



Crisis Residential Programs

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CALIFORNIA MENTAL HEALTH PLANNING COUNCIL (CMHPC) – ADULT SYSTEM OF CARE SUBCOMMITTEE
Crisis Residential Program Study Report

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Issue: Crisis residential programs reduce unnecessary stays in psychiatric hospitals, reduce the number and expense of emergency room visits, and divert inappropriate incarcerations while producing the same, or superior outcomes to those of institutionalized care. As the costs for inpatient treatment continue to rise, the need to expand an appropriate array of acute treatment settings becomes more urgent. State and county mental health systems should encourage and support alternatives to costly institutionalization, and improve the continuum of care to better serve individuals experiencing an acute psychiatric episode.

Background:

Starting in 1963 with the Community Mental Health Centers Act and through the Olmstead Decision of 1999 and beyond, the intent of the federal government has been for states to provide community-based services in the least restrictive environment possible. The phase-out of hospital beds and institutionalized services was meant to be replaced by community-based services operating on recovery-oriented principles.

In 1978, the Community Residential Treatment Systems Act established non-institutional alternatives to institutionalization as the policy of the California mental health system. Crisis Residential Programs (CRPs) were one the types of programs established under that Act. Crisis residential programs (CRPs) are a lower-cost, community-based treatment option in home-like settings that help reduce emergency department visits and divert hospitalization and/or incarcerations. These include peer-run programs such as crisis respites that offer safer, trauma-informed alternatives to psychiatric emergency units or other locked facilities. Although credible as a cost-effective and successful treatment model, particularly as part of a broader crisis response system, the number of programs remain disappointingly small. CRPs should be the preferred treatment option as mental health systems remain persistently vulnerable to funding reductions or elimination and jails and emergency departments become the de facto guardians of someone experiencing a psychiatric crisis. Yet, after nearly thirty years of operation, the CRP is sidelined as an exception rather than a principle player who is an equal partner in the care continuum with law enforcement, emergency departments, or community referral agencies. This lack of consideration as a legitimate resource can result in inappropriate referrals that do little to legitimize the value of the treatment received at a CRP or demonstrate its cost-effectiveness.

As Steve Fields observed in the *Crisis Residential Treatment Manual*¹, the CRP is "...a level-of-care as opposed to a type of treatment intervention" that "is often established in communities desperately searching for less expensive forms of acute, 24-hour care." Programs have a very distinct role to play in providing intensive services to mentally ill patients experiencing acute psychiatric episodes, and may also be useful in shortening hospital stays. Ideally a CRP would have a working agreement with acute psychiatric

¹ This is a draft, unpublished document submitted to SAMHSA for inclusion in its EBP Toolkit.

hospitals, hospital emergency rooms, mobile crisis teams, hospital inpatient psychiatric units, law enforcement and other related entities that will ensure appropriate referrals. Provided that the level-of-care needed determines placement, it is the most cost-efficient and effective service option available.

Crisis residential treatment is a positive, temporary alternative for people experiencing an acute psychiatric episode or intense emotional distress who might otherwise face voluntary or involuntary commitment. Programs provide crisis stabilization, medication monitoring, and evaluation to determine the need for the type and intensity of additional services within a framework of peer support and trauma-informed approaches to recovery planning. CRPs often include treatment for co-occurring disorders based on either harm-reduction or abstinence-based approach to wellness and recovery. The safe, accepting environment nurtures the individual's process of personal growth and is essential to individuals as they work through crises at their own pace. They operate under a flexible, social rehabilitation model that adapts to the needs of the client at the time. They emphasize mastery of daily living skills and social development using a strength-based approach that supports recovery and wellness in homelike environments. CRPs do not schedule services for the convenience of the facility or arbitrarily assign systemic requirements for the sole purpose of consistency and efficiency. Their residential setting creates a continuum of care with links to community resource centers and supports that ease the transition into independent living.

The flexibility of the CRP model makes it extremely well-suited to address the specific needs of special populations such as Transition Age Youth, who are increasingly institutionalized due to lack of alternatives. Over the last twenty years, CRPs have successfully admitted and treated individuals who are at risk of harm to themselves or others, may be dually diagnosed, or have otherwise come to the attention of the psychiatric emergency system. Experience has shown that there are no kinds of behavior that that cannot be addressed successfully at this level of care.

Target populations of CRPs may vary, but the following principles are consistent throughout the most successful models:

- Creating a residential community/setting that places an expectation on the client to participate in the day-to-day operation of running a household, practice basic living skills of budgeting, meal preparation, and housework, and social/interpersonal skills, even when distracted by personal or external crises.
- Recruiting staff (including mental health clients/survivors/persons in recovery) that bring a wide range of experiences and perspectives, are not uncomfortable with clients in psychiatric distress, and with enough flexibility to skillfully function in an open, rather than clinical, environment.
- Involving clients in creating their own treatment plan, defining their immediate and long-term goals, and deciding how those goals will be met.

- Differentiating the program from institutions by creating program flexibility, individualizing treatment, and committing to the principle that no types of behavior should be excluded, yet maintaining awareness of the therapeutic capacity of the facility to avoid overloading staff and residents.
- Recognizing that the open environment of a CRP is a strength that allows recovery to proceed unimpeded, uses a more trauma-informed approach, and provides a more accurate assessment of the client's ability to function outside of the program.

Existing Treatment Systems

When articulating the argument for re-orienting public perception of CRPs from that of an “alternative” to a preferred, mainstream care system, it is helpful to frame the premise as - an alternative to what? The loss of institutional beds was not balanced by the establishment of community-based care systems originally envisioned by the Community Mental Health Centers Act. California has the largest population nationwide and the poorest array of care options. Between 1995 and 2008 California lost 42 psychiatric facilities and their corresponding 2,816 beds². The California Hospital Association Center for Behavioral Health reports that California had a total of 6,179 inpatient care psychiatric beds to serve its population of 36.5 million in 2007³. The national average is 1 psychiatric bed for every 2,734 persons. California's average is 1 bed for every 5,916 people. Twenty-five California counties do not have any inpatient psychiatric services at all. Increasing the number of CRPs could help fill that gap.

Acute care hospitals are a necessary component in the mental health system of care when physical health issues are present in people experiencing an acute psychiatric episode. Emergency Departments in these hospitals can and do have a role to play during times of acute crises but are not equipped to provide psychiatric care once emergency physical health issues are resolved. Acute psychiatric hospitals and acute inpatient psychiatric units in medical hospitals should only be used for individuals in the most acute phase of their psychiatric crisis and should be considered more of a last treatment resort rather than a first option.

Many people who experience an emotional crisis are likely to have experienced psychological trauma, and have reported feeling re-traumatized when they were hospitalized and forcibly treated^{4,5}. Too often, patients languish in acute medical and

² California Hospital Association Center for Behavioral Health chart “Acute Psychiatric Inpatient Bed Closures/Downsizing - California 1995 - 2008” www.calhospital.org/PsychBedData

³ California Hospital Association Center for Behavioral Health data on number of psychiatric beds in California is sourced from Office of Statewide Health Planning Healthcare Information Division and includes city and county hospitals, but not State Hospitals, and includes county owned Psychiatric Health Facilities.

⁴ U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Situational Analysis for the Development of the CMHS Resource Center to Address Discrimination and Stigma Associated with Mental Illnesses: Final Report*, 2002

⁵ Delphine Brody, *Normal People Don't Want to Know Us: First-Hand Experiences and Perspectives on Discrimination and Stigma*, CNMHC Bay Area Regional Self-Help Project, 2007. The Executive Summary can be viewed at <http://delphinegrll.googlepages.com/execsum>. The full report may be downloaded at <http://strategiesforchange.googlepages.com/>.

psychiatric beds due to lack of alternatives, creating a potential civil rights infringement issue as well as an uncompensated expense for the hospital. Many who have experienced involuntary hospitalization consider it to be an act of discrimination⁶. In California, data shows that African Americans are forced into treatment and hospitalized more often than other groups⁷. Individuals with psychiatric illnesses and no emergency physical health needs are increasingly being transported and abandoned in hospital emergency rooms because of a lack of alternative treatment settings. Hospital emergency rooms are neither a safe nor appropriate place for psychiatric treatment. The increased dependence upon emergency department has resulted in an increase in waiting times and diversions for individuals in need of life sustaining physical health emergency medical care.

Psychiatric Health Facilities (PHFs) are licensed and certified by the Department of Mental Health and provide short-term, acute, psychiatric care, although not necessarily in the least restrictive environment. Stays usually range from three to seven days. PHFs can be either publicly or privately run. The Office of Statewide Health Planning Department (OSHPD) reporting system lists 24 licensed PHFs in 19 counties providing 678 beds as of June 2009⁸.

California Association of Social Rehabilitation Agencies (CASRA) sponsored legislation in the mid-1980's to establish the "social rehabilitation" facility category under Department of Social Services Community Care Licensing (CSS/CCL) and to establish DMH oversight through a programmatic certification process. CRPs fall under this category and are eligible for Medicaid reimbursement. As of December 15, 2009, the State of California Department of Social Services Community Care and Licensing Division reports that there are currently 35 short term crisis residential facilities operating in 18 counties, and providing a total of 417 beds. Current licensing specifications limit the client load to a maximum of 15 per facility, although there are exceptions based on previous or original licensing requirements that were grandfathered in.

The State Maximum Allowance (SMA) for Short-Doyle Medi-Cal Reimbursement rates posted by the Department of Mental Health illustrates a substantial difference in reimbursement rates for 24 hour care between hospitals, PHFs, and CRPs.

24 HOUR CLIENT DAY STATE MAXIMUM ALLOWANCES FOR FISCAL YEAR 2009-10		
Short-Doyle/Medi-Cal Reimbursement Rates		
CRP	PHF	Hospital Inpatient
\$330	\$585	\$1,129

⁶ *Ibid.*

⁷ A 2002 DMH State Quality Improvement Council study shows that a far greater Medi-Cal dollar amount has been spent per African American client, and that African Americans have been placed in inpatient units with far greater frequency per client than other ethnic groups, even while African Americans are under-represented in penetration rates for outpatient services.

⁸ The OSHPD data list of 2009 also reports that three of the PHFs are in "suspense" status, which amounts to a net loss of 105 beds, and Sacramento County Mental Health Treatment Center reduced its census by 50 beds to due to budget cuts in 2009. The actual number of PHF beds is currently 523.

Due to their lower overhead costs for medical staff and general facility expenses, CRPs can operate far less expensively than hospitals or PHFs. In 2008-09, the cost for CRP care was nearly half the cost of PHF care, and slightly more than 25% of the cost of Hospital Inpatient Care.

Aside from the cost savings, CRPs are more effective than PHFs because the smaller scale created by reduced staffing ratios and fewer beds allow for focused, individualized recovery-oriented treatment plans. The homelike environment of a residential setting creates a safe base from which clients can assess their needs and assist in framing their own recovery plan.

Considerations:

- Legislation and court rulings have favored community options for the last 50 years. The Olmstead Act was instituted in 1999 as a mandate to states to integrate those living with disabilities into their communities and accommodate their needs. Crisis residential programs exemplify the intent of the Olmstead Act by providing services in the least restrictive environment in the comfort of a client's own community. Since that time, it has been an upward battle for states to meet that mandate and programs that attempt it seem to be the last funded and the first to be cut. Mental health programs in particular face the double whammy of poor representation due to concerns about stigma, and competing, or incompatible federal and state regulations related to licensing and/or reimbursement.
- The level of care found in CRPs exemplifies the spirit, intent, and guidelines of the Mental Health Services Act (MHSA). It is a recovery-oriented, client-driven system that modifies to the needs of the client for optimal outcomes. Peer-run programs should also be considered and encouraged as part of the MHSA vision.
- The flexibility of the CRP is well suited to meet the specific psycho-social needs of adolescents, adults, and older adults, and the scale is appropriate for addressing and treating co-occurring disorders.
- Substance Abuse Mental Health Services Administration (SAMHSA)/Community Mental Health Services (CMHS) consistently ask for data on reducing the number and duration of involuntary hospitalizations. State mental health funding applications require states to set annual goals of reduced institutional admissions every year and then report on their success in adherence to those goals. Unfortunately, in terms of establishing crisis residential programs as a viable alternative to PHFs and hospitalization, this creates a "chicken and egg" situation. State systems are encouraged to seek community care options, but crisis residential programs have not been standardized enough to mine outcome data and prove their success rates. Most federal grant opportunities typically

require states to incorporate evidence-based practices (EBPs) and use the protocols associated with them, but the lack of standardization has resulted in insufficient baseline criteria or outcomes to merit EBP status. Without funding, the system cannot be standardized and quantified, and without quantified outcomes, the system won't be funded.

- Social awareness and governmental identification and policy support need to be increased. For example, existing Medicaid and Medi-Cal policies serve as disincentives due to ambiguous distinctions between 'room and board' and treatment in residential settings. This lack of identification and definition makes it difficult to establish a less restrictive, individuated client-centered system of care. Federal Medicaid regulations prohibit billing for room and board, but neither the federal nor the state governments have fully defined what is, or is not, "room and board" in the context of a residential treatment facility. Counties have been allowed to define room and board since 1992, but the State Department of Mental Health has not confirmed its agreement with county definitions, and residential treatment providers frequently find their billing challenged during audits.

Recommendations:

1. Request MHSA funding to create additional CRPs, including peer-run crisis residential programs. Capital Facilities funding could be requested to acquire facilities, and Community Services and Supports (CSS) funding could be requested for operational support. This would meet the MHSA funding regulations by not supplanting any funding streams, increase infrastructure of care, and could fill in funding gaps left by inconsistent Medi-Cal/ Medicaid regulations. The flexibility to blend Medi-Cal and MHSA funding might ensure a better array of services, more individualized care, and better provide "whatever it takes" services to a larger group of people.
2. State and community mental health systems should take the opportunity presented by the architecture and intent of the new 1115 waiver proposal to advocate for crisis residential programs as the foundation of the restructured system of care. They fully meet the goals of the new waiver in that they have demonstrated improved outcomes, can slow the long-term expenditure growth rate, and emphasize coordinated care.
3. Improve existing performance indicators and data collection to document effectiveness of crisis residential treatment facilities. SAMHSA should support studies that compare outcomes of hospitalizations and CRPs and demonstrate their respective efficacies.
4. Request that the DMH produce and post data showing expenditures for 24 hour modes of service by county annually.

5. Request that the DMH create a resource directory that includes information on Americans with Disability Act (ADA), Fair Housing law, and site/zoning considerations. The DMH should contract with a professional organization to provide technical assistance to people wishing to establish crisis residential programs in their community.

The MHSA is intended to transform the “fail first” crisis-based system to a “help first” recovery-based model. MHSA Services and supports are based on the successful AB 34/2034 model, which reduced clients’ hospitalization days by 55.8%⁹. Mental health funding has always been the most vulnerable of all the social services and, in the face of ongoing state budget troubles remains the last apportioned and the first to be cut.

In keeping with MHSA principles, DMH set a benchmark for CSS implementation to increase client-run services, including crisis services, and reduce institutional care¹⁰. Despite nearly thirty years of research and documentation demonstrating their effectiveness and cost-efficiencies, CRPs still face the barriers of public and professional resistance, federal and regulatory biases, lack of facilities, and the political will to support them. Clients use crisis residential programs, including peer-run crisis respite programs, when they are available.

Recovery, resilience, wellness, and community have always been the cornerstones of the Crisis Residential Program model, and they are entirely congruent with federal and state mandates for community-based mental health services. The economy and effectiveness they represent makes the need to “mainstream” them into the community an essential priority for every county mental health department straddling the two worlds of human needs and fiscal constraints. Crisis Residential Programs are a time-tested yet long-underutilized model whose time has come.

⁹ CA Dept. of Mental Health (DMH) Director Stephen W. Mayberg, *Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness*, May 2003, P. 5.

¹⁰ DMH, *Vision Statement and Guiding Principles for the DMH Implementation of the Mental Health Services Act*, February 2005.