RESIDENTIAL CRISIS UNITS. ARE WE MISSING OUT ON A GOOD IDEA?

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ABSTRACT

Residential Crisis Units (RCU) are non-hospital-based facilities that provide mental health crisis intervention. This paper reviews the RCU literature base and finds good evidence of the ability of RCUs to function as alternatives to hospitalization for many consumers, with equivalent effectiveness and for significantly less cost. Despite this promising research, the RCU model has not been widely adopted. Using two crisis units as case examples as well as key informant interviews, this paper explores factors affecting the lack of dissemination and potential barriers to the growth of the RCU model.

INTRODUCTION

Residential crisis units (RCU) have been described in mental health literature for almost 30 years (Bond et al., 1989; Brunton & Hawthorne, 1989; Budson, 1994; Fields & Weisman, 1995; Gibbons, 1986; Hartmann & Sullivan, 1996; Hyde et al., 1987; Kresky-Wolff, Mathews, Kalibat, & Mosher, 1984; Lamb & Lamb, 1984; Leaman, 1987; MacCarthy et al., 1989; Moltzen, Gurevitz, Rappaport, & Goldman, 1986; Mosher, Menn, & Mathews, 1975; Simpson, Hyde, & Faragher, 1989; Warner, 1995; Weisman, 1985). Various terms are used in the literature to describe this general model, including: crisis hostels, safe houses, residential crisis programs, psychiatric health facilities, etc. They are home-like, non-hospital-based programs that provide mental health crisis intervention and help people to re-establish community functioning. Early examples of this type of non-institutional, psychosocial rehabilitation approach were the halfway house of the early 1960s (Weisman, 1985) and foster-family care (Polak & Kirby, 1976). The development of the first independent residential crisis units followed in the 1970s (Brook, 1973; Keisler, 1982; Mosher et al., 1975; Weisman, 1985). Although the number of these units increased in the 1980s (Fields & Weisman, 1995), currently they are not widely used (Rissmeyer, 1985; Warner, 1995).

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RCUs appear to be an innovative, alternative system to hospital-based mental health crisis care for a large population of consumers. Anecdotal reports indicate that people in the mental health field feel that RCUs are needed and useful. Why is such a good model not more widespread? We will look at evidence supporting their effectiveness and identify some of the reasons why RCUs might be underutilized. The RCU model is a non-hospital-based, non-medical model, run by consumers or paraprofessionals with links of varying degrees to professional and medical services. Key factors in their success as well as barriers to the dissemination of the model will be outlined, including research base, leadership and stakeholders, politics, funding, and public support.

The information in this paper was gathered through a literature search of Medline from 1966-2002 using the key words "community mental health services," "crisis intervention," and "housing." We contacted some of the authors and searched the bibliographies of relevant articles for additional references. We also conducted ten key informant interviews with various stakeholders. Leaders in this area helped to identify appropriate informants, and we checked with those selected to ensure we had identified the appropriate individuals. Stakeholders were selected to represent the areas of administration, history, policy-makers and planners, staff, consumers, and government. We followed a semi-structured interview guide and interviews were taped as a memory aid. We reviewed tapes and notes taken, and key issues were classified and summarized. In addition, two Canadian crisis units are used as case examples: the Gerstein Centre in Toronto, Ontario and Seneca House in Winnipeg, Manitoba. We selected these due to their high-profile nature and their presence in two different provinces.

WHAT IS THE IDEA?

Residential Crisis Units provide short-term support during periods of mental health crisis. These residential alternatives are not halfway houses that support a consumer after a hospital stay, but rather treat acutely decompensated consumers, often in lieu of a voluntary admission to a psychiatric ward. They are neighbourhood homes that are staffed by paraprofessionals or consumers who focus on providing psychosocial support. RCUs are not hospital-based and do not follow a medical model, but they often have connections to professional and medical services. It is hoped that a home-like environment encourages people to behave as responsible members of a temporary family (Stroul, 1988), possibly avoiding regressive and dependent tendencies that are sometimes seen in hospital. The RCUs provide a place of retreat and 24-hour staffing for support, but generally do not provide other formal programming. In this way, consumers do not become dependant on RCUs but rather maintain their ties to community services and support. People are expected to continue in their regular daily activities and use community resources, including medical therapy, which is considered less stigmatizing and disruptive than admission to a psychiatric ward, and should facilitate a smoother discharge to community. The normative and less restrictive environment of an RCU also provides a more realistic context for assessment of functioning, and may allow for better development of interpersonal skills (Fields & Weisman, 1995).

The flexibility inherent in the RCU model allows consumers to take the lead in defining their own goals and treatment plans, thereby increasing their sense of empowerment. Consumer accounts suggest that this in turn leads to improved self-determination, independence, improved skills, assertiveness, self-esteem, and self-

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understanding (Nelson, Lord, & Ochocka, 2001). Finally, the staffing of the RCUs by paraprofessionals and peer counsellors (current or prior consumers of mental health services) is thought to decrease any potential power imbalance, enhancing a sense of community within the unit, and promoting openness and genuineness more quickly (Hartmann & Sullivan, 1996).

The RCU residential model provides separation from the client's environment, which may be necessary to resolve a crisis. It offers a unique alternative to the other forms of community mental health crisis service programs (i.e. ACT teams, mobile crisis teams).

WHAT ARE THE EXAMPLES?

The two case examples that are cited in this paper are the Gerstein Centre and Seneca House. The Gerstein Centre was established in 1990 in Toronto, Ontario. The Centre consists of a home-like residential crisis unit with ten beds open 24 hours/day and 7 days/week, a 24-hour crisis telephone line, and a mobile crisis team. The staff typically consists of multidisciplinary paraprofessionals, and one third are psychiatric consumers. The Gerstein Centre is the only independent RCU in Toronto mandated for adults experiencing mental health crisis. (In addition, within the shelter system in Toronto there are 15 crisis beds for the homeless and mentally ill, and a 5-bed unit for dually diagnosed adults). Seneca House is located in Winnipeg, Manitoba and was developed in 1996. A consumer-run program based on principles of self-help and peer support, Seneca House has five beds in a home-like environment, provides service 24 hours/day and 7 days/week, and provides short-term accommodation of up to 7 days. In contrast to Toronto, which has only one RCU, there are a total of 3 crisis houses in Winnipeg, each providing a different level of support for increasing levels of illness acuity. The other two units are not consumer run; one is a non-medical unit with multidisciplinary staff, and the other is also a non-hospital-based facility but has medically trained staff, and a physician on call. In the province of Manitoba (pop. 1.1 million), there are a total of 8 facilities following an RCU model, compared to only one in the province of Ontario (pop. 11.4 million).

A GOOD IDEA?

Support from the Literature and Key Informants

The RCU literature that will be cited includes three randomized controlled trials, (Dumont & Jones, 2001; Fenton, Mosher, Herrell, & Blyer, 1998; Sledge, Tebes, Rakefeldt, et al, 1996). Sledge, Tebes, Rakefeldt, et al. examined 197 consumers of an RCU staffed by mental health workers, with a ten month follow-up. The paper by Fenton et al. (1998) involved 119 consumers, staffing by paraprofessionals, and a six month follow-up. Finally, Dumont & Jones (unpublished) examined a total of 265 consumers, at a consumer-run facility, and conducted a one year follow-up. In addition, there is a quasi-experimental cohort study by Rappaport et al. (1987) of 790 consumers, examining a non-hospital facility staffed by a mix of "licensed and non-licensed staff" with follow up over the length of admission. Hawthorne, Green, Lohr, Hough, & Smith, (1999) provided an observational cohort study involving 554 consumers, with staffing by paraprofessionals, and a four month follow-up. Finally, Brook (1973) conducted a cohort study looking at 98 consumers, with staffing by non-professionals and a nurse, and a follow-up of six months. There have been three

surveys of decision makers conducted (Beck et al., 1997; Flannigan et al., 1994; and Lesage et al., 2002).

The rationale behind the creation of RCUs has been supported by increasing levels of evidence over the years, showing that RCUs can function as an alternative to hospitalization. Providing a continuum model of care, they may be the most appropriate intervention for certain consumers. A survey of potential alternatives to hospitalization was conducted by Flannigan et al. (1994). Surveyed keyworkers in London, England responded that the availability of a 24-hour supervised hostel might have prevented 52% of admissions in one district, and 6% in another. A similar study in Montreal suggested that a supervised hostel or foster family care could have diverted 20% of admissions (Lesage et al., 2002). In two randomized studies, a substantial proportion of consumers (83% and 87%) who were first judged to require inpatient care were deemed appropriate for and treated in an experimental crisis residence (Sledge, Tebes, Rakefeldt, et al., 1996; and Fenton et al., 1998). Finally, in a non-experimental study by Leaman (1987), 80% of consumers who were going to be admitted to hospital were successfully diverted to a foster-home program. From these studies it would seem that many consumers can be treated in an RCU, thus providing an alternative to hospitalization.

RCUs also help to ease the pressure on hospital emergency departments. Consumer self-reports at one program indicated that 61% would have gone to emergency departments had the RCU not been available (Hartmann & Sullivan, 1996). The Gerstein Centre in Toronto reported that due to excessive demand and lack of resources, they were frequently obliged to send persons to the hospital emergency department who otherwise could have been seen by their mobile crisis unit. When Seneca House in Winnipeg closed for several months there were anecdotal reports of increased presentations of psychiatric crises to the emergency department.

When compared with inpatient crisis service, studies have shown that RCUs decrease readmission rates to hospital (Bond et al., 1989; Brook, 1973) or the number of days spent in hospital (Dumont & Jones, 2001). It should be noted that in Dumont's large randomized control trial (RCT) the RCU cohort had similar illness severity to the hospital cohort, and therefore, the result cannot be explained by attributing increased readmission rates of inpatients to increased illness severity. However, two other studies compared any type of acute care (whether inpatient or RCU) following discharge, and found no difference between the cohort treated initially in the RCU versus those treated initially in hospital (Fenton et al., 1998; Hawthorne et al., 1999). If, as has been criticized, an admission to an RCU simply postpones an "inevitable" hospital admission, then one would expect a higher re-admission rate to hospital in the group initially treated in an RCU. Since studies show that the RCU cohort has, in fact, similar or decreased readmission rates to hospital, it is incorrect to surmise that the use of an RCU only postpones hospitalization.

Criticism of RCUs has also included the perception that they do not treat the severely mentally ill. Among the key informant interviews there was agreement that RCUs cannot be alternatives to hospitalization for those who are acutely dangerous, who possess little or no impulse control, and/or who require involuntary admission. However, studies show that RCUs can support an acutely ill population. One RCT enrolled *all* consumers who accepted voluntary admission and who were thought to need admission to hospital, without having any psychopathology exclusion criteria, and found that the RCU could support patients similar to those in hospital (Fenton et al., 1998). The two groups showed comparable symptom reduction and levels of sa-

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tisfaction. It should be noted that although RCUs are typically non-medical, clients can receive any necessary medical therapy through existing community supports.

Several RCTs and observational studies have shown that crisis care in an RCU results in similar or improved outcomes when compared to hospital control groups. These include satisfaction (Fenton et al., 1998; Hawthorne et al., 1996; Dumont & Jones, 2001), level of functioning (Fenton et al., 1998; Sledge, Tebes, Rakefeldt, et al., 1996), level of symptomatology (Fenton et al., 1998; Hawthorne et al., 1999; Sledge, Tebes, Rakefeldt, et al., 1996), and increased levels of empowerment and self-care (Dumont & Jones, 2001). One quasi-experimental study did, however, show that consumers treated in an RCU were more ill upon discharge than patients receiving hospital care (Rappaport et al., 1987).

In terms of cost, it appears that RCUs are a cost-effective alternative to hospitalization for certain patients, as supported by three RCTs (Dumont & Jones, 2001; Fenton, Hoch, Herrell, Mosher, & Dixon, 2002; Sledge, Tebes, Wolff, & Helminiak, 1996). All service costs over a period of 6 months to one year were included in the analysis, providing a more accurate reflection of true costs over a per diem cost analysis. These studies revealed that all service costs were decreased by 20–33% through the use of RCUs.

WHY ARE THERE NOT MORE?

To implement innovative ideas in mental health, one must have a model that is believed to be effective, and worthy of adoption over the existing model. The RCU model has existed for 30 years and has an encouraging research base, so why is this model not more prevalent in the mental health system? We will look at some key factors which suggest success, and then present potential barriers to implementation, including the effects of the research base, the leaders and stakeholders, the political climate, funding, and public support.

The Research

Despite some good controlled studies of RCUs, there has been a lack of extensive replication of these results and no research has directly compared the RCU model to other alternative mental health crisis services such as mobile crisis teams or ACT teams. One could argue that the RCU model is unique from these other modes of service delivery as it is residential. Anecdotal reports suggest that a residential setting is often invaluable for consumers in crisis, however, this has not been formally evaluated and the lack of comparison research could affect the relative success of the RCU model in a fund-restricted, competitive health care field.

In addition, the lack of individual program evaluation on a grass-roots level has possibly hindered adoption of the model. RCUs have only modest resources for the collection of information, which is limited to keeping demographic records and recording consumer surveys. RCUs face increased barriers to quality program evaluation because they are not directly affiliated with an academic or research based institution. A heightened commitment to the formal assessment of these centres requires that the government allocate additional resources, including funding, human resources, and expertise. Even within the government there is acknowledgement that resources for this purpose are insufficient.

The research base that does exist has not effectively helped to spread this model. Why has there not been more effective dissemination and uptake of the research

base? This is partly because there has been no recent literature review to summarize the evidence. Also, the research has been conducted over the course of 25 years. Because of this, the model may have lost the natural momentum of interest that a new, innovative idea generates. In contrast, during the development of ACT teams, extensive research was conducted over a relatively short time and specific resources and leadership were devoted to the dissemination process, resulting in widespread adoption of the concept.

The Leaders and the Stakeholders

The success of any new model or program is dependent on positive and ongoing support from those parties directly involved with the program itself. These internal groups include consumers, families, mental health staff, and administration. For the two RCUs investigated, positive consumer feedback has been evident. The Gerstein Centre reports that their consumer surveys express the highest levels of satisfaction and government officials have indicated that they receive widespread consumer endorsement of these centres, including a demand for greater availability of the type of services that they offer.

The success of these programs is also contingent upon strong leadership. In a hospital-based system, availability of resources and a pre-existing infrastructure facilitate the adoption of new programs. Non-institutional programs, however, must pave their own way, and must do so without the accompanying resources and expertise typically present in multimandated health care institutions. A lack of specific areas of expertise may be particularly challenging for a consumer-run program. Several informants stressed that initiative and perseverance provided by effective leadership help to overcome these obstacles. This point was cited as essential in the development of both the Gerstein Centre and Seneca House. Currently these programs must focus on day-to-day functioning, and do not have the additional resources to encourage a broader awareness of the RCU model.

Wider acceptance is needed for the adoption of any new program and may involve overcoming resistance from parties that hold power in the existing system. Many key informants believe that the mental health profession as a whole has become more accepting of alternative programs such as RCUs. However, it was highlighted that the level of acceptance continues to vary among individual practitioners, and that some mental health professionals perceive alternative models as a threat to the status quo, and are therefore less supportive of them. Another possible boundary consists of medical-legal concerns regarding the perceived risk of mental health crisis care in a non-hospital based system. However, this was only minimally commented upon in the literature and was not perceived to be a major problem by key informants. The RCUs used as case example have safeguards in place that involve screening for level of safety risk.

Resistance might arise when there is a perception that the existing system already offers services that the new model proposes to introduce. Some have pointed out that hospitals are entering into the area of community-service provision and becoming more flexible in their treatment approaches. Yet it has also been argued that these new approaches are just "institutions without walls" (Nelson et al., 2001), and that there remains a difference and an advantage to having non-hospital based community programs such as RCUs. Concern has been expressed that the implementation of policy statements describing an increased emphasis on community-based and client-centred care does not actually live up to the intended theoretical shift which the

policy proposes to introduce. In fact, some informants raised queries about whether psychiatric care is becoming less holistic and psychosocially based as the field becomes more biologically oriented and subspecialized. They stressed the need for the continued development of alternatives such as RCUS in care delivery.

The Politics

The role of political will and voice are important to the success of RCUS and several key informants felt that the non-institutional status of RCUS places them at a disadvantage. It is conceivable that a hospital-based institution commands greater credibility and, therefore, holds increased political leverage. Further, supporters of a hospital-based program include health care professionals, who are presumed to have a stronger political voice than RCU advocates such as mental health consumers.

The general political climate can either help or hinder the growth of alternative models in mental health. It is suggested that in times of political shift there is a “window of opportunity” for change. For example, the years 1985–1994 in Ontario have been described as having offered this “window of opportunity” for the development of community-based programs (Nelson et al., 2001, p. 96). Indeed the Gerstein Centre in Toronto, Ontario was developed during this period in 1991. At this time, the Liberal and New Democratic Party governments gained a short period of power, after a preceding 42 years of Conservative party rule. Following this period, the Conservative government regained power in 1995. Nelson describes this subsequent era, which was also an era of economic slowing, as having seen a “shift in health from a moral issue to a business/commodity” (Nelson et al., 2001, p. 89). This political swing facilitated a change from the privileging of more elusive and qualitative values, such as patient self-determination, quality of life, and community participation, to a stricter accounting of “the bottom line.” Due to the continually shifting political horizon, there is a lack of continuity in both priorities and values, which Nelson argues stifles the development of innovative programs. It is possible that these political factors played a role in the lack of development of the RCU model in Ontario after the early 1990s.

The Funding

A lack of funding was identified in most interviews as a barrier to innovation, and implementation of RCUS. Competing for funds are other types of programs that also provide crisis service delivery such as ACT teams, crisis hotlines, and mobile crisis teams. Also, because funding of essential services such as low-income and supportive housing was also reduced, these services understandably become the top priorities for any increased funding. In 2000, a proposal was submitted for another RCU in Toronto but was turned down by the government due to the expense.

Research suggests that RCUS can be less costly alternatives to hospitalization for certain populations. It is possible that with extensive development of RCUS, hospital admissions would decrease, and money could be diverted from hospital funds to further RCU development. Unfortunately, the money has to be invested to create the programs in the first place before the potential savings can be realized. Otherwise a “vicious circle” can emerge: funds are tied up in hospital services, insufficient funds are left to develop alternative forms of care, and this perpetuates the pressure on the in-patient beds.

This “vicious circle” may be partially addressed by the system of “regionalization” of health care in Winnipeg, Manitoba where Seneca House is located.

Regional health authorities in Manitoba oversee the implementation of health care for a smaller geographical region (as opposed to Ontario where the Ministry of Health is provincial and not subdivided into regions). It follows that in a smaller, regionalized system the funders would be more aware of the local effects of policy. The Winnipeg Regional Health Authority funds both hospital and community services, can examine the system as a whole, and could shift funds between them if one model proved more effective. One could postulate that this partly explains why Winnipeg (pop. 638,000), a much smaller city than Toronto (pop. 4,264,000), has three RCUs in comparison to Toronto's one.

The Public

Finally, poor public support for new programs could be a barrier to the adoption of programs, but does not appear to have hindered the development of the two RCUs investigated. Both the Gerstein Centre and Seneca House canvassed door-to-door and conducted community visits to other agencies and the public to introduce the program. Seneca House did experience some initial resistance due to misconceptions about mental health, which resolved with community education. In spite of some initial difficulties, both programs currently feel that they have very good community relations.

CONCLUSION

The relatively low number of operational Residential Crisis Units might seem to suggest that the program model itself does not offer a good alternative to traditional hospital care and treatment for the mentally ill. And yet, there is a surprising body of research that suggests that the RCU is, in fact, a good idea. So why has the encouraging research base not been further developed and built upon, and why has it not been reflected by a greater prevalence of RCUs? Is it simply that we do not know a good thing when we see one, or is it more complicated?

The first answer is that there has been poor dissemination of research that supports the concept of an RCU model. It naturally follows that if we are not aware of the relative benefits of an innovative model then there will be little if any initiative taken to introduce change. But even if this was remedied, is it fair to expect that more RCUs would be created? Unfortunately, there is a more significant and complex impediment involved here. We must recognize that the issue of whether or not to develop the RCU model (or any innovative idea) becomes political at some level. The implication is that our deliberations over the desirability of the model cease to be based solely on research findings. The question is no longer just: "Is the RCU model a good idea?" but instead becomes: "Does the RCU model stand out as a top priority among many competing interests and needs for health care dollars?" In other words, it no longer suffices that the model is a good one, but rather, in the political arena it must stand out as something that is more desirable than other health care spending options. Suddenly a "good idea" must become a "better idea." But the transition involved here requires an important element—an agent of change. Only through persistent and dedicated advocacy and strong leadership can a good idea gain support among a broader public or political consciousness. Without the necessary political leverage a good theoretical model such as a Residential Crisis Unit will fail to develop into an operational healthcare reality.

Finally, we should recognize that the political process discussed here is not as simplistic and transparent as a mere weighing of clearly defined and understood

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options. More realistically, the deliberations will have to take place despite the fact that information is wanting, budgets are uncertain, communication between different parties may be incomplete and any consensus on quantifying the “value” of competing options is difficult to reach.

RÉSUMÉ

Les unités d'urgence en centre d'hébergement des installations situées hors du milieu hospitalier qui effectuent des intervention en case de crise en santé mentale. Cet article passe en revue la documentation disponible au sujet de ces types d'unités, où il est démontré que les unités d'urgence constituent une alternative efficace et très économique à l'hospitalisation pour plusieurs personnes ayant un vécu psychiatrique. En dépit de ces résultats encourageants, le modèle des unités d'urgence n'est pas encore largement répandu. L'article expose le cas d'espèce de deux unités et fait état d'entrevues avec des intervenantes et intervenant clés afin de tenter d'expliquer les raisons qui expliquent le manque de dissémination du modèle et les obstacles possibles au développement du modèle.

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