# Findings from a Consumer/Survivor Defined Alternative to Psychiatric Hospitalization

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## Introduction

Having a place in Tompkins County New York where people could retreat to if they viewed themselves in need and at risk of psychiatric hospitalization was the primary purpose of the Crisis Hostel Project. This place, which would consist of staff who had "been there," a simple set of rules, meditation/massage space, raging space, was many years in the planning. During its evolution we applied for and were awarded a National Research Demonstration Grant to operate and evaluate the Crisis Hostel. In the session myself, Jeanne Dumont, who served as principal investigator, and Kris Jones, the cost analyst investigator, present the outcomes findings of the project.

We'd like to begin by telling you upfront about our findings. We found that access to and actual use of the Hostel significantly contributed to healing, empowerment and satisfaction with services. In addition, we found that people with access to and who actually used the Hostel spent less time in the hospital. This shift in acute care services use, coupled with the lower per diem costs of the Hostel as compared with the general hospital, accounted for modest cost savings. Thus we conclude that the Crisis Hostel was an effective innovation. How is it then that an effective innovation is not currently in operation?

You are all probably familiar with the story of the three little pigs and the wolf that blows down their houses. When we consider the gap between research and services there may often be various versions of what happens in translating particular findings into practice. Even with the three little pigs there's the story according to the wolf you might not be aware of. Mr. T. Wolf as he refers to himself claims circumstances are what brought the houses down. A bad cold, big sneezes. He was just looking to borrow a cup of sugar to make a cake for his sick grandma. Although there was no big bad wolf that blew the Hostel away, the research itself was both friend and foe — Foe in that vying for continuing funds before all the results were in, the service was held to a higher effectiveness standard than pre-existing services.

We would now like to describe the service and research components of the project in further detail and providing the evidence, we would like to take some time to talk with you about the existence of a hostel as a viable service option.

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The Crisis Hostel, involving a small five bed residence, operated for two years in Tompkins County, NY, as an alternative to psychiatric hospitalization. Throughout the project's planning and development, ex-patients and other consumers provided the initiative, expertise, concepts and staffing. A National Research Demonstration Grant funded by The Center for Mental Health Services was awarded to operate and evaluate the project. The type of evaluation that was conducted should provide insight for consumers and payers who are searching to improve the existing delivery system of specialty mental health services.

The Crisis Hostel Project distinguished itself from other crisis centers in its consumer/survivor involvement, voluntary non-medical model, self-definition of need, and basis in peer support. This alternative was designed to avoid the involuntary treatment system and the negative ramifications associated with inpatient hospitalization, e.g., disruption, loss of control, traumatizing treatment, avoidance of help, exaggeration of conditions to get in. Consumers also felt that retreating to a healing supportive environment sur-

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rounded by others who have experienced similar problems or who show an implicit understanding of the effect of the experience could help them learn from and work through a crisis.

Organizers believed that this alternative would result in less frequent and shorter durations of crisis service use, either of the Crisis Hostel or traditional hospital-based services. They predicted that persons with access to the Crisis Hostel would experience a movement toward healing/recovery, a greater sense of empowerment and satisfaction with services than would person without access to the Hostel. They predicted that the reduction in use of crises services would lower crises service and total mental health treatment costs, when compared to the usual treatment system.

## Methods

Using a random design, the presenters investigated these outcomes for 265 participants having or not having access to the Crisis Hostel (CH). All study participants had been labeled with a DSM-III R diagnoses. They had experienced substantial hospital stays with a majority having had four or more admissions and a median 'longest stay' or over one month. The median annual income of the group was $8,400.

Persons in the test group had access to all CH services. CH services included preparatory Hostel training, crisis services, on-going workshops, peer counseling, advocacy and entry to a rage or meditation/massage room. Use of CH services was voluntary. Test group members also had access to usual services as did the study's control group. The control group was not able to avail themselves to CH services. Both groups were evenly distributed on all baseline variables.

Participants were assessed upon admission to the study, and both at six and 12 months with measures of empowerment, healing, symptoms, hospital admissions and length of stay, job maintenance and satisfaction with services. They were also asked about stays in the Crisis Hostel, the local community hospital and state hospitals as well about use of community-based specialty mental health services. Providers were contacted with the consent of participants to provide information concerning volume of service use. Each service category was assigned a unit-cost based on accounting data.

## Results

The test group had better healing outcomes at the six month interval (p=0.04) and when a repeated analysis was conducted from baseline to 12 months (p=0.05). With respect to empowerment, the test group had greater levels of empowerment than the comparison group at the 12-month (p=0.02) and when repeated analysis was conducted from baseline to 12 months (p=0.01). Both groups reported the same number of hours spent in paid or volunteer employment over the entire study period.

Not surprising, the test group reported that the CH offered crises services that were more timely and useful by more competent staff who respected the consumer's rights than persons receiving usual crises services only. Greater levels of promotion of healing and self-care had been experienced by the test group than experienced by the control group. All in all, the test group had greater levels of service satisfaction than the control group (p=0.00).
In the six months prior to entry into the study, a greater proportion of persons in the study group experienced hospital admissions (24.7% vs.17.5%). Despite this, during the first six months the proportion of the test group with any hospital admissions was a similar 11.9% as compared to the control group's admission rate of 12.6%. While not significantly different in the second six-month period, the proportion for the test group was reduced to 7.7% as compared to a virtual no change in proportion of 13.2% for the control.

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When the length of stays associated with those who had hospital admissions were taken into account, those in the test group did stay in the hospital for shorter periods than the control group. Over the year, the average stay was 10.7 days for the test group and 15.15 days for the control group. Hospital stays for those with hospital admissions in the control group were nearly fifty percent greater than the test group. This difference did not reach a level of significant difference. However, a repeated measure approach that took into account the entire sample did find a significant difference in mean hospital stay (p=0.02).

Turning to whether or not a service system that includes a CH would

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result in lower costs, a comparison of the two groups' psychiatric hospital costs (measure as inpatient stay-cost and emergency room service-cost) found that persons with access to the CH experienced significantly lower psychiatric hospital cost over the study period (p=0.05). Their average cost were $1,057 while the control group's cost averaged $3,187. The control group's crisis services costs were over 200 percent greater than those of the test group's. Even when the CH costs are combined with the other crisis service costs the test group average costs trended lower than the control groups. Their total crises service average costs were just $2,018. Or, the test group's costs are slightly greater than a third of the average cost for the control group.

When all specialty mental health services are included - the crisis services cost as well as the expenditures on community mental health service and supportive housing programs, the test group was still associated with lower treatment costs. The test group's average cost for this expanded set of services was $9,088 and these costs averaged $13,919 for the comparison group. This represents a cost difference of $4,831 per person over just a year's time!

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## Conclusions

In nearly all areas, persons who had been assigned access to the CH were associated with both better outcomes and lower costs. Persons in the test group were associated with greater levels of healing, empowerment and satisfaction. They experienced no less disruption in their work life. Hospital stays were relatively less frequent and shorter. Crisis service costs and total mental health service costs were lower for the test group than for the control group.

So what do the findings suggest about the existence of a hostel as a viable service option? And can savings be realized even as persons are given the choice whether and when to use an overnight night hostel?

We found that people's self assessments of their need to use the hostel ran the gamut from taking a time-out, to early prevention of crisis, to actually being in a crisis that in the past resulted in a hospitalization. People added the hostel to their service use or substituted the hostel for other service options such as the hospital.

During the study period, the Hostel was used as an early prevention option for the majority of users. They made use of the Hostel instead of doing whatever they would have done if the Hostel didn't exist, which in some cases included nothing, or included either riding the crisis out or finding that it was exacerbated with time, and more drastic measures such as going into the hospital were realized either on their own volition or through involuntary means.

In some cases, the Hostel was used in addition to the hospital. Usually persons went into the hospital and then subsequently used the Hostel. On average hospital stays were comparatively shorter for persons with access to the hostel than for those without access. If a hostel were to become a service option and not merely a temporary innovation during a grant period, we think that a hostel might continue to be used in a step-down fashion; however, people would also more frequently turn to the hostel instead of hospitalization. This would be facilitated by people working at the hospital referring people to the hostel. In this project, attempts were made to facilitate hospital personnel seeing the hostel as a choice instead of a hospital admission, but we think it would be more likely to be realized if a hostel was in operation longer and positive findings from testing its effectiveness were distributed.

Finally, we think that with a hostel operating for a longer duration and persons learning how best to use it to fit their individual needs, for example, having period short term overnight stays, or making use of ongoing trainings and drop-in support, we would find that a hostel would be substituted for other service options, including high-end residential support. Although it's primarily through the substitution or use instead of hospitalization that cost savings would be realized, the findings from the Crisis Hostel Project suggest that the comparatively low cost of a hostel to a hospital would render modest cost savings even when a significant number of people add such an option to their support system or service utilization pattern.

The Hostel stemmed from the expertise of consumer/survivors and their desire for an entirely voluntary choice based on their self-defined needs. Since the findings point to effectiveness and modest cost savings, we hope the findings will translate to the implementation of voluntary self-defined alternatives to hospitalization in practice. ▲