Peer Services in a Crisis Setting; The Living Room

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Background

META Services is a non-profit agency that has been contracted through publicly funded sources to operate behavioral health emergency crisis services in Maricopa County for the past ten years (1996-2006). The crisis services operated by META throughout most of this time were the licensed screening sites in Maricopa County for involuntary commitments due to danger to self or others. The center received referrals from the police, jail, hospital emergency rooms, clinical teams, and families. There were two different locations, one on the west side in the city of Peoria, and one in central Phoenix. The services were available, free of change, to any of the 4 million people living in the County who were experiencing psychiatric difficulty. The two sites served over 13,000 people each year, of which nearly 4,000 were brought in under an involuntary status, usually by law enforcement. Approximately 50% of those who used the services were there for the first time and around 25% were first time users of psychiatric services all of whom were human beings with a wide range of issues and situations. Both facilities were licensed as an inpatient sub acute program, giving them the same status as a hospital with the capacity to hold people involuntarily. They were staffed with multi-disciplinary teams, overseen by psychiatric staff.

The Clientele

Once we made a commitment to re-gear services and programs to align with recovery principles and practices, we took a close look at what was actually happening in the crisis programs. It became immediately clear that a lot of work needed to be done. We wanted to understand who the people were who were coming in for help, and what they wanted. We found that some people were there only because they were forcefully and involuntarily brought there by other people who believed them to be a danger to themselves or others. Some people came voluntarily because they were frightened by their own thoughts and feelings and needed reassurance, support and/or medication. Other people came because they didn't know what else to do. Many of these people were homeless, hungry, with no other alternatives. Many of them were self-medicating with other prescription medications, street drugs and alcohol. They tended to fall below our materialistic cultural standards of cleanliness, self-sufficiency and self-control because of their life circumstances. They were often disheveled, poorly dressed, and had issues with personal hygiene. Some were angry due to being brought in against their will. Most were overwhelmed, frightened, in pain, confused and disconnected from themselves and their reference points that connect them to what is familiar and comfirming.

The Staff

We took a close look at what our staff did to help people and found that while they weren't consciously aware of it, many staff members often reacted to people in the above described condition with low expectations for each person's ability to recover. This lack of hope created an environment that promulgated a lack of motivation and momentum that is necessary to move recovery forward. Staff themselves, tended to operate in a crisis mode of management, reacting to the situation or behavior instead of responding to the needs of the person being served. This only added more "crisis" and confusion to an already chaotic situation. This often caused them to overlook the person's inherent strengths and resources by focusing primarily on the problems or challenging aspects of the behaviors exhibited by the person. Staff were then left trying to solve problems and manage behavior instead of engaging the person in a way that would empower them to come up with their own plans and solutions. While it was not uncommon to catch a glimpse of the recovery process taking place in the people being served, it was often missed because staff were focused on the problems instead of the person.

The Services

While people's reasons for coming to the crisis program varied dramatically, they were more or less treated the same – with medication – usually sedatives used to calm them. Medications lessened the external evidence of a problem and/or quelled the challenging behavior. This sometimes gave the person a chance to "rewind" their life enough to get back on track. It sometimes gave staff a chance to assess the person's level of distress and their options and either move them back into the community or to a higher level of care. In fact, m*oving the person on* often seemed to be our goal. Armed with our new knowledge about recovery, we asked ourselves: Did people leave with a renewed sense of hope and self-determination that could add meaning and purpose to their lives? Did they learn how to better manage their life circumstances so they could avoid this experience in the future? Did we learn anything about them or ourselves that could increase our skill in serving people? … Or did we just *move the person on*? These questions created a context that gave us the courage to make some changes that were considered radical, but to us they were absolutely necessary. Early in this questioning, it became clear to us that the use of seclusion and restraint was an approach that re-traumatized people and did not promote recovery. As a result, we began to consider new ways of being with people that promoted wellness, recovery and resilience and entirely avoided the use of seclusion and restraint (see META article on eliminating seclusion and restraint).

The Solutions

The changes we had in mind would have a significant impact on the crisis services. We weren't sure if or how we could reach our goals, but we knew from our other experiences with peers joining our workforce that they could provide a lot of the energy, strength and hope we would need to make the necessary changes. We have other articles available on how we reached our goals of eliminating restraint and seclusion in these facilities, and on how to create recovery environments, and on the appropriate

training for peers working in crisis settings. For the purposes of this paper, however, we will focus now on the impact peers can have in a crisis program, and on the work they have done in the Living Room Program.

The Living Room; Central Phoenix Location

In our quest to solve the problems that were keeping us from being a recovery oriented crisis services, we knew that one of the things that would have to be addressed early on was the sub-standard facility we were working in at the Phoenix location. While this seemed like a relatively straight forward solution, it took way too long to address it. We had explored many other optional spaces and had requested repeatedly to move this program to another location. Our funding source was willing to consider this and tried to negotiate other options. However, months and years would pass with little progress toward a solution. Some relief came when a space next to the existing facility opened up. This was not ideal and would not solve the systemic issues we were grappling with, but would allow us to create a better environment for those coming to us for help and support. During the initial walk-through of the vacant space, we tried to visualize ways of making the best use of it. We had been reinventing our company to be recovery oriented, and during the process had come to understand that the "more is better" approach often compounded the problem instead of solving it. In fact, doing more of what was already not working usually did not produce the outcome we had hoped for. Shifting a traditional behavioral health program to a recovery based services required more than just tinkering with what existed; it required more than a jumble of minor changes. It required a transformation. With this in mind, we decide to do something completely different with our new space. Instead of just adding more of what wasn't working so well to begin with, we would introduce a whole new concept.

We had already experimented with adding peers to the workforce in both crisis facilities with positive results. We also had added peers to all of our other programs with great results. The next logical step in our progression then was to use this new space as a peer operated crisis alternative. We had watched them enter into new ways of being with people and successfully engaged those who were distant, deescalated those who were agitated, and inspire those who had learned to be helpless and hopeless. Our peer employees receive 70 hours of peer employment training, plus another 35 hours of orientation training before they join our workforce. We knew we would need to add a little more training to those who worked in the Living Room in order to assure their level of competence in areas that were unique to a crisis setting. We also felt that maintaining the integrity of peer interventions in a crisis setting could be more challenging due to the emergency nature of the work. We knew that the most effective contributions peers could make would come from a position of mutuality, sharing their own recovery experiences, and holding the hope for those who had lost track of who they were.

We wanted to create an environment that was less clinic-like and more comfortable and natural. I didn't take long for us to come up with a living room setting with couches and a TV, a refrigerator with snacks, and rest areas around the perimeter in small rooms

that had been little office spaces before. We furnished the main room like a living room, and the rest spaces had futons in them so people could sleep comfortably if they wanted to. There were a couple of small office spaces where peers could meet privately with people if they wanted to, and where they could do paper work.

A few weeks later we started hiring peer staff. We knew we'd need a nurse to stop by throughout the day. As luck would have it, we had a nurse who worked in the crisis clinic -- just on the other side of the double doors -- who found this concept believable, so we arranged for her to drop by throughout the day, and/or be on-call to the peer staff.

It's fair to say that most of the medical staff on the crisis side of the house were quite annoyed when they realized this plan was actually going to come to fruition. We had consistence positive outcomes by using peer employees in our other programs by now, and had under estimated the resistance we would encounter form the medical staff who had had limited exposure to peers in their work force. We met with them in order to understand their concerns. They had many reasons for resisting this idea. First of all, they wondered why we were using the new space for such an unconventional purpose when they needed the space to expand what they already did. They also had concerns that the living room would become a "flop house where anyone could stop by and hang out whether or not they were in crisis". Mostly, their concerns evolved around safety. They were afraid the peers would be at risk and in harm's way if they were subjected to the daily stress and risks present in the crisis environment. They were also afraid for their own safety saying that since the peers would not be able to handle the risk factors, this would put them all at more risk. Then there were issues related to workload coverage and an assumption that peers should not carry their share of the work. We had long since learned from our other peer operated recovery programs that most of what the staff were saying would not prove to be true. But since this staff had not worked with peers before, they would not have known the level of courage and competency of this workforce.

Marianne Long was the first peer employee META had hired, and she was picked to head up the Living Room program. She had already been working in the crisis area as peer support leader and knew the territory. Marianne took the lead in meeting with the medical staff and was fully supported by the crisis manager, Rosa Gillespie. The peers did a great job of expressing their excitement and their competencies, but we can't say that the medical staff were convinced. When the issues of safety surfaced, the peers reminded staff that they themselves had been in the crisis clinic several times, and that they were not frightened of being there. Regarding the "flop house" concerns, staff were reassured that this was still going to be a crisis service, and that all referrals to the Living Room would come through them.

And so we began. The first day was a little awkward, but as relationships developed between the medical staff and the peer staff, things started to roll. Business was slow for the first month, but picked up shortly afterwards as the medical staff learned how to use and appreciate the skills and knowledge of the peers. If they were working with someone who had an issue with substance use, they would bring them over to talk to one of the peers who had recovered from substance use to explain how it could happen

and to give them hope that they too could recover. If they were working with someone they could not engage, they would often bring in a peer who could engage on a mutual level, gaining trust and confidence that could further the recovery process. At one point, Marianne asked the Medical Director what had shifted, and why the referrals had sky-rocketed. The answer was very rewarding: "I can't speak for anyone else, but I've been sending people over here because you guys write better discharge plans than anyone else here."

Peoria Location

The Living Room in our Central Phoenix facility had been in operation for about a year and a half before we were able to replicate it in our facility in Peoria. This new Living Room had opportunities that we had not been afforded in the central space which was locked and only allowed for a stay of up to 24 hours. The new space in Peoria was unlocked and had eight beds with stays up to five days. Some of the same concerns surfaced from staff, but this was mitigated by the strong support the Living Room had in central Phoenix. Of course the strongest objection had to due with this Living Room being unlocked, but that subsided after a few months of successful operation. Probably the most astonishing learning experience we had with this program came when we looked at the discharge statistics after the first month. Before the Peoria Living Room had come on-line, the center had been sending an average of 16 people each month on the hospitals. The first month of having the peer operated Living Room in operation, that number dropped to six. At first we thought this was a mistake in our data collection system, but the second month this number dropped to five. The third month the number held steady at five. The only change had been the opening of the peer operated Living Room. What were those peers doing to make such a big difference?

Upon further investigation, the answer became clear. When people were engaged by the regular crisis staff trained in traditional ways of assessing and evaluating people, the focus tended to be almost exclusively on the person's problems. This appeared to overwhelm the person even more and render them less capable of identifying workable solutions. When the peers listened to the same stories people came in with, they were more likely to say something like, "I know what you mean. I have that too. This is something you can recover from – let's think of what you can do to get over this. So without pathologizing the situation, or exaggerating it by making it the singular point of interest, the peers where engaging people in conversations about recovery instead of illness. The outcome was much more positive and better prepared the person to negotiate the problems that had brought them in for help.

The Central Phoenix Living Room program was eliminated in November, 2005 when the Regional Behavioral Health Authority (RBHA) took over this crisis services and moved it to the new location we had been hoping for. They wanted to redirect the focus of the crisis services to be more of a traditional medical model service, and changed the name from "Psychiatric Recovery Center" to Urgent Psychiatric Care". META Services still operates the Psychiatric Recovery Center in Peoria will continue to institute changes

that move the model towards an innovative recovery-based alternative to the medical version offering the people of Maricopa County choice in how and where they will respond to and be assisted through their psychiatric “crisis” experiences.
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Guidance for the Future

In the fall of 2005, we held a total of three focus groups with people who had either used one of the crisis programs, or had been hospitalized for psychiatric care. The topic of discussion was this: “If you were to need crisis services in the future, tell us what type of facility and program would be the most helpful in promoting your rapid recovery?” Here are the answers that will serve to guide our thinking in the future development of recovery services for those in immediate need of intervention:

- A place that looks and feels more like a home than like a clinic or hospital. A place that feels natural and has a friendly accepting and supportive environment.
- A place where I will be treated with respect and dignity that is non-judgmental about my condition or situation. A place where I feel safe and valued.
- A normal mode of transportation not involving law enforcement, which makes us feel like we’ve broken the law by being ill. If you would come and pick us up, we’ll go voluntarily.
- We want a continuation of META’s policy of not using restraints or seclusion. We also don’t want chemical restraint. These approaches set back our recovery process.
- A place with lots of peer staff on board who can give us hope and remind us who we really are.
- A place where we can be in contact with our friends, families and children; where they can come and be with us during our hard times.
- A place where we can access food and snacks. We’d like to make a sandwich, or get someone else a cup of coffee.
- A place with outside space so we can be outdoors if we feel like it.
- A place that provides interesting things to do, activities that will promote our recovery process.
- A place that offers medication education and choices.
- A place that offers lots of help with recovery – recovery planning, recovery options, and good solid plan for recovery when we leave.
- A place we can come back to if we start to slip, and not worry about being locked up.

Frequently Asked Questions about the Living Room

- **How is the peer staff in the Living Room supervised?** We have created a career ladder that allows peers to become team leaders and recovery services administrators. In the living room, peers are supervised by another peer in a team lead position. The team leader works reports to the director of the crisis center.

- **What role did the peers play in eliminating seclusion and restraint?** When the central recovery center finally reach "0" restraint, we asked the medical staff what helped them reach this goal. Without hesitation, they said "the peers". Peer staff are very good at de-escalation and engagement. "Having been there" puts them in a position to relate to people on a different level that is non-threatening and mutual. These characteristics seem to create a level of trust that permits people to relax and participate in their exit plans.

- **What changes would you make if you could start over?** See the points listed above under ***guidance for the future.*** We would get as close as we could to following this guidance we received from those who have used our services.

- **When the peer staff need to use crisis services, where do they go for help?** We leave this up to them. Some of them like to come to the center they work in because they know the staff and are comfortable with their colleagues. Others like to go to the other center because they want a little distance from where they work. Either way is OK with us. This hasn't been an issue.

- **What draws peers to work in crisis services?** The peers who are drawn to working in the Living Room or the Crisis services are often those who have been there for services and have received help from peer staff. This has been so effective, and has made such an impression on them that they feel like this is the place where they want to "give back". Others may work there because it is close to where they live, or because they like the hours or specific shifts.

- **Are peers considered equal members of the team in the crisis setting**? Yes. In all of our programs, peers are considered equal members of the team. They have earned an ITE degree (I'm the evidence) and we consider it to be as valuable as any other degree and an important contribution to the team.

- **Were staff trained in how to work with peers and include them as a member of the team?** Yes. This is an important aspect of having integrated teams. Peers need to be well trained in what they do and staff need to be trained in how to work with peers. Untrained staff are likely to treat peers like junior members with less knowledge and a less valuable contribution. This is a huge waste of talent.

- **What kind of programming takes place in the Living Room?** The daily programming is built around what each person wants to do. Peer staff are able to create individualized activities, as well as group activities if people want to do things together like watch recovery videos, complete recovery planners, etc. Peers also help connect people with the things in their lives that need attention, or that help them get back on track. They are experts in discharge planning by supporting people in finding creative community opportunities.

- **Is burn-out a problem with peers working in crisis settings?** Peers may suffer less from burn out than other staff, but it does happen. We use a part of the Peer Employment Training called “Meaning and Purpose at Work” to combat this. We often retrain peer staff in this material to help them regain as sense of what their work means to them and how they can make such a meaningful contribution to others.

- **How do peers working in the Living Rooms manage to avoid being “co-opted” and operating like junior staff?** This also takes continuing training. For this we use something called the “Recovery Tune-up” when we think peers may be loosing their edge and slipping into a role that is lees valuable.