An Inpatient Skills Training Stabilization Model

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A recovery orientation during brief psychiatric hospitalization focuses on improving adjustment and functioning and reducing future psychiatric crises and hospitalizations. Crisis rehabilitative skills training imparts knowledge, understanding, and abilities during a critical period of restabilization. After describing a rehabilitation oriented skills training program that occurs during brief inpatient treatment, information about its effectiveness and efficiency are examined. The preliminary data indicate rehabilitative skills training during acute inpatient crisis stabilization is an effective and economic tool for improving current functioning and reducing subsequent hospital eliciting crises. Given the promising results gathered from this project, there is a need for controlled studies.

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A recovery vision in the treatment of seriously mentally ill individuals encompasses activities occurring throughout all of the service delivery system, including psychiatric hospitalization (Anthony, 2000; Sullivan, 1999). Although psychosocial skills training and rehabilitation typically are applied in outpatient and community work with seriously mentally ill individuals, they can be effectively employed in structured clinical inpatient environments (Lucca & Allen, 2001). There is some evidence that participation in skills training actually may shorten lengths of stay and result in improved reported satisfaction (Ackerson, 2000). Training that integrates fundamental life skills in the hospital program, regardless of the length of stay, appears essential in preparing a person for a successful return to the community (Bellus, Kost, & Vergo, 2000).

The rehabilitation goal of inpatient stabilization is to enable people to function and grow within their community. Inpatient programs have been effective in decreasing lengths of inpatient stays, but readmissions have increased subsequently. Usually brief hospitalization does not appear to have a prophylactic effect on emergency room recidivism (Davidson et al., 2001).
Currently close to 70% of all inpatient episodes are readmissions (Young, Kapur, & Murata, 2001) suggesting many of our current procedures have fallen short of keeping individuals in the community and out of the hospital. The greatest percent of the costs in treating adults with severe mental illnesses in the public sector results from hospital use, accounting for close to 70% of the total amount (Segal, Akutsu, & Watson, 1998).

Teaching skills to individuals in a group setting may inoculate them against stress-induced relapse (Liberman, Eckman, & Marder, 2001) and the need for multiple hospitalizations. Research strongly supports the use of psychosocial and psychoeducational interventions in mental health treatment (Bustillo, Lauriello, Horan, & Keith, 2001; Torrey et al., 2001). Access to appropriate mental health services, including education, provides consumers with the knowledge, skills, and strategies that can help relieve symptoms and control the effects of stress (Jacobson & Greenley, 2001). Social skills training results in significant improvements subsequent to the training (Tsang, 2001). Psychoeducation for family members also helps reduce rehospitalizations (Amenson & Liberman, 2001).

Psychoeducational skills training may help increase the use of outpatient services as a place to continue learning new skills. Individuals who receive educational and training services in an inpatient setting are more likely to continue getting educational and training services from an outpatient provider. The belief they will and the fact that they do receive services in addition to pharmacotherapy increases their likelihood of using outpatient care during the acute stage of their illness (Centorrino et al., 2001). Individuals who receive outpatient care use less inpatient care (Rabinowitz, Bromet, Lavelle, Hornak, & Rosen, 2001). Learning to problem-solve allows individuals to monitor symptoms, isolate problems, work on resolution, and avoid unnecessary hospitalizations (Thomas, 2000). Involving hospitalized individuals in discharge planning, providing them with education regarding the emotional and behavioral difficulties that often follow hospital discharge, and connecting them to community supports helps them more successfully manage their psychiatric symptoms in the community (Olson, Mechanic, Boyer, & Hansell, 1998; Wells, 1992).

Mental health services for persons with severe mental illness, whether community programs or hospitalizations, should reflect the goals of consumers. Outcome measures need to include their desires to pursue normal, functional, satisfying lives and not just treatment compliance and prevention of rehospitalizations (Drake et al., 2001). Inpatient staff members can enhance recovery by believing in, teaching skills for, and communicating hope for each person’s potential successful return to the community (Bellus et al., 2000; Torrey & Wyzik, 2000). Competent service providers can know and use recovery-oriented crisis intervention, treatment, and support strategies and models applied in hospital settings (Coursey et al., 2000).

When conceptualized in the context of a psychosocial rehabilitation model, an acutely disturbed individual’s arrival on a brief psychiatric inpatient unit initiates a series of clinical and administrative activities oriented toward stabilization and discharge. Usual procedures center on providing the necessary biological (medication) and environmental (therapeutic milieu) supports that facilitate functioning at a level that no longer requires the structure and intensity of a 24-hr protective setting. The time it takes to discharge a person from such settings depends on the type and acuity of the psychiatric condition, the protocols and intervention procedures employed, and the availability and use of community assistance and resources by the inpatient unit’s personnel.

Usually the supports, structure, and safety of the inpatient setting result in rapid symptom relief. The overwhelming circumstances leading to admission are contrasted by a physical and
social environment focused on improving feelings, thoughts, and behaviors. Often the inpatient setting provides the forum to elicit additional assistance and understanding from family and friends.

In addition to being a place to gain symptom relief and support, the inpatient setting can be a primary learning site (Kopolowicz, Wallace, & Zarate, 1998). During the crisis stabilization process, there is a phase in which a person is particularly receptive to the acquisition of new understandings and skills. Crises generally occur when usual coping skills fail, leaving the person feeling vulnerable and helpless, but also more receptive to outside assistance and direction (Caplan & Caplan, 2000). Between the initial overwhelming disruption and the subsequent regaining of control, there is a period of seeking assistance and direction. It is during this period, when defense mechanisms are more permeable, that rapid new learning most likely occurs. Acute inpatient treatment helps stabilize serious crisis-precipitated behavioral disruptions and breakdowns, and thus provides an opportunity to significantly influence the receptive learning phase of the stabilization process. This enhanced learning in turn enables the person to benefit from outpatient and community-based psychosocial rehabilitation services.

Teaching new coping techniques and skills during acute crisis stabilization can be challenging. Hospitalized individuals often are concerned about feeling safe and experiencing some control, and are all too contented to have both their safety and control issues handled by the inpatient setting and staff. Many feel so relieved to be away from overwhelming conditions that they readily become passive recipients of the therapeutic unit’s structure. Often they “regress” to earlier, more dependent phases of their lives, preferring to be taken care of, rather than exercising ways to better take care of themselves. Individuals with extremely disruptive disjointed thinking or behaviors may require further stabilization prior to initiating certain psychoeducational and skill building experiences.

This article describes an acute stay psychiatric inpatient unit that has integrated a psychoeducational skills training model during brief, crisis-oriented inpatient treatment.

The Crisis Stabilization Unit Program

In 1989, Wood and colleagues (Wood, 1993) developed the Inpatient Crisis Stabilization Unit (CSU) program in collaboration with psychologists, psychiatric nurses, physicians, social workers, counselors and therapists, hospital administrators and system monitors, police and legal system professionals, consumers, and mental health advocates. Forms of this program are now being used at other hospitals and facilities throughout the country. The central focus of the CSU program is rapid stabilization through proper psychiatric and psychosocial evaluations and interventions. The broader goal is facilitating the person’s return to the community at a higher functioning level than at his or her pre-crisis condition. Those admitted to the unit are involved in treatment decisions and interventions, actually collaborating on clinical methods and measured outcomes. Collection of evaluation and laboratory data, the development of a team Individual Service Plan with objective measures, the use of multiple medical and non-medical interventions, supportive and psychological individual and group counseling, and psychoeducational skill building are all components of the CSU program.

Psychiatric and Psychosocial Examinations

Prior to admission, an emergency psychiatric screening evaluation is conducted. This usually
occurs following a disturbing event or experience. This screening evaluation assesses the current functioning of the individual in terms of imminent danger to self and/or others, gross disruption of thoughts and/or behavior, and the presence of an identified psychiatric disorder. The screening evaluation data are used to determine if and what level of psychiatric intervention is warranted. Individuals assessed to have significant psychiatric acuity (usually with global assessment of functioning scale scores below 35), recent disruptive behaviors that are possibly part of a crisis reaction, and a recent history of being able to function in the community are eligible to be immediately admitted to the CSU.

Within a few hours of admission to the CSU, psychiatric and psychosocial evaluations are performed. Consistent with standard practice, the psychiatric evaluation assesses the person’s history, including the events leading to the current condition, general medical and psychiatric information, family psychiatric histories, and mental status functioning. This information is used in diagnosing psychiatric disorders, determining needed additional laboratory and other assessments, and making initial treatment intervention orders (i.e., medications, seclusion, special needs). Also, in keeping with standard practice, a physical examination, including laboratory screenings, is completed within 24 hr of admission. This information is used in identifying medical and substance-related problems and recommending specific intervention strategies to address them.

In addition to the above, the CSU admission process includes a specialized psychosocial evaluation. This initial assessment identifies the current specific problematic thoughts, behaviors, and feelings that are interfering with the admitted person’s adaptive functioning and growth. This assessment identifies current and recent distressful events that appear directly, indirectly, or temporally associated with the current disruption in functioning. The intensity of each identified problematic symptom (acute psychiatric reaction, not psychiatric disease) and related distressful condition is rated according to a six-point scale from none to catastrophic (see description below). This initial assessment information is used in categorizing and rating symptoms and stressors to be addressed during inpatient treatment and is reassessed and re-rated at discharge or transfer.

Clinical and Educational Interventions

Admitted individuals are informed in detail about the evaluation and treatment procedures being used and the reasons for the assessments and daily and shift monitoring. An educational plan is developed and documented with and for each individual. Within 36 hr of being on the unit, each admitted person is informed of the psychiatric, psychosocial, medical and laboratory findings, the given diagnoses, the identified symptoms and stressors, and the proposed educational and treatment plan for their consideration, modification, and approval. Each person is involved actively in his or her treatment planning and the resulting agreed upon plan is one he or she reports a willingness to adhere to and follow. His or her perceptions and personal evaluations are included as part of the assessment team’s daily rating and recording of progress or regress, and their desires and input are included in discharge and follow-up planning and decisions.

Discharge is contingent on three primary factors: (a) stabilization of acute, disruptive symptoms, (b) connection and involvement with community resources and supports, and (c) skill acquisition, improvement, and practice.

The identified psychiatric and psychosocial problems are addressed through clinical and educational approaches. Both clinical and educa-
tional interventions occur in a therapeutic hospital inpatient environment that includes supportive clinicians and clinical activities, and a therapeutic milieu.

Clinical interventions, often considered “treatment,” focus on directly handling the specific problems identified in psychiatric, physical, and psychosocial evaluations. Clinical interventions include the use of medications (e.g., to reduce hallucinations), behavioral techniques (e.g., to control aggressive acts), instructional techniques (e.g., to improve sleep), family sessions (e.g., to provide psychoeducation to the family), and resource facilitation (e.g., to address housing problems). These interventions usually are done on a one-on-one basis between the client and a clinician.

Educational interventions focus on teaching methods and skills the person can use to recognize, endure, and handle areas of difficulty. Admitted individuals are taught about their illness, its manifestations, and common associated difficulties likely to reoccur some time in the future. They are helped to understand that their responses to stress may take different forms based on their personal history of handling difficult situations and characteristics associated with their illness. They are helped to see how their current symptoms are related to environmental and social factors, and thus part of an acute crisis reaction. Individuals are shown how to identify and acknowledge early signs of difficulties, and the benefits of employing intervention methods to help avoid future crisis reactions. They are taught how to access support and resources, especially during a crisis. They are educated on how to deal with anticipatory fears such as losing personal control, being rehospitalized or incarcerated, medication complications, mental health system issues, and living problems (i.e., family conflicts, housing troubles, work, transportation, relationships, finances, etc.).

Education on how to define a crisis experience is taught. It is explained that the acute changes associated with a crisis disruption are a reaction to some causative event or events, and not a random experience. The clarification of cause and effect relationships in reference to being acutely hospitalized is used to define crisis experiences more realistically, correct erroneous attributions, and help decrease the random triggering of subsequent crisis reactions. Persons are given information and taught skills on how to deal with common posthospitalization occurrences such as being labeled crazy, having to take psychiatric medication, difficulty readjusting to being in a stress-inducing environment, difficulty sleeping, reestablishing routines, and refacing the stressor that hospitalization avoided.

The focus of training is to teach skills that help individuals adaptively function in the community, thereby reducing postcrisis-hospitalization recidivism. Those in the program are taught prevention, early warning sign detection, intervention (e.g., problem solving, social skills training, assertiveness training, communication training), and support/resource facilitation skills that enable them to cope with many crisis situations in a personally constructive manner. These “training” modules include ways to identify problems and their early signs, ways to solve and/or cope with problems, methods to understand feelings, tools of effective communication, and ways to set and accomplish goals (Liberman, DeRisi, & Mueser, 1989).

Most educational interventions are done in small group settings. Each day a new skill set is introduced in two separate sessions, first didactically in an informational format, then experientially in a skill-practicing format. The daily psychoeducational skill topics are (a) problem solving, (b) communication, (c) goal setting, (d) warning signs, (e) coping, (f) understanding feelings, and (g) health and wellness. During the didactic phase the clinical instructor employs a
structured educational format, giving specific information on a topic, teaching specific techniques to handle problems, and initiating the use of rehabilitative and preventative skills. Informational materials and measures are distributed during these sessions. During the experiential phase the clinician facilitates using and practicing the didactically learned skills. Interactive activities such as role playing, staging situations and exercises, and therapeutic and processing activities are used. The goals of each psychoeducational skill session are to assist in preventing relapse, increase knowledge concerning symptoms and treatment, improve quality of life, maximize strengths and ability to assume self-care, identify health within illness, give specific information and techniques, and preserve normalcy and promote ordinary lives.

Clinical and Utilization Outcomes

Typically inpatient stabilization is rapid. Often those admitted appear calm and rational within a few moments on the unit, almost as if they did not have a major disruptive response a few hours or days earlier. Thus, it is often challenging to assess outcomes.

In general, indicators of inpatient treatment effectiveness are assessed during and subsequent to the period of hospitalization, with the assumption that those admitted should get better during hospitalization and stay better for extended periods afterward. Indicators and measures of on-the-unit improvements tend to consider the impact of services on the individual (i.e., symptom reduction, length of inpatient stay, overall rated improvement, satisfaction with services, and cost of treatment). Indicators and measures of postdischarge functioning tend to look at the impact of the treatment on the service system (i.e., number of repeated psychiatric hospitalizations, the community’s rate of utilizing hospital based and community based services, and the overall service system costs).

Outcome Measures

The skill acquisition and mastery rating scale is part of the Group Record Form described elsewhere (Rogers, McCarthy, & Wood, 1993). It allows ratings of each person’s participation in and demonstrated appropriateness during training groups, using a five-point scale ranging from “extremely poor” to “extremely good.” Ratings on the first and last day of group involvement were made.

The symptom/stressor rating scale is part of the Crisis Rehabilitative Individualized Service Plan (Wood, 2002). It allows disrupting ratings of identified symptoms and stressors on a six-point scale ranging from “none” to “catastrophic.” Ratings at admission and discharge or transfer were used for comparison purposes.

Satisfaction with overall improvement and with treatment and progress feedback is part of the Consumer Satisfaction Survey designed to address community mental health service satisfaction (Wood, 1998). It is a consumer rating that uses “not satisfied,” “satisfied,” and “very satisfied” ratings to stem statements. Ratings done within 3 days of hospital discharge were used.

The recorded number of days from admission to discharge or transfer was used to determine the hospital length of stay.

Hospital admission and length of stay rates were based on the number of admissions and the number of days hospitalized in local state-funded or supported psychiatric inpatient units.

Costs for crisis stabilization and milieu hospitalizations were based on the charges made for each unit.

Sample

A convenience sample of adult consumers \( N = 109 \) admitted to the CSU and discharged with a primary diagnosis of schizophrenia were studied. A demographically (age, gender, ethnicity,
SES), clinically (diagnosis, prior hospitalizations, discharge medication), and temporally (date of admission) matched sample \((N = 109)\) of consumers admitted to the milieu unit were used for comparison purposes.

**Results**

Individuals stayed on the crisis stabilization unit an average of 5.1 days. A total of 91% of those admitted to the CSU were discharged home or to a community setting; the remaining were transferred to another inpatient setting. Sample data are shown in Table 1. Adaptive skills improved by 20%, or from an admission range between “poor” and “marginal” to a discharge range between “marginal” and “good.” Identified symptom disruption decreased by 50%, or from an admission level between “severe” and “extreme” to a discharge level between “mild” and “moderate.” Identified stress decreased by 25%, or from “severe” at admission to “moderate” at discharge.

Also seen in Table 1 are measures of hospital use before and after a CSU admission. Hospital recidivism rates were 35% less during the 2 years following tenure on the CSU than during the 2 years preceding admission. The actual number of days in the hospital was 65% less during the 2 year follow-up than the 2 years preceding admission.

Table 1 also shows demographic, clinical, follow-up, and cost comparisons with individuals from the CSU and a standard milieu unit in the same hospital facility. Individuals from the CSU with similar demographic, clinical and outpatient treatment profiles to individuals from the milieu unit, were hospitalized for fewer days (a mean of 5), recorded higher levels of satisfaction with treatment and outcomes, and tended to have lower hospital recidivism rates. The per diem hospital cost was $8 higher for the CSU than the milieu unit, but the overall hospitalization episode costs were $8,046 less.

**Conclusions**

These results suggest that individuals can learn important skills during brief inpatient treatment that help them adapt in their communities and require less subsequent hospitalization. While the intensity and per diem cost of a brief

| TABLE 1. Changes Associated With Brief Inpatient Psychoeducational Skills Training on the Crisis Stabilization Unit |
|---------------------------------------------------------------|------------------------------------------------------------------|
| **Criteria**                                                 | **Change**                                                        |
| CSU admission to discharge adaptive skill level               | 20% Increase                                                     |
| CSU admission to discharge symptom intensity level            | 50% Decrease                                                     |
| CSU admission to discharge stress intensity level             | 25% Decrease                                                     |
| 2-Year pre-CSU to 2-year post-CSU hospital admissions         | 35% Decrease                                                     |
| 2-Year pre-CSU to 2-year post-CSU hospital days              | 65% Decrease                                                     |
| CSU’s length of stay as compared to standard unit             | 75% Fewer days                                                   |
| CSU’s demographics as compared to standard unit               | No difference                                                     |
| CSU’s clinical profile as compared to standard unit           | No difference                                                     |
| CSU’s outpatient follow-up as compared to standard unit       | Slightly lower                                                   |
| CSU’s satisfaction rating as compared to standard unit        | Slightly higher                                                  |
| CSU’s readmission rate as compared to standard unit           | Slightly lower                                                   |
| CSU’s per diem rate as compared to standard unit              | Slightly higher                                                  |
| CSU’s hospitalization cost as compared to standard unit       | 72% Less                                                          |
inpatient training unit is higher than that of standard psychiatric units, the overall hospitalization costs, both for hospital episodes and subsequent hospitalization, is significantly less. These results support the effective use of brief inpatient treatment. Short-stay inpatient treatment has been considered a stop-gap intervention to deal with problems associated with de-institutionalization, and thus it has been associated with hospital recidivism and the creation of young adult chronic homeless, incarcerated, and community-resource needy individuals (Elliott, 1996; Lamb & Weinberger, 2001; Pepper, Ryglewicz, & Kirshner, 2001). While our findings support the need for community resources, without which the brief stays would not be possible, they also suggest many community adaptation skills may be efficiently and effectively taught in a brief inpatient treatment setting.

Using psychoeducational skill interventions during crisis hospitalization may help facilitate acute stabilization, enable the person to benefit more fully from outpatient and community-based psychosocial rehabilitation services, and support longer-term recovery. The addition of a psychoeducational skills component to inpatient treatment does not have to increase hospital lengths of stay. In fact, the inpatient CSU’s average stay of 5 days is significantly less than the non-CSU unit in the same facility, and slightly less than what is reported in other hospitals (Brown, 2001).

The use of inpatient psychiatric stabilization in an environment that emphasizes the development and use of community-based crisis intervention resources is complex. Economic, philosophical, and social pressures to use noninstitutional stabilization procedures has resulted in more stringent criteria for admission to and stay on inpatient units and questions about the immediate and subsequent results of hospital-based treatment. Outcome measures highlight the multi-influenced events that happen during extended periods after discharge (i.e., keeping outpatient appointments, using nonhospital resources, not being rehospitalized, community adaptation) as much as or more than the immediate result of the stay. Effective inpatient treatment must help individuals constructively function in community settings over an extended period of time; stabilization is not enough.

The necessity to look beyond the immediate effects of inpatient stays places a greater emphasis on what is done and learned during hospitalization. Psychoeducational and psychosocial interventions during psychiatric inpatient treatment help individuals make the shift from being semi-institutional passive recipients to becoming active participants involved in treatment planning and interventions, and decisions regarding discharge and posthospitalization activities.

While promising, our results are far from being conclusive. Several factors can influence learning, symptom and stress reduction, length of stays, recidivism, costs, and community adaptation. Our findings that individuals on a brief-stay skills training inpatient unit tended to do “better” than a matched sample on a milieu unit failed to include several other, possibly significant differences in the units. For example, the CSU was a relatively new, community-oriented program that had three social workers for an eight-bed site; the milieu unit was a long-term established hospital-based program that had two social workers for a 24-bed site. Rapid clinical improvement has been established in crisis stabilization settings with no specific skills training (Ligon & Thyer, 2000). Economic factors, family support, education, work history, housing resources, transportation, bed availability, city ordinances, community receptiveness, community resources, facility standards, program structure, and even special events such as the Olympics and a presidential visit have been shown to influence hospital recidivism and community tenure. There is a great need for controlled studies to help clarify the outcomes of
skill training during the crisis stabilization and brief intensive treatment.

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References


Olsson, M., Mechanic, D., Boyer, C. A., & Hansell, S.


