

THREE DAY CRISIS RESOLUTION UNIT

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SUMMARY

This paper describes a three day crisis resolution unit within the confines of the psychiatric emergency service of a general hospital. It utilizes a crisis model of acute intervention, time limited psychotherapeutic approach combined with family therapy, and psychotropic medications when indicated. 136 consecutive admissions were reviewed, 49% were discharged within 72 hours, and 51% required further hospitalization. 77% of the patient's discharged had involved families (significant others) in the treatment process, in comparison with only 28% family involvement with those patients who needed further hospitalization. This may be even more significant for psychotic patients who were discharged (14/18 family involvement) versus those who needed long hospitalization (13/50 family involvement).

For many reasons there is a trend to reduce the length of psychiatric hospitalization. Most studies have demonstrated few differences in outcome between long term (standard) or brief hospitalization (Burham 1979; Caffey, Gabrecht and Klete 1971; Endicott *et al* 1979, Herz, Endicott and Spitzer 1975, 1976, 1977, Herz, Endicott and Gibbon 1979; Kennedy and Herd 1980; Weisman, Feierstein, and Thomas 1969). Currently in California the number of psychiatric beds for public patients has been drastically reduced and yet there are very few community based alternative programs existing. This has created a crisis in providing services for those psychiatric patients needing acute care and hospitalization. Several authors have reviewed the importance of the role of crisis intervention in the emergency room (Bartolucci and Drayer 1973; Hankoff *et al* 1974) and in preventing hospitalization or reducing length of stay (Rhine and Mayerson 1971). This paper describes an effective alternative treat-

ment program for these patients providing up to three day hospitalizations within the frame work of psychiatric emergency services of a general hospital. The program activity seeks the involvement of the family or important others from the earliest moments of contact with the patient and prompt initiation of the treatment program including medications. It utilizes both a crisis model of acute intervention combined with a time limited psychotherapeutic approach.

Historically our Crisis Resolution Unit (CRU) at Harbor /UCLA Medical Center grew out of the severe shortage of psychiatric beds in Los Angeles County. There was no place to send patients brought in restraints for involuntary hospitalization to the hospital emergency room. With no psychiatric beds available, evaluation and treatment were initiated in the emergency room with the patients transferred in restraints to the medical and surgical wards of our hospital until State hospital

beds became available. The CRU was developed to provide treatment for such patients within the context of the emergency room service. Harbor-UCLA Medical Center is the main country referral centre for public patients from a catchment area of 2½ million people, and approximately 500-600 psychiatric patients are treated in the emergency room monthly. Twenty percent of the emergency patients are subsequently hospitalized in the CRU. The CRU was opened in October 1979, and by November 1982 over 3000 patients have been treated. At the present time 55 % of our patients are discharged within three days.

Organization and Philosophy

The CRU is at present an eight bed unit, with future plans to increase to twelve beds. The permanent staffing pattern consists of an on staff psychiatrist, a psychiatric resident, two social workers and a case worker. Two nurses and attendant are on duty during every eight hour shift.

Patients are referred from the emergency room for admission to CRU who fulfill the criteria for a 72 hour involuntary hospitalization (suicidal, homicidal or gravely disabled). CRU criteria for admission are the following: 1. Crisis situation, 2. Acute psychotic episode, 3. Psychosis with acute exacerbation of recent onset in a chronic patient, 4. Those with a history of good response to medications and prior treatment. Diagnosis, severity of psychopathology, duration of illness, and social resources per se are not influential in our admission criteria.

Each patient is assigned a primary therapist (nurse, doctor, social worker). The therapist's role is to obtain good history, make an initial formulation and diagnosis, and to choose a universal issue around which treatment will revolve. All the staff are made aware of this issue, and work individually with the patient and family in this

area. Psychotic patients are treated with rapid neuroleptics. Therapeutic levels of neuroleptics, antidepressants, and lithium are reached within the shortest period of time.

Patient stay varies from hours to three days. Each morning there is a one hour group meeting open to all patients and staff. Patients learn a great deal from other patients and they are encouraged to take a therapeutic role with each other. In the group the patients are directly confronted with their problems and become aware of each others problems, and hopefully they support and assist each other. This happens with considerable regularity thereby allowing group process to be continued throughout the day in an informal manner between patients and family and staff. Group meetings are conducted early in the day after which the individual and family sessions are scheduled. An art therapy group is conducted every afternoon. The staff spends the remainder of the day interacting with the patient and with their family members in an informal manner. The needs of all present are considered and assigned high value with the emphasis on human contact.

A multiple etiological model, is emphasized in treating the patients. Crisis arise because of changes which may occur initially at any one of the biological, psychological, interpersonal, economic and sociological systems affecting the individual (Mendel and Green 1967). As Caplan (1964) states "The essential factor influencing the occurrence of crisis is an imbalance between the difficulty and importance of a problem and the resources available to deal with it". The CRU combines both crisis theory with a psychotherapeutic approach based on short-term, brief psychotherapy similar to the approach of Mann (1973). The major universal issue with which the patient is struggling is identified and treated. These issues include self-worth, loss or termination of relationship, death and dying, sepa-

ration and individuation from the family in the development of one's own identity, independence vs. dependency and omnipotency vs. impotency.

Family involvement and treatment on the first day of admission is strongly emphasized. CRU staff assume that there are great matters of importance to discuss with family or significant others concerning the patients' problems and recognize the relationship between family and the patients' psychopathology. In the therapeutic process, significant others (not just the immediate family) are involved in both short term and post CRU treatment plans (if they were willing). These discussions and plans take place in the presence of the patients.

Results

From May 1 through July 15, 1980, 136 patients were hospitalized in our CRU, 49% were discharged within three days and 51% required further hospitalization.

Their charts were reviewed (unable to locate one patient's chart). Demographic factors related to this population are noted on Table 1. Over half the patients had prior hospitalizations and 50% were psychotic on admission. Approximately 25% of the patients had made a suicide attempt and over half were suicidal on admission. Thus individuals with severe psychopathology made up most of the patient population. As noted on Table 1 the majority of our patients were below 45 years of age and both sexes were equally represented. The patients were divided in this study into three diagnostic categories, psychosis, major affective disorder, and personality-character disorder. Psychosis included atypical or brief psychosis, schizophrenia and paranoid disorders. Drug screens were done on those patients suspected of a drug related psychosis. Major affective disorders included both manic depressive illness and major depression. Personality disorders consisted of bor-

Table 1

Age	Home (n = 66)	Further Hospitalization (n = 69)
15-24	25	22
25-34	17	22
35-44	16	12
45-54	6	7
55	2	6
Sex		
Male	31	32
Female	35	37
Marital Status		
Single	34	35
Married	18	14
Widowed	3	4
Divorced	8	10
Separated	3	6
Diagnosis		
Psychosis	18	50
Affective disorders	4	10
Personality disorder	44	9

Table 2

	Discharged with Family Involvement	Further Hospitalization with Family Involvement
Psychosis	14/18* 78%	13/50 26%
Affective Disorder	2/4 50%	2/10 20%
Personality Disorder	35/44 80%	4/9 44%
Total	51/66** 77%	19/69 28%
*P < 0.001		
**P < 0.002		

derline, sociopathic and schizoid personality an Axis II diagnosis and/or adjustment disorder with depressed mood on Axis I.

The CRU model worked best with personality and/or character disorder i.e. 83% discharge and least well with psychosis - 26% discharged within three days. However, we also reviewed our records in order to see which groups had involved families or significant others working with them in the CRU i.e. were involved in family session, since they are actively included within our treatment plans and encouraged to participate. There was a marked difference in outcome between those who had family involvement and those who did not in terms of who needed further hospitalization (Table

2) 77% of patient's discharged within three days and involved significant other or family in the treatment in comparison with only 28% family involvement with those patients who needed further hospitalization ($p < .001$). In the psychotic group there was significant difference between those discharged with family involvement vs those needing further hospitalization ($p < .002$). Overall 73% of the patients (51/70) who had important others participating the therapeutic process were sent home after three days. In comparison only 23% (15/65) were discharged who received only individual treatment without family intervention.

Discussion

The purpose of our retrospective study was to examine several issues. First, can a short term crisis resolution unit have a viable, effective integral treatment role within an acute general hospital? Second, can acutely psychotic patients be appropriately returned home within three days or less? We have found that our CRU does provide an alternative model for longer term inpatient hospitalization. Initially we expected that 30% of our patients would be spared longer term hospitalization. However, within several months of functioning 50% of our patients were able to return to the community and presently 55% of our patients are being discharged.

The last issue is what kind of patient may benefit from such a service. The results of our study revealed that 83% of our patients with personality disorders returned to the community in comparison to only 26% of the psychotic patients. Such a finding is logical as the patients with personality disorders appear in emergency from summarily as a result of acute crisis and within a short time period can return to the community and the psychotic patients usually need longer treatment than three

days. However, if the variable of the involvement of a family or a significant other is considered the results suggest that return to the community as significantly related to the involvement of a family member as well as to the diagnosis. In fact family involvement may be even more significant to those who are psychotic, who need a supportive caring social system. This is demonstrated by the fact that 14 out of 18 psychotic patients who were discharged had family involvement versus only 13 out of 50 psychotic patients who needed further hospitalization ($p < .002$). Thus if families are included in the treatment process a significant higher percentage of patients can be discharged to the community regardless of diagnosis. Thus family involvement can significantly decrease the length of hospital stay.

We have consistently run into problems when the "family" is seen for the first time on the third day. Although the patient is ready to return home, the family may seem resistant or unwilling to accept the changes in the identified patient. Or the late arriving family may make us more fully aware of the extent of the pathology in patient or family. Our plans or goals have to be changed at the last minute, resulting in further hospitalization. By including the "family" early, it becomes possible for the staff to validate the patient's perspective of his problems, to be aware of the group pathology and its effect on the patient, and to make effective decisions as to on how much of the patient's support system can be utilized for our post-CRU planning.

A three day time limit is an important factor in helping the patient to mobilize his or her external resources. It is very important to have an existential, here and now approach, but one must be aware of the impact of personal history, environmental and support system on the individual's present situation. We do not expect to markedly

change behaviour in three days. However, we can offer a cognitive understanding, labeling and explaining the major issues and how the individual is dealing with it. This understanding may help reduce the feelings of being out of control, overwhelmed, and hopefully make one curious about himself. We subsequently refer the patients to the appropriate mental health facility and encourage them to continue to work on their problems within the community.

Therefore, our initial study demonstrates that our CRU program can play an important role with hospitalized patients. A three day time limit forces the patients to confront their illness and problems, and to utilize their support systems and resources. The CRU is cost effective, therapeutically useful and prevents pressure on the inpatient facility. At a time of diminishing Mental Health resources, short term approaches are appropriate. Our results confirm that working with both the individual and his family or significant other helps in maximizing care, provides better treatment, shorter hospital stay, and more fully utilizes our depleting resources.

References

- BARTOLUCCI, G. & DRAYER, C.S. (1973), An overview of crisis intervention in the emergency room of general hospitals, *American Journal of Psychiatry*, 130, 653-660.
- BURHAM, A.S. (1969), Short term hospital treatment: A study. *Hospital and Community Psychiatry*, 20, 369-370.
- CAFFEY, E.M., GABLRECHT, C.R. & KLETE, C.J. (1971). Brief hospitalization and after-care in the treatment of schizophrenia, *Archives of General Psychiatry*, 24, 81-86, 1971.
- CAPLAN, G. (1964), Principles of preventive psychiatry. Basic Book Inc. New York.
- ENDICOTT, J., COHEN, J., NEE, J., FLEISS, J.L. & HERZ, M.I. (1979), Brief vs. standard hospitalization for whom? *Archives of General Psychiatry*, 131, 47-50.
- HERZ, M.I., ENDICOTT, J. & SPITZER, R.L. (1975), Brief hospitalization of patients with families: initial results, *American Journal of Psychiatry*, 132, 413-418.
- HERZ, M.I., ENDICOTT, J. & SPITZER, R.L. (1976), Brief vs. standard hospitalization: the families, *American Journal of Psychiatry*, 133, 413-418.
- HERZ, M.I., ENDICOTT, J. & SPITZER, R.L. (1977), Brief hospitalization: a two year followup, *American Journal of Psychiatry*, 134, 502-507.
- HERZ, M.I., ENDICOTT, J. & GIBBON, M. (1979), Brief hospitalization: a two year followup. *Archives of General Psychiatry*, 36, 701-705.
- KENNEDY, P. & HIRD, F. (1980), Description and evaluation of a short stay admission ward, *British Journal of Psychiatry* 136, 205-215.
- MANN, J. (1973). Time limited psychotherapy. Cambridge Howard, University press.
- MENDEL, W.M. & GREEN, G.A. (1967), The Therapeutic Management of Psychological Illness. Basic Books, Inc., New York.
- RHINE, M.W. & MAYERSON, P. (1971), Crisis hospitalization within a psychiatric emergency service. *American Journal of Psychiatry*, 127, 122-127.
- WEISMAN, G., FEIRSTEIN, A. & THOMAS, C. (1969), Three day hospitalization a model for intensive intervention, *Archives of General Psychiatry*, 21, 620-629.