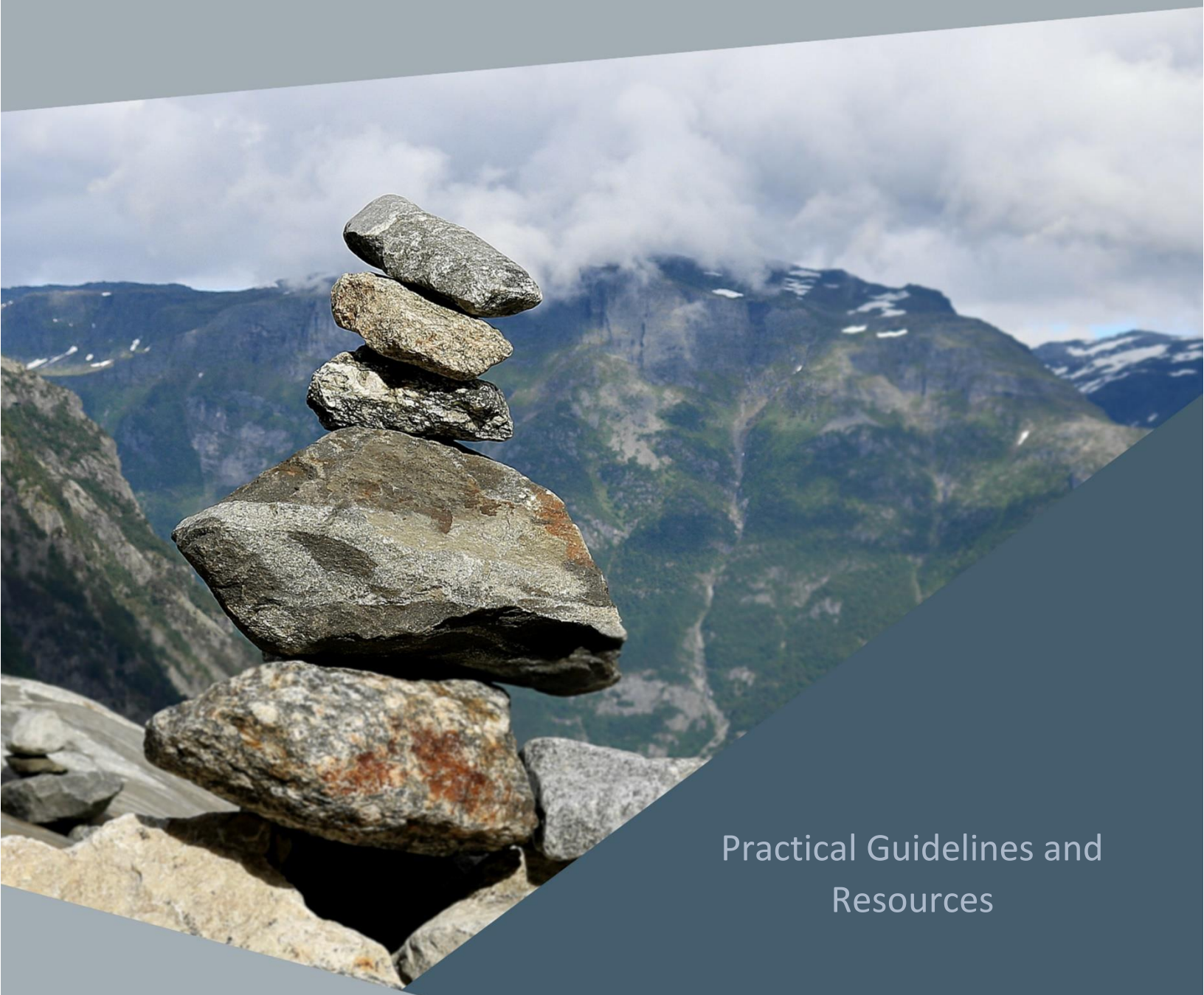
CRISIS RESIDENTIAL BEST PRACTICES HANDBOOK



Practical Guidelines and Resources

tbdSolutions

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TBD Solutions would like to thank all of the providers, behavioral health administrators, and advocates that contributed to the Crisis Residential Best Practices Handbook through survey responses, participation in interviews, and conference discussion.

Specifically, we would like to mention the following programs for their substantial participation in our year-long workgroup (completion of 80% or more of the workgroup surveys):

Aurora Mental Health Center	Aurora, CO
Baltimore Crisis Response, Inc.	Baltimore, MD
Bay Cove Human Services, Inc.	Boston, MA
Birch Tree Center	Duluth, MN
Burke	Lufkin, TX
Charleston Dorchester Mental Health Center	Charleston, SC
COMCARE of Sedgwick County	Wichita, KS
Community Access, Inc.	New York, NY
Community Reach Center	Westminster, CO
Community Research Foundation, Inc.	San Diego, CA
Cornerstone Montgomery	Rockville, MD
CREOKS Behavioral Health System	Sapulpa, OK
Denton County MHMR Center	Denton, TX
DuPage County Health Department	Wheaton, IL
Family & Children's Services	Tulsa, OK
Hope Network	Grand Rapids, MI
Human Development Services of Westchester, Inc.	Mamaroneck, NY
Integral Care	Austin, TX
Legacy Treatment Services	Mount Holly, NJ
MADO Healthcare	Chicago, IL
MHMR of Tarrant County	Fort Worth, TX
Mosaic Community Services	Towson, MD
Netcare Access	Columbus, OH
Pathways, Inc.	Ashland, KY
Presbyterian Medical Services	Santa Fe, NM

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Productive Alternatives, Inc.	Fergus Falls, MN
Region 6 - Life Help Mental Health Services	Grenada, MS
Region IV Mental Health Services	Corinth, MS
Resources for Human Development	Philadelphia, PA
RI International	Peoria, AZ
River Edge Behavioral Health Center	Macon, GA
Rosecrance Health Network	Rockford, IL
So Others Might Eat	Washington, DC
Texana Crisis Center	Rosenberg, TX
The Harris Center for Mental Health and IDD	Houston, TX
Waubonsie Mental Health Center, Inc.	Clarinda, IA
Western Montana Mental Health Center	Missoula, MT

Your contributions and participation in this process are greatly appreciated.

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Introduction

Approximately 20% of the population struggles with a mental illness at any time[1], and suicide is the 2nd leading cause of death for people under age 35[2], yet the United States does not have a behavioral health care system that adequately meets the needs of its most vulnerable citizens. While treatment has advanced and stigma has waned, we are still faced with a health care system with pronounced disparities in access and quality between physical health care and mental health care, and many communities lack a comprehensive continuum of services to assist and support people in psychiatric crisis.

When a country possesses the resources to reduce suffering among its people but does not exercise them, it cannot be considered great. As Mahatma Ghandi said, “The true measure of any society can be found in how it treats its most vulnerable members."

Crisis Residential services are a cairn[3] on the trail of a person’s mental health treatment, providing agency, dignity, and hope to individuals experiencing a mental health crisis. In an industry where fear, exploitation, and segregation have permeated treatment, Crisis Residential services invite a new paradigm of connection and recovery into the pursuit of stability and wellness.

This guide to Crisis Residential Services was developed to inform and offer perspectives on a highly effective model of services that is under-utilized and not well-documented in the national literature in hopes that more communities will consider enhancing their response to mental health crisis through the use of this alternative to psychiatric hospitalization.

About TBD Solutions

TBD Solutions is a consulting, training, and research company based in Grand Rapids, Michigan. Since 2011, TBD Solutions has helped behavioral health providers, payers, and administrators answer some of the most challenging questions facing the industry and the people served by them.

For more information, visit www.TBDSolutions.com.

Purpose of Handbook

Developed through crowdsourcing and dialog with national crisis programs, this handbook is intended to provide insight and perspective on how providers and communities are innovatively delivering critical behavioral health care to those experiencing a crisis. While decades of empirical research have been conducted on psychiatric hospital alternatives, a qualitative analysis of this magnitude has not been executed by any public or private entity with broad distribution.

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[1] Substance Abuse and Mental Health Services Administration (2017). *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

[2] Center for Disease Control. *Leading Causes of Death Reports, 1981-2016.* Retrieved from: https://webappa.cdc.gov/sasweb/ncipc/leadcause.html

[3] A cairn is a mound of rough stones used as a landmark to guide hikers and travelers along their journey (see cover photo).

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This handbook is geared towards two audiences: those who are currently operating Crisis Residential Programs who seek to standardize and improve their practices, and those who are considering opening some type of alternative to psychiatric hospitalization or other intensive service to support people experiencing a mental health crisis.

Approach & Methods

In 2016, TBD Solutions developed and led a comprehensive national workgroup to develop a Best Practices Handbook for Crisis Residential services. Over the course of one year, this multi-agency collaborative, consisting of over 150 Crisis providers, administrators, and payers from 45 states completed monthly online surveys and convened telephonically to share their experiences about the critical components of their Crisis Residential Programs.

As there are approximately 600 Crisis Residential Programs (CRPs) in the United States, this workgroup created and collected an unprecedented amount of information about these programs. This was accomplished through a crowd-sourcing model that included providers of all sizes and dimensions with minimal barriers to participation. Nearly all data included in this report comes from the structured responses and anecdotes of workgroup participants unless otherwise noted.

Limitations

While the survey and data collection process for this guide provides more comprehensive data collection around Crisis Residential Programs than has ever been collected, it still only represents approximately 10% of all CRPs nationally.

Referencing Persons Served

Individuals receiving inpatient mental health treatment have been referred to by many different names, including patient, client, consumer, resident, guest, individual, and person served. This report is built upon the foundation of recovery-oriented principles in mental health treatment and choosing the least stigmatizing language. We have chosen to use the word “client” when referring to a person receiving services as it is universally understood while being less stigmatizing than words like “patient” and “consumer,” and it was the most commonly used term by survey respondents.

While many of the principles identified in this handbook are universal to CRPs serving individuals of all ages, over 95% of participants represented adult CRPs, likely revealing a bias in the data towards adult CRPs[4].

While participation was offered to Crisis Residential providers and advertised on national listservs and online forums, participation required some level of balance and availability on behalf of the provider, and providers who are struggling, have more challenging programs, or have less resources at their fingertips may be under-represented in this handbook. What’s more, crisis providers who can barely keep their head afloat may find it difficult to reference resources such as this one to help manage their overwhelming challenges and move from a state of mere survival to one of thriving and sustaining.

[4] Of the approximately 675 Crisis Residential Programs identified as of August 2018, about 80 (12%) provide services to youth.

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Overview of Crisis Residential Services

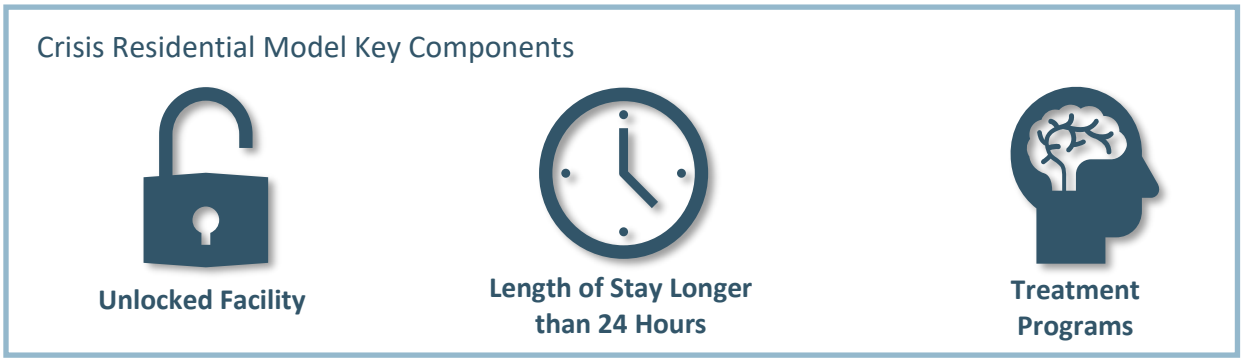
Crisis Residential Programs serve individuals experiencing a mental health emergency in a community-based setting. As one component of subacute crisis stabilization services, CRPs provide a critical component of a healthy behavioral health crisis services continuum, offering substantial benefits when compared to psychiatric inpatient hospitalization—namely, comparable outcomes[5], comparable client satisfaction, and substantially lower costs[6]. Over 40 years of research supports the efficacy and value of the Crisis Residential Model. Crisis Residential Programs distinguish themselves from these other levels of care due to their home-like environment, blended psychosocial model of care, multi-day lengths of stay, and healthy mix of autonomy and accountability.

Mission/Purpose of Crisis Residential Programs

Crisis Residential Programs assist individuals experiencing a self-defined behavioral health crisis that prevents them from maintaining a healthy life in the community, such as depression, anxiety, psychosis, and suicidal ideations. Services are delivered in a person-centered environment, meaning much attention is given to the environment and treatment approach such that clients feel welcomed, affirmed, and validated. Clients play an active part in the treatment planning process, providing input on their goals for treatment.

In some ways, CRPs resemble a halfway house model used in substance abuse treatment, in that they are recovery-focused, community-based, and often found in a neighborhood or residential setting. They can be used as a stepdown from more acute treatment services, and they utilize a familiar communal environment to provide treatment and encourage prosocial skills. CRPs across the U.S. are successfully used as a diversion or alternative to inpatient psychiatric treatment.

The Crisis Residential Model varies between communities based on need, capacity, and funding.



However, the three main concepts used to distinguish crisis residential from other models of care are its unlocked environment, length of stay greater than 24 hours, and treatment provided.

Taxonomy

While this study was an effort to build consensus around crisis services, the programs struggled to find common language to name the services they provide. Including the term “crisis” in the title of these

[5] Bola, J. R., & Mosher, L. R. (2003). Treatment of acute psychosis without neuroleptics: two-year outcomes from the Soteria project. *The Journal of nervous and mental disease*, *191*(4), 219-229.

[6] Adams, C. L., & El-Mallakh, R. S. (2009). Patient outcome after treatment in a community-based crisis stabilization unit. *The journal of behavioral health services & research*, *36*(3), 396-399.

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programs seemed like a misnomer to some, as most clients seemed to be past the most acute phase of their crisis by the time they were admitted (for example, a suicide attempt). "Residential" gave the illusion of a long-term stay well beyond the typical 3-10 day stay that most clients experience in these types of programs. Despite these disagreements, the phrase "Crisis Residential" will be used to refer to these programs throughout the handbook.

CRPs take on a variety of names depending on the terminology employed by the state behavioral health authority[7]:

- **Crisis Residential Unit:** California, Hawaii, Michigan, New York[8], Pennsylvania, Texas[9], Washington[10]
- **Crisis Stabilization Unit:** Alabama, Colorado, Indiana, Kentucky, Minnesota, Mississippi, Missouri, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Virginia, West Virginia
- **Facility-Based Crisis:** North Carolina
- **Crisis Respite:** Arizona, Washington
- **Community Crisis Stabilization:** Massachusetts
- **Crisis Resolution Center (Class III):** Oregon
- **Wellness Recovery Center:** Utah

History of Crisis Residential Services

Formal Crisis Residential Programs took shape in the United States following President John F. Kennedy's signing of the Community Mental Health Act in 1963, but their origins trace as far back as community caretakers who provided refuge to their citizens. Amidst the psychiatric counterculture of the 1960's, programs like Soteria and Diabasis house began opening homes that were voluntary and unlocked. This new concept of treatment seemed paradoxical, but researchers found that people would want to stay if they felt they had control of their treatment[11].

Many of the first CRPs were focused on serving those experiencing psychosis or diagnosed with schizophrenia. These facilities offered medication-free or limited medication treatment, a diverging practice from the psychiatric hospitals at the time[12]. Arguably the most famous Crisis Residential

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[7] States listed in this section meet the aforementioned criteria of unlocked facilities providing mental health treatment with lengths of stay greater than 23 hours, and program nomenclature was verified through provider manual language or program descriptions.

[8] New York also has Crisis Respite Centers, which align more with Peer Respite programs.

[9] States like Colorado, Tennessee, Texas, and Washington maintain multiple versions of locked and unlocked Crisis programs. **Colorado** has Crisis Stabilization Units (secured programs with delayed egress) and Crisis Respite Units. **Texas** has Extended Observation Units (locked facilities for 48-72 hours), Crisis Residential Units (3-7 day LOS), and Crisis Respite Units (7-14 day LOS). **Tennessee's** Crisis Stabilization Units have a length of stay of up to 4 days, with Crisis Respite services utilized for stays longer than 3 days. **Washington** has unlocked Crisis Respite Centers and Crisis Triage Facilities, and locked Crisis Stabilization Units.

[10] In Washington, Crisis Residential Centers serve youth in crisis, while Crisis Respite Centers and Crisis Triage Facilities serve adults.

[11] DeWyze, J. (2003, January 9). Still Crazy After All These Years. *San Diego Weekly Reader*. Retrieved from https://www.sandiegoreader.com/news/2003/jan/09/cover-still-crazy-after-all-these-years/.

[12] Calton, T., Ferriter, M., Huband, N., & Spandler, H. (2007). A systematic review of the Soteria paradigm for the treatment of people diagnosed with schizophrenia. *Schizophrenia Bulletin*, *34*(1), 181-192.

program, Soteria, was developed out of a study formulated by the National Institute for Mental Health in 1973. Psychiatrist Loren Mosher conceived the Soteria program, which was staffed largely with laypersons and used medications sparingly. Mosher's inspiration for Soteria came from his time spent at Kingsley Hall, a similar experimental psychosocial treatment facility in England[13]. When he returned from his time at Kingsley Hall, Mosher, working for the National Institute of Mental Health at the time, drafted a grant proposal for a 5-year study for Soteria (meaning "salvation" in Greek), and later for a second home called Emanon ("No Name" spelled backwards)[14].

After Mosher's time with the National Institute for Mental Health ended, he was instrumental in the development of two of the oldest CRPs in the United States: Crossing Place in Washington, D.C. and Fenton-McAuliffe House in Rockville, MD. While both of these CRPs were further removed from the Soteria Model, they built the foundation for psychiatric hospital alternatives in the eastern United States.

CRPs emerged across the United States in the 1970's for a number of reasons. As state psychiatric hospitals closed in concert with national deinstitutionalization efforts, an estimated 560,000 people previously hospitalized became in need of care elsewhere[15]. Community-based services, including group homes and CRPs, filled some of the treatment gaps for those who were previously institutionalized but still in need of care. Some communities opened crisis programs as pilot projects to decrease hospitalizations, while others have found Medicaid waiver funding or grants to expand the crisis service array. Other communities opened crisis programs to save money or to improve treatment for symptom severity as a viable alternative to inpatient hospitalization. Some states have expanded their crisis services in response to a tragic event[16].

CRPs have evolved and expanded throughout the United States since their inception in the mid-1960's, taking shape based on the funding, treatment philosophy, and direction (or lack thereof) of the state behavioral health entities.

The stories of the 450+ CRPs are maintained anecdotally by the tenured historians of the behavioral health systems. However, the stories of CRPs that have not survived—whether because of funding insolvency, utilization challenges, or poor management—are at risk of being lost. Without proper attention, their lessons do not heed adequate warnings to current and future CRPs.

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[13] Lichtenberg, P. (2011). The residential care alternative for the acutely psychotic patient. *Psychiatric quarterly*, *82*(4), 329-341.

[14] Hawthorne, W. B., Green, E. E., Lohr, J. B., Hough, R., & Smith, P. G. (1999). Comparison of outcomes of acute care in short-term residential treatment and psychiatric hospital settings. *Psychiatric Services*, *50*(3), 401-406.

[15] Torrey, E. F. (1997). *Out of the shadows: Confronting America's mental illness crisis*. New York: John Wiley. Excerpt retrieved July 26, 2018, from: https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html

[16] Colorado Department of Human Services, Office of Behavioral Health (November 2017). *Expansion of the Colorado Crisis System Report (C.R.S. 27-60-103 (6) (b))*. Report. Retrieved from: https://drive.google.com/file/d/0B_7n3ujVHBrwcXFQNUVTNXdwN2s/view?usp=sharing.

Crisis Residential and the Crisis Services Continuum

Crisis Response and Crisis Treatment services have expanded greatly as providers and communities have engaged new and promising efforts to provide meaningful treatment interventions. Inpatient psychiatric hospitals have their origins in the asylums built in the United States in the early 1800's[17], psychotherapy became popular in the early 1900's, but it was not until the 1970's that the Crisis Residential model began to take shape in the United States. Since then, the following treatment options have grown in size and popularity:

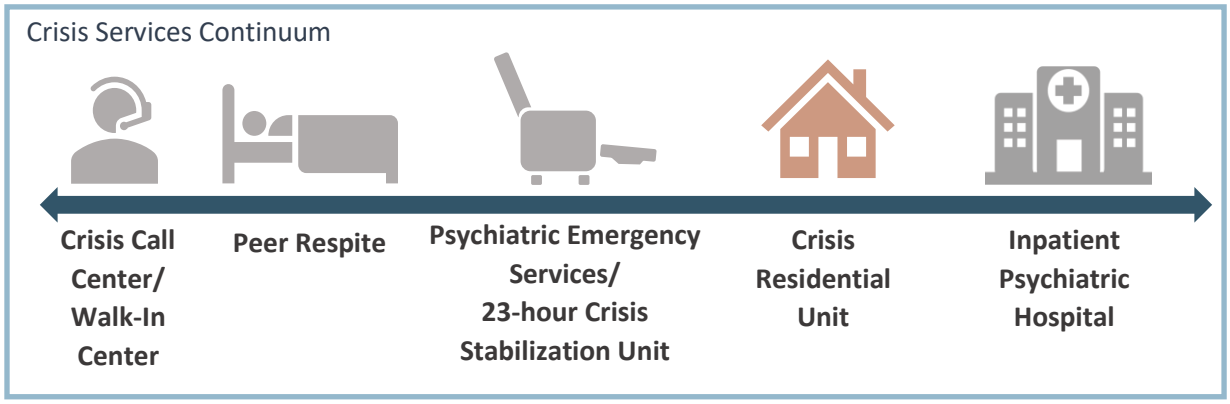
> *"If you don't have, in your county, a fully staffed Crisis Residential treatment program... you are hospitalizing people who don't need to be hospitalized."*
>
> -Steve Fields
> Executive Director, Progress Foundation

- **Crisis Call Centers/Walk-In Centers:** Crisis Call Centers and Walk-In Centers provide frontline support to individuals in crisis. Crisis Call Center employees provide critical support through de-escalation, active listening, and referrals to community resources. In some communities, Crisis Call Centers can dispatch mobile crisis teams, or schedule next-day follow-up appointments directly with outpatient providers. Walk-In Centers are often co-located with other types of Crisis services, offering assessment and referral services.
- **Mobile Crisis Team:** Mobile crisis teams provide emergency screening, assessment, and triage at the point of the crisis, with the goal of referring people to the appropriate level of care, and subsequently serving as a diversion from an Emergency Room or Psychiatric Hospital. Mobile crisis teams typically include a clinician (usually licensed) and a medical professional (RN), Peer Support Specialist, and/or police officer. Many communities have also implemented Crisis Intervention Training[18] (CIT) for law enforcement officers to gain specific skills in responding to a mental health emergency.
- **Psychiatric Emergency Services (PES)/ 23-hour Crisis Stabilization Unit (CSU):** PES facilities provide emergency psychiatric care to individuals that would often otherwise frequent the local Emergency Department to seek behavioral health treatment. Individuals typically have access to an interdisciplinary team consisting of nurses, social workers, prescribers, and sometimes Peer Support Specialists.

[17] Whitaker, R. (2001). *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill*. Basic Books, p. 15.
[18] For more information on CIT, visit http://www.citinternational.org/Learn-About-CIT.

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- **Peer Respite**: Peer Respite programs are completely operated and staffed by people with lived experience with a mental illness[19]. No medical staff are present in the home, and individuals stay for a period of a few days to a few weeks.
- **Inpatient Psychiatric Hospitals:** Inpatient psychiatric hospitals provide the most intensive and expensive level of services, designed for people who are in severe emotional distress with symptoms of depression, anxiety, psychosis, and/or are at risk of harm to self or others.
    - **Partial Psychiatric Hospitals** provide day treatment options with medical oversight for people who are ready to discharge from an inpatient setting but still need clinical support and medication monitoring.



Benefits of Crisis Residential vs. Psychiatric Hospitalization

Over 40 years of research provides compelling evidence that Crisis Residential Programs provide comparable treatment to psychiatric hospitals, meeting the triple aim goals of better outcomes[20], higher client satisfaction[21], and lower cost[22]. Care in CRPs is often provided in less restrictive settings with a more home-like environment, allowing more freedom and client choice while promoting more engagement between clients and staff.

Diversity in Treatment Options

CRPs offer payers and clients a meaningful alternative to inpatient psychiatric hospitalization through treatment in an accessible, comfortable, and person-centered treatment environment. The program is typically unlocked, and treatment is typically voluntary, in sharp contrast to psychiatric hospitalization.

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[19] For a toolkit for evaluating peer respite programs, visit https://www.hsri.org/publication/peer-respite-toolkit/.
[20]Polak, P. R., & Kirby, M. W. (1976). A model to replace psychiatric hospitals. *Journal of Nervous and Mental Disease*.
[21]Hawthorne, W. B., Green, E. E., Lohr, J. B., Hough, R., & Smith, P. G. (1999). Comparison of outcomes of acute care in short-term residential treatment and psychiatric hospital settings. *Psychiatric Services*, *50*(3), 401-406.
[22] Fenton, W. S., Hoch, J. S., Herrell, J. M., Mosher, L., & Dixon, L. (2002). Cost and cost-effectiveness of hospital vs residential crisis care for patients who have serious mental illness. *Archives of general psychiatry*, *59*(4), 357-364.

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Better Outcomes

Studies comparing CRPs and inpatient hospital settings show similar or better clinical outcomes in people using the crisis residential settings over hospitals[23,24,25]. Favorable clinical outcomes included level of functioning, symptom severity, self-rated symptoms scales, and self-esteem.

Higher Client Satisfaction

CRPs are designed as home-like settings that contrast the sterile, clinical atmosphere of an inpatient hospital setting. In controlled studies, clients receiving services from a Crisis Residential program often report higher levels of satisfaction with treatment[26,27,28,29]. A comfortable and inviting treatment environment with less focus on medication and restraint provides individuals the freedom and dignity they deserved.

> *"The clients could dash out nude into the street if they had to; we didn't like it, but they did! You see, we wanted them to be in this house of their own free will. They had to realize their* **own desire to belong** *in the house, and they did."*
>
> - John Weir Perry, Founder of Diabasis

Lower Cost

As the workgroup survey results revealed, Crisis Residential Programs can vary greatly in cost from one region of the country to the next, but typical CRPs cost approximately $300 to $450 per day, about 50-60% of the cost of a psychiatric hospital per day.

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[23] Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. *American Journal of Community Psychology*, *42*(1-2), 135-144.

[24] Howard, L., Flach, C., Leese, M., Byford, S., Killaspy, H., Cole, L., ... & McNicholas, S. (2010). Effectiveness and cost-effectiveness of admissions to women's crisis houses compared with traditional psychiatric wards: pilot patient-preference randomised controlled trial. *The British Journal of Psychiatry*, *197*(S53), s32-s40.

[25] Thomas, K. A., & Rickwood, D. (2013). Clinical and cost-effectiveness of acute and subacute residential mental health services: a systematic review. *Psychiatric Services*, *64*(11), 1140-1149.

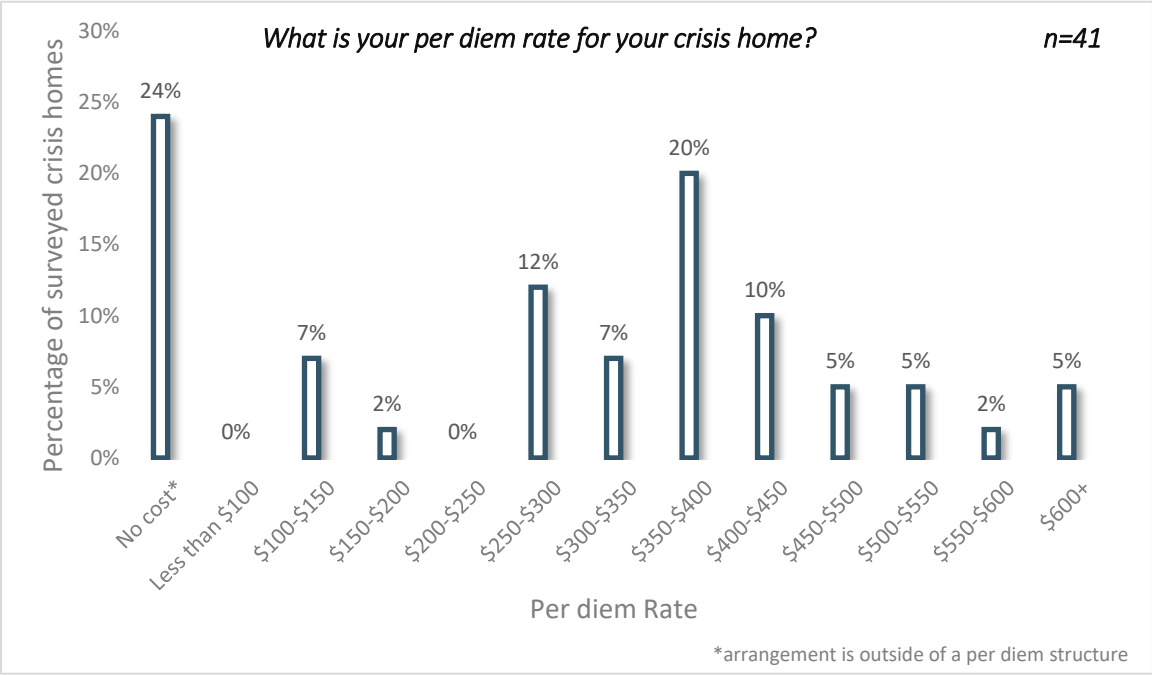
[26] Hawthorne, W. B., Green, E. E., Folsom, D., & Lohr, J. B. (2009). A randomized study comparing the treatment environment in alternative and hospital-based acute psychiatric care. *Psychiatric Services*, *60*(9), 1239-1244.

[27] Greenfield, Ibid.

[28] Osborn, D. P., Lloyd-Evans, B., Johnson, S., Gilburt, H., Byford, S., Leese, M., & Slade, M. (2010). Residential alternatives to acute in-patient care in England: satisfaction, ward atmosphere and service user experiences. *The British Journal of Psychiatry*, *197*(S53), s41-s45.

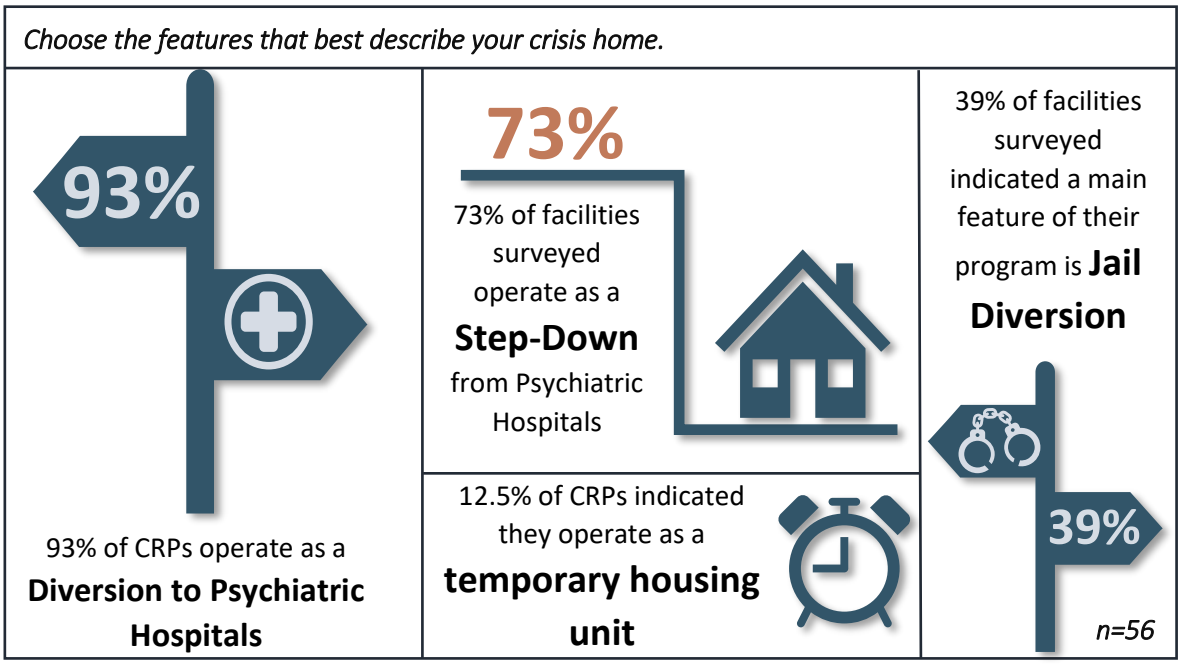
[29] Thomas, Ibid.

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Scope and Function of CRPs

Crisis Residential Programs represented in this study ranged in tenure from less than 6 months to over 30 years. They function in a variety of ways depending on their community, but over 90% of survey participants stated that their crisis program existed to help divert people from the psychiatric hospital.



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Treatment is varied and dynamic within each Crisis Residential Program, based on funder preference, cultural expectations around client choice or treatment philosophy, or practical limitations.

Philosophy of Care

Crisis Residential Programs were formed to provide community-based care to individuals in a psychiatric crisis, serving people in a more humane and compassionate way than was previously offered in a psychiatric hospital. While some components of treatment are reflective of the Medical Model[30] (psychiatry, nursing, and pharmacology, for example), most programs provide a blended model of care that promotes the Recovery Model[31] as well as components of the Medical Model.

Evidence-Based Practices

Many CRPs infuse, or embrace the philosophies of, clinical evidence-based practices such as Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Motivational Interviewing (MI), and Acceptance and Commitment Therapy (ACT). The short-term nature of the program can inhibit full fidelity to an evidence-based model, but clinical staff often adapt a hybrid model that best meets the needs of the persons served.

When survey participants were asked to select which evidence-based practices they utilize in their practice, 71% reported having Trauma-Informed Care principles embedded into their practices, and 63% reported using the Recovery Model of Care. Trauma-Informed Care takes a "universal precautions" approach and assumes that most, if not all, individuals receiving services in a program have been exposed to some type of trauma during their life[32]. Because the incidence and

THE HISTORY OF MINDFULNESS IN CRISIS RESIDENTIAL PROGRAMS

Early Crisis Residential pioneers used mindfulness in treatment, and it is still utilized in many Crisis programs today, whether as meditation or in concert with other treatment modalities like DBT or ACT.

One of the first alternatives to hospitalization, Diabasis House, used themes of opposites when working with people experiencing first-episode schizophrenia.

One room was dedicated for the expression of anger. It was a sound proof room they entered and exited willingly, vocalizing their anger loudly and later processing with a therapist.

Diabasis House also maintained a mindfulness room meant for quiet, relaxation, and meditation.

Michael O'Callaghan, "A Conversation with Dr. John Weir Perry," 1982, http://www.global-vision.org/papers/JWP.pdf.

[30] The Medical Model refers to the modern method of health care delivery, typically involving a deficit, symptom, or presenting problem, a subsequent intervention (medication or surgery, for example), and a result, usually a diminished intensity or extinction of the presenting problem. Looking at psychiatric treatment through the Medical Model lens, symptoms such as depression or psychosis resemble a deficit caused by a neurochemical imbalance.
[31] Jacob, K. S. (2015). Recovery model of mental illness: A complementary approach to psychiatric care. *Indian journal of psychological medicine*, *37*(2), 117.
[32] Trauma-Informed Care - New Publication. (2014). *SAMHSA News*, *22*(2).

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severity of trauma exposure is unknown, all clients are treated with compassion and empathy, as if each has been exposed to trauma at some time in their life.

Addressing Trauma During Treatment

There are differing views within Crisis Residential Programs about the most appropriate way to address client trauma during treatment. While nearly all crisis programs surveyed reported subscribing to a trauma-informed approach to care, some programs believe that crisis residential treatment is not conducive to effective trauma treatment and should be left to trained therapists. Others find it to be a safe and appropriate place to process and treat traumatic events.

Does your crisis program follow any of the models or approaches?

Trauma Informed Care	**71%**
Recovery Model	**63%**
Clinical Evidence Based Practices (DBT, CBT, ACT, etc.)	**45%**
Seeking Safety	**37%**
Medical Model	**32%**
Soteria Model	**5%**

n=38

Therapeutic Approaches

Clients in CRPs are typically empowered to make their own treatment decisions, including group participation and program involvement, and in some cases, medication compliance. Therapy groups, psychoeducational groups, and peer-run groups (AA, NA, etc.) provide clients opportunities to engage with others in whatever way they are most comfortable. Successful Crisis Residential staff are versatile and adaptable, allowing treatment to be provided in a way that meets the client where they are at that point in their recovery. When programming is flexible to meet the clients' needs and leverage the staff's strengths (art, music, mindfulness, etc.), Crisis Residential Programs achieve a new level of therapeutic effectiveness.

CRP staff report that clients who are agitated and resistant to treatment the day they are admitted to the

How do you address the physical, spiritual, emotional, and creative needs of the people you serve?



n=56

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program often experience symptom reduction within a few days, and eventually fully engage in treatment for the remaining duration of their stay in the program.

Alternatively, staff report that setting expectations for treatment participation that are unrealistic can cause clients to resist or disengage, delaying the onset of the influence of treatment.

Crisis Residential Programs operated or funded by more traditional providers may prioritize safety over individual choice, not allowing individuals to leave the program until they are discharged. Other providers embrace the philosophy that clients will need to navigate the psychosocial treatment programs once they have discharged from Crisis Residential. They believe that finding therapy groups and support groups in the community instills agency in the client to use the same community resources once they are discharged. Over 50% of the CRPs surveyed reported that clients are allowed to leave the Crisis home for treatment-related matters.

Most CRPs offer therapeutic activities during the day in the form of psychoeducational groups, group or individual therapy, and recreational activities. Still, other Crisis programs blend both models together, offering some specialized groups while allowing clients to occasionally leave the program to attend community groups such as Alcoholics Anonymous, yoga, or a peer advocacy group. Both the all-community and blended models align well with a community-based philosophy of care, on which the current Community Mental Health system is predicated.

Self-Expression and Non-Traditional Therapies

Some Crisis Residential Programs infuse art, music, and other methods of expression and connection into their treatment curriculum. Groups like art therapy, music therapy, and pet therapy can be facilitated by degreed professionals (therapists and recreation therapists), volunteers, or staff who currently serve in other roles within the program. Playing to the strengths and interests of a crisis



Introducing Pet Therapy in Your Crisis Program

When implemented with intention and thoughtfulness, pet therapy can provide tranquility and connection to clients.

1. Check with all current clients of the program to make sure there are no life-threatening allergies or aversions to pets.

2. Ensure your HR policies, business insurance policies, and animal owner's insurance (or pet therapy company's insurance) are aligned and up to date with having an animal on the premises.

3. Notify clients a few days ahead of time about pet therapy's place in the upcoming treatment schedule.

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residential program's staff empowers the employee to engage and lead in unconventional ways, allowing the clients to benefit from a holistic treatment offering. This can be especially helpful for programs that have a limited staffing and programming budget.

Art Therapy

At The Retreat, a Crisis Residential Program operated by Common Ground in Pontiac, MI (a suburb of Detroit), the program's leadership demonstrates its commitment to recovery by having a full-time art therapist on staff. Art therapy is a regular part of the program's treatment schedule, and client self-expression is strongly encouraged. Artwork is displayed prominently around the facility, and generative artwork, where current clients contribute to artwork initiated by past clients, is utilized as a way to inspire hope and leverage shared experiences. One example of generative artwork is the Recovery Quilt shown in the graphic below.

How to Create A Recovery Quilt



Materials:

- (3) Large, stretched canvases (36" x 48")
- Scissors
- Roll of canvas
- Gallon of Gesso paint
- (1) Large container of Rubber Cement
- Mixed media materials (markers, ribbons, glitter, construction paper, glue, etc.)

Directions:

1. Draw lines on the stretched canvases to divide them into a grid of 6"x6" squares
2. Cut the canvas roll into 6"x6" squares
3. Give each client a canvas square, and ask them to decorate their square with the theme of "Recovery" and what it means to them.
4. Encourage clients to use the mixed media materials available to them.
5. Attach the completed squares onto the canvas grid. Each grid will contain 48 spaces, so it may take several weeks before enough clients complete the activity before the grid is full.
6. Once the grid is complete, hang the canvas in the Crisis program for clients and staff to see.

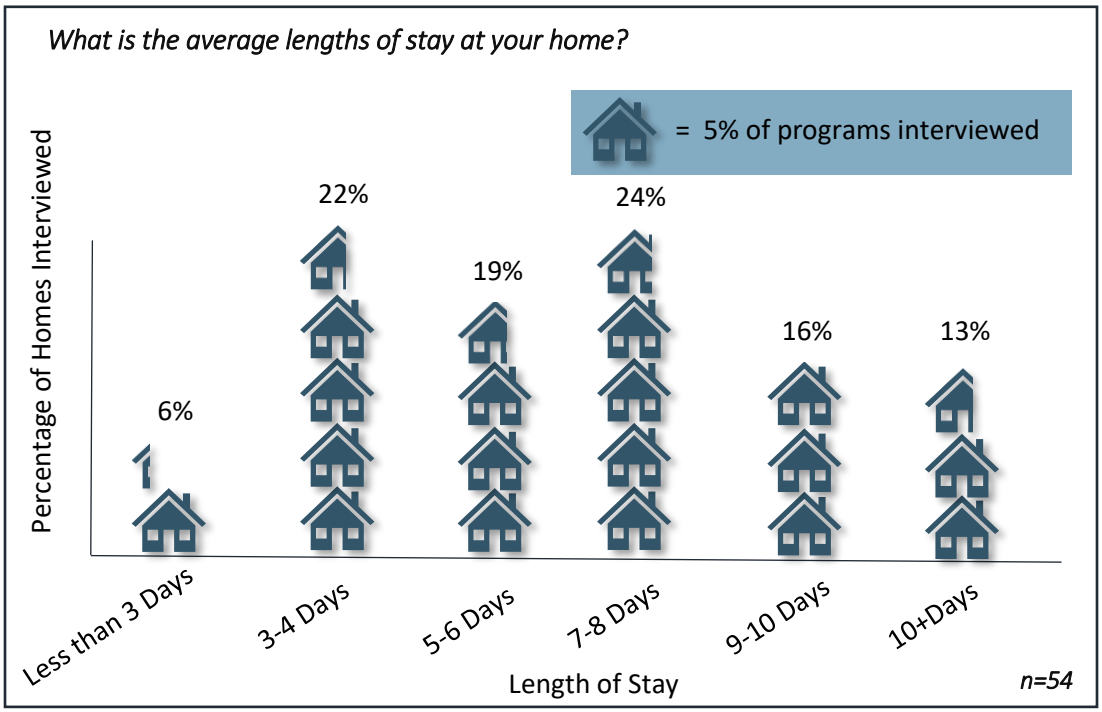
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Length of Stay

Broad differences exist in the average length of stay when compared between Crisis Residential Programs across the country. The programs represented in the survey reported a range in the length of stay in treatment from 3 days to 28 days. Programs justify their length of stay in a number of ways, including:

- Some funders state that the purpose of CRPs is basic crisis stabilization, and once the person's symptoms have stabilized, or they are no longer considered in crisis, they should discharge from the program. Programs that operate under this philosophy typically have a length of stay of 3-5 days.
- Other funders indicate a preference that the person develop needed skills and acquire the necessary community supports to avoid future hospitalization, resulting in a length of stay of 7-14 days (or longer), to ensure substantial and sustained progress.
- CRPs are guided by the number of service days authorized by a payer, state licensure guidelines, and the best fit for the treatment philosophy and goals of the CRP

Managed care in Medicaid and other insurance programs has had significant impact on the average length of stay, as some programs have seen a 50% decrease in average length of stay in the past 10 years. This reduction in length of stay has a substantial impact on treatment, staff workload, and program scope.



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The Added Burden of Decreasing the Length of Stay

Below are two estimates of time and treatment allocations for a 6-bed CRP with a 10-day length of stay versus a 5-day length of stay (both CRPs at 100% occupancy). The intake process is estimated at 3 hours per person, and the discharge time is estimated at 2 hours per person. Clinical treatment is estimated at 4 hours per day, and cost is $500 per day[33]. Notice the increased staff resources spent completing intake and discharge paperwork, and the decreased amount of time each client spends in treatment.

10 Day Length of Stay	5 Day Length of Stay
30 Admissions per Month	**60** Admissions per month
90 hours intake, **60** hours discharge total	**180** hours of intake, **120** hours discharge total
40 hours of clinical treatment	**20** hours of clinical treatment
Total cost: $**5000**	Total cost: $**2500**

Freedom of Movement

Communities whose beliefs and values align more with a linear, medical model of mental illness or who stringently manage their psychiatric treatment budget often look at the idea of a "community treatment" philosophy with skepticism. "*If they are safe enough to leave the program and return, then why wouldn't they be ready for discharge from the program?*" is how the argument often goes. Yet there is often still progress to made in a person's readiness for discharge once the acute crisis has stabilized, and if intensive support services are not available outside of the CRP, it may serve the client and the community best to extend the length of stay by a few days to ensure progress is sustainable. When the risk is managed appropriately, individuals can safely and therapeutically access the community, building trust between the client and the provider.

Over 50%

of CRPs surveyed reported that clients are permitted to leave the Crisis home for treatment-related matters.

Physical Structure

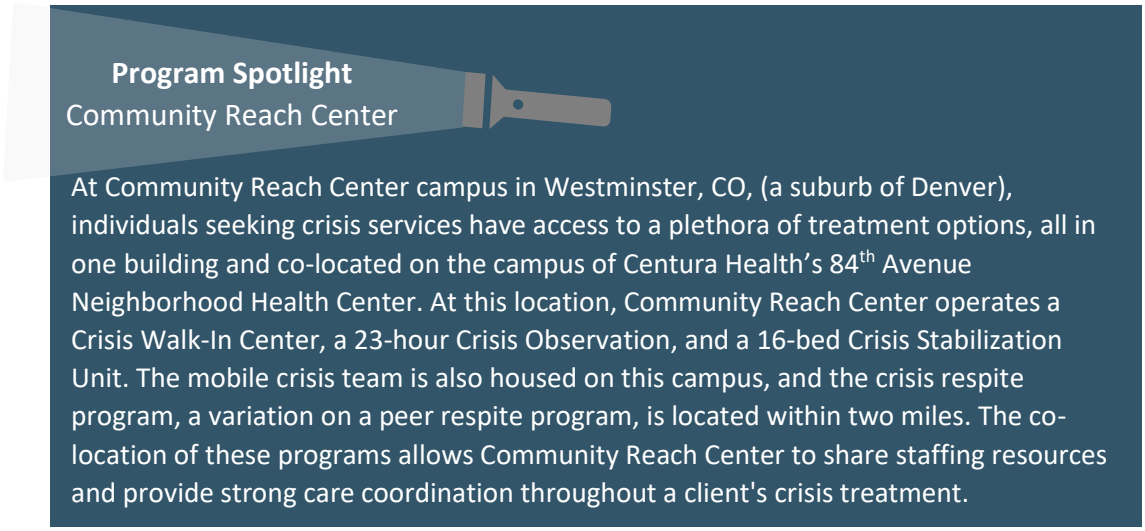
Crisis Residential Programs are often built as inconspicuous residential structures within a neighborhood or on the campus of another service offered by a community mental health provider or nonprofit. Most CRPs range in size from 6 to 16 beds in accordance with the Medicaid Institutions for Mental Disease (IMD) Exclusion, which limits the size of mental health treatment facilities to 16 beds. A typical CRP in the United States is a one-story ranch house in a moderate-income residential area, with access to public transportation. A number of creative variations exist, including CRPs co-located on a medical hospital campus (Manchester, NH and Westminster, CO), a refurbished warehouse (San Francisco, CA), and a renovated orphanage (Grand Rapids, MI).

[33] This cost is based on daily rates reported by Crisis Residential Providers. Nearly 80% of Crisis Residential Programs charge a per diem rate of $350 or more, and about 30% charge $500 or more.

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The Benefits of Co-Located Services

Successful CRPs often benefit from a well-positioned location that is ideal for clients, referral sources, and other community partners. Care coordination is executed best when services are co-located in the same building or on the same campus as other health and human service programs. In Colorado, for example, many of the crisis walk-in centers, mobile crisis teams, and other crisis services are located in the same building, allowing people to transition easily from one level of care to another, and for minimal loss in sharing information between programs.



Why Crisis Programs are Created

In the business world, it is said that "necessity is the mother of invention." This phrase rings true in crisis services also, as individuals in crisis, their families and friends, and communities all saw a need for these services at some point. Through various ways described below, they became established parts of the community's service continuum.

Legislation/Community Mental Health Act

After President John F. Kennedy enacted the Community Mental Health Act in 1963, federal funding for community mental health centers and research facilities allowed community-based treatment to take shape in counties across the country, and Crisis Residential Programs soon emerged.

More recently, states like Colorado and California have passed legislation to expand crisis services and improve the efficacy and care coordination of such programs.

Community Need

Programs like CRPs are created because community providers identified an urgent need for mental health treatment in the community. For example, in 1978, The Progress Foundation, a nonprofit behavioral health provider, noticed that there was insufficient capacity at San Francisco General

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Hospital to treat individuals experiencing a psychiatric emergency[34]. The Progress Foundation developed La Posada, one of the first Crisis Residential Programs built in the United States.

State & Federal Mandates/Litigation

States like Arizona[35], New Hampshire[36], Delaware[37], and Georgia[38] have expanded their crisis services as a result of class-action lawsuits and investigations that were settled after years of litigation. Not all cases resulted in widespread changes to state mental health services; some shed light on the systemic and historical struggles of those living with mental illness.

1976 Brewster v. Dukakis (Massachusetts)

Those being treated in Northampton State Hospital alleged they were not being offered treatment in the least restrictive environment, were not provided proper medical attention, and did not have access to the services they needed. In response to the inadequacies, patients filed a class action lawsuit against the state of Massachusetts[39].

1999 Olmstead vs. LC Decision

Two women in the Georgia Regional Hospital at Atlanta accused the hospital (and eventually the State of Georgia) of institutionalizing them when they were deemed fit for community-based services. The United States Supreme Court ruled that the institutionalization of these women was a violation of the Fourteenth Amendment and that the ADA required these women to be treated in their communities.

This Supreme Court decision paved the way for future access and utilization of community-based services and the obligation to provide the correct level of care. [40,41]

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[34] Fields, S. (2014). Crisis Stabilization and Triage. https://www.youtube.com/watch?v=xl7Te2YISIo . Retrieved July 14, 2018.

[35] A class-action lawsuit, Arnold v. Sarn, was filed in 1981 against the State of Arizona alleging that the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS) and Maricopa County did not provide a comprehensive community mental health system as required by statute.
A. (2007, September 25). *Arizona State Senate Background Brief, Arnold v. Sarn* (Issue brief). From Arizona State Legislator website: https://www.azleg.gov/briefs/senate/arnold v. sarn.pdf

[36] *New Hampshire Ada Mental Health Settlement Fact Sheet* (No. 1:12-CV-53 (SM)). (n.d.). From: https://www.ada.gov/olmstead/documents/nh-fact-sheet.pdf

[37] United States v. Delaware, (No. 11-cv-591, D. Del., October 11, 2016), available as document no. PB-DE-0003, at http://clearinghouse.net

[38] The Department of Justice and the State of Georgia reached a settlement agreement in 2010 after agreeing on terms to improve the treatment of people in its mental health and developmental disability system. ADA Settlement Agreement. (2018, June 29). Retrieved August 13, 2018, from: https://dbhdd.georgia.gov/ada-settlement-agreement

[39] Brewster v. Dukakis, (No. 76-4423, D. Mass., December 15, 1976), available as document no. MH-MA-0001, at http://clearinghouse.net

[40] Olmstead v. L.C., (No. 98—536, 527 U.S. 581, 1999). Retrieved from: https://www.law.cornell.edu/supct/html/98-536.ZS.html

[41] *Olmstead v. L.C.* (Issue brief No. 98-536). (1999, March). Retrieved http://www.apa.org/about/offices/ogc/amicus/olmstead.aspx

2008 United States v. Delaware

In an investigation started by the U.S. Department of Justice, the Delaware Psychiatric Center (a state hospital) was under scrutiny for the violation of its patients. This case evolved to include a larger assessment of the state and its compliance to the Olmstead vs. LC Decision. In 2016 the case was dismissed because of adequate changes made to the states services and use of state hospitals[42].

Tragedy

Many of the greatest advances in crisis mental health services were born out of tragedy. Major Sam Cochran, the founder of Crisis Intervention Training (CIT), founded this approach after the shooting of an individual with a mental illness by the Memphis Police Department in 1987[43].

Two tragic shootings in Colorado in the 1990's and 2000's, the Columbine school shooting and the Aurora theater shooting, spurned legislation that added increased funding for behavioral health crisis services in the state. Following the Aurora theatre shooting, the state of Colorado released an RFP for a coordinated crisis system, including walk-in services, mobile crisis teams, crisis call centers, and Crisis Stabilization Units.

Staffing

Crisis Residential Programs are largely defined by the staff that make up the program. In some ways, they are a microcosm of a psychiatric hospital with medication prescribers, nurses, clinicians and care technicians. However, some key differences remain between the staffing of psychiatric hospitals and a typical CRP. First, staff ratios and the presence of clinicians and prescribers vary between psychiatric hospitals and CRPs. Second, an increased emphasis on paraprofessionals such as peer support specialists distinguish CRPs from psychiatric hospitals. With more staff to individuals served and the push for peer and paraprofessional presence, CRP clients have access to more resources and opportunities for rapport building.

The following positions exist in over 50% of the crisis programs surveyed:

- Prescribing Practitioner (97%)
- Direct Support Professionals (88%)
- Program Managers (80%)
- Nurses (73%)
- Clinician (66%)

Other notable positions include peer support specialists case managers, administrative assistants, LPNs, discharge planners, intake coordinators, and medical assistants.

Prescribing Physicians

Psychiatrists, nurse practitioners, and physician's assistants provide medical oversight and access to psychotropic medications for clients. Prescribing physicians typically see a new client within 48 hours of admission and make rounds at the program a few days a week or every day, depending on the

[42] United States v. Delaware, (No. 11-cv-591, D. Del., October 11, 2016), available as document no. PB-DE-0003, at http://clearinghouse.net

[43] Watson, A. C., & Fulambarker, A. J. (2012). The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners. *Best Practices in Mental Health*, *8*(2), 71.

frequency of new admissions. State policy frequently dictates the frequency of physician visits and the use of mid-level professionals as prescribers in crisis programs.

Some crisis programs use telemedicine because of the limited access to prescribers in their community. Some states are changing their Medicaid provider manual language to be more accommodating of telemedicine in behavioral health programs[44].

Clinicians

Clinicians (social workers, counselors, and psychologists) are a multi-faceted tool of the Crisis Residential Programs. Smaller crisis programs use clinicians in a dual role as a manager and social worker, overseeing the day-to-day operations as well as completing risk assessments and overseeing treatment interventions. Larger programs have a clinical team made up of a clinical supervisor and bachelor's- or master's-level case managers and therapists who complete initial assessments, facilitate treatment groups and family sessions, and link clients to community resources.

Nurses

Nurse provide a consistent medical support presence in CRPs. They may be responsible for an initial comprehensive assessment, overseeing the administration of medications, coordinating referrals and ongoing care with hospitals and outpatient clinics, and supporting the prescribing physicians during psychiatric evaluations and medication reviews. Some states require a nurse in the program 6-8 hours per day, while CRPs that also offer detox and substance abuse treatment may be required to have 24-hour nursing coverage.

Direct Support Professionals

Direct Support Professionals (DSPs) play a vital role in the Crisis Residential services continuum. Tasked with a broad range of responsibilities, DSPs must have a dynamic skill set that allows them to complete intakes and discharges, facilitate groups, de-escalate individuals in crisis, manage the milieu and dynamics between diverse clients, handle some operations tasks, pass medications, and provide therapeutic support through empathic listening. At times, all of these skills must be exercised within the same shift.

CRPs typically provide a comprehensive training ground for people to begin their mental health career. While a handful of people work their entire career as mental health professionals, most move on to other clinical and administrative positions within the behavioral health field.

[44] In 2018, Michigan made changes to its Medicaid provider manual to include language around the use of telemedicine.

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Program Spotlight
Fenton-McAuliffe House

While most crisis residential staffing patterns follow a typical schedule of three 8-hour shifts, one provider takes a profoundly different approach. At Fenton-McAuliffe House, a Crisis Residential program operated by Cornerstone Montgomery in Rockville, MD, direct care staff work 24-hour shifts! This approach allows staff to take an approach of "being with" their clients. This schedule provides flexibility for staff to get their preferred number of work hours into a very short period of time.

Peer Support Specialists

Peer Support Specialists are people with lived experience with a mental illness and/or substance use disorder. Peers play a vital role in any recovery-oriented treatment program, and especially in Crisis Residential Programs, as they can leverage their experience to help others navigate and manage their crisis. Some peer support specialists have previously received services in the Crisis Residential Program that they work in, and, after demonstrating a period of sustained recovery, are able to come back and help others in a paraprofessional treatment capacity. Some states require specific training and/or certification for peer support specialists before working in certain settings.

The origins of hiring program alumni trace back to two sources: Harry Stack Sullivan's hiring of former patients in his psychiatric hospital in the 1920's[45], and the hiring of staff at addiction recovery programs. Over the years, the pendulum of perception of quality treatment has gone back and forth from clinical expertise to lived experience. Many effective crisis programs have found a helpful balance of peer support and degreed clinicians to serve their clients.

Shared Staffing Arrangements

CRPs that are co-located with other services in the treatment continuum (such as walk-in centers or outpatient clinics) have the advantage of cross-training staff to work in multiple programs, utilizing them when the CRP receives a number of referrals in the same day or as additional support to help with a client's de-escalation. Having access to additional trained staff allows CRPs to



[45] Jacobs, S., & Steiner, J. L. (Eds.). (2016). *Yale Textbook of Public Psychiatry*. Oxford University Press.

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be more adaptable and responsive in meeting the needs of their clients and community partners.

In addition to the staffing benefits, co-located services also allow for "warm handoffs" between the programs if a client is referred from a walk-in center to a CRP, eliminating expensive and sometimes stigmatizing transport in an ambulance or police car.

Interns

Crisis Residential Programs can be an ideal center of learning and development for a clinical internship. Providing exposure to acute psychiatric treatment in a recovery-oriented, non-hospital setting, interns are exposed to critical aspects and challenges of the behavioral health care delivery system.

While some programs casually welcome interns and the addition of both the benefits and responsibility, other programs have become almost completely dependent on them, leveraging the energy, engagement, and optimism of students to fulfill critical roles in the service delivery system. Students who have completed their internship at the CRP can be highly sought after as potential employees because of their knowledge base, training, and exposure to the program.

91%

of CRPs have graduate interns

n=35

The most common types of internship students are Social Work (70%), Counseling (55%), and Psychology (48%), with Nursing (30%), Marriage and Family Therapy (27%), and Psychiatry (9%) being less prevalent.

Traits of Effective Crisis Residential Program Staff

Not all employees of Crisis Residential Programs need to have advanced degrees in a health profession to be effective. In fact, the majority of staff within a typical CRP are direct support professionals, most of whom have a bachelor's degree or a high school diploma. Soteria, one of the earliest developed and most well-known CRP, hired what they called "non-professional staff"—individuals without a clinical degree in psychology or similar field—to provide the majority of treatment within the program. Staff were chosen instead for their open minds and unique attributes that would make for meaningful contributions to the milieu, such as music, carpentry, and yoga. At Soteria, "staff were to relate to [individuals with schizophrenia] personally rather than through detachment. Soteria saw the individual experiencing a "schizophrenic" reaction as someone to *be with*—tolerated, interacted with, indeed appreciated[46]."

Today, effective CRPs employ staff who possess a diverse set of traits[47], including:



Empathy: the ability to relate to, or appreciate, another person's experience. While lived experience with mental illness is one gateway to empathy as exemplified by peer supports and by Peer Respite centers, helpful employees express genuine interest by asking questions to understand clients' experiences, as empathy requires curiosity.

[46] Mosher, L. R., Hendrix, V., & Fort, D. C. (2004). *Soteria: Through madness to deliverance*. Philadelphia, PA: Xlibris Corporation, p.12.

[47] While all of these traits are relevant to Direct Support Professionals and peer support specialists, most, if not all, are also important for other professionals within a CRP.

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Adaptability: Depending upon the size and resources of a CRP, employees may be asked to do a number of things within a shift, from consoling a client who is struggling, to passing medications and completing multiple intakes and discharges, to facilitating a group or cooking a meal. While clear role responsibilities are helpful, employees that can handle multiple responsibilities and unexpected changes often fare well within programs.



Poise and prioritizing under pressure: At times, CRPs appear to function like a psychiatric hospital, with fewer resources available. When several clients experience an increase in stress, anxiety, or other symptoms concurrently, staff must be able triage issues, make well-informed decisions, and remain present and helpful.



Open-mindedness (and tolerance for the unusual): Inevitably, staff will encounter clients with a different set of beliefs or values. Being open to new perspectives and the client's individual narrative paves the way for connection and healing. The ability to accept every person regardless of their symptoms, values, health conditions, cultural norms, and beliefs, while discerning between when to listen and when to challenge a perspective, is a coveted trait of a CRP employee.



Self-awareness: Even when operating well, CRPs are stressful, fast-paced environments full of people who are struggling with some type of mental illness or extreme emotional disturbance. Being aware of biases, triggers, and personal mental health state helps CRP staff to maintain effectiveness with clients and know when and how to engage in self-care. This can include seeking help via individual therapy and/or using supervision and peers to support and process effectively.

Hiring for Crisis Residential Program Staff

Because CRPs require staff with a multi-faceted skill set and the ability to manage a diverse set of tasks, hiring effective employees is one of the most important responsibilities of a CRP manager. Behavioral-based interviewing can increase efficiencies in the interview process for hiring managers. Based on the premise that past behavior is the best predictor of future behavior, behavioral-based interview questions focus on times when an interviewee has exhibited a behavior or skill (such as open-mindedness or self-awareness), and not on hypothetical scenarios of what someone *would* do in a certain situation. For example, a question about empathy might ask, "Tell me about a time when your ability to notice another person's feelings helped you to proactively address a situation."[48]

Infrastructure

Crisis Residential Programs vary greatly in the physical structure of their programs but share some common characteristics. CRPs must be accessible for people with varying physical abilities. Very few programs are multi-level or built above ground level. The layout of the CRPs must be conducive to easily

[48] For more behavioral based interview questions, read Victoria Hoevermeyer's *High-Impact Interview Questions: 701 Behavior-Based Questions to Find the Right Person for Every Job*.

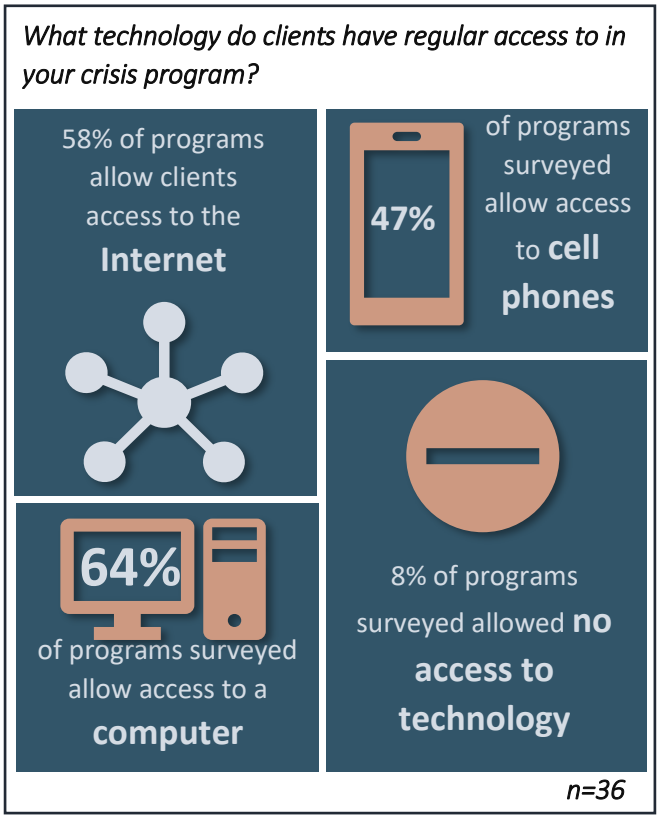
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and quickly monitoring all clients, so lines of sight are rarely obstructed. Most CRPs offer access to outdoor space for clients to relax, engage in physical activity, or smoke.

Staff at CRPs usually have one or two offices, although privacy can be at a premium in a busy program with several clients who need regular support. These offices often have computers, client belongings, and other private information, and some may also store medications. Clients and staff usually eat together in a common dining room, where staff are often cooking the meals in a residential kitchen for smaller CRPs or an industrial kitchen for larger CRPs.

Technology

Nonprofit behavioral healthcare providers are not typically known for their sleek technology outfitting. In fact, if you visited 10 crisis residential programs in the early 2010's, 8 of them would likely include staff still taking notes in a paper chart. Limited resources, organizational priorities, and limited impact are all reasons that technology has not advanced within CRPs at the same rate as in other services or industries.



Email Access

Based on the Technology survey results, CRP staff have business email addresses at the following frequency: managers/administrators: 100%; clinical professionals: 97%; Direct Support Professionals: 95%; administrative support: 92%; interns: 55%; and volunteers: 13%.

Technology in Treatment

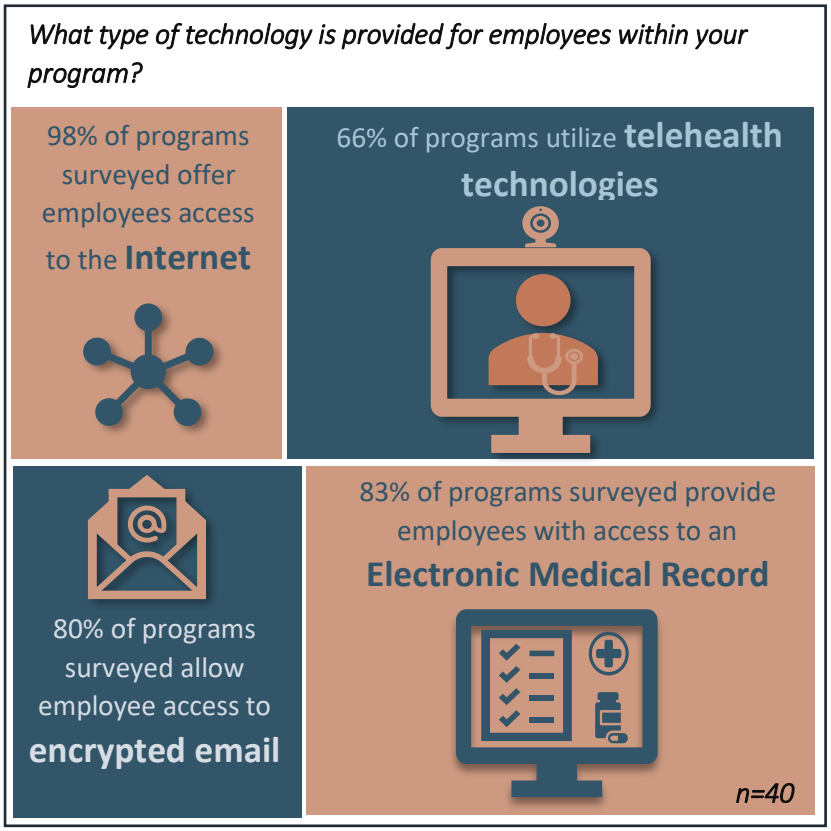
Adaptable Crisis Residential Programs have embraced technological advances by leveraging these resources to improve service delivery and quality. 58% of CRPs allow client access to the internet, and 64% allow client access to a computer. Proponents of clients' access to technology cite the importance of freedom and agency during their stay, while adversaries point to the distractions that technology can cause which inhibit treatment progress, including unmonitored access to people outside of the program.

Many CRPs have adapted with technology advancements out of necessity because of the national shortage of psychiatrists[49]. When alternative prescribers such as Nurse Practitioners and Physician's Assistants are not an option because of program requirements, CRPs often adapt through the use of telepsychiatry. 66% of surveyed programs use some type of telehealth technology, either exclusively or as a supplement for times when psychiatric coverage is difficult to maintain.

[49] See *Safety Net* footnote on page 50.

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Advances in computer accessibility and affordability have allowed CRP staff to have regular access to computers to access electronic medical records, email and other organizational communication, and to obtain information about community resources for clients. Secured laptops can be connected to mobile workstations, allowing staff to meet with clients in the living areas of the program, complete concurrent documentation, and spend time in the milieu.[50]



For CRPs that also manage other parts of the behavioral health treatment continuum, health management apps have blossomed to provide strong care coordination and symptom management for individuals to use post-discharge. By using their own smartphones to rate and describe their depression, anxiety, psychosis, or other symptoms, providers can dispatch care in the appropriate scope, amount, and duration to assure the individual receives the right care and subsequently avoids recidivism to a CRP or psychiatric hospital.

Referrals, Admissions, and Intake

54%

of programs interviewed use clinicians as primary staff to conduct intake assessments.

n=35

Referrals to Crisis Residential Programs typically occur in one of two ways: as a referral from a clinician authorized to place individuals in acute levels of psychiatric care, or as a stepdown from inpatient psychiatric hospitalization to reduce length of stay. Survey responses suggest that the credentials of the facilitator of the intake process vary greatly among CRPs nationally. Staff who complete admissions at crisis homes may include any combination of: Master's prepared clinicians, program managers, bachelor's level case managers, nurses, direct support professionals, dedicated admissions coordinators, and peer support specialists.

[50] One crisis program that uses mobile workstations learned about misunderstood acronyms the hard way. Referring to their workstations as "Computers on Wheels", or "COWs", they later changed the name to "Workstations on Wheels" or "WOWs", as a client heard staff referencing the former without context and took offense to it.

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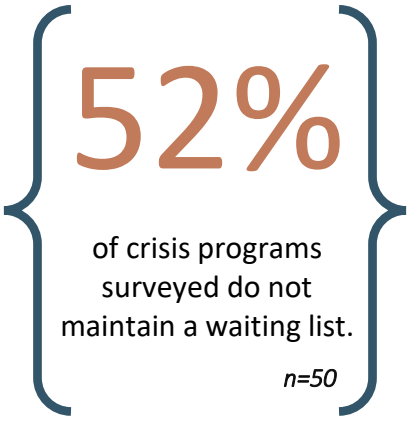
Several community providers can make referrals to CRPs, including:

- Case managers
- Outpatient therapists
- Psychiatrists
- Law enforcement
- Individuals (self-refer)
- Access center clinicians
- Psychiatric hospital staff
- Emergency Department staff
- Emergency dispatch/Crisis call centers
- Jail employees

Crisis Residential Programs generally require a prior authorization from the payer source before admission is approved. Initial authorizations typically cover 2-3 days of treatment, while some may cover 14 days or more. The expansion of managed care and the increased scrutiny on high-cost behavioral health treatment interventions has resulted in CRPs seeing initial authorizations and continuing stay authorizations decrease by 50% or more, in addition to shortened lengths of stay. This change has led to daily continuing stay reviews in some programs, increasing the amount of staff time needed to complete the reviews, shortening the client's stay, and increasing the number of admissions per year and their associated paperwork.

Over 60% of crisis programs surveyed do not track the length of time from referral to completion of the intake and admission to the program. 36% of those that track intake time report a total time of 1-2 hours to admit someone to their crisis home, while 26% reported taking 3+ hours to complete the admission.

More than half (52%) of crisis programs surveyed do not maintain a waiting list, meaning that when the program is full, referral sources must call back periodically until they reach the program at the right time when a bed has opened up. This may disincentivize referral sources from calling back when other levels of care, such as a psychiatric hospital, maintain a waiting list and a referring provider can stop calling around to programs once they have provided the basic information needed to place their client on the waitlist.



Some states are working to ensure timely access to crisis services through the use of a statewide crisis bed registry that includes psychiatric hospital beds, Crisis Residential Program beds, and other urgent treatment programs (e.g. substance abuse residential treatment). By maintaining an online census of current bed capacity, referral sources can more easily refer people to appropriate treatment without calling every provider to find an open bed. Sixteen states currently maintain an active psychiatric bed registry[51], and eight more are in the process of developing a bed registry. Only a handful of the functioning bed registries across the U.S. include Crisis Residential Programs. In Georgia, for example, the state maintains a statewide electronic bed registry with real-time census data for psychiatric hospitals, Crisis Stabilization Units (Georgia's version of locked CRPs), and residential substance abuse treatment programs.

[51] National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) (September 2017). *Psychiatric Bed Registries*. Retrieved from: https://www.nri-inc.org/media/1359/psychiatric-bed-registries-report-2017.pdf.

First Impressions

Staff who greet incoming clients or complete the in-person portions of the intake process at Crisis Residential Programs are most effective when they leverage their empathy for new admissions to make new clients feel welcome, comfortable, and cared for. Many providers offer some type of welcome bag that includes essential toiletries and supplies that a person who has been in crisis may not have access to or had the means to acquire. Some crisis programs maintain a clothing closet full of donated items, recognizing that their guests also frequently struggle with socioeconomic factors such as poverty and homelessness.

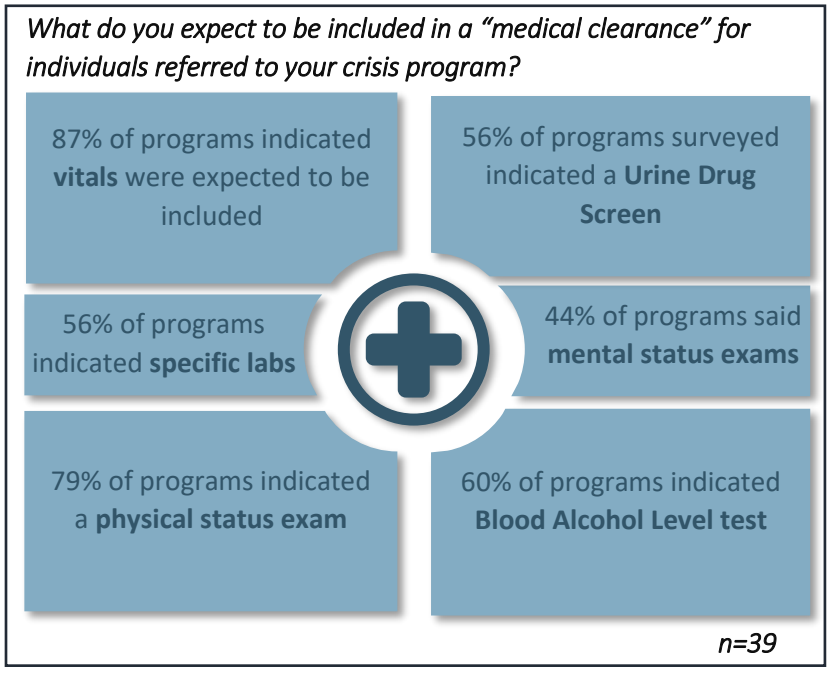
Program rules are typically reviewed during intake, and guests are provided a copy for reference. House rules are usually vetted by the community mental health center's recipient rights office to ensure clients are not restricted in movement or other freedoms. House rules are dynamic and can be modified based on trends in substance use, contraband, or visitors exploiting privileges extended to them.

Barriers to Prompt Referrals

Because most Crisis Residential Programs are unlocked and have fewer staff than psychiatric hospitals, a more stringent intake process is typically required to ensure safety and ability to provide treatment. This means the intake process can last up to twice as long as it takes to admit someone to a psychiatric hospital. Some CRPs report limiting the hours in which they can accept referrals due to staff capacity, and clinicians and medical staff may not be available to make admission decisions during evening, weekends, or holidays.

Medical Clearance

"Medical clearance" is an issue addressed by nearly all CRPs, but neither the definition of medical clearance, nor the requirements for medical clearance, are applied consistently across all CRPs or hospital emergency departments. The American Association of Emergency Psychiatrists published consensus recommendations for "medical clearance" in 2017. Those guidelines include the following language: "The term 'medical clearance' should not be used…as it is not in line with current ED terminology. … In place of a statement that the patient is "medically clear," a transfer note should accompany the patient indicating the patient is medically stable and



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appropriate for treatment in a psychiatric setting[52]."

However, based on reports from the workgroup, these recommendations have not as yet been widely and consistently implemented in actual practice settings. As Dr. Les Zun points out, the definition of medical clearance is rarely consistent between hospitals, psychiatric inpatient units, and CRPs: "The meaning may vary widely among clinicians and is often somewhat suggestive. There are no absolute definitions, and the term has a greater capacity to mislead than to inform; subsequent caregivers may erroneously believe a patient is indeed clear of all medical conditions[53]."

From the perspective of CRPs therefore, the intended purpose of "medical clearance" is not to affirm that a person has no medical issues, but instead confirm that a person has no acute medical conditions that require emergency medical intervention or a hospital level of medical care. Ideally, CRPs should be equipped to handle any client who is psychiatrically appropriate for CRU services, and either has no indication of an acute medical issue (and therefore does not need to be seen in an ED), or, if seen in an ED, has been medically evaluated and would have been sent home from the ED were it not for the psychiatric issue.

In practice, CRPs vary in both their ability to address medical issues (that is, the degree to which they have access to nursing or medical support around the clock, whether on site or by telephone) and in their stated protocols for whether and when "medical clearance" is required prior to admission. A small percentage of CRPs require medical clearance for all admissions, which carries the risk of being a barrier for both clients and referral sources. The medical director of a CRP typically requires medical clearance under specific conditions: if an individual has possibly overdosed, has evidence of alcohol or drug intoxication that compromises the ability to engage in treatment, has indication of significant withdrawal risk that may require medically managed detoxification[54], or presents with an acute or complex medical condition that may be exacerbated beyond a level manageable by CRP staff. (Discussion of CRP capabilities to manage intoxication and withdrawal will be discussed in the next section).

As part of its community relations and communication plans, CRPs often develop procedures to educate referral sources about when medical clearance is, and is not, needed. CRPs have to strike a balance between appropriately screening out individuals who may first require medical evaluation (e.g. someone who has overdosed) and promoting easy access for individuals who are in crisis and their referring clinicians. Requiring an otherwise medically healthy individual who requests admission to a CRP because of suicidal ideation to go to an ED for "medical clearance" may represent a significant barrier to care.

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[52]Wilson, M. P., Nordstrom, K., Anderson, E. L., Ng, A. T., Zun, L. S., Peltzer-Jones, J. M., & Allen, M. H. (2017). American Association for Emergency Psychiatry Task Force on medical clearance of adult psychiatric patients. Part II: controversies over medical assessment, and consensus recommendations. *Western Journal of Emergency Medicine*, *18*(4), 640.

[53]Reeves, R. R., Perry, C. L., & Burke, R. S. (2010). What does "medical clearance" for psychiatry really mean?. *Journal of psychosocial nursing and mental health services*, *48*(8), 2-4.

[54] This is true in nearly every CRP except for those that have 24-hour nursing staff available to monitor for symptoms of withdrawal.

Because CRPs typically do not have the resources to complete screenings and blood tests needed to complete medical clearance, they are often overlooked by referral sources that believe a high level of medical stability and accompanying medical clearance are required for a person to be admitted to a CRP. This may result in underutilization of CRP services, and potential overuse of psychiatric hospitalization. Some states are working towards developing a common definition for medical clearance that would create a common language for EDs, crisis teams, CRPs and inpatient psychiatric units[55].

Co-Occurring Treatment Capabilities

For individuals who present in mental health crisis, co-occurring substance use is very common, and may often contribute to the crisis itself. While there is no consistent data on how this impacts CRPs, in one Midwest CRP that purposely welcomed and identified individuals with co-occurring SUD. Further, nearly 50% of the individuals admitted struggled with a substance use disorder[56]. 40% of all Americans with a substance use disorder have a mental illness[57] and many of those may present in a crisis with both active mental health symptoms (e.g., suicidal ideation) as well as active substance use.

31%

of facilities interviewed conduct screenings for co-occurring disorders.

n=52

The ideal design of a CRP assumes that co-occurring mental health and substance use disorders will be prevalent in the population they serve, and consequently reflects in its design the ability to be "co-occurring capable". This means that CRPs which organize policy, procedure, practice, and staff competencies with this assumption will more effectively support and provide integrated assistance for both MH and SUD issues to individuals in MH crisis[58].

Managing Intoxication and Withdrawal

Because of the high prevalence of co-occurring substance use of all types in individuals who may present in MH crisis, the most effective CRPs ideally are equipped to welcome individuals who may be actively using substances, including those who may be intoxicated. CRPs are most successful when recognizing that individuals who are using substances can be helped effectively with a kind and respectful approach that allows them to engage safely in the CRP. It is important for CRPs to have a formal process for assessing the risk of withdrawal – and the severity of that risk – by assessing withdrawal history and by using formal tools to measure withdrawal symptoms such as the Clinical Institute Withdrawal

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[55] In 2017, The Michigan Department of Health and Human Services established an initiative called the Michigan Inpatient Psychiatric Admissions Discussion Workgroup (MIPAD) to address systemic challenges in access to crisis services and quality care for individuals in a psychiatric crisis. The full workgroup report can be accessed at https://www.michigan.gov/documents/mdhhs/MIPAD_WorkgroupReport_613570_7.pdf.

[56] While much of this information is shared anecdotally, a large Midwest provider shared that of the 1,800+ admissions they received in FY2017, 47% had co-occurring mental health and substance use disorders.

[57] Of the 20.2 million adults with a substance use disorder in the United states, 7.9 million people had both a mental illness and a substance use disorder. Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from: http://www.samhsa.gov/data/

[58] Minkoff, K., & Cline, C. A. (2005). Developing welcoming systems for individuals with co-occurring disorders: The role of the comprehensive continuous integrated system of care model. *Journal of Dual Diagnosis*, *1*(1), 65-89.

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Assessment (CIWA) or Clinical Opiate Withdrawal Scale (COWS). These can be used by the referring ED, as well as by the CRP to assess and manage alcohol and opiate withdrawal.

To adequately meet the needs of this large portion of their population, CRPs should be capable of managing mild-to-moderate withdrawal symptoms, with consultation available after scheduled clinical shifts from an on-call psychiatrist or nurse.

Many CRP providers use simple detox protocols for people who are identified as at risk and use the same mechanisms as they might use for providing psychiatric medication as needed to assist individuals who have uncomplicated withdrawal.

Approaches to Addressing Co-Occurring Mental Health and Substance Use Disorders

Dr. Ken Minkhoff, a psychiatrist and nationally recognized co-occurring systems consultant, recommends the following interventions to address co-occurring substance use disorders within a mental health Crisis Residential Program. Note that none of these interventions require SUD licensing or funding.

- Reinforcement of **hopeful**, **recovery goals**
- **Routine screening** for Substance Use Disorder
- Identification of the **severity** of Substance Use Disorder
- Identification of the individual's **stage of change** for Substance Use Disorders
- Identification of the individual's **strengths and skills** for managing substance use without getting into trouble
- Incorporation of **strength-based, stage-matched interventions** for SUD into individual crisis intervention and/or group programming
- Providing **basic teaching** on how to **avoid use** or **ask for help** in specific circumstances that may prevent crisis
- **Linking** the individual to ongoing service providers that can help address the co-occurring issues in a way that is matched to the individual's **needs**, **hopes**, and preferences

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Adaptable CRPs that can engage and treat an individual's dynamic needs (who is intoxicated but not at risk of withdrawal, or under the influence of substances but not at risk of overdose) make the biggest impact on their communities, finding effective ways to respond to the challenges of individuals in crisis.

Developing Co-Occurring Capabilities in CRPs

Some CRPs are working towards functioning as both mental health and substance abuse CRPs, allowing them to admit individuals with SUD crises alone, in addition to those with MH crises who have co-occurring SUD. Some states already have dynamic CRPs that provide both services, while other states are working towards developing this capacity. In Virginia and North Carolina, CRPs (referred to as Crisis Stabilization Units) can provide mental health treatment, substance abuse treatment, or both. In Michigan, CRP providers and TBD Solutions have advocated for legislative changes to allow CRPs (called Crisis Residential Units in MI) to carry a dual license as a mental health and substance abuse treatment provider. Another option is for states to create a regulatory structure (licensing, certification, and reimbursement) in which CRUs can address both MH and SUD crises within a single designation, just as is the case for other components of the emergency services system.

Outdated Health Care Policies

Many states have longstanding policies meant to keep individuals safe in times of emergency, but they often end up adding another expensive and unnecessary layer to emergency psychiatric treatment. For example, in Michigan, if a person is transported by an ambulance, the law requires that they only be dropped off at an Emergency Department or approved receiving hospital[59]. This disincentivizes individuals being referred to go to a Crisis Residential facility when they are transferred to multiple locations before they can be admitted.

Some Crisis Residential and 23-hour Crisis Stabilization Units allow for police and ambulance drop-off directly to their facility[60,61], with special entrances created so that coordination between law enforcement and crisis staff is efficient, police do not need to remove their weapons or spend unnecessary time onsite, and triage can happen quickly in a designated environment.

Alternative or Additional Functions Beyond Mental Health Crisis Stabilization

The most common way that CRPs are asked to extend outside of their treatment scope is through emergency or temporary housing, as many individuals in crisis also experience unstable living conditions. Community Mental Health Centers or payers trying to place an individual without housing options often look to CRPs as a temporary shelter. Some referral sources will creatively try to find criteria for at least an initial authorization; others spend no time trying to mask the reality of their situation. These instances of emergent housing needs can sometimes last for months until a placement is found. Meanwhile, the individual who is not in crisis occupies a bed that could be utilized by someone in the crisis; in addition, these people often disrupt the milieu and its consistency in treatment focus.

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[59] Michigan Public Health Code, Regulation R325.22122. Retrieved From: https://www.michigan.gov/documents/FINAL_2001-015__EMS_95428_7.pdf

[60] Ducet, R., & Cornelia, F. (2017). *Senate Bill 17-207 Rollout Update*. Accessed August 1, 2018 from: https://leg.colorado.gov/sites/default/files/chbc-12-05-17.pdf.

[61] Cenpatico Integrated Care (2015). *Cenpatico Crisis Protocols with Law Enforcement Agencies in Pima County*.

Providers that receive authorizations for services based on Severity of Illness Criteria are left in a compromised state. If it is discovered that a program was paid for services provided to an individual who did not meet medical criteria, who is held accountable? The provider or the referral source?

Other functions that crisis homes are asked to extend themselves for include transportation and medical monitoring and treatment.

When Adjusting Criteria Threatens Sustainability

When crisis programs are not consistent in adhering to admission criteria that meet their funder's definition for medical necessity, their financial integrity comes into question.

61% of surveyed programs stated they experience instances where they are asked to compromise the integrity of the program or its guidelines by accepting people who don't meet medical criteria for admission.

These include individuals without stable housing, individuals who need a higher or more intensive level of care because of violence or medical monitoring, those who refuse participation, and individuals who need medical detox due to substance abuse without a diagnosed mental illness.

Discharge

For some individuals in Crisis Residential treatment, discharging from the program is a welcome idea, a natural culmination of their progress during their time in treatment. For others, discharge is a harrowing thought that signifies a return to an unstable living environment or uncertain implications on employment, access to treatment, or relationships with loved ones. However, when crisis residential providers deliver quality services that emphasize linkage to resources and care coordination, many of these fears can be assuaged.

As funders of Crisis Residential Programs, Community Mental Health agencies and managed care organizations usually maintain requirements around scheduling follow-up appointments for therapy and psychiatry appointments[62]. Therapy appointments must typically be scheduled within 7 days of discharge, and psychiatry appointments must be scheduled within 30 days of discharge. Finding practitioners of either type who accept Medicaid can make those timelines very challenging.

Over 80% of the survey respondents stated that discharge planning is initiated during the intake process. These practices reinforce the idea of a short, deliberate, treatment-focused experience. At this time, natural supports are identified, and stable discharge placement is verified, or the CRP team members can begin partnering with the client if there are foreseeable barriers to discharge.

Some crisis programs will not admit an individual for referral who does not have stable housing to return to upon discharge, mainly because the risk for boarding a person who is homeless increases once their crisis has been resolved.

CRPs vary significantly in their approach to providing medication supplies at discharge. Some prescribers will approve for clients to receive a 3-day supply of medications, and a prescription is written for enough

[62] National Quality Forum (NQF) Measure #0576 is "Follow-Up after hospitalization for Mental Illness (FUH)." https://cmit.cms.gov/CMIT_public/ReportMeasure?measureId=745

medication for the client to have adequate coverage until their scheduled follow-up appointment with a psychiatrist. Because many crisis providers serve people with no insurance and limited access to resources (although Medicaid expansion has helped in some states), finding the financial resources to even cover the cost of the new medications can be a challenge, and medication assistance programs have become more difficult to access.

CRPs that operate on a tight budget within a fee-for-service arrangement rely on efficient admission and discharge processes that capitalizes on opportunities to keep beds full. There are times when discharge times can be uncertain and dependent on a client's ability to obtain a ride or find alternative transportation. To this end, CRPs stand to benefit from maintaining a "check-out time" policy similar to a hotel so that they have adequate time to clean the room and prepare for the next referral. Even contributing to transportation solutions in the form of bus fare or cab fare could mean the difference between having a full census and having 1 or 2 beds consistently open while waiting referral sources seek placement at other programs and hospitals.

Outreach/Follow-Up

Crisis providers exist within a unique sphere of the behavioral health care services continuum: they encounter individuals who are in a crisis, usually with no prior exposure, and, after helping them to stabilize, they discharge their clients, sometimes never seeing them again or knowing if the provided treatment was effective and promoted their recovery journey. While staff may wonder about a former client's wellbeing, they have not traditionally been incentivized to be invested in their continued care coordination, as the people currently in their program demand their attention and dictate how they are reimbursed.

33%

of facilities interviewed conduct follow-up phone calls after discharge.

n=52

Program Spotlight
The Harris Center

In Houston, Texas, The Harris Center operates several crisis programs, including: a **Psychiatric Emergency Service** (PES) that admits both voluntary and involuntary patients; a voluntary **Crisis Stabilization Unit** (CSU) which provides 3 – 5 days of care for medication stabilization; a **Crisis Residential Unit** (CRU) which is a 10 – 14 day psychosocial rehabilitation program; a **Post-Hospital Crisis Residential Unit** (PHCRU), an 18 – 21 day psychosocial rehabilitation program; a **Crisis Respite** program (up to 30 days of respite service) and a 5 – 7 day, **Peer Respite** program. At both the CRU and the PHCRU, individuals who successfully complete the programs and some additional requirements are welcomed back as alumni who can attend group, receive informal case-management services, receive meals, shower and spend holidays with their families of choice. Some Thanksgiving meals have attracted as many as 120 alumni, providing a critical social support for individuals with mental illness.

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Behavioral health providers that operate multiple programs within the service continuum are more likely to have natural follow-up opportunities with former clients of the CRPs. For example, if a behavioral health organization provides case management services, crisis residential services, and outpatient therapy services, then they will have much more knowledge and control over supports and treatment than an organization that only provides crisis residential services.

Some programs have engaged in unfunded follow-up calls with past clients because of their commitment to their clients' wellness, having case managers or peer support specialists engage within a few weeks of discharge to assure they made it to their scheduled appointments and assess the symptoms addressed while in treatment. One study around outreach through the use of postcards for individuals who were suicidal highlights the impact of follow-up care on connectedness and future



Starting a Postcard Outreach at your Crisis Program

Postcards are a simple, cost-effective way for crisis programs to follow-up with former clients to express interest and empathy towards their recovery. To start a postcard outreach initiative at your crisis program, you will need generic postcards, stamps, and access to client's addresses. Here are some considerations when starting a postcard initiative:

1. Choose postcards that have an encouraging picture or message on the front, or at least are not stigmatizing if someone else were to read them (for example, "Hope You're Feeling Better" might appear sincere but come across patronizing, or it might initiate an unwanted conversation between the former client and their family. Be cautious before purchasing postcards that have a giant logo of your organization, or your crisis homes' name in big print. Tourist postcards from your own state often are aesthetically pleasing and neutral in messaging.
2. Buy enough postcards and stamps for 3-6 months of discharges from your program and assign a person to manage the supplies.
3. Include a handwritten note in the message area of the card and have the postcards available for staff to sign over a 24-hour period. Make sure the message is personal enough that they feel cared for, but not so specific as to compromise the confidentiality of their treatment.
4. Establish the postcards into the workflow. For example, if you know a person is discharging, ask 3rd shift to initiate the postcard process by attaching it to the discharge paperwork so employees know to sign it.
5. Ask for consent from the client if it is ok to send a follow-up note to their address and verify their address.
6. Check with your program director or Compliance Officer to assure that your actions are not violating any HIPAA or organizational policies.

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suicide attempts[63]. Crisis Residential programs and psychiatric hospitals in Michigan have experimented with using postcards as non-invasive ways to demonstrate sincere concern for former clients' well-being.

Funding

Crisis Residential Programs require a sustainable (and sometimes diversified) funding stream to maintain operations and consistently meet the needs of its community members. Since most Crisis programs find their origins in their county's community mental health system, the vast majority (over 75%) of the surveyed programs are funded by Medicaid. This funding can originate from a fee-for-service arrangement where programs are reimbursed in a bundled per diem rate, or as part of a block grant with dollars allocated annually or monthly to cover program costs, regardless of occupancy.

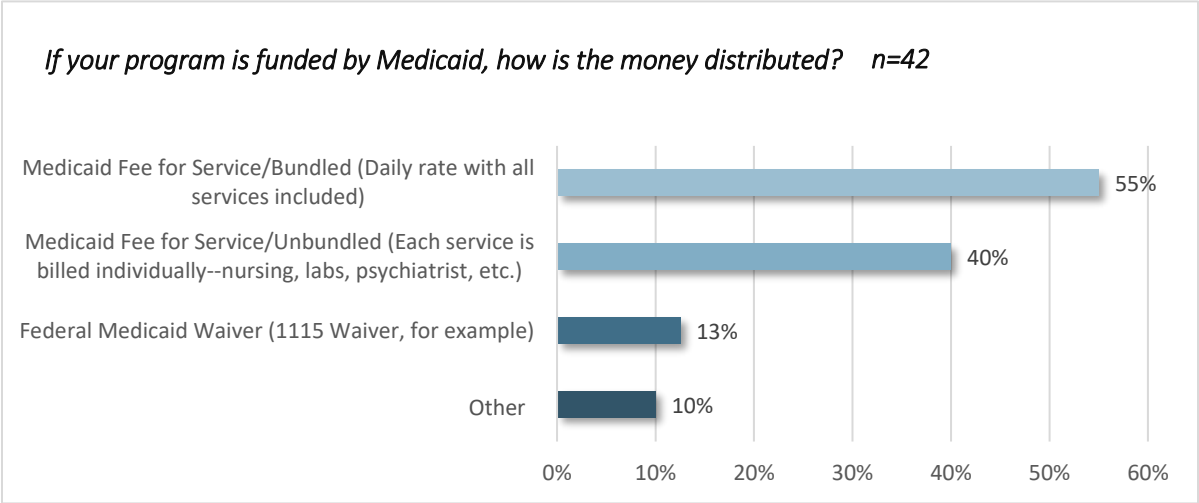
Many programs receive funding for individuals without insurance (sometimes called the indigent population) through state general funds, but states with Medicaid expansion saw their general funds diminish significantly. This transition reduced their ability to cover uninsured individuals, although fewer individuals were uninsured following Medicaid expansion.

Diversifying Funding

Crisis programs that have historically suffered from under-funded services have two choices: continue to bargain and barter with their current funders for rate increases/cost settling to survive another year or seek new revenue sources that will make the

COMMERCIAL HEALTH PLANS IN ACTION

In 2016, Anthem Blue Cross Blue Shield began a pilot project with a Crisis Stabilization Unit (CSU) in Virginia to use the CSU as an alternative to hospitalization. After 12 months, Anthem BCBS, pleased with the results, set out to enter into contracts with any willing CSU in Virginia that was properly certified by the state. In 2018, Anthem BCBS then branched out to other Crisis Residential providers in the 12 states in which they have a commercial insurance presence to explore opportunities to contract with other certified CRPs.



[63] Motto, J. A., & Bostrom, A. G. (2001). A randomized controlled trial of postcrisis suicide prevention. *Psychiatric Services*, *52*(6), 828-833.

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programs less reliant on the primary funder for sustainability. 42% of survey respondents reported contracting with private health insurance plans (besides Medicaid Managed Care organizations). While many providers a diversified funding stream, 49% reported that their funding sources have not changed significantly in the recent past.

Commercial Health Plans

More crisis programs have begun contracting with commercial health insurance plans, who see the value of serving individuals in crisis in an environment that boasts similar clinical outcomes at a substantially reduced rate compared to psychiatric hospitalization. 42% of surveyed crisis programs reported contracting with commercial health insurance plans, and 16% reported their relationship with a commercial health plan was new in the last 18 months.

Legislation

Between 2010 and 2016, legislation passed in California and Colorado increased the scope and number of crisis services and incentivized communities to build or expand their crisis services, providing support through start-up costs to build new CRPs and other programs.

Adding Referral Sources

States that once had a regionalized, non-competitive behavioral health structure are becoming more homogenous, paving the way for providers to reach beyond previously held regional borders to contract with other payers. As the regional community mental health entities are required to contract for certain core services, Crisis Residential providers are further incentivized to contract with payers outside of their county. One Crisis Residential program in Michigan increased its contracted Community Mental Health Centers (CMHCs) from 4 CMHCs to 14 CMHCs within the course of three years due to this regionalization trend.

Cost Settling

When Crisis Residential programs are contracted in a fee-for-service arrangement, and various factors contribute to a reduced number of referrals over the course of the year, some programs may go to their funders to discuss a cost-settling arrangement in which the provider can recoup some of their lost revenue from the previous year to keep their program operational. However, this is not an option for most providers in the workgroup, as 80% of survey respondents said they are not privy to a cost-settling arrangement with their funders.

Variable Rate Structure

Some CRPs have moved to a variable rate structure, where rates are determined by occupancy to ensure that, even at low-census intervals, CRPs can maintain the revenue needed to basic operations of the program. For example, a six-bed CRP might charge $600 per day per person when 1-3 beds are full, but the rate would change to $500 per day when more than 3 beds are full. This arrangement works best when one payer is responsible for a majority of the referrals.

Future innovative funding partnerships may include value-based purchasing arrangements where providers bear additional risk as part of their contract in the form of sustainable client progress after discharge. Providers may also be incentivized and receive financial rewards for reporting on key performance indicators, or for making and/or sustaining improvements in processes and outcomes.

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Crisis providers will increasingly be seen as a critical part of the care continuum and will be contractually and financially incentivized for their contributions to achieving the triple aim.

Tips for Diversifying Funding Sources

Whether you're looking to diversify your funding streams through commercial health plans, the Veterans Administration, or grant funding, consider beginning by building a strong portfolio of key performance indicators, using metrics like the ones listed here:

- Average Length of Stay
- Volume of admissions
- Projected cost savings compared to other parts of the crisis system
- Number of diversions from ER
- Number of diversions from Psychiatric Hospital
- Recidivism rate (% of discharges where the client returns to psychiatric hospital and/or crisis stabilization within 30 days)
- Client Satisfaction Scores
- Most common diagnoses at admission/treated
- Desired daily rate
- Symptom Reduction (Pre/Post)

Regulations and Governance

Since their inception in the community mental health services continuum, Crisis Residential Programs have been under the purview of various regulatory agencies at the city, county, state, and federal levels. While regulatory and governance structures intend to assure quality service provision through program compliance, their statutes can sometimes conflict with other local regulations, or impede a provider's

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ability to meet a client's needs or innovate to meet the evolving needs of its community. For example, if a client is homeless and needs to visit their local DHS office in order to reinstate their benefits or get the cash assistance they need to put down a security deposit for an apartment, yet the funder considers any departure from the treatment facility as grounds for immediate discharge, the client is not able to get their needs met, and may remain in the CRP when a few accommodations would have assisted them in moving closer to discharge.

Licensing

Many CRPs fall under the residential licensing requirements within a state, even though it serves as a temporary residence for clients during their crisis stabilization. Licensing rules dictate many aspects of the program's infrastructure such as the presence of staff 24 hours per day, home furnishings, medication storage and handling, staff credentials, and safety protocols.

Medicaid Provider Manual

CRPs that qualify as a Medicaid-billable services are bound to the treatment components and credentialing requirements in the state's Medicaid provider manual. Adherence to these guidelines allows a provider to bill Medicaid for reimbursement using a pre-approved billing code.

State Health & Human Services Contracts

CRPs contracting directly with their state health & human services division and not billing Medicaid are beholden to whatever their contract stipulates. Fulfillment of contract requirements can be provided directly by a division of the health and human services department or subcontracted to a managed care organization or regional community mental health administration.

Accreditation Bodies

Nearly 40% of surveyed crisis programs are not accredited by an outside entity. 35% are accredited through the Commission on Accreditation of Residential Facilities (CARF), which classifies programs as Crisis Stabilization facilities. Others are accredited by the Joint Commission (13%, classified as Crisis Stabilization), the Council on Accreditation (5%, classified as Crisis Response & Information Services), and the American Association of Suicidology (2%). It is unclear why more programs are not accredited, although it may be because it is not a requirement for funding or state certification.

Inconsistencies in Regulations

Nearly one third of survey respondents reported inconsistencies in audits or site reviews between the same entity, or discrepancies between different entities. For example, in Colorado, the state licensors recommend a "hard" lock on the facility, while the local fire department would not approve a locked facility, so the program applied for special waiver to have a 30-second egress lock system. In another program, the CARF requirements for crisis stabilization facilities contract the County's contract requirements.

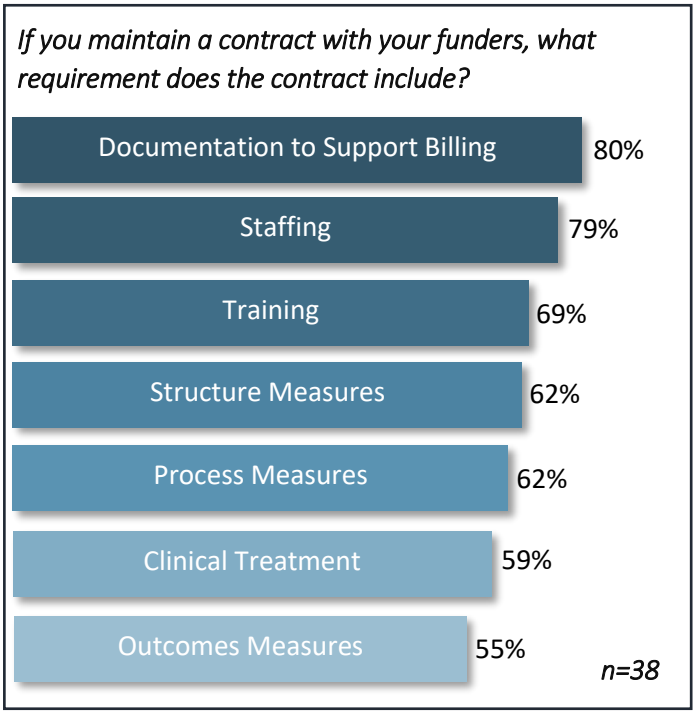
As one CRP leader described, "[Our accreditation auditors] are wildly unpredictable to the point that it is sometimes difficult to recognize the standards at all."

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Federal Regulations

The Medicaid Institutions for Mental Disease (IMD) exclusion prohibits the use of federal Medicaid financing for care provided to patients in mental health and substance abuse treatment facilities larger than 16 beds. For this reason, most crisis residential programs are not larger than 16 beds[64].

While Medicare does not currently pay for crisis residential services, this should be considered a substantial opportunity for CRPs to effectively serve more people.



Contract Requirements

Most providers have a primary county-based funder that determines contract requirements. Traditionally, these requirements have maintained a compliance focus to meet the minimum requirements of treatment, whether in staff make-up, training, documentation, or procedures. Contracts are now beginning to include more outcomes-driven metrics in a value-based purchasing arrangement, so funders are more able to see if the services led to positive outcomes, and paying providers accordingly based on their effectiveness.

When providers are not able to maintain their contract requirements, they can lose their allocated funding, be asked to return payments if funding was already appropriated, be placed on a corrective action plan, or, in the worst cases, lose their contract or see it publicly re-procured.

Smoking

Many clients at CRPs smoke cigarettes or use other forms of tobacco inhalation, and 69% of survey respondents allow smoking in their program (n=54). In 2013, the Centers for Disease Control and Prevention reported that 37% of adults with any mental illness reported current use of tobacco, a prevalence rate nearly 50% higher than the general population[65]. In the 20th century, tobacco companies and psychiatric treatment facilities maintained a relationship that sparked curiosity as to its

[64] Center for Medicare and Medicaid Services (n.d.). Medicaid Emergency Psychiatric Demonstration Frequently Asked Questions. Retrieved July 14, 2018, from https://innovation.cms.gov/initiatives/Medicaid-Emergency-Psychiatric-Demo/faq.html

[65] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Mental Health Detailed Tables.* Retrieved August 5, 2018, from https://www.samhsa.gov/data/sites/default/files/2013MHDetTabs/NSDUH-MHDetTabs2013.pdf

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propriety, partly because of tobacco companies' invested interest in extoling the virtues of smoking on reduced or diminished symptoms of mental illness[66], although recent evidence suggest otherwise[67].

> *"Documents indicate the tobacco industry monitored or directly funded research supporting the idea that individuals with schizophrenia were less susceptible to the harms of tobacco and that they needed tobacco as self-medication. The tobacco industry promoted smoking in psychiatric settings by providing cigarettes and supporting efforts to block hospital smoking bans[68]."*

Psychiatric hospitals often requested free cigarettes from psychiatric hospitals to hand out to long-term patients[69]. These historical dynamics have had a substantial impact on CRPs, as the policies and treatment professionals that grew out of this time affected practice and philosophy of mental health treatment in other areas of the behavioral health crisis continuum.

Smoking policies at Crisis Residential programs are informed by organizational policies, state licensing and certification regulations, and client agitation in response to nicotine withdrawal symptoms. As one of the most polarizing discussion items of the Crisis Best Practices Workgroup, smoking policies are also informed by beliefs around informed choice, short-term treatment, and secondary health effects.

Programs in favor of allowing individuals to smoke while at their facility cite the inherent crisis that brought the client to the program as enough of a challenge to face without adding another stressor. One CRP reported that allowing clients to manage their own cigarettes has actually decreased instances of self-harm and aggression while increasing treatment engagement. Proponents of smoking within a CRP also acknowledge that time at the crisis program is short, and it is ambitious to expect people to sustain any changes to nicotine use after they discharge. Some have found that the amount of resistance experienced by people upset by the loss of smoking privileges has impacted engagement in treatment, and some individuals have refused to be admitted to the crisis program when learning about their smoking policy. Even when clients have access to nicotine replacement therapy and resources for quitting, many prefer to make the decision to quit on their own terms.

68%

of surveyed programs said they would lose funding or have to return payments to funder if performance metrics were not met.

n=34

Individuals who advocate against smoking in their programs point out the philosophy of health and wellness as a holistic concept to be carried out in all aspects of treatment. They also state that nicotine replacement therapy, such as nicotine patches, is readily available to combat the effects of nicotine withdrawal, and the best time to make substantial changes in your life is when other changes are being initiated ("*You're deciding to make your mental health a priority; why not*

[66] Prochaska, J. J., Hall, S. M., & Bero, L. A. (2007). Tobacco use among individuals with schizophrenia: what role has the tobacco industry played?. *Schizophrenia bulletin*, *34*(3), 555-567. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2632440/

[67] Taylor, G., McNeill, A., Girling, A., Farley, A., Lindson-Hawley, N., & Aveyard, P. (2014). Change in mental health after smoking cessation: systematic review and meta-analysis. *Bmj*, *348*, g1151.

[68] Prochaska, Ibid.

[69] Letter to R.J. Reynolds Tobacco Company from Department of Health, Education & Welfare of the National Institute of Mental Health. August 1980. RJ Reynolds Records. Unknown. https://www.industrydocumentslibrary.ucsf.edu/tobacco/docs/#id=qxxw0083

do the same with your physical health?"). The burden on staff is considerable, as direct support professionals tend to manage the cigarettes and spend considerable time each hour passing out and lighting cigarettes. This time-consuming process can also affect treatment engagement.

Transitioning to a Smoke-Free Facility

As the cost of tobacco continues to rise, and smoking falls further out of favor, more crisis programs may decide to become smoke-free facilities. Transitioning to a smoke-free environment should be done deliberately and carefully, engaging stakeholders in discussions and decision-making whenever possible. The Substance Abuse and Mental Health Services Administration (SAMHSA) has even released a best practices toolkit for tobacco-free living in psychiatric settings, authored by the National Association of State Mental Health Program Directors (NASMHPD)[70].



"We formed a staff workgroup and spent 9 months completing a program assessment to determine if we should ban smoking from our campus. We involved program staff at all levels, as well as current and past residents, and our funder. We contracted with a consultant who specializes in transitions to a smoke-free workplace. After weighing the pros and cons, we ultimately determined that it was best to become a smoke-free campus, for both residents and staff. We set the transition date and notified residents, staff, and referral sources. Within three months, a number of residents complained, and our leadership team decided to reverse the smoking ban."

–Michigan Crisis Residential Provider

"Each of the [crisis] units is different. The state has tried to make all the units non- smoking; however, this has been difficult within some units. Each of the units sets their own policies for smoking."



-Virginia Crisis Residential Programs



"Our community mental health clinics are tobacco-free campuses. As they operate these facilities, smoking is not permitted on the premises. However, for many of these facilities, there is an area away from the unit designated for smoking."

-Texas Crisis Programs

[70] Robbins, D. (2007). Tobacco-free living in psychiatric settings: a best practices toolkit promoting wellness and recovery. *Alexandria, Va: National Association of State Mental Health Program Directors*.

Metrics and Outcomes

Behavioral health crisis service providers (psychiatric hospitals, Crisis Residential Programs, 23-hour Crisis Stabilization Units, etc.) face a daunting challenge in embracing a measurement-based care philosophy: while they provide high-cost services to people with some of the most intense psychiatric symptoms, they can be hesitant to take ownership of long-term outcomes because of their limited scope of treatment within the service continuum.

87%

of surveyed programs said they provide clients with an opportunity to provide feedback about their level of satisfaction in the CRP.

n=52

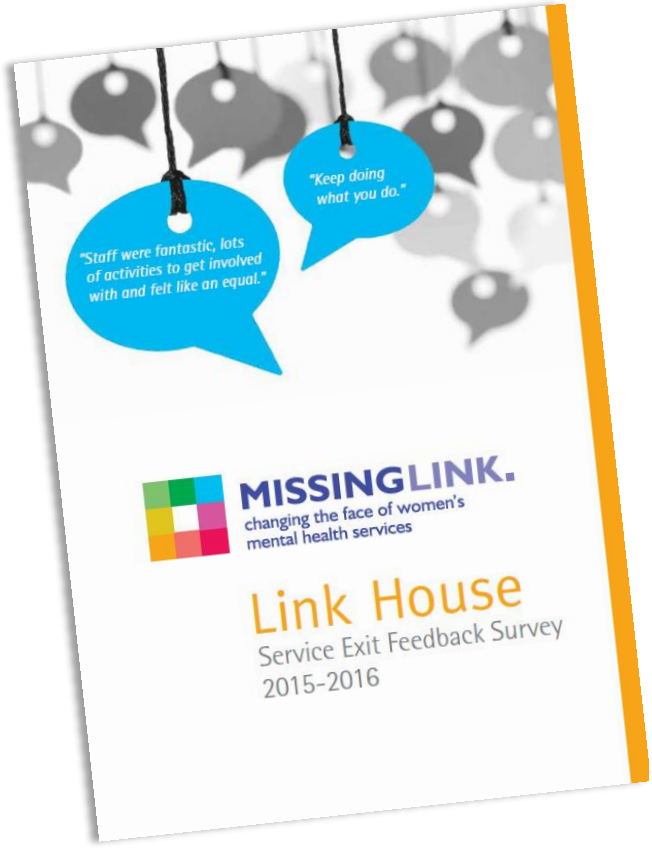
While most Crisis Residential services exist within a Fee for Service arrangement, more and more funders are moving to a value-based purchasing arrangement in which providers are held accountable for outcomes like customer satisfaction and recidivism.

87% of survey respondents stated that clients receive a written survey to measure client satisfaction, and 36% provide clients with an opportunity to provide oral feedback. Less than 2% of Crisis Residential program surveyed do not collect feedback.

Nearly 70% of respondents stated that client satisfaction is measured with structured manual data, likely meaning that surveys are administered on a paper form, entered manually, but then able to be analyzed and summarized easily. One respondent reported that their organization now has tablets that clients can use, and the data goes directly to their quality management department.

In order for surveys to have an impact on the sustainment of current high-quality services or to improve lower quality services, the results must be shared with caregivers and decision-makers. 80% of respondents stated that they share the survey results with program leadership and executive leadership to improve service delivery, and 66% reported that they share the results in monthly staff meetings.

The extent to which Crisis Residential Programs openly and publicly share their client satisfaction data speaks to their commission as a compliance-focused organization versus a quality-focused one. While most organizations are not required to share their survey results publicly, those that choose to share them with staff, leadership, clients, and stakeholders demonstrate a commitment to



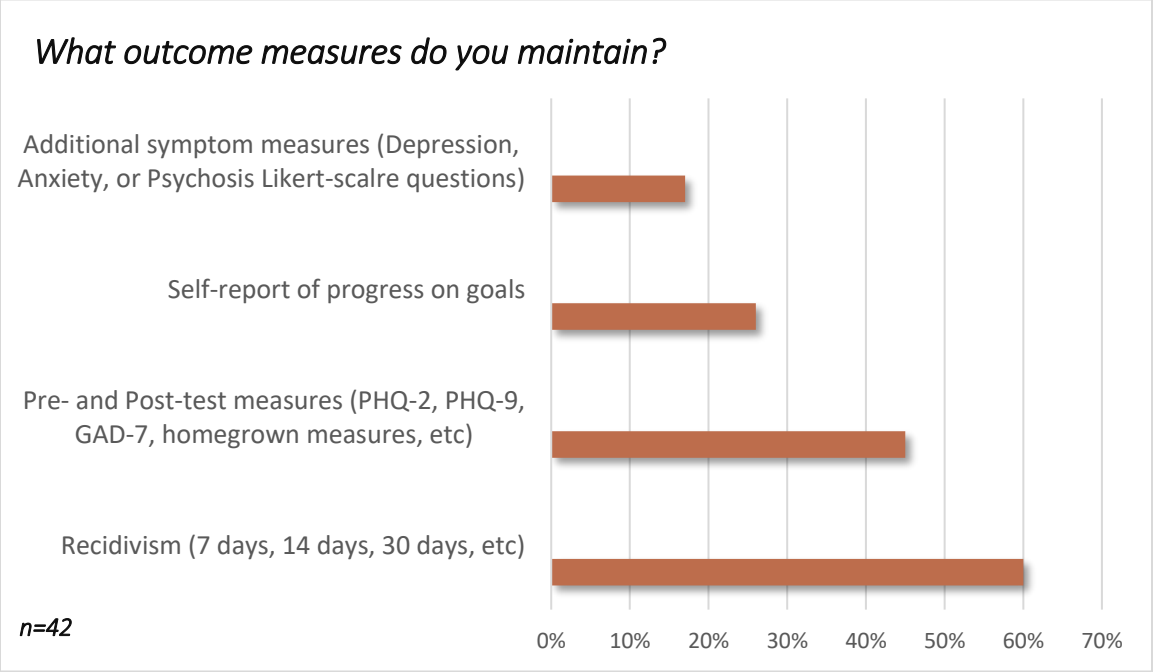
Feedback survey from *Link House*, a peer respite provider in Bristol, UK.

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improvement through vulnerability and honesty, especially when the results are less than ideal.

At Link House, a peer respite provider in England, all guests are given a feedback survey prior to leaving the program, and all responses, positive and negative, are included in their survey summary. In addition, this information is shared publicly on their website[71]. This level of transparency provides tremendous accountability to quality services for their community.

When asked about outcome measures tracked, only recidivism (7- and 14-day re-admission to a Crisis Residential program) is tracked by more than half of the programs polled (60%).

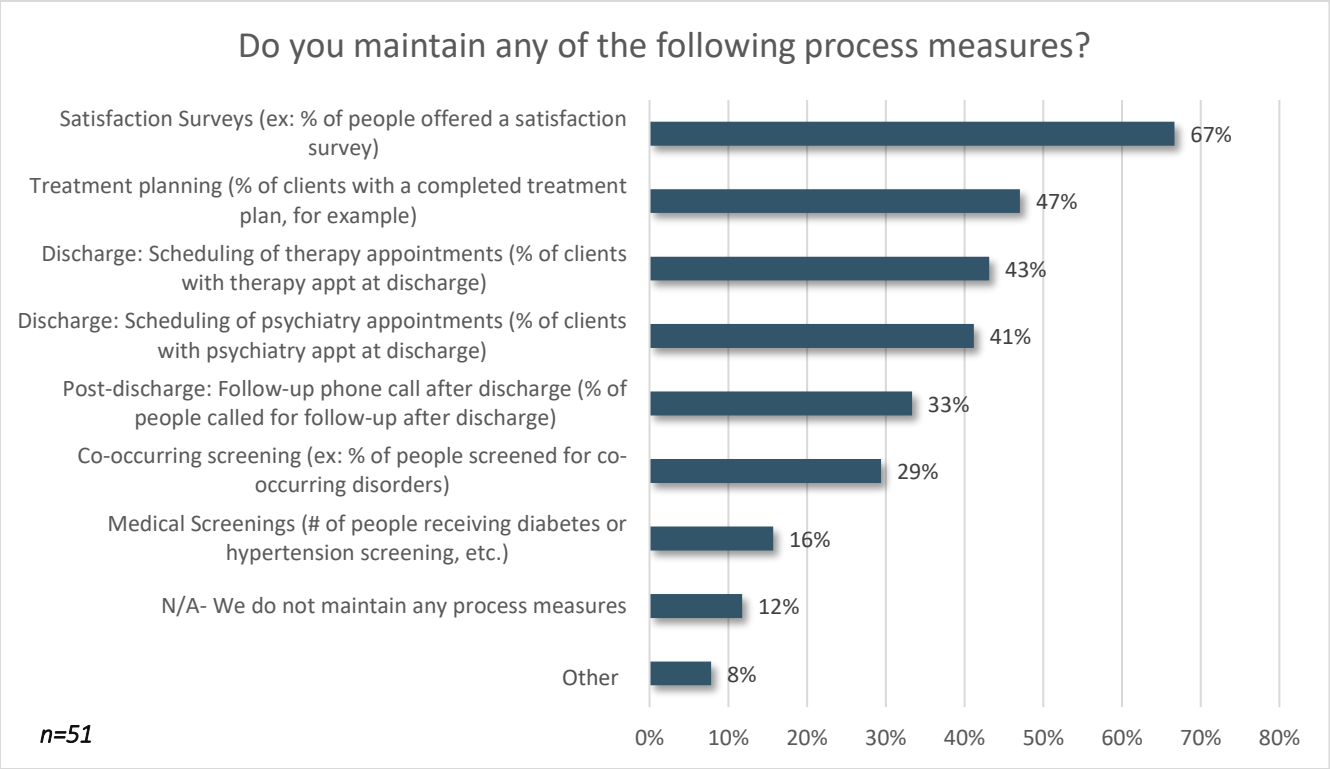


Limited Resources in Metrics Collection

The narrow financial margins at which Crisis Residential Programs operate can affect their ability to invest in systems or human resources to track data, measure progress, and use metrics to drive decision-making. 68% of surveyed programs reported insufficient personnel resources as a barrier to metrics collection, while 41% cited lack of specialist resources like IT support or a data analyst, and 41% said that they don't have the necessary technology to measure the metrics that are important to them.

[71] Missing Link. *Link House Service Exit Feedback Survey 2015-2016.* Accessed from: https://missinglinkhousing.co.uk/missinglink2016/wp-content/uploads/2016/12/LinkHouseSatisfactionSurvey_Nov16.pdf

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Employee Satisfaction

Only 56% of Crisis Residential Programs surveyed use a formal survey to track employee satisfaction, and 66% of those programs discuss results with leadership team members to improve service delivery. Without a regular feedback loop to assess staff satisfaction, burnout, and compassion fatigue, CRP supervisors might miss out on opportunities to engage with their employees, provide supportive interventions, and encourage them to use the vacation and fringe benefits available to them that may promote continued sustainable employment.

Organizations that establish a culture centered around employee engagement and satisfaction may post the results of their surveys publicly, publishing even the negative responses (depending on their comfort level with vulnerability). Some providers use Stay Interviews to ask current employees what keeps them satisfied in their current position, or what factors might influence their decision to leave in the future.

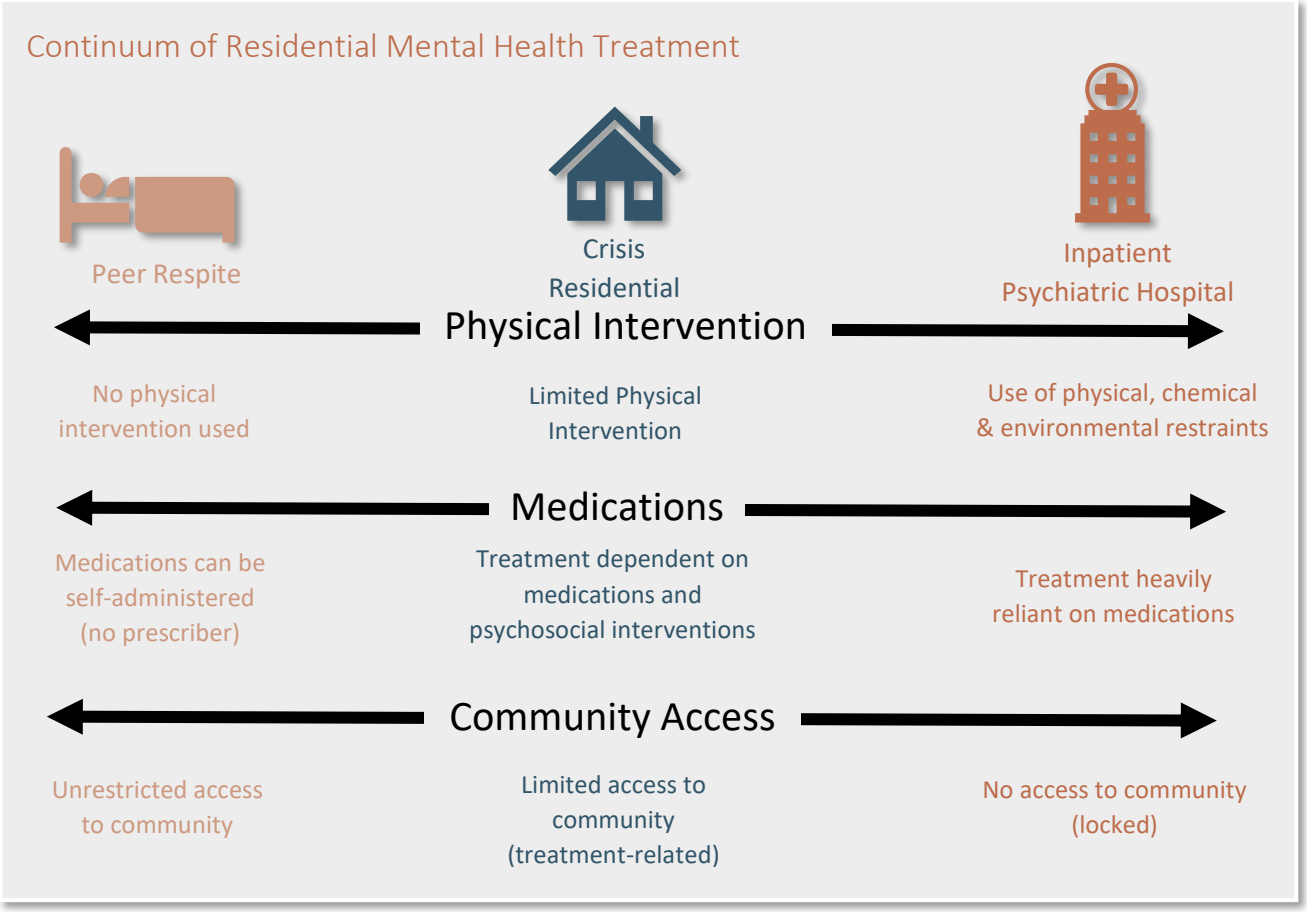
Average Length of Stay (ALOS)

A number of factors contribute to the average length of stay for a program, including:

- The impetus of the utilization management team to save money
- The existence of additional supports in the crisis continuum, especially emergency housing and medication prescribers
- The stakeholders' view of the function of a Crisis Residential as short-term stabilization (2-4 days) vs. psychiatric rehabilitation (5-21 days)
- A client's previous history with receiving services at a Crisis Residential program (and their responsiveness)

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- How recently a client was last admitted to the Crisis Residential program
- The reason for referral
  - Referrals that are purely medication adjustment-related may be given a very short authorization by the insurance company/funder
- The state's regulations on maximum length of stay in a program



Community Relations

Crisis programs have an abundance of community partners that they interface with on a regular basis, including emergency departments, psychiatric hospitals, law enforcement, outpatient therapists, case management agencies, mobile crisis teams and referring clinicians, community mental health centers, homeless shelters, food pantries and other social services agencies, local Department of Human Services (DHS) offices, primary care clinics, pharmacies, drug treatment facilities, emergency medical services, and churches.

Crisis programs that have the strongest working relationships with their community partners are often the ones that are proactive about educating, communicating, and collaboratively resolving issues. When serving such an acute and distressed population, one negative experience can damage a crisis residential program's reputation. Just as turnover is high in direct support professional positions, many community

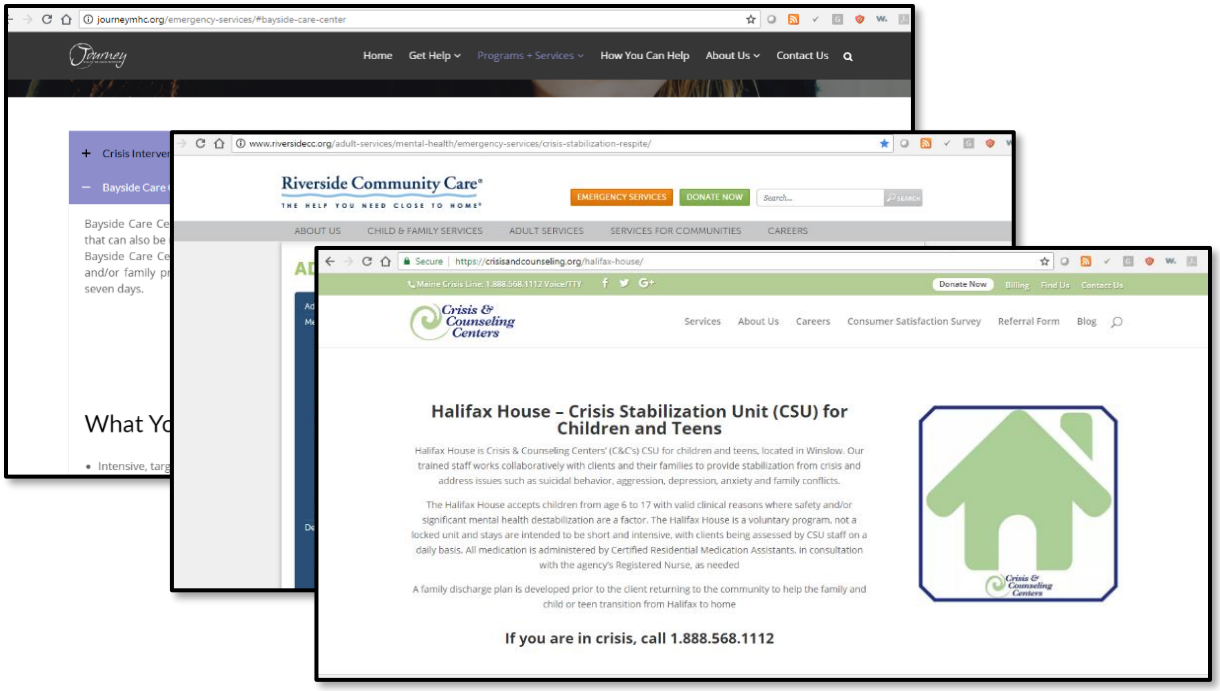
partners experience high turnover in their positions, meaning that a positive reputation must be established and reinforced consistently with open houses, lunch 'n learn sessions, and outreach such as visits to community partners' staff meetings or dropping off literature about the programs.

Program Spotlight
Pivot

Hope Network operates eight Crisis Residential Units (CRUs) across Michigan. At Pivot, a CRU in Grand Rapids, MI, the clinical and leadership staff take shared ownership in the development and maintenance of community relationships with other providers and stakeholders. These efforts are an expectation of their job and a regular part of their working schedule. By scheduling regular visits to ERs and health clinic staff meetings and offering community presentations to referral sources, Pivot assures that issues are proactively addressed, accurate information about the program is communicated to referral sources, and successes and outcomes have a platform in an otherwise crisis-focused treatment setting.

Community Presence

Crisis Residential programs that are the most successful and maintain the highest levels of community engagement and satisfaction are the ones that continue to demonstrate their relevance and helpfulness to their community partners. The Crisis Residential programs at The Progress Foundation in San Francisco, CA, trace their roots back to addressing a community need of overcrowding and insufficient bed capacity at San Francisco General Hospital. By accepting their overflow patients and not denying any referrals from the hospital, they were able to demonstrate their value to the people they served as well as to funders and fellow treatment providers.



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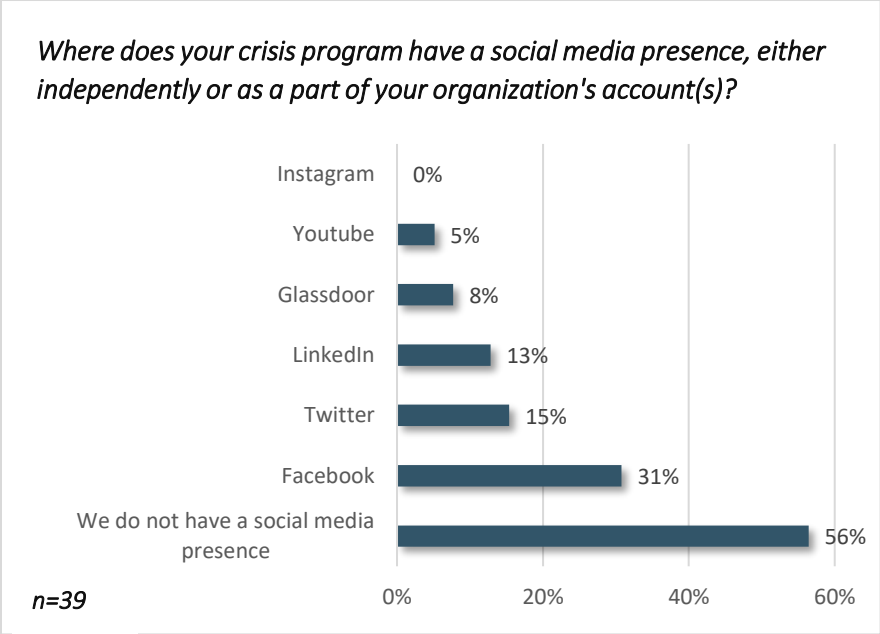
Marketing & Online Presence

Since many Crisis Residential homes have their origins in the regional-based community mental health systems, referral sources have consistently admitted individuals with Medicaid or no insurance, and competition was not a concern. This may be the reason that only 66% of the crisis programs surveyed have a website focused on their crisis program. However, as commercial health plans begin contracting with Crisis Residential providers, and provider networks compete for business between regions, the presence of a comprehensive website will greatly influence referrals. Crisis Residential programs that have a website with a thorough list of Frequently Asked Questions, including admission and referral processes, will have the advantage in attracting future customers.

Crisis programs should also maintain brochures and other literature that explains the overview of the program and what treatment expectations should be. This literature should be distributed widely and frequently.

Managing Online Presence of CRPs

Nearly 60% of surveyed programs reported having no social media presence. For CRPs that have traditionally been funded by Medicaid or grants, this has not been an issue, as these sources were fairly secure, and CRPs may have preferred to keep a low profile in the community. However, as CRPs begin to diversify funding sources, especially with commercial health plans, potential clients may have choices in what mental health treatment they receive, and it may be beneficial to advertise or promote awareness of CRPs.



Where customers and consumers used to rely on feedback for services like restaurants, home repairs, and vacation resorts, in the era of online reviews, people are using this feedback to make decisions about health care treatment for themselves and their loved ones. It is important that CRPs manage their online reputation and are aware of their client's experience of care. In an industry like emergency behavioral health care, often the negative experiences of some can overshadow the positive results of many, so celebrating success and improvement is an important step in controlling the narrative of a CRP, and social media platforms can be a great way to effectively manage community perception.

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Safety Net

Crisis programs do not exist for any self-fulfilling purpose; they are designed to help individuals in the community who are suffering from some type of psychiatric crisis. While the best crisis programs are always asking themselves how they can be the most helpful to the individuals they serve, funders have been known to ask programs to bend their rules, compromise their staffing resources, and work with individuals representing a population for which staff have not been trained or equipped to support.

> ***What is a Safety Net?***
>
> Within behavioral health care and social services, a safety net is defined as a set of services that prevents an individual from worsening in condition or illness. Often considered the last line of defense, behavioral health crisis services such as CRPs and psychiatric hospitals often shoulder much of the responsibility for a person's recovery, as they are the most intensive services available.

This tension favors the funder more often than the provider, as the provider faces tough decisions: attempt to serve a client that does not meet treatment criteria and/or presents with complex co-morbid conditions or adhere to your programs policies and face the threat of being considered an inflexible program that is not community-oriented or willing to be adaptable.

Alternative or Additional Functions Beyond Mental Health Crisis Stabilization

The most common way that crisis programs are asked to extend outside of their treatment scope is through emergency or temporary housing, as many individuals in crisis also experience unstable living conditions. Community Mental Health Centers or payers trying to place an individual without housing options often look to Crisis Residential programs as a temporary shelter. Some referral sources will creatively try to find criteria for at least an initial authorization; others spend no time trying to mask the reality of their situation. These housing respite instances can sometimes last for months until a placement is found. Meanwhile, the individual who is not in crisis occupies a bed that could be utilized by someone in the crisis; in addition, these people often disrupt the milieu and its consistency in treatment focus.

Providers that receive authorizations for services based on Severity of Illness Criteria are left in a compromised state. If it is discovered that a program was paid for services provided to an individual who did not meet medical criteria, who is held accountable? The provider or the referral source?

Other functions that crisis homes are asked to extend themselves for include substance abuse detox, transportation, and medical monitoring and treatment.

Comfort Level with Referrals

75% of respondents reported they are usually comfortable with the referrals they receive in their crisis program, although occasionally they are asked to serve someone whose presenting issues are outside of what is typically seen. Conditions not typically seen by crisis programs but managed might include history of aggression or violence, complex medical conditions such as brittle diabetes or the use of a feeding tube, dementia, developmental disabilities or cognitive impairments, or mobility impairments.

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Implications of Expanding/Adjusting Admission Criteria

Most CRPs have an agreement with their funders (usually state-sponsored Medicaid) to provide services to individuals who meet specific criteria for admission. CRPs vary greatly in their approach to accepting non-traditional referrals: some CRPs maintain strict admission criteria that adheres to their state's Medicaid Provider Manual or other funder's service specifications, while others try to maintain a flexible and adaptable admission policy[72].

When referral sources inquire about sending people with other issues such as homelessness or addiction problems without meeting the other mental health criteria, crisis programs bear additional risks, such as committing insurance fraud by billing for services that were provided to someone who does not meet eligibility criteria. However, the ability of a CRP to adapt to the needs of its referral sources and clients is vital to its relevance and helpfulness as a community provider and partner.

Some survey respondents cited an increase in both co-occurring substance abuse disorders and co-morbid medical conditions for individuals admitted to the CRPs, and they are pursuing dual licensure or specific staff training to meet the needs of individuals with complex needs.

Compromised Staffing Ratios

Staffing adjustments that a referral source might take for granted, such as one-to-one staffing, require substantial adjustments by the providers (not to mention that these requests usually take place at a moment's notice, or often on a Friday afternoon). In an industry that is already challenged by a shrinking talent pool of direct support professionals and clinicians[73], finding additional staff to meet client

MICHIGAN CRISIS RESIDENTIAL NETWORK

In 2015, Crisis Residential providers in Michigan formed the Michigan Crisis Residential Network (MCRN). Each month these providers meet via phone to share experiences and challenges around operating a Crisis Residential Unit (CRU).

In 2016, MCRN began collecting a small set of discharge data with the purpose of benchmarking and standardizing practices (inspired by the work of Dr. Margie Balfour, MD). MCRN decided on these measures and adjusted them over time, now collecting eight measures each month, including:

- Percentage of individuals discharging according to plan
- Percentage of individuals reporting a favorable satisfaction rating
- Percentage of individuals with Length of Stay 14 days or more
- Percentage of individuals with 3+ admissions in 90 days (a recidivism measure)

In 2018, MCRN advocated with the Michigan Dept. of Licensing and Regulatory Affairs to allow for dual licensure of mental health and substance abuse treatment facilities in the same building, as currently only one license type is allowed.

[72] For more about building a program by maintaining a flexible admission policy, read the Community Relations section on page 44 about The Progress Foundation.

[73] By 2025, shortages are projected for: psychiatrists, clinical, school, and counseling psychologists, mental health and substance abuse social workers, school counselors, and marriage and family therapists.
US Department of Health and Human Services. (2017). National projections of supply and demand for selected behavioral health practitioners: 2013-2025.

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demands can compromise the quality of care for the other individuals being served. In addition, funders are sometimes unwilling to pay a prorated amount for increased staffing. 57% of the CRPs in our survey reported they are expected to accept non-traditional referrals without any additional incentives, such as increased training, increased staffing ratios, or increased reimbursement rates for serving that individual.

Diversity of Psychiatric Acuity

Crisis programs build their infrastructure and treatment model around serving individuals in a mental health crisis who are able to agree to a safety plan while in the program. When a person not meeting this criteria is admitted, it can cause a ripple of disruptions throughout the clients and staff, from treatment groups to the milieu. While effective crisis programs are dynamic and adaptable, sometimes even the best teams struggle to provide effective treatment when an inappropriate referral is admitted.

When Adjusting Criteria Threatens Sustainability

When crisis programs are not consistent in adhering to admission criteria that meet their funder's definition for medical necessity, their financial integrity comes into question.

61% of surveyed programs stated they experience instances where they are asked to compromise the integrity of the program or its guidelines by accepting people who don't meet medical criteria for admission.

These include individuals without stable housing, individuals who need a higher or more intensive level of care because of violence or medical monitoring, those who refuse participation, and individuals who need medical detox due to substance abuse.

Implications of Denying Referrals/ Upholding Admissions Standards

When crisis programs attempt to maintain fidelity to their treatment model by denying referrals that don't meet medical criteria or would negatively affect other clients' treatment, the response can vary from reasonable to aggravated, depending on the relationship with the funder or referral source.

Reduced Referrals

Community partners often judge the relevance of a crisis program on their willingness and ability to accept the referral source's most challenging individuals. If concessions are not made by the crisis provider to admit these difficult clients, these community partners may not recognize the utility of the crisis program and look past them when trying to place other more appropriate clients.

57%

of surveyed programs said they are expected to serve non-traditional referrals without any added incentives, such as additional reimburse-ment or increased staffing ratios. *n=44*

Strained Relationships with Funders

Funders that do not completely understand the model of a crisis residential program may contend every service denial, believing it is more important for the program to be adaptable to accept referrals and keep them out of the emergency department or psychiatric hospital. Consistent upholding of admission requirements may frustrate referral sources, especially if no other options are available for placement.

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Incentives for Accommodating Non-Traditional Referrals

55% of crisis programs surveyed reported there are no added incentives or accommodations provided for accepting non-traditional referrals, such as increased pay, increased staffing ratios, or special training. When these programs run on a tight operating budget, being asked to make consistent staffing adjustments and admission concessions can compromise program sustainability.

Other Absorbed Safety Net Functions

Programs reported providing the following support services "regularly" during a person's crisis residential treatment: education about and direct referrals to substance use disorder treatment (84%), assisting with applications and providing referrals to housing resources (73%), employment assistance (27%), and long-term medication stabilization of one week or more (24%).

Challenges

While Crisis Residential Programs have existed for over 40 years in some capacity in the United States, they still face considerable challenges from communities and stakeholders in the expansion of new Crisis homes and the sustainability of current programs.

NIMBY-ism

Many progressive health care and social service interventions attempting to take shape in a community are met with varying degrees of NIMBY-ism, a territorial and fear-based acronym that stands for "Not In My Back Yard"). Neighbors and community partners often fear what they don't know or don't understand, and skepticism and sensationalism often replace practical, commonsense rationale when approaching these treatment approaches. For example, crimes committed by people with mental illness receive an inordinate amount of news coverage, even though individuals with mental illness are much more likely to be the victim of a crime than they are to be a perpetrator[74].

Why Crisis Programs Fail

Nearly all crisis programs are met with some level of resistance prior to opening their doors, and some face continued scrutiny throughout their existence.

In Michigan, three Crisis Residential Programs closed their doors between 2016 and 2018, for reasons varying from insufficient referrals to unsustainable wages and program costs. Other crisis homes in the U.S. have closed or were consolidated in the previous 10 years, although the exact number is uncertain.

In March 2018, a Crisis Residential Program in Utah closed because it was not able to find an affordable facility in which to continue operations.

In Iowa, as of 2017, there are no policies and procedures developed by DHS for billing processes. In 2014, Oak Place, a pilot Crisis Residential facility, was opened in Centerville, Iowa. This program closed its doors in October 2017 due to lack of funding options and no payment structure from the Managed Care Organizations or DHS.

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[74] Desmarais, S. L., Van Dorn, R. A., Johnson, K. L., Grimm, K. J., Douglas, K. S., & Swartz, M. S. (2014). Community violence perpetration and victimization among adults with mental illnesses. *American Journal of Public Health*, *104*(12), 2342-2349.

The stories of crisis programs that have closed over the years often go untold, known only by a few historians in the system who eventually retire or leave their position. Without the institutional knowledge and lessons gained from understanding the underlying causes for closing a crisis program, communities struggle to learn from the experience and find tangible solutions to addressing emergent psychiatric needs of its people in the future.

Other reasons that Crisis programs have failed:

- **Lack of community support**, and inconsistent or insufficient public relations development of the program.
- **Lack of data**, including outcome measures, to demonstrate their efficacy, customer satisfaction, and cost savings compared to psychiatric hospitals or emergency departments.
- **Lack of transparency** about the Crisis program's purpose, function, and improvements.
- **Lack of sustainable funding**. Crisis programs that are grant funded may have to periodically submit grant renewals or extensions for continued funding, while fee-for-service reimbursement crisis programs are constantly trying to keep their beds full, usually at an 85% occupancy rate or higher.
- **Deficiency of qualified, committed, and recovery-oriented staff**. The strong presence of clinicians, peer support specialists, and direct support professionals distinguish the Crisis Residential model of care from more intensive levels like psychiatric hospitals or other locked facilities.
- **Poor Reputation**. Crisis homes take on the challenging task of serving people in acute psychiatric crisis in an environment that is less restrictive than a psychiatric hospital. Dozens of positive treatment experiences can be negated by one negative outcome that turns into a public relations disaster. Celebrating successes and victories, both within the organization and publicly, can help to proactively offset any negative news that might be transmitted from the crisis home.

Conclusion and Opportunities

As communities enhance their behavioral healthcare delivery system, while continually asking the question, "How can we be the most helpful?", they will undoubtedly continue moving in the direction of treatment that is dynamic, person-centered, and cost-effective, with measurable results. Crisis Residential Programs meet all of these needs while aligning with the vision of the Community Mental Health Act of 1963 of providing treatment in community settings in the least restrictive setting.

While there are over 600 CRPs across the country, there are no practice standards or formal trade associations established to advocate for their funding and quality at a state or national level. The unprecedented connection between CRPs across the country as a result of the aforementioned workgroup provides a great opportunity for establishing a trade association or advocacy organization, similar to the National Association of Crisis Organization Directors (NASCOD) that represents crisis call centers and the National Association for Behavioral Health that represents psychiatric hospitals[75].

Efforts towards advocacy and quality standards can begin at the state level. States like Maine, Michigan, Tennessee, Texas, and Wisconsin have provider-sponsored or state-sponsored consortiums provider

[75] CRPs are not alone in their lack of a developed trade association or advocacy organization. There are also no trade associations or practice standards for mobile crisis teams or state psychiatric hospitals.

networks that meet monthly to talk through changes in licensing or funding, program successes, and challenges or questions. The validation that CRP managers receive through peer networks cannot be understated, as most organizations only operate one CRP, leaving supervisors to sometimes feel isolated in their agency's service array.

Because there are no national standards for crisis services, CRPs have a unique opportunity to leverage their relationships and connections to identify their own definitions of practice standards before their funding sources dictate the terms of their payment. Just as the best time to look for a job is when you already have one, the best time to establish performance indicators and collect data is when you aren't yet required to.

CRPs are well-positioned to leverage the decades of research behind the model's efficacy with the interests of health care payers to decrease high-cost expenditures. CRPs can actualize opportunities to diversify funding streams through partnerships with new payers like commercial health plans and the U.S. Department of Veterans Affairs. Long-term goals may include lobbying for the addition of crisis services as part of a Medicare benefit so that even more individuals in crisis can receive proper access to a broad continuum of treatment options.

Individuals in a mental health crisis benefit when their communities have a fully developed continuum of crisis services. Crisis Residential Programs play a critical component in a healthy crisis continuum, and their continued sustainability brings hope for the future to any individual suffering with mental illness.

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