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# Characteristics of Adult Residential Crisis Stabilization Units in Virginia

S.A. Larocco

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**Institute of Law, Psychiatry, and Public Policy**

1228 CEDARS CT. | SUITE 102 | CHARLOTTESVILLE, VIRGINIA 22903

PHONE: 434.924.5435 | FAX: 434.924.5788 | WEBSITE: UVAMENTALHEALTHPOLICY.ORG


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## Summary

In recent years there have been dramatic increases in admissions to both public and private hospitals. Residential crisis stabilization units (CSUs) have been suggested as a possible solution to this problem, allowing an alternative environment where people in crisis can go instead of the hospital. This report explores the characteristics of Virginia's adult CSUs, including the populations they work with and the features and resources that allow them to do their work. CSUs work with patients with depression, anxiety, bipolar disorder, post-traumatic stress disorder or substance use disorder, but they are not equipped to care for patients with medical complexities.

## Contents

# I. Introduction

Over the past three years, temporary detention order (TDO) admissions to state psychiatric hospitals have been on the rise in Virginia. This creates unsafe conditions as state hospitals reach, or at times exceed, their capacity. At the same time, admissions to private hospitals have been increasing, resulting in a shortage of beds across the system.

One strategy that might relieve pressures on the hospital system is to provide residential crisis stabilization as an alternative to hospitalization. Residential crisis stabilization provides a place for people to stay during a psychiatric crisis where they will have access to therapeutic services they need in order to stabilize, but are still encouraged to engage with community resources. These units have up to 16 beds. Stays are of limited duration, unlike stays in acute inpatient facilities, which can last for months, sometimes over a year, although the latter is rare in non-geriatric patients. Virginia's Department of Medical Assistance Services does not reimburse for more than 15 days of crisis stabilization per visit or more than 60 days per calendar year.

Virginia's Department of Behavioral Health and Developmental services provides the following definition of crisis stabilization units:

> "Residential Crisis Stabilization Services provide direct care and treatment to non-hospitalized individuals experiencing an acute crisis related to mental health, substance use, or co-occurring disorders that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in crisis, and mobilize the resources of the community support system, family members, and ongoing rehabilitation and recovery. Residential crisis stabilization services are provided in a community-based program licensed by the Department. These services are planned for and provide overnight care."[1]

In considering CSUs as an alternative to acute inpatient hospitalization, several questions arise. It is necessary to know the characteristics and circumstances of the patients they work with, factors impacting the volume of admissions, the services that they can provide to patients, the safety features and protocols that allow them to work with patients at risk, and the funding sources that allow them to continue to provide services.

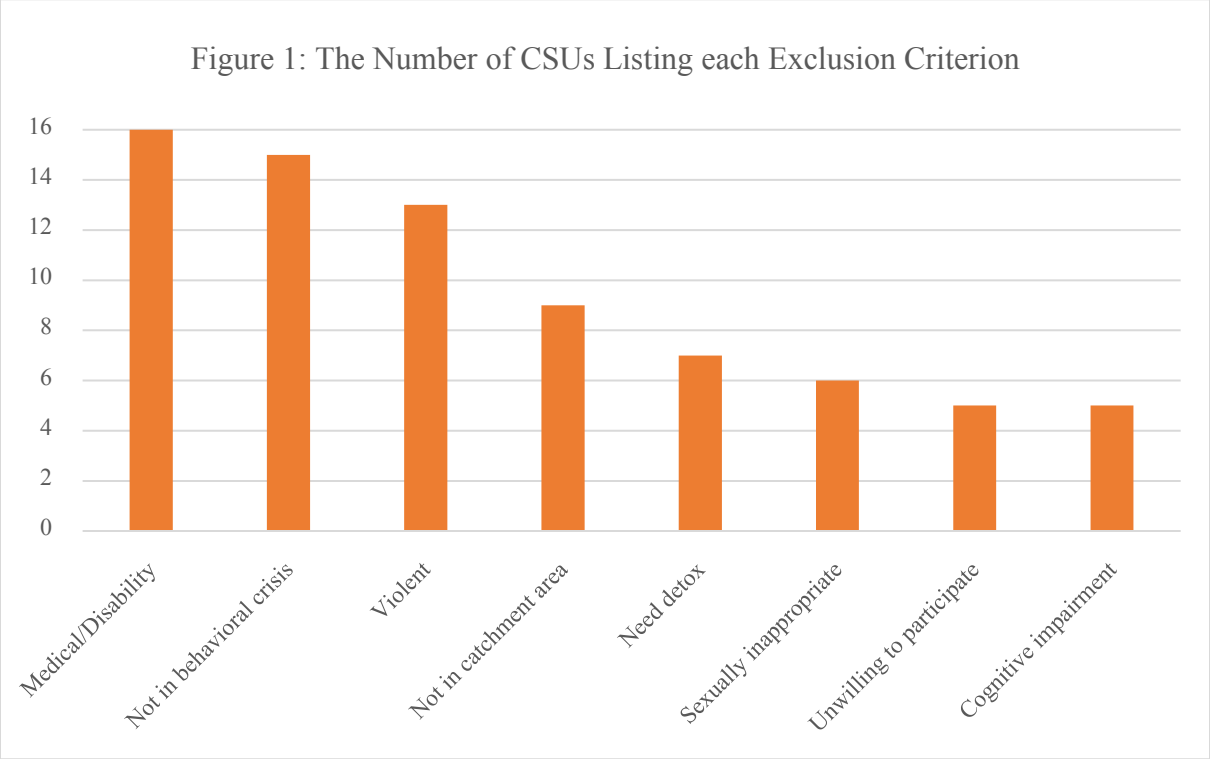
# II. Data Sources

Staff from CSUs across the state of Virginia filled out a 26-question survey asking them for information on their intake process, the types of clients they work with, volume and type of services they provide, security and financing. All sixteen free-standing adult CSUs across the state that work with patients 18 years of age or older participated.

# III. Populations Served

## A. Inclusion/Exclusion Criteria

There were a variety of patient characteristics that could be cause for excluding applicants from CSU treatment. The unit at Virginia Beach excludes clients if treatment at a more restrictive level of care, such as inpatient hospitalization, has not led to improvement. The unit in Roanoke excludes clients who have friends or family already on the unit. The unit in Prince William County does not allow patients with commercial insurance. The remaining official exclusion criteria are depicted in Figure 1. All CSUs accept patients with co-occurring substance use disorders, as well as transfers from acute psychiatric wards. Only nine units accept patients who were transitioning out of state facilities after having been judged not guilty by reason of insanity (NGRI).




A CSU may have many reasons for exclusion, but not all of those are applied frequently. The representatives from the CSUs were asked which reasons for rejection were the top five most frequently observed at their unit. Medical complexity is the most often cited by far, having been observed regularly in 13 of the CSUs. Nine of the CSUs say that they commonly received applications from patients who are too acute, and require hospitalization. Eight CSUs list patient refusal to participate in treatment as one of the most common reasons for rejection. Seven CSUs observe frequent applications from patients who were not, in fact, experiencing a behavioral crisis that required residential care. There were also seven CSUs that list violent behavior as a frequent reason for rejection.

CSUs do not always reject applicants based on exclusion criteria. There were five units that list bed unavailability as a frequent problem. This is likely due to high volume of appropriate applicants, as the average length of stay for these five units is not remarkably high (Table 1). The average length of stay for the other CSUs ranges from five to 15 days.

| Table 1: Average length of stay in CSUs with frequent bed shortages. | | |
|---|---|---|
| CSU Name | Catchment Area | Average length of stay in days |
| Community Alternative for Recovery and Empowerment (CARE) | Northern Region | 9 |
| New Horizons | New River Valley | 5-7 |
| Brandon House | Prince William County | 8.5 |
| Richmond | Central Region | 5-7 |
| Recovery Center | Virginia Beach | 5 |

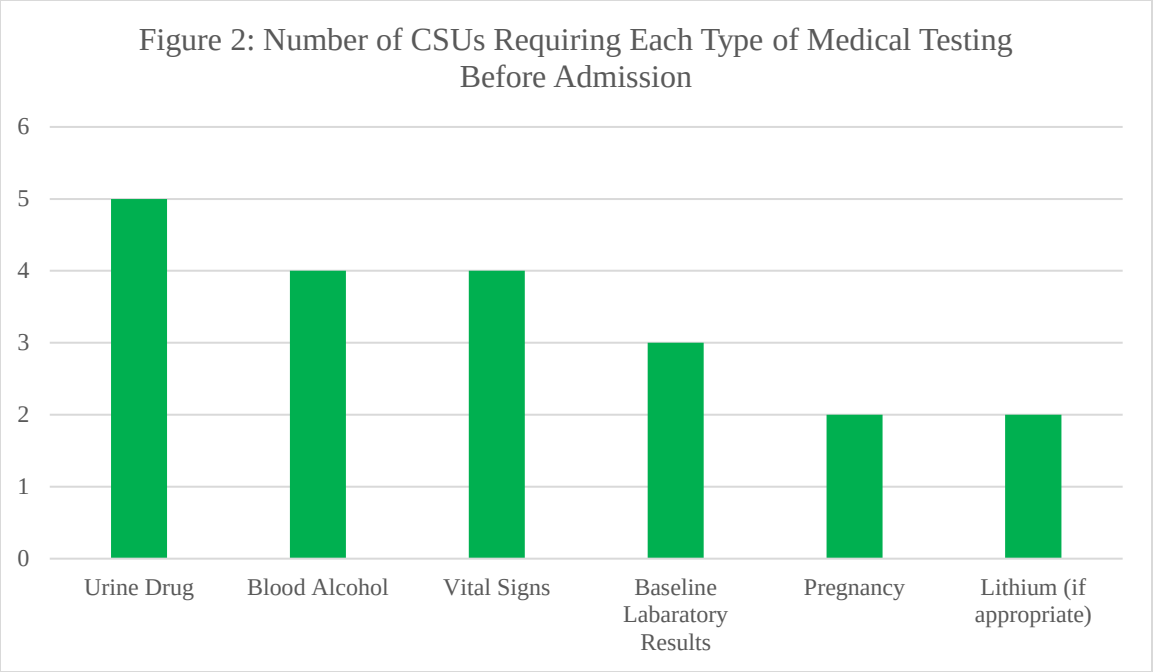
Nine of the CSUs stated that winter was their busiest season, including the units in Prince William County, New River Valley and the Central Region. Some reported that this winter-related increase was driven by homeless applicants. Five reported no pattern, including the CARE program and the one in Virginia Beach. There were two CSUs in the Hampton Roads area that reported being busy in the summer, and the unit in Marion reported being busy in spring and fall.

### B. Intake Process

The intake process determines who can be admitted, how they can be admitted and when they can be admitted. All of the adult CSUs reported having admission hours all day, every day.

Each unit has slightly different processes for admission and different paperwork. The CSU in Arlington requires clients to sign a release of information form before they can be admitted. The CSU in Lebanon requires identification. The CSU in Prince William County requires an evaluation from a psychiatrist to determine need for medications. The CSU in New River Valley is the only unit to allow referrals from a client's ongoing mental healthcare provider, although they also accept referrals from community services board (CSB) Certified Preadmission Screening Clinicians, also known as prescreeners. There are eight CSUs that require clients to undergo a pre-admission screening by CSB prescreeners, and six additional CSUs that require complete mental health screenings, though not necessarily through the CSB.

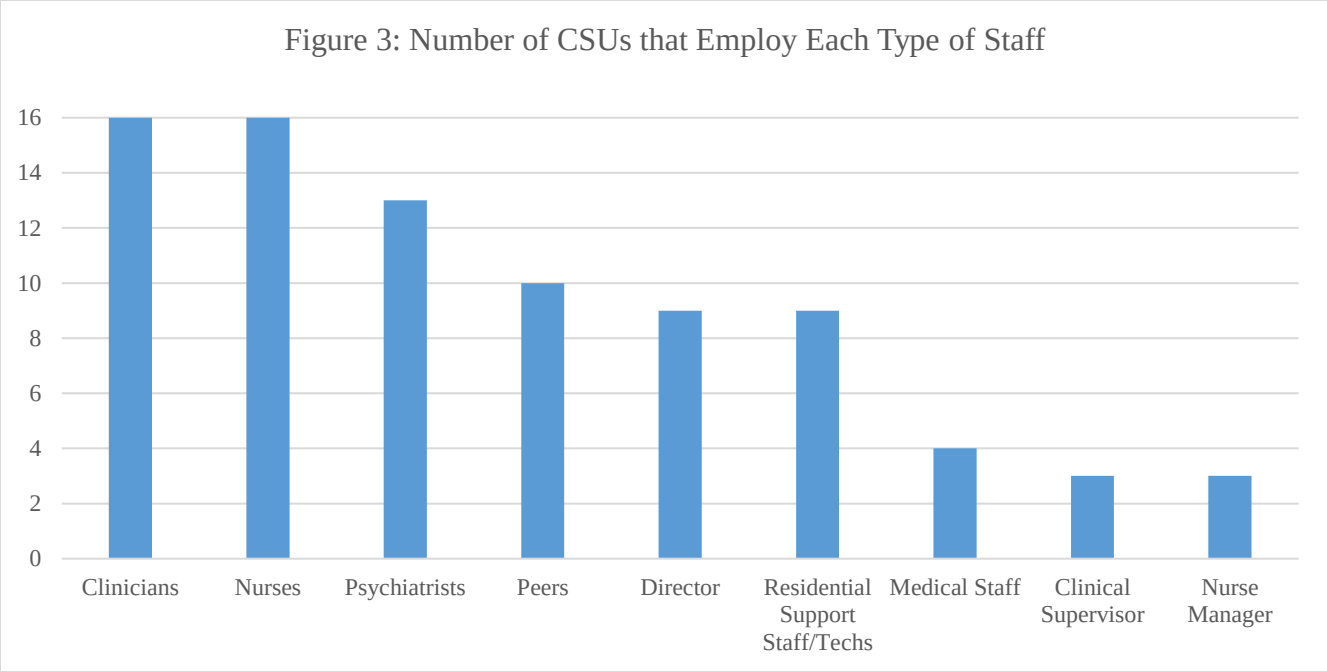
There are also different approaches to medical screening. The CSU in Arlington requires transfer clients to have physician notes from the hospital. The CSU in Lebanon requires a tuberculosis test. The CSU in Fredericksburg requires glucose testing. Other types of medical testing are listed in Figure 2. Five units do not require any medical testing.




# IV. Services

## A. Staff Coverage

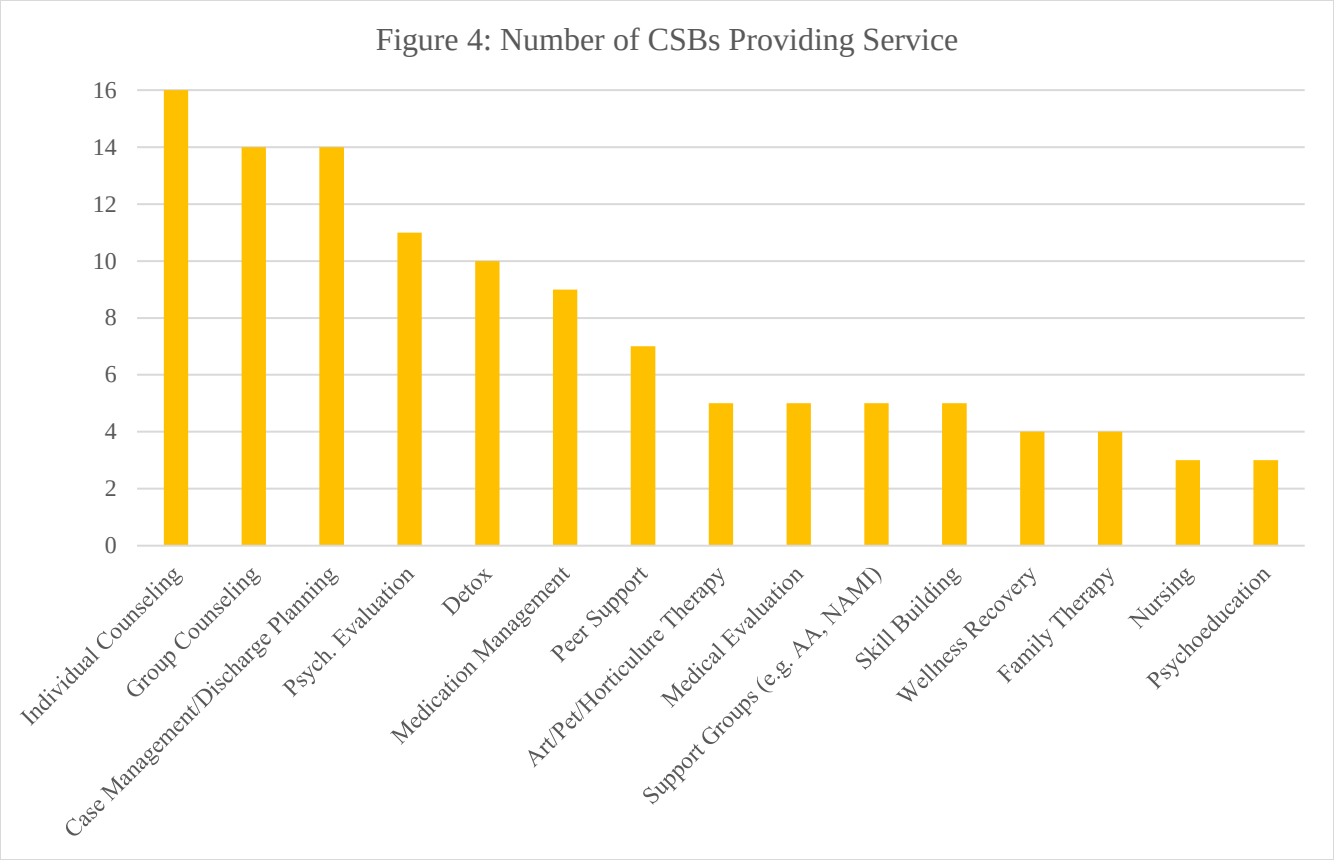
CSUs are designed to be therapeutic environments. They provide a variety of services, which require a mix of professional and paraprofessional staff. The unit in Lynchburg has three certified nursing assistants on staff. The one in Charlottesville has a case manager and the one in Radford has a qualified mental health paraprofessional. Other types of staff are listed in Figure 3.




Eleven units employ different levels of staffing at different times of the day. Eight of those 11 also have reduced staffing on the weekend. Three of them have staff on call to come in as needed depending on the changing needs of the CSU milieu.

### B. Services Provided

CSUs are expected to offer 8 hours of scheduled programming a day, every day of the week. There were variations in the services provided at the different CSUs. The units in Lebanon and Norfolk provide trauma-focused therapy. In addition to this, the unit in Lebanon provides educational services. The unit in Fairfax County provides employment services. The units in Lynchburg and Virginia Beach provide health education services. The units in Fairfax County and Marion provide groups specifically for people with co-occurring mental health challenges and substance use disorder (SUD). The units in Charlottesville and Harrisonburg provide Dialectical Behavior Therapy, a mixed-mode treatment designed for clients with personality disorders, although it is used for other purposes. The other types of treatment are shown in Figure 4.




Mental health skill-building is a broad term for training that is specifically tailored to people with mental health challenges who have difficulty managing their daily lives and functioning in the community. These skills can include housekeeping, money management, employment skills, social skills training, behavioral self-management and other skills of that nature.

Case Management is not a type of treatment, but it supports treatment. It involves evaluating a client's diverse needs and collaborating with their various service providers to facilitate optimum progress.

Psychoeducation entails helping people with mental health challenges understand their condition and the purpose, risks and potential benefits of recommended treatment approaches. This has been shown to improve the results of treatment in patients with depression.[2] Group psychoeducation has been effective in improving treatment results in patients with bipolar disorder.[3]

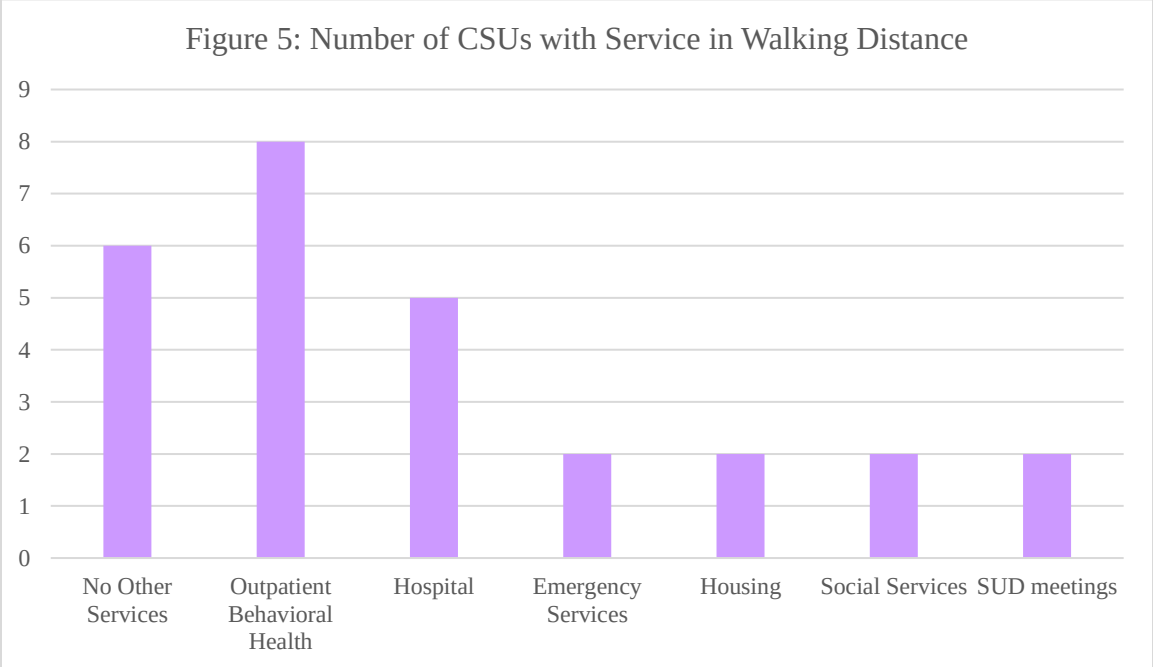
Pet therapy is much like other types of therapy, except that animals are brought in to assist. Art therapy is a type of therapy in which art is used as a medium of communication. Horticultural therapy involves gardening or other plant-based activities, moderated by a mental health professional. Research suggests that horticultural therapy reduces symptoms of anxiety and depression.[4]

The Wellness Recovery Action Plan (WRAP) involves the development of strategies for helping a client identify when their symptoms are worsening. The client develops a list of resources and activities that can be used on a daily basis to improve their mental health, and they create a crisis plan and post-crisis plan for if they become worse. A typical WRAP plan takes a long time to fully develop, but it gives individuals a say in their recovery, which is empowering. Research suggests that WRAP is helpful in reducing addictive behavior.[5]

Peers, in this context, are people who have a history of mental health challenges that clients can relate to. They offer emotional and practical support to clients and teach them coping skills. They can facilitate groups, function as a mentor to an individual, and assist in developing advance directives. For programs that offer WRAP, peers are a critical part of that process, with some of them specially trained in it. Peer support has been shown to reduce depressive symptoms.[6]

### C. Access to Other Services

Unit representatives were asked if their program was located within walking distance of any other services. This can make discharge planning and care coordination easier if staff can walk people to their service providers. It also supplements the activities within the CSU if the client's other providers or referrals can meet with them before discharge. The unit in Charlottesville is the only one that reports being within walking distance of employment services. Other services are listed in Figure 5.



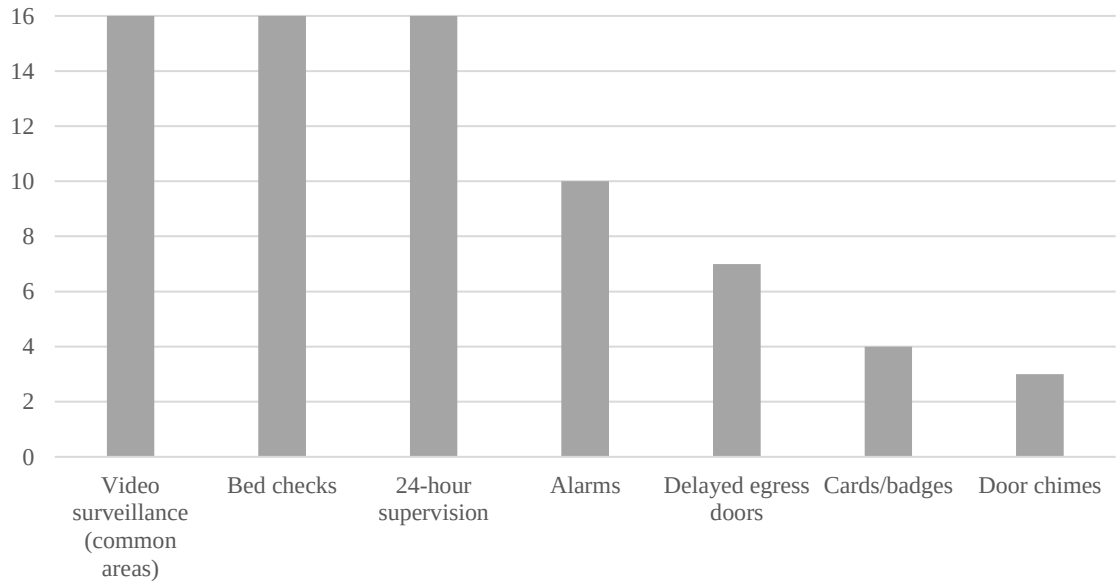

## V. Safety and Involuntary Status

When a person in a state of psychiatric crisis cannot be treated safely through outpatient care, and that person either will not or cannot consent to inpatient treatment, the CSB

prescreener, who conducted their pre-admission screening, sends their written report to a magistrate to request a temporary detention order (TDO, Code of Virginia § 37.2-809). A TDO places a patient at an inpatient facility for up to 72 hours without the need for their consent, with possible extensions if the 72 hours ends on a weekend. By the end of the TDO period a person will receive a psychiatric evaluation from an independent evaluator and a commitment hearing will be held. At the commitment hearing, a judge or special justice will ask the individual if they agree to stay at the hospital for treatment for three days and then provide a 48 hour notice on desire to be discharged. If the individual declines this then an involuntary commitment hearing is held. The judge or special justice will review the evidence presented to determine if the person meets the criteria in the state code for involuntary commitment or if they can be released. From 2013 through 2017, TDOs increased dramatically, according to data provided by the Supreme Court of Virginia.

None of the CSUs have a formal policy against accepting TDOs, although the Central Region unit has not taken any TDO applicants due to the layout of their physical plant not being deemed appropriate for the applicants. CSUs have implemented physical security features allowing the CSUs to be licensed by DBHDS to accept individuals subject to a TDO, as well as other individuals with a higher acuity. The CSU in Lynchburg has Plexiglas windows and observation windows on the doors. The Central Region unit has metal detectors. The unit in Prince William County has sensors on the windows and doors, and the one in Norfolk has security guards. Other, more common security features are listed in Figure 6.

Figure 6: Number of CSUs with Each Security Feature




There are also prescribed protocols for handling clients when they are aggressive or agitated. All licensed CSUs are required to have behavior management training for staff, so that they know how to de-escalate clients verbally. The use of physical restraints is rare in CSUs due to the fact that they are not staffed to provide this while still being able to manage the other

clients. Clients who are likely to require physical restraint are denied admission for this reason. The unit in Lynchburg utilizes mental health first aid, and the one in Harrisonburg uses limit-setting as appropriate. Other approaches are listed in Figure 7.

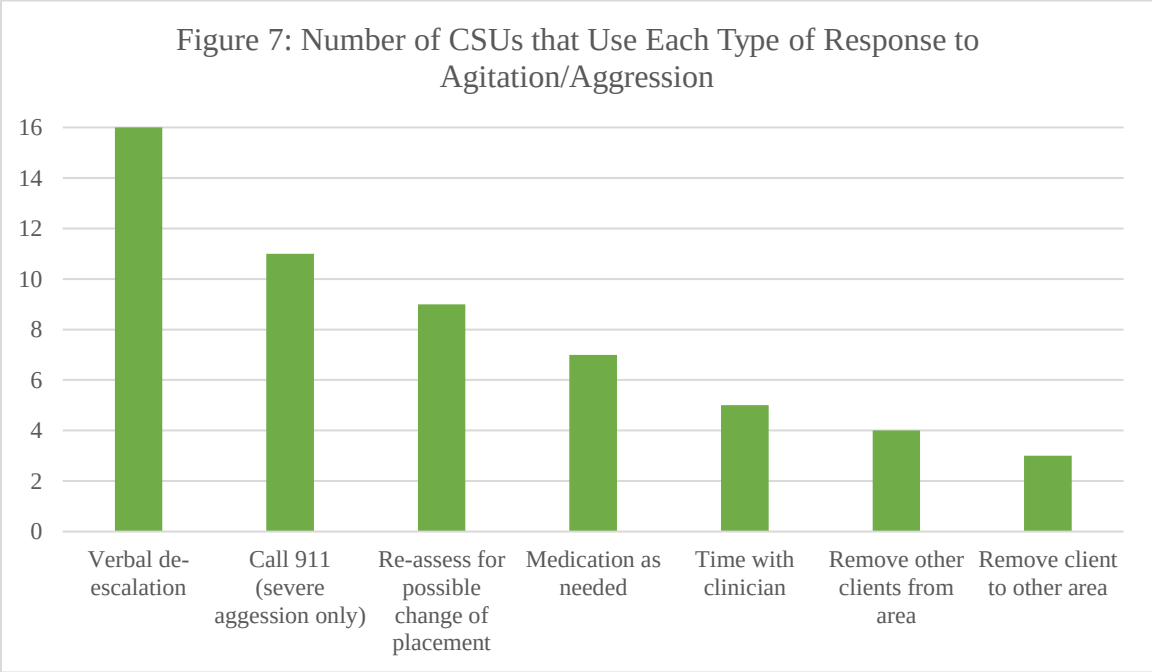



Figure 7 makes it clear that verbal de-escalation techniques are the cornerstone of CSU management of challenging or concerning behaviors. Three approaches to verbal de-escalation were described: Therapeutic Options, the Crisis Prevention Institute approach (CPI), and Mandt.

The Therapeutic Options program is used in five CSUs. Therapeutic Options is a program that uses individualized supports, relationship-development and communication-based de-escalation to prevent the need for physical restraint. There are also physical restraint approaches that can be used as a last resort.

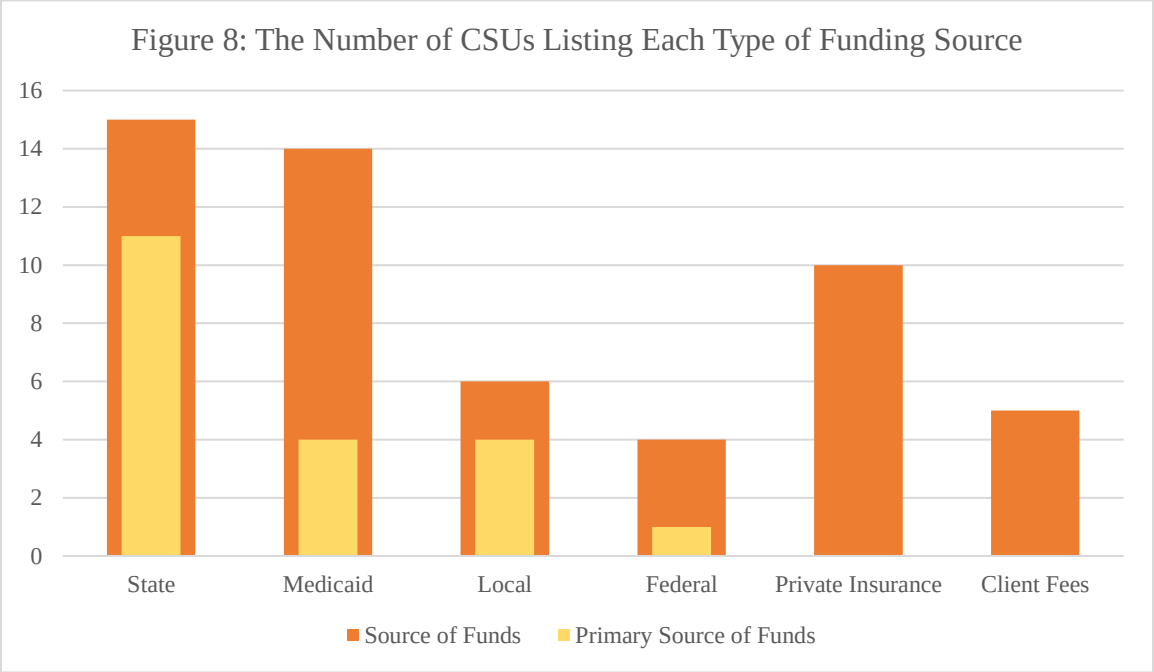
Five other CSUs use methods endorsed by the Crisis Prevention Institute (CPI). As with the Therapeutic Options approach, physical restraint is used as a last resort. The emphasis is on de-escalating behavior problems before they become dangerous, using a variety of verbal approaches that are geared toward the specific nature of the escalating behavior.

The unit in Fairfax County uses the Mandt system to handle patients who become physically aggressive or agitated. The Mandt system involves building healthy relationships between the patient and staff to allow staff to teach the patient healthy replacement behaviors and minimize dangerous or concerning behaviors.

## VI. Funding

Funding for CSUs comes from a several sources: local government, state funds, federal funds, Medicaid payments, private insurance payments and client fees. The CSU in Roanoke also receives payments from other CSBs. Figure 8 shows the number of units that receive

funding from each source. The counts of primary sources of funding are greater than 16 because some of the CSUs list two main sources of funding.




Eleven units mention that financial constraints are limiting their ability to provide the quantity or array of services that they would wish. Desired improvements include larger space to serve more clients, automatic medication dispensing cabinets, presentation technology, Naloxone to prevent future opioid overdoses, more staff training and promotions or outreach for mental health services. Some units desired more staff in order to provide medical detoxification, more therapy hours, more weekend support, nursing services for more challenging clients or security for more challenging clients.

## VII. Tracking Outcomes

Fifteen CSUs solicit feedback from clients about their satisfaction with the program. Eleven use surveys and two use confidential comment cards or a suggestion box. Client satisfaction is important, but quantifiable mental health outcomes are also critical to determining the usefulness of a CSU stay is to an individual.

Approaches to measuring mental health outcomes varied considerably. The CSUs in Lynchburg, Marion and Virginia Beach monitor their discharge data for trends in placement. The unit in Fredericksburg follows up with former clients to determine utilization of community services as well as hospitalizations. The CSUs in the Northern Region (Northern Regional, Fairfax County, Prince William County, Arlington), review data on discharges, readmissions and hospitalizations monthly. The CSUs in Harrisonburg and the Central region used the Behavior and Symptom Identification Scale (BASIS-24), a 24-item assessment used to measure symptoms of mental illness at the end of stay[7]. The units in Norfolk and the Central region use the Patient Health Questionnaire (PHQ-9), a nine-item inventory of depressive symptoms, to determine depression severity at discharge[8]. The Central region CSU also uses the Columbia Suicide Severity Rating Scale (C-

SSRS), a measure of suicide risk[9]. The unit in Lynchburg uses the Post-Traumatic Stress Disorder Checklist[10].

## VIII. Conclusions

Virginia's adult crisis stabilization units are designed to meet the needs of patients with conditions such as depression, anxiety, bipolar disorder, post-traumatic stress disorder and in some cases a co-occurring substance use disorder, who find themselves in a behavioral health crisis that cannot be managed safely through outpatient care. Their patients can be aided with verbal de-escalation techniques. For these patients, the CSU can divert them from more costly acute hospitalization. They can also help people transition out of acute care more quickly if the individual has partially stabilized to the point that they no longer need the more restrictive type of treatment.

CSUs are not, however, equipped to care for patients with complex medical needs or patients whose symptoms are too severe to allow meaningful participation in the available services and therapies. Challenges related to patients with complex medical needs are particularly pressing, as evidenced by high numbers of clients being denied admission to CSUs for that reason. Other alternatives need to be developed for this population. There is also a need for expanded crisis response capability in places that frequently reject appropriate applicants due to high utilization.

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