Literature Review: Crisis Stabilization and Crisis Respite

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Date: August 15, 2016

Definition: Crisis services are designed to serve individuals who are experiencing a psychiatric emergency. Crisis stabilization and crisis respite services are part of the crisis services continuum and because they are close on the continuum are reviewed here together. Crisis stabilization services are alternatives to hospital emergency departments, (ED) or an inpatient setting, providing 23-hour crisis stabilization care and proper step-down services. Twenty-three-hour crisis stabilization services specify that the patient stays under observation for less than 24 hours. Crisis respite services, on the other hand, are designed to be 24/7 and patients stay longer than a day. Crisis respite services can take a variety of forms including short-term inpatient and residential and be peer-operated/assisted. Residential crisis stabilization services are used to avoid inpatient hospitalization. Crisis stabilization services and crisis respite services can also be co-located with other services (i.e. crisis hotline and ambulatory crisis services), but this is not necessary (SAMHSA, 2014).

Target Population: Crisis stabilization and respite services accept all peoples experiencing a behavioral health crisis that have been determined fit for the stabilization/respite program. The target population is adults.

Description: Considering the services are inter-connected **t**his review reports on both crisis stabilization and crisis respite services. Some of the reviewed literature does not clearly distinguish between the two types of services (SAMHSA, 2014).

Crisis Stabilization: Crisis stabilization is described as a 23-hour crisis observation, or stabilization service that directly provides individuals in severe distress with up to 23 consecutive hours of supervised care to assist with de-escalating the severity of their crisis and/or need for urgent care. The primary objectives of this level of care are prompt assessments, stabilization, and/or a determination of the appropriate level of care (SAMHSA, 2014) with the goal of avoiding unnecessary hospitalizations for individuals whose crisis might be resolved within a short time and observation. The brief observation period/hospitalization of crisis stabilization has shown to be associated with tangible benefits for both the service users and providers. For example, patients gain earlier functional independence following rapid stabilization, and reduction of psychiatric symptoms, including self-harming behavior (San Thinn et al., 2015and SAMHSA, 2014).

Crisis Respite: Crisis respite differs from crisis stabilization in that crisis respite provides 24-hour continuous observation and supervision. Crisis respite services are short-term and are described by the CPI as averaging 7-14 days (CPI, 2015), although this can vary widely. Since crisis respite lasts more than 24 hours some requirements for the space used may include: access to natural light, reading materials, and other recreational activities usually available in a home, single rooms; that have at least 80 square feet of usable space, and shared rooms with at least 60 square feet of usable space per person, and sleeping quarters that meet standards in terms of privacy and equipment (Allen et al., 2002). The primary goal of crisis respite is the de-escalation of patients experiencing acute psychiatric symptoms so patients are able to interact with society in a healthy manner when released. Ideally, crisis stabilization and respite should provide further step-down services, and follow-up upon patient release.

Triage assessment is crucial to the correct treatment and routing of patients within the Crisis Services Continuum. Triage does not simply mean labeling patients for their prospective destinations, but rather triage involves making crucial determinations, within several minutes, about an individual's course of treatment (Ries, 1997).

Peer-run crisis respites are usually located in a house in a residential neighborhood. They provide a safe, homelike environment for people to overcome crisis. The intended outcomes are diverting hospitalization by building mutual, trusting relationships between staff members and users of services, which facilitate resilience and personal growth (Ostrow, 2011). The National Coalition for Mental Health Recovery (NCMHR), a driving force behind the establishment of peer-run crisis respite services nationwide, has described PRCRs as a place for people in crisis to process stress, explore new options for short-term

solutions, increase living and coping skills, and reduce susceptibilities to crisis in an environment that provides support and social connectedness.

Research Summary: Crisis stabilization services typically are in the form of 23-hour observation units that are designed for crisis stabilization and in-patient/hospital admission diversion. In our review it appears Medicaid may cover up to 48-hour observation services. The examples of crisis respite service were residential programs and daily hospital models. Residential programs can be run by medical staff, be peer run, or peer assisted.

Crisis Stabilization:

Twenty-three-hour observation units focus on the potential better management of patients to decrease unnecessary hospitalization, health care costs, and illness burdens in patients and caregivers (San Thinn et al., 2015). A study of an overnight psychiatric observation program that took place at a veterans' affairs medical center showed positive results for an observation program lasting ideally less than 24 hours. The process for the patients was fairly simple. Following admission, the patient was interviewed by the resident physician who obtained a history, completed a physical exam, and ordered the appropriate laboratory tests and admission orders. The next morning following observation the patient was seen by the entire observation team and planning for further care was discussed. When comparing admission to an inpatient psychiatric unit before and after the overnight observation program, a significantly larger proportion of the patients were admitted to a psychiatric unit before the observation period than after. In the preceding six months, the patients' use of inpatient resources was substantial, with more than half having been admitted to psychiatric medical units. In the six months following the admission and observation, only 12 percent of the patients were admitted to inpatient care. Overnight observation programs may provide a cost-effective alternative to traditional inpatient treatment for some individuals with psychiatric disorders (Francis et al., 2000).

Another study compared the rates of hospitalization from two similar psychiatric emergency services, but one service had an extended evaluation unit allowing up to 24 hours of evaluation. Each patient placed in the extended evaluation unit was seen by a primary therapist who made a judgment about their immediate disposition (i. e. hospitalization or discharge from the PES). The therapist also indicated how the extended evaluation unit had been useful in the case of the original disposition. The need for extended evaluation was also assessed. The article roughly concluded that if the extended evaluation capacity allows for appropriate referral to outpatient treatment of some patients who would otherwise be referred for inpatient treatment, then the holding capacity is probably worth its cost to the mental health system. If the emergency service holding area does not reduce hospitalization, then the funding used should be put somewhere else. In this study the results showed that the hospital with the up to 24 hours extended evaluation had 36% hospital admissions, while the comparative control service had 52% admissions (Gillig et al., 1989). An example of a 23-hour observation facility in the Department of General Psychiatry of the Institute of Mental Health/ Woodbridge Hospital in Singapore, mentions a 23-hour observation unit with 6 beds in a hospital serving 5.2 million people. This observation unit provides acute and crisis intervention services for patients with behavioral health disturbances, whose conditions are not clinically assessed to be of sufficient severity or risk to require in-patient admission. When given an observation bed, the patient is assessed by a medical officer and then subsequently reviewed by a specialist for further management decisions such as discharge with outpatient review appointments or transfer to an inpatient ward. Interventions by a medical social worker or a counselor are offered if deemed necessary, and upon discharge patients are provided with available community support information (San Thinn, 2015).

Crisis Respite: Crisis Respite includes two types of services which are described next.

Residential Crisis Care: Two models of residential crisis care are discussed. First, we discuss models where the program is administered by clinical staff and second peer run and peer assisted models.

Clinical staff run residential crisis care models have been found to provide outcomes comparable to those of hospital care to patients who are willing to accept voluntary treatment (Fenton et al., 1998 and Fenton et al., 2002). Two studies are discussed in this review. The first involves an eight-bed residential crisis program located in a ranch-style house in a residential

neighborhood, with a staff of two bachelor's-level counselors 24 hours per day under the direction of a master of social work-level program director. The requirements for admissions included that the patients were: 1) in need of hospital-level care, 2) did not require acute general medical care or detoxification, 3) had Medicaid or Medicare funding, and 4) were willing to accept voluntary placement. The control group consisted of patients treated in a general hospital setting. The average length of stay at the residential facility was approximately 8 days longer than the stay at hospitals (11.7 days on average). Services provided at the residential treatment site included a supportive environment, one-to-one staff monitoring, supervised medication self-administration, continued participation in ongoing community-based treatment, rehabilitation, school, work, or other activities is supported to an extent allowed by patients' symptoms. In contrast, the control model provided a 31-bed inpatient psychiatric treatment unit supported by a day hospital and outpatient clinic with care including medical assessment, individual psychotherapy, group therapy, and pharmacologic management (Fenton et al., 1998). The difference in the psychosocial functioning for patients was comparable to patients treated in hospitals or the alternatives.

The second study of residential crisis care was a randomized control trial of a 4-bed crisis respite apartment combined with day-hospital treatment for acute patients willing to accept voluntary admission (Fenton et al., 2002). This 4-bed crisis residence was compared to an inpatient program for urban, poor, severely ill voluntary patients who usually required hospitalization. Over a two-year period, 197 patients were enrolled in the program and followed for 10 months. The results showed that the satisfaction measures were not statistically different for the patients in the two treatment conditions; however, there was a slightly more positive effect of the residential program on measures of symptoms, overall functioning, and social functioning (Sledge et al, 1996). For the residential crisis care program services, the average cost for acute treatment episodes was 44% lower than the episode cost for the general hospital (Fenton et al, 2002). The main inconsistency between the two models was the presence or lack of day-hospital care.

A meta-analysis conducted on the topic of residential alternatives to acute psychiatric hospital admission, reviewed and analyzed 15 studies of community-based services such as the ones mentioned above, and concluded that more research was needed, but that community-based residential crisis services may provide a feasible and acceptable alternative to hospital admission (Lloyd-Evans et al., 2009).

An emerging form of residential crisis respites are Peer-Run and Peer-Hybrid Crisis respites. Funded peer-to-peer crisis supports – PRCR and PHCR – are a relatively new concept. In fact, most of those in the United States have opened only in the past five to ten years (Ostrow and Croft, 2016). These forms of crisis respites follow the same model of a residential crisis respite, providing stable supportive environments to gain access to services and stabilize. They only differ by the structure of the staff, leadership and governance. These incorporate employees who are the target populations peers; individuals who share similar experiences of having dealt with substance abuse or dependence, or diagnosed with an SMI. In order for a program to be defined as peer-run, it must be 100% staffed by peers, 100% leadership (managers, supervisors, etc.) are peers, and the peer respite must either be operated by a peer-run organization or have an advisory group with 51% or more members identifying as peers. A peer-hybrid respite is composed of both peers as well as clinicians, nurses, counselors, social workers, etc.

Evidence is still being built for peer-run crisis respites, but one randomized controlled trial of a PRCR has been conducted (Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008). This study found that the average rate of improvement in symptom ratings was greater in the alternative than in the hospital comparison group, and that the peer-run alternative group had much greater service satisfaction. The cost was significantly less: $211 per day versus $665 per day for hospitalization. The study authors concluded that this alternative was "at least as effective as standard care" and a "promising and viable alternative" (Greenfield, Stoneking, Humphreys, et al., 2008).

An example of a Peer-Hybrid crisis respite is The Living Room, located in a Chicago suburb, and is a community crisis respite center that offers individuals in crisis an alternative to obtaining services in an emergency department (ED). *The Living Room* utilizes one counselor, one psychiatric registered nurse, and three peer counselors for staffing on a regular basis, all of whom have extensive experience working with persons in crisis (Heyland, 2013). In its first year of operation, *The Living Room* hosted 228 visits by 87 distinct individuals (termed "guests"). Guests were deflected from EDs on 213 of those visits – a 93% deflection rate. These deflections represent a savings of approximately $550,000 to the State of Illinois since guests of *The*

Living Room were overwhelmingly individuals with Medicaid or no insurance of any kind. On 84% (n=192) of the occurrences in which guests were deflected from EDs, they alleviated their crises sufficiently to decide to leave *The Living Room* and return to the community. These guests reported an average decrease of 2.13 points on the Subjective Units of Distress Scale. (Heyland, 2013).

Day Hospitals: A psychiatric day hospital is a facility for patients needing intensive treatment within a relatively structured environment. While it offers the same variety of treatment procedures as a psychiatric hospital, it differs in that patients are present for part of the day and do not live at the hospital (Winick, 1960). Day hospitals are a form of crisis respite care that can serve as an alternative for hospital/residential inpatient care. A study by Davidson et al. (1996) compared the social environment of a conventional psychiatric inpatient setting with that of a combined acute day hospital and crisis respite program found that the social environment of the community-based day hospital crisis respite program embodied several principles of community support systems. Compared with the inpatient setting, the hospital-crisis respite program had higher expectations, a lower tolerance for deviance, and more flexibility in patients' choice of activities. The program also had a more attractive physical environment and was more comfortable. The setting offered patients respect and opportunities for self-determination, and enhanced their dignity, and encouraged fuller integration of patients in the community. A review compared the acute day hospital to hospital admissions for patients with acute psychiatric disorder(s). The review concluded that day hospitals were viewed as an attractive option in situations where demand for inpatient care is high and facilities exist that are suitable for conversion. Conversely day hospitals are an unattractive option when inpatient care demand is low and where effective alternatives already exist.

In four out of five trials the day hospital care was less expensive than inpatient care. (Marshall et al., 2001). Another article suggested that though they have been in decline since the 1980s, acute day hospitals did not fall from favor in the U.S. because they were ineffective, but due to social trends. Compared to home-based care, acute day hospitals have shown evidence of increased satisfaction of patients and no evidence of an increased burden on care-givers. A commendable aspect of day hospital care is that a small number of nurses can maintain a high level of input to substantial numbers of patients, in a safe environment for one to one treatment. Doctors are available as needed, potential outreach services available for patients who aren't attending, and a few beds should be on the premise for patients temporarily too ill to be at home (Marshall, 2003). An example of a day hospital that was not cost-effective, but costlier than regular hospital inpatient services was a study analyzing the effectiveness and costs of acute day hospital treatment compared with conventional inpatient care found that the day hospital service appears to be more effective but costlier than conventional inpatient care. Day hospital patients had a significantly greater reduction in psychopathology at discharge and their subjective quality of life tended to be higher. (Priebe et al., 2006) However, as shown in the extensive literature review comparing acute day hospitals to hospital admissions for patients with acute psychiatric disorders (Marshall et al., 2001), about 4 out of 5 day hospitals had care that was cheaper than inpatient care. The model of each day hospital, as there is no standardized layout or treatment, can determine whether the day hospital is cost-effective or not.

In summary, Crisis Stabilization works to divert target populations from ED's or jails by providing 23-hour crisis observation or stabilization service that directly provides individuals in severe distress with up to 23 consecutive hours of supervised care to assist with de-escalating the severity of their crisis and/or need for urgent care. Residential Crisis Care works to divert target populations from ED's or jails by providing continuous 24-hour observation and supervision for persons who do not require inpatient services lasting typically from 3-14 days. Crisis Stabilization, Residential Crisis Care (including Peer-Run and Peer-Hybrid respites), and Day Hospitals all represent an important alternative to EDs by remedying many criticisms of traditional EDs that have historically treated individuals in crisis. Outcomes from all of the cited examples suggest that these crisis respite centers and crisis stabilization centers are cost-effective, effective in helping many individuals alleviate crises, and have the potential to decrease the use of EDs for mental health crises. After a patient goes through stabilization and respite services the next step is follow-up with outpatient services and community supports.

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