtually no behavior that cannot be treated in an alternative setting, but not all individuals can be served effectively in a residential setting. The pressure to respond to increasingly disabled clients and volatile situations has led to an emphasis on crisis interventions that can approximate or even duplicate the capability of twenty-four–hour inpatient services. This necessity is particularly acute when serving clients in crisis who have substance abuse problems. Treatment in residential settings with adequate staff has shown that the noninstitutional environment often provides a better clinical outcome than institutional interventions.

CRT programs at all levels of intensity have a balanced responsibility to serve clients and to respond to the needs of a system of care. The success of CRT programs is measured both by clinical outcomes and utilization data.

Types of Crisis Residential Treatment

There is no single, best way of running a CRT program. In fact, one critical element of a successful crisis response system is its adaptability to varying environmental conditions. CRT programs can take many forms, depending on the needs of a particular community and the patterns of inpatient and emergency room utilization in each community.

CRT programs generally fall into three categories, depending on the intensity of the program and the target population for the service: (1) a minimally staffed *respite program*, which is available around the clock and mainly serves those without adequate housing; (2) the *crisis residential program*, which is more heavily staffed and targets individuals who present a more significant psychiatric crisis; and (3) the most intense type of crisis program—the *acute diversion program*.

Respite programs have only one person on duty at any time. They are designed for individuals who require a twenty-four hour supervised environment only because their existing housing is untenable. In many communities, individuals are hospitalized simply because of an immediate need for twenty-four-hour support and the lack of any other resource. This represents an unnecessary and costly use of hospital beds, and respite level care significantly decreases the need for hospitalization.

Crisis residential programs, with at least two counselors on duty at all times for a maximum of sixteen clients, are designed to prevent the further escalation of crises that, left unchecked, would require hospitalization.

An acute diversion program is designed to be equivalent to hospitalization for individuals who present in an acute crisis but who do not require involuntary treatment in a hospital setting. Such services attempt to replicate the response of an inpatient unit in a social model setting.

Each of these levels focuses on clients who are either at risk of imminent hospitalization or who have been assessed as requiring hospitalization but are deemed appropriate for an alternative setting. As Stroul points out (1993), CRT programs may vary widely in the level of disability or even the type of behavior they are designed to treat and tolerate. Clearly, the most highly staffed models have the most flexibility in regard to client characteristics.

Most programs in the acute diversion category have a no-refusal policy and will work with the full range of clients, including those with a high potential for violence or suicide and those with significant substance abuse problems. Other programs in the respite and crisis residential categories that are less well staffed will exclude clients with these problems.

Even the least intense CRT programs have a measurable impact on the utilization of hospital beds if the programs are aimed at diverting unnecessary referrals to inpatient units. The degree or level of intensity of a CRT service depends on the needs of the community, the availability of providers with experience serving clients in acute crisis, and the level of tolerance for innovation within the mental health community and the community at large. Whatever the level of CRT, however, some practices are common to most noninstitutional crisis settings. These include stabilizing crises and developing community support for clients.

Characteristics of Crisis Residential Treatment Programs

CRT programs at all levels emphasize the integration of the client into the daily operation of a small, personalized household. In this model, the requirements of daily living, practiced with support and assistance from staff, become essential elements of the stabilization process. These settings also focus on the social and relational aspects of the treatment environment. Support is offered in individual interventions and counseling sessions, as well as in a group context. The normalized setting itself becomes a critical element in the effort to stabilize the crisis, orient the client through concrete tasks and responsibilities, and provide practice in the development of interpersonal skills. The residence becomes a context for a realistic assessment diagnosis of each individual's functional skills and interpersonal capabilities. Operating as a small household, with staff present to support clients and encourage interaction, the residential setting becomes an intentional community that is a group designed to minimize the alienation of the client from his or her environment.

CRT programs utilize a wide range of staff; most direct service staff members are paraprofessionals (Stroul, 1993). CRT programs have demonstrated, even at the most acute level, that paraprofessionals are highly effective,

empathic crisis intervention workers when they are supported by consultation and training. Psychiatrists and other mental health professionals often play the critical role of consultant and trainer in crisis programs. This approach to staffing also promotes an element of CRT programs that is central to their effectiveness: the ability to incorporate staff who bring valuable community experience and different perspectives to the intervention—even staff members who have themselves been consumers of mental health services.

Another common element of CRT services is that the client plays a central role in defining and implementing his or her own treatment and rehabilitation plan. The participation of the client in identifying priority tasks and developing a strategy to achieve personal goals is central to the stabilization process and the effort to move clients to the next level of care. Crisis programs must respond quickly and develop specific strategies with clients; there is no time to waste on treatment goals that are not shared by the client.

CRT programs must be continuously available; the length of stay should be competitive with that of the inpatient unit from which the crisis program diverts clients. Programs with lengths of stay longer than thirty days undermine their responsiveness to the system of care. Acute diversion programs, in particular, should have a maximum stay of two weeks. In her survey, Stroul (1993) found that the average length of stay was eleven days. This element is critical because CRT programs must be regularly available to the emergency rooms or other triage points in order to provide a legitimate alternative to hospitalization.

La Posada: An Acute Diversion Program

Progress Foundation, a nonprofit agency in San Francisco, developed its first residential alternative to hospitalization in 1977 (Weisman, 1985). This program—La Posada—was designed to provide a nonhospital alternative for clients who needed immediate, twenty-four-hour, structured treatment and support but who did not necessarily require the services of a general psychiatric hospital. This original program has been replicated four times by Progress Foundation and has demonstrated the importance of CRT in a public mental health system.

La Posada is an acute diversion program—the most intense level of CRT programming. Certain patients do need to be hospitalized prior to a La Posada referral. These would include involuntary patients and patients with acute medical problems, including withdrawal. Some individuals who will not accept voluntary hospitalization and would otherwise require involuntary hospitalization will choose to be voluntary clients of La Posada instead.

Individuals are diverted from hospitalization by two PESs in San Francisco (accounting for 42 percent of admissions). Clients are also admitted after a short stay on a locked inpatient unit (accounting for 54 percent of admissions). The remaining 4 percent are clients who are decompensating but who do not yet require hospitalization. Medication needs have little bearing on whether

the client will be hospitalized or diverted because the psychiatrist at La Posada prescribes and monitors medications in the same way as in the hospital except for intramuscular injections.

La Posada is situated in a two-story Victorian house in the Mission District of San Francisco. The house can accommodate ten clients. The program serves approximately 225 clients each year, with an average length of stay of thirteen days. The staff consists of a program director, a senior counselor, a day program coordinator, and twelve paraprofessional counselors. The program has a consulting psychiatrist for thirteen hours each week. A minimum of two, and often as many as four, direct service staff are on duty around the clock. This high staff-to-resident ratio ensures adequate coverage and response to individuals who are in an acute episode, while allowing for intensive programmatic involvement with the residents.

The client population is about two-thirds male; approximately 40 percent of the clients are diagnosed with a schizophrenic disorder, while another 40 percent carry a diagnosis of affective disorder. The co-occurrence of major mental illness and significant substance abuse is high—approximately 70 percent.

The La Posada staff responds to the needs of the emergency and inpatient system when screening admissions. For this reason, the client demographics at La Posada are virtually a mirror image of the persons seen in the emergency rooms and the patients treated on the hospital units. The population served at La Posada reflects the broad mix of people living in San Francisco. The program was originally designed to provide a bilingual, bicultural program for Spanish-speaking clients of the mental health system. The program has maintained this focus, while striving to serve the entire range of ethnicity and culture in the city. Approximately one-fourth (23 percent) of the residents in 1994 were Latinos, one-half were white, and 26 percent were African American. Although La Posada serves a relatively low number of Asian clients (3 percent), another Progress Foundation acute diversion program has a bicultural, bilingual Asian focus and serves many Asians in acute crisis. The resident population also reflects the life-style diversity in San Francisco, with 14 percent identifying as gay. The average age is thirty-six.

Intensified Crisis Intervention

The program is structured day and night in order to engage each client in a variety of therapeutic interactions. At the beginning of each day, there is a house meeting in which all clients discuss and plan activities for the day. These activities may include securing long-term housing, applying for entitlements or vocational opportunities, keeping medical and social services appointments, and participating in the operation of the household.

At any given time, there are three distinct populations in the house: clients who have just entered the program and are still in the process of stabilizing from an acute episode; clients who have developed their rehabilitation plan

and are implementing specific goals; and clients who have a discharge date and are waiting to move to another level of care or to return home. The house environment is a consistent mix of these three stages of recovery from an acute psychiatric crisis. Clients support one another in rehabilitation efforts and help new residents adjust to the program.

The day and evening program includes individual counseling, the development and assessment of personal treatment and rehabilitation plans, formal group meetings, informal gatherings, and activities or outings. All clients are expected to participate in cleaning, meal planning, and meal preparation.

Meals are a particularly potent element of the treatment program at La Posada. The process of planning, preparing, sharing, and cleaning up after a meal contains all the elements that are central to the philosophy and practice of social model crisis intervention.

A fundamental precept of La Posada is that crisis stabilization and the expectation of functioning within the residential environment occur concurrently. The program does not wait for the crisis to abate before involving the client in some level of responsibility within the program. La Posada uses the need to focus on a chore or task, in cooperation with others, as a primary tool in crisis interventions. Meetings with family members or significant others are a regular part of the La Posada program. Because of the high incidence of substance abuse among clients, the program also incorporates a regular program for recovery from drug addiction or alcoholism.

Community Expectations

Entering La Posada means becoming part of a family-like community, which in turn imparts certain behavioral expectations in a powerful yet noncoercive manner. These expectations are very high relative to the severity of the individual's pathology and to the expectations of other treatment programs. The key to programmatic success is to combine these high expectations with high support, both from staff and from the residential treatment community of staff and clients.

Indigenous Paraprofessional Staffing. In developing La Posada, hiring practices were directed at minimizing class, cultural, and other social differences between staff and clients. Staff are hired from the community and selected to closely mirror the client population in terms of ethnicity, language, culture, and sexual preference. Although the program does not require any specific degree or credential for counselors or for the program director, the staff consistently represents a broad range of experience, including individuals with traditional degrees and credentials. Former consumers of public mental health programs have always been an integral part of La Posada staffing.

The use of nonprofessionals has eliminated many barriers that class and race pose to the formation of a therapeutic alliance. Openness and genuineness develop much more quickly between the nonprofessional staff and clients

than would be the case between medical personnel and clients. The relationships have a strong peer quality that enhances the sense of community within the program. This environment also provides an ideal opportunity for the personal growth of staff. Crisis work can be extremely stressful. Progress Foundation has found that the interactive program design at La Posada has provided support to staff because it minimizes the institutionalizing effects of many hospitals. The average tenure of staff at La Posada exceeds five years.

Discharge. Within two or three days of admission, the staff and client are actively working on plans to move successfully to the next level of care or to go home. In addition to crisis stabilization, the goal of La Posada is to establish, along with the client, as many of the necessities of community survival as possible within a two-week time limit. Financial assistance, housing or continuing residential treatment, mental health and social service linkages, and connections with family and friends are established through intensive work during the client's stay.

Approximately 40 percent of the clients discharged from La Posada go on to receive transitional residential treatment services in both mental health programs and programs designed for dual-diagnosis treatment. About 15 percent return home, and another 10 percent are discharged to single-room occupancy hotels. Another 18 percent leave the program stabilized but without a specific plan for housing. This group reflects the high number of homeless individuals seen in the PESs. The availability of well-staffed, transitional residential treatment programs following the crisis phase is a critical element in the success of La Posada. San Francisco has a full range of residential treatment resources that are designed to provide three to six months of continuing rehabilitation and treatment.

One of the key outcome measures for the program is the number of clients who are hospitalized from La Posada. These are clients who are admitted as a diversion but who cannot be contained in the facility and must be involuntarily admitted to the hospital. The average in that category at La Posada has been between 5 and 8 percent. This means that between 92 and 95 percent of the diversions to La Posada do not require more acute care.

Cost-Effectiveness. The cost of La Posada is $218 per day, for all services, including physicians' services, which compares favorably with an estimated cost of $650 per day in San Francisco General Hospital. La Posada, like all other CRT programs in California, is reimbursed by Medi-Cal under the Rehabilitation Services Option.

By keeping the length of stay less than two weeks, the program also compares favorably to other programs in total cost of an acute episode. Treatment at La Posada is generally less than one-third the cost of inpatient hospitalization. These cost data apply to the most expensive level of CR services—the acute diversion programs. Programs in the respite and crisis residential categories represent even greater savings for individuals who are diverted from hospitalization or whose length of stay is significantly shortened.

Conclusion

Acute diversion programs such as La Posada, along with other levels of CR services, have become central elements of community crisis response systems. This level of care has moved far beyond the original model of the halfway house to incorporate a philosophy and practice of residential treatment that expands the ability of community-based programs to serve a full range of acute problems without requiring hospitalization.

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STEVEN FIELDS is executive director of Progress Foundation and past president of the California Association of Social Rehabilitation Agencies.

GILBERT K. WEISMAN, M.D., is medical director of La Cheim Schools Mental Health Center and assistant clinical professor of psychiatry at the University of California, San Francisco School of Medicine.

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