

A Recovery-Oriented Alternative to Hospital Emergency Departments for Persons in Emotional Distress: “The Living Room”

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Persons with severe mental illness experience episodic crises, resulting in frequent visits to hospital emergency departments (EDs). EDs, however, are not the most effective treatment environments for these individuals who might better be served elsewhere in an environment based on recovery-oriented framework. The purpose of this study is to describe the lived experience of guests (persons in emotional distress) and staff (counselors, psychiatric nurses, and peer counselors) of a community, recovery-oriented, alternative crisis intervention environment—The Living Room (TLR). The total sample is comprised of 18 participants. An existential phenomenological approach was used for this qualitative, descriptive, study. Through non-directive in-depth interviews, participants were asked to describe what stands out to them about The Living Room. Interviews were audio-recorded, transcribed verbatim, and systematically analyzed using descriptive phenomenological methods of analysis by an interdisciplinary and community-based participatory research team. Participants’ experiences in hospital EDs and inpatient psychiatric units contextualized the phenomenological experience of TLR environment. The final thematic structure of the experience of TLR included the following predominant themes: A Safe Harbor, At Home with Uncomfortable Feelings, and It’s a Helping, No Judging Zone. Findings from this qualitative study of a recovery-based alternative to hospital EDs for persons in emotional distress are supported by anecdotal and empirical evidence that suggests that non-clinical care settings are perceived as helpful and positive.

Persons with severe mental illness experience episodic crises, which result in frequent visits to hospital emergency departments. Emergency departments (EDs), however, are not always the most effective treatment environments for psychiatric patients (Shattell, 2013; Shattell & Andes, 2011) who might better be served elsewhere and who might best be cared for from

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a recovery-oriented framework. Recovery-oriented alternative crisis intervention treatment environments exist in the US but are few in number; little research could be found about these treatment environments and none from a phenomenological perspective.

LITERATURE REVIEW

Treatment for Psychiatric Patients in Emergencies

In 2007, 12 million visits to EDs were due to a mental disorder, a substance abuse problem, or both (Agency for Healthcare Research and Quality [AHRQ], 2010). EDs are often not able to meet the needs of psychiatric patients, forcing patients who require psychiatric care to be held in the ED until an inpatient psychiatric bed is available—a practice termed “boarding” (American College of Emergency Physicians [ACEP], 2008). Alakeson, Pande, and Ludwig (2010) define boarding as “time spent waiting in an emergency room for a hospital bed or for transfer to another inpatient facility” (p. 1637). Due to the nationwide shortage of inpatient psychiatric beds, persons with mental illness in crisis at EDs are often forced to wait for long periods of time until beds on psychiatric units become available. According to the ACEP’s 2008 Psychiatric and Substance Abuse Survey, over 60% of psychiatric patients in need of admission are boarded in the ED over 4 hours after the decision to admit has been made, 33% are boarded over 8 hours, and 6% are boarded over 24 hours. Long wait periods in chaotic EDs can be especially detrimental to persons in emotional distress, whose needs often include a safe and quiet place to rest, reflect, and problem solve (Clarke, Dusome, & Hughes, 2007).

Boarding times, however, are not the only way in which EDs fail persons with mental illness in crisis. Shattell and Andes (2011) report that ED health care professionals often have minimal training in mental illness and psychiatric care. Alakeson,

Pande, and Ludwig (2010) concur that EDs are often poorly equipped to handle persons in emotional distress and may be unable to provide them with high-quality care. Patients are often left alone, monitored by low-level staff, such as patient care technicians or hospital security personnel, subjected to invasive tests such as blood and urine screenings, and are required to strip their clothing and wear a hospital gown (Shattell & Andes, 2011). Shattell and Andes (2011) further assert that psychiatric patients in EDs often must repeat their stories three times before being seen by a mental health professional, a process that is at best stressful, and at worst, harmful to persons already experiencing emotional distress.

THE RECOVERY MOVEMENT IN MENTAL HEALTH CARE

The recovery movement in mental health care is rooted in the idea that recovery from mental illness is possible, and that recovery does not mean only absence of symptoms, but also the development of meaning and purpose in life beyond the effects of illness as well as freedom from the effects of stigma and discrimination (Anthony, 1993). The movement has grown over the past few decades to offer hope and guidance to individuals working to manage mental illness as well as to mental health professionals who seek the best ways to work with these individuals toward optimal outcomes. The recovery movement encourages the development of alternative modes of care provision that integrate principles such as person-centered care, instillation of hope, and the supportive embrace of peers and allies (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011). Recovery models of care recognize that pathways to recovery are highly individualized and that better outcomes may be realized when people are active participants in their own healing process (Caldwell, Sclafani, Swarbrick, & Piren, 2010). The traditional medical model employed in most EDs involves educated authorities and passive consumers and an emphasis on persons' dysfunctions, while the recovery model emphasizes persons with mental illness having a significant and active voice in choosing their treatment options (Migdole et al., 2011).

ALTERNATIVE TREATMENT ENVIRONMENTS FOR EMOTIONAL DISTRESS

There is some controversy as to whether the recovery model is suitable for persons experiencing severe emotional distress or crisis. Some authors believe that "clients are too sick for this model" in that those persons with mental illness and in crisis are unable to effectively voice their choices (Moser, DeLuca, Bond, & Rollins, 2004, p. 930). Deegan (1988, 2007), a psychologist, researcher and person with mental illness, disagrees with this perspective, asserting that programs can be developed to provide collaborative care to persons in crisis. Frese, Stanley, Kress, and Vogel-Scibilia (2001) acknowledge that while there may be greater need and service-user support for biomedical, evidence-based interventions, in psychiatric emergencies, the recovery

model can be integrated with these interventions to better assist people with all levels of need.

There is support for psychiatric emergency care from a recovery model perspective. A recent study shows that compared to inpatient hospitalization, significantly greater improvement in psychopathology was noted in a consumer-managed residential crisis program (Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008). A variety of alternative approaches are being developed and studied, including community-based crisis resolution teams (Cotton et al., 2007), provision of peer-support in EDs (Migdole et al., 2011), and interventions for frequent users of the ED for psychiatric crisis (Adams & Nielson, 2012). Other studies show that service-users are less likely to be admitted to an inpatient setting if they go to a peer-managed crisis setting when in severe emotional distress, than if they go to an ED (Howard, Rigon, Cole, Lawlor, & Johnson, 2008) and suggest that service users prefer alternatives to EDs for addressing emotional distress (Mead & Hilton, 2003).

This new direction is promising but as research continues to accrue, there is a need to provide detailed illustrations to guide providers to effectively use a recovery-oriented model for persons with mental illness who are on the verge of being hospitalized or who are in psychiatric crisis (Felton, Barr, Clark, & Tsemberis, 2006). It also is critical that researchers seek out and include the voices and perspectives of those who use psychiatric services; recovery needs vary in relation to the severity of crisis as well as the context of the crisis (Migdole et al., 2011). In addition, because recovery is a "full human experience," characterized by change, complexity, and varying levels of wellness and distress, the voices of those with experience are essential to the development of a fully informed, effective model of recovery-oriented care (Gwinner, Knox & Brough, 2013, p. 99).

The purpose of this study was to describe the lived experience of guests (patients) and staff (counselors, psychiatric nurses, and peer counselors) in one alternative care setting for individuals who are experiencing emotional distress. This setting, The Living Room (TLR), is an outpatient, voluntary program for persons in emotional distress, operated by Turning Point Behavioral Health Care Center and funded through the Illinois Department of Mental Health. The aim of the study is to provide a detailed view of how one community-based, recovery-oriented, alternative crisis intervention treatment environment functions to provide care to individuals experiencing emotional distress.

METHODS

Theoretical Framework

Existential Phenomenology

The study reported here used an existential phenomenological design. As researchers and community partners, we were interested in the individual experience of TLR. The ability to reflect comes from an individual's prior experiences.

Merleau-Ponty (1962) poses the idea that figure-ground constitutes how we perceive and interact in various experiences. What is “figural” in the moment is what stands out to the perceiver, such as another person who is talking; what is “ground” is the latent environment that is integral to the meaning of the lived experience. The phenomenologist is interested in capturing both figure and ground when interviewing participants. Much nursing research follows medicine’s mechanistic lens, which fails to recognize the complexity of human experience (Thomas & Pollio, 2002). These quantitative studies “cannot shed light on the meaning of what is happening to those experiencing it” (Thomas & Pollio, 2002, p. 6). The practice of existential philosophy involves engagement with human concerns. By approaching subjects phenomenologically, we focus on the obvious exposed by the situation in the moment—grasping what is and meeting the participant within his or her environment, without preconception or speculations. Through this qualitative descriptive study, we sought to better understand the experience of those who spend time at The Living Room, including guests who are in crisis, professional clinical staff members who triage guests and serve as resources throughout their visits, and trained peer counselors who counsel guests and serve as mentors.

Setting

The sample of this study consisted of persons who sought help at TLR for emotional distress (persons called “guests”), clinical staff, and peer counselors who are employed there. TLR opened in 2011 and is part of an existing outpatient community mental health center in Skokie, Illinois, a suburban area of Chicago. While TLR is a part of a community mental health center, it has a separate street-level entrance. At the time of this study, TLR was open three days per week—Wednesday, Thursday, and Sunday from 3–8 p.m. (it is now open five days per week). TLR is staffed with one licensed professional counselor, one registered nurse, and three trained peer counselors. TLR is a space that is arranged and furnished like a living room in a person’s home. The main space includes two separate seating areas with chairs and tables, a couch and coffee table in front of a television, a round table with chairs, a desk with a computer and telephone used for triage, and a refreshment area with coffee and a refrigerator.

Data Collection

Phenomenological interviews were conducted with guests, clinical staff, and peer counselors. Recruitment flyers for staff participants were distributed via staff mailboxes, and recruitment flyers for guests were posted in prominent places in TLR. Staff members who wanted to participate in the study contacted the researchers directly and scheduled an interview at a mutually agreeable time. Potential guest participants who expressed interest in participating in the study informed a staff person at TLR. The university researchers then contacted these potential guest participants. Guest participants were interviewed by uni-

versity researchers two or more days after their TLR visit, at a mutually agreeable time, at TLR during the non-operating TLR hours. Each participant was asked to describe his or her experience of the TLR environment, in as much detail as possible. We intentionally did not define “environment,” and consistent with Fall-Dickson and Rose (1999), we believed that nothing was too trivial to mention. Each participant was asked, “What stands out to you about The Living Room?” Clarifying questions such as, “Could you tell me more about that?” were used. Interviews were audio-recorded and transcribed verbatim. Interview length varied from 18–90 minutes, however most interviews were about an hour. Each individual received a \$20 gift card for his or her participation. The university’s Institutional Review Board and the agency’s Quality and Performance Improvement Committee approved the study.

Data Analysis

The interview data was analyzed using the method described by Pollio, Henley, and Thompson (1997), and Thomas and Pollio (2002). Interviews were transcribed and read in the order in which they occurred. Researchers analyzed each transcript for meaning units. Meaning units were read from the part (meaning units) to the whole (entire transcript). An initial structure of the experience of each transcript was developed, and then a structure of the experience for each group (guests, clinical staff, and peer counselors) was developed. The researchers then developed an overall structure of the experience that was presented to two study participants. Feedback from participants was considered in addition to the re-reading of all transcripts to finalize the thematic structure.

Our participants’ experiences in hospital EDs and inpatient psychiatric units contextualized the phenomenological experience of TLR environment. The final thematic structure of the experience of TLR included the following predominant themes: A Safe Harbor, At Home with Uncomfortable Feelings, and It’s a Helping, No Judging Zone. The demographic data from our participants was analyzed using mean, mode, ranges, and frequency distributions.

FINDINGS

Demographic Data

The total sample of 18 persons included 9 guests, 5 peer counselors, and 4 clinical staff. Guest participants were seven women and two men; three were African American, and six were Caucasian. Self-reported psychiatric diagnoses included depression ($n = 5$), bipolar disorder ($n = 3$), post-traumatic stress disorder ($n = 3$), schizophrenia ($n = 1$), schizoaffective disorder ($n = 1$), Asperger’s syndrome ($n = 1$), “stressed to the max” ($n = 1$), anxiety ($n = 1$), and borderline personality disorder ($n = 1$) (some guests reported multiple diagnoses). Most guests had some college or a bachelor’s degree ($n = 7$); one had a high school diploma or a GED, and one had less than

high school. Most of our guest participants ($n = 7$) were not currently employed; one worked part-time, and one had occasional/temporary work. The number of previous visits to TLR ranged from 1–20 (mode = 1). Most visits lasted two hours (the range was 1.5–4 hours, mean = 2.4 hours). Reasons for visiting TLR included severe depression and anxiety, hearing voices and thoughts of suicide, pressures in dealing with life, family stress, emergency shelter, acute crisis, dying pet/overwhelmed feelings, mental health crisis, "crisis in my living situation," and "felt like hurting myself."

The peer counselors were three women and two men. Four were Caucasian; one person was Asian. Their ages ranged from 39–55 years (mean = 46 years); their experience working as a peer counselor ranged from three months to five years (mode = 3.5 months); peer counselors' work tenure at TLR ranged from 3 months to 12 months (mean = 7.4 months). The highest educational degree for most peer counselors was a baccalaureate degree ($n = 4$); one had a master's degree.

The clinical staff consisted of three women and one man. All were Caucasian. Their ages ranged from 26–32 (mean = 29.25). Most of the clinical staff had a master's degree ($n = 3$) and worked full-time ($n = 3$). The clinical staff were from the following disciplines: nursing ($n = 1$), counseling ($n = 2$), and social work ($n = 1$). Educational levels ranged from a bachelors degree to a masters degree; the majority had graduate degrees ($n = 3$). The amount of time that they worked at TLR ranged from nine months to 12 months (mean = 10 months); the amount of time that they worked with the affiliated agency ranged from nine months to 3.5 years (mean = 2.5 years); their mental health-related work experience ranged from four years to ten years (mean = 7.25 years).

The Context: Experiences in Hospital Emergency Departments for Emotional Distress

Findings from a phenomenological study include both the context (ground) and the predominant (figural) themes. Participants' experiences of TLR environment were contextualized by their experiences in EDs. Participants in our study had experiences as either a person in emotional distress who went to an ED for help, or as a person who worked with persons in emotional distress in these settings.

The experiences of EDs for persons in emotional distress were characterized by feelings of insecurity, loneliness, intimidation, fear, and discomfort. Participants described feeling unsupported by ED staff. They believed that seeking treatment at a hospital could be "a waste of time;" there are guards, isolation, and a lack of support "where you can wait for hours, sitting in a room, waiting to be seen." Many participants described their experiences in EDs as intimidating. They felt immediately judged because of the reason for their visit. Persons who visited EDs for emotional distress feared they would be ignored or put aside in favor of other patients who staff deemed to be more important or in greater need of treatment. EDs were considered

too sterile or clinical for persons in emotional distress to feel at ease. According to one participant:

Well let's just say hospitals aren't the greatest at providing these kinds of services because they have more of a medical model. The medical model is necessary to achieve medical results, but in a psychiatric emergency a hospital is sometimes like using a nuclear weapon to kill a small animal.

In this study, previous visits to EDs provided the ground against which experiences of TLR were perceived and understood. These particular experiences of TLR (figure) would not have been experienced in the same way without the previous experiences of EDs (ground).

Figural Themes in the Experience of The Living Room

Within the context of experiences in EDs, the experience of TLR environment was expressed in three figural themes, titled with participants' own words: A Safe Harbor, At Home with Uncomfortable Feelings, and It's a Helping, No Judging Zone.

A Safe Harbor

The Living Room is a quiet and peaceful "safe harbor" or "oasis" for persons experiencing emotional distress. It is a welcoming, home-like place for persons in crisis, where persons can talk to trained therapists and, in the words of one guest, "calm down." As one peer counselor said, "It just feels like home, because I'm there to care about people, like in my home . . . usually the people in my home are people that I care about very much, and that's how I feel in the Living Room." Participants describe TLR as calming, relaxing, healing, open, pleasant, person-centered, comforting, uplifting, non-threatening, reassuring, and informal.

Guests experience TLR as welcoming and inviting. Several guests described how meaningful their first entry to the environment was—when a guest arrives, one or more staff members immediately greets the guest, asks the guest their name, and then introduces them to all staff members present. Refreshments are offered and a staff member offers to take the guest's coat. A peer counselor described the staff's intention: "We welcome people with open arms, and we want people to feel invited." And people do. Guests are welcomed as "a fellow human being, not like a patient." TLR is consistently a place where guests "feel safe to be vulnerable," where guests "can let their guard down." This all happens right away: "When I first walked in the door, I felt safe." TLR is a dependable place to go, where guests know what to expect. TLR offers silent support—the idea and the knowledge alone that TLR is there, even if the guest is not physically present at TLR, is helpful to some guest participants.

Guests experience TLR as a relaxed place that puts them emotionally at ease. It provides a respite; "it de-escalates the stress," "it's a place to have a timeout." Another guest said, "It's just calm. It makes me feel like I'm standing on the beach." The space communicates care, concern, and respect; it is functional with some open space, some semi-private space (the rest and

relaxation room), and some entirely private space, which hardly gets used. The space is contained entirely, with the exception of a bathroom, which is in the adjacent community mental health agency. Participants think that the way that the furniture, space, and process are designed, promote and communicate a sense of progress through the process of feeling better: greeting/intake, move to quiet place to talk, and then help with resources (e.g., help finding a homeless shelter, an outpatient therapist, a support group). For some guests, eating snacks, viewing the artwork, listening to music, and talking about “normal stuff,” were aspects of the environment that provided a distraction from the internal, emotional distress.

The physical environment was described as new, pristine, and clean. TLR is nicely painted and furnished, and visually appealing, almost in an unexpected or surprising way. As stated by one guest who reflected on her first visit to the space, “Wow, this is a lovely environment, just a lovely place.” Guests appreciated the informal non-clinical setting of couches, upholstered furniture, “not a lot of office things,” and good variable lighting. Most participants liked the artwork that hung on the walls, and the blue carpeting and “restful” wall colors (“nice shades of green and yellow”). Some said that they liked that the furniture was placed at angles. Participants described the physical environment as non-sterile, not stuffy, and non-clinical. The semi-private space off the main area, called the “rest and relaxation room,” provides privacy and the space for confidential, respectful talks “about real things.” Participants described this room as a private and comforting place where guests felt relaxed and under no pressure. The room contains a small sofa that transitions into a bed; there are pillows and blankets for warmth and comfort. Guests can lie down and nap. In the words of one participant, the rest and relaxation room is “a quiet room when you just wanted to get off by yourself and not be bothered with anyone to just come back to yourself.”

The colors and coordination of furnishings and the presence and availability of staff who were “at attention and waiting for guests,” communicated to guests that someone cares about the environment and perhaps, by extension, the people coming to the environment. Guests felt valued because of the time and resources that were put into the facility. Guests and staff members appreciated the connection to and support from the community mental health agency that houses and supports TLR. As said by one staff member about the agency, “They are invested in us. I think that’s really good for the morale of the team, including my own . . . The agency’s level of commitment is very high.”

All of the guests and staff felt that the homelike environment of TLR was unique and helpful. Almost all said they wished the hours of TLR could be expanded so they and others could have better access when needed because emotional crises often occur on weekends or other times when people are isolated or idle. Several participants suggested that more marketing and advertising be done to let people know about TLR. Others felt that TLR services would be very useful to people in underserved areas of the city that are not close to TLR’s geographic

location. One person suggested partnering with local EDs to increase awareness of TLR and to increase access for those who needed it.

There were only a few suggestions offered by participants to improve the environment of TLR. Several mentioned lack of ventilation, or a sense of “stuffy air.” A staff person commented that some of the wall colors might be too stimulating for persons in emotional distress. However, a guest felt there should be more color and artwork on the walls. A concern about confidentiality and privacy was raised by several guests in relation to the exterior glass doors of the street entrance and the glass windows on the interior that separated the space of TLR from the main agency. Guests’ concerns were that a person passing by on the street or in the hallway of the agency might see them in TLR.

At Home with Uncomfortable Feelings

Guests come into TLR with varying levels of emotional distress. One guest said, “When I first came in I was nervous. I was worried. I was sort of kicked out of my house. I didn’t know where I was going; what was going to happen.” Guests may be worried about physical health or relationships in addition to emotional distress. At other times, specific events, such as illness of a family member or the death of a pet, precipitated an emotional crisis. They are overwhelmed:

I was about nine and-a-half . . . on a mental crisis scale . . . I mean, I was a total basket case when I came in here. I was just—I was very frightened, and I was very overwhelmed. It was a very difficult time just saying what was happening to me or what I was experiencing.

Guests appreciate that there are few forms to complete and that help is delivered almost immediately. “There are people who will talk to the person right away. There is no waiting period. Right then and there.”

No matter how distressed, guests felt free to be however they felt in the moment. One guest noted, “You can be yourself, no one expects you to be happy, you don’t have to “put on a façade.” Another voiced similar thoughts, stating how nice it was that at TLR there was no “pressure on you to make up stuff to make everyone else feel better—make everyone else think you are okay.” Peer counselors and other staff members described how they use the TLR environment as a way to give guests as many choices or options as possible—“choice is privileged”—for guests to do what they need to do to relieve distress, solve problems, or regain emotional equilibrium. One guest noted, “The staff and the space are very accommodating—they can adjust the lighting if you want, or you can sit in the open or the closed space, and they allow you to make decisions about where you want to be. The space of TLR was described by one guest as being, “dedicated to you;” a private space where “it is just you.” The environment is flexible, “not so static [like the hospital].” Another, commenting on the flexibility, said, “If you need to be quiet, if you need it to be a place of just brainstorming, or if you need it to be just decision making without the smell of alcohol and the police at the door.” A peer counselor suggested that the

flexibility enhances guests' empowerment by giving them ways to advocate for themselves through their choices.

Staff members take their time with each guest. "You're not rushed and hurried, and you don't have that feeling like I've got to tell them right away because they've got somebody behind me and I've got to hurry up and move." "You're allowed to just be, to speak, just organize your thoughts as you need to, not hurry, heard but not judged." Another says, "Your emotions are allowed to surface in a calm and confident kind of way."

The absence of clinical aspects of traditional health care settings further enhances guests' abilities to address their emotional distress. Some guests' past health care experiences with physicians and nurses in uniforms were "scary . . . because you don't know what they are going to do to you." Guests appreciated that TLR staff members do not wear uniforms. They also liked that there are no physicians at TLR because this allows guests to feel more in control, more empowered, less intimidated. Guests also note that they do not have to worry about whether they will be admitted to an inpatient unit or that they will be medicated against their will.

There's not that element that's gonna hold you for 72 hours against your will while they're evaluating you . . . You're relaxing. It's completely comfortable in every way, physically, psychologically, emotionally. They're not challenging you in anything you say unless you are dangerous.

The absence of fear or stress generated by the potential for loss of control and autonomy in traditional health care settings is a significant part of the TLR experience. Even if a guest is found to have thoughts or feelings that could result in danger to self, the process is handled differently, enabling guests to let go of worry that decisions will be made out of their control. One guest who had to be transported by ambulance to the hospital from TLR felt that the process was respectful; she appreciated the honesty of the staff in telling her they needed to call an ambulance "instead of someone doing it behind your back."

It's a Helping, No Judging Zone

Guests do not feel judged at TLR. One guest connects judgment to stigma and mental illness, and says that she has experienced people labeling her behaviors and thoughts as symptoms of mental illness and when they responded to her from that position she felt misunderstood and discounted, or worse; when it occurred in a treatment setting, she felt that this judgment contributed to quick decisions to treat or hospitalize against her will. Guests do not experience this at TLR. TLR staff have a non-clinical, compassionate approach and help guests "deescalate the stress" and relieve negative or suicidal thoughts or feelings. One guest noted that the absence of judgment allowed her to fully relax, or "breathe" as she put it. For another guest with experience of verbal abuse in her home life, the experience of not having to worry about being judged, freed her from having to be vigilant, cautious, or afraid to say anything. She thus had more energy and focus for her crisis work in TLR. The lack of

judgment extends beyond the focus on mental health and toward acceptance of other aspects of the person. For one guest who was sensitive to being judged about her physical size, not worrying about being judged allowed her to focus freely on her emotional issues and needs.

Peer counselors at TLR are an important piece of the non-judgmental nature of the environment. Peer counselors are described by some guests as the "heart and soul" of TLR and as their favorite aspect of TLR. "The peer counselors are really caring, and they have been through things so they understand." It also helps that peer counselors sometimes share their personal experiences with mental illness, assisting guests to feel like they are not the only one who has gone through what they are experiencing. As one guest says of peer counselors, "They just talk with a guest hearing voices as they would anybody else or any other guest, and that's not always the case outside of The Living Room or outside of Turning Point." Staff concurs, noting that peer counselors are not easily intimidated and that they develop rapport with guests quickly. Peer counselors agree that the non-judgmental nature of TLR is very important and note that their own previous experiences with mental illness assist with this. As one says, "I don't judge anybody who comes in by their diagnosis . . . I have been judged myself." And as another says, "We are not going to judge you, because we are you."

Many of the helpful aspects of guests' experiences in TLR relate to a sense that they are being accepted and seen as human beings worthy of respect. As one guest put it, "your disease doesn't have to define you." Staff communicated similar perceptions, emphasizing that TLR is not a "diagnostically driven space;" instead, focus is placed on the crisis that a guest presents with in order to facilitate its resolution: "We look at, how can we help you the most today? We care about you, we want you to leave here feeling okay. We want to give you services that you can continue when you leave TLR." This is communicated in myriad ways, from checking on guests regularly to see if they need food or drink, to greeting them promptly and with a welcoming attitude, as well as through direct help to ease their emotional distress. The human, interpersonal environment was described as "giving" and "offering" things to guests in response to guest needs: empathy, a person who does not blame, a person who understands.

Specific interventions by TLR staff that were identified as helpful and caring by guests include being understanding, attentive, and respectful, allowing the exploration of coping techniques, and use of a gentle, calming voice. One guest valued the "fresh opinions" that were offered in relation to her crisis while another found working with a peer counselor to identify the positive aspects of a negative situation to be helpful. While one guest noted that she was annoyed with the attentiveness of TLR registered nurse at times, she also felt good about the registered nurse's consistent and "undivided attention" to her physical well-being. Staff and peer counselors note that they provide lots of hands-on support such as counseling about coping strategies, managing symptoms, a little case

management, queries as to what guests hope to gain from being there, and development of a plan to help guests move forward. One peer counselor likens his time with guests as a dance that occurs through listening, offering food and drink, and allowing guests to take charge and empower themselves. Even if the engagement is around small talk, instead of dealing directly with the crisis that brought the guest to TLR, there is benefit in that it can prevent a worsening of negative thought patterns or provide a welcome relief from emotional pain. One guest said of her time at TLR, “it was more like you were just talking to a friend, kind of. It was kinda casual, but it was always your interest at hand.”

Attention to all of a person’s needs also was identified as an expression of caring in TLR. One guest appreciated that there is a “medical person” (registered nurse) available because his medical questions and concerns caused him a lot of stress and addressing these calmed him and helped him to cope. Another guest who was facing homelessness felt grateful to have received emotional support as well as tangible and practical help in the form of a list of shelters and assistance in finding housing. Another was helped to find assistance to repair her CPAP (continuous positive airway pressure) machine.

The sense of feeling cared about is strong and, at times, extends beyond the encounter in the TLR. There is a sense of “unwavering support” and of the peer counselors being “in my corner even when I am not there.” There is a sense that the caring endures: “I feel good just knowing The Living Room is still here and that anytime in the future if I do have a problem, and I probably will over the years from time to time, [I’ll] be able to come here and having this not clinical environment, but a genuinely caring people.”

Staff and peer counselors also identify caring, toward guests and each other, as integral to TLR. One counselor described her experience working with the team after a particularly difficult shift, “We stayed until 9:00 [one hour past closing time], so that I could talk about it, so that the team could talk about it with me. I felt very cared about then.” Peer counselors in particular feel cared about and supported. They valued the TLR environment, and wanted to share this with guests, to invite them in to share in this place of healing and possibility. This sense of mutual care may be the source of one guest’s feeling that staff all work together and seem to be “of one accord.”

While the person-centered, caring approach at TLR was valued by participants, a concern was raised by some that people may misuse TLR, coming to TLR at times when they needed support or companionship but were not experiencing a crisis, or may come semi-regularly instead of working with a therapist or counselor outside of TLR. A newer staff member, for example, felt unsure at times as to who was appropriate to receive care, concerned that a guest’s needs were not sufficiently urgent to merit TLR care. One guest felt this—although he perceived himself to be in crisis, he also reported feeling that one staff member did not deem his concerns serious enough during one visit.

DISCUSSION AND IMPLICATIONS

The findings from this study reveal valuable information about understudied recovery-oriented alternative treatment environments for persons in emotional distress. Persons who are guests or staff of the alternative environment that we studied—The Living Room—describe an environment that is contextualized by experiences in EDs and other acute care settings but is itself experienced as a comfortable, safe, healing place where persons can feel free to be themselves without fear of judgment and discrimination and where they can go for help for emotional distress. Guest participants felt cared for, connected with peer counselors and other staff members, and felt better after their TLR visits.

Our findings are consistent with Shattell, McAllister, Hogan, and Thomas (2006) who found that persons with mental illness wanted mental health care providers to connect with them and make them feel like human beings instead of judging them based on preconceived notions, biases, and stigmatizations. Persons in our study described peer counselors and staff members at TLR as persons who listen to them, another important aspect of mental health care, which is what Koivisto, Janhonen, and Vaisanen (2004), Shattell et al. (2006), and Gaillard, Shattell, and Thomas (2009) also found. Listening and understanding may be especially important during a mental health crisis. Consistent with Mead and Hilton (2003), guests prefer TLR than hospital EDs when in emotional distress. Our findings also show that TLR environment provides care that is consistent with the recovery model of care—it offered empowerment, hope, peer-provided services, and individual control.

Although our findings are overwhelmingly positive about TLR, the study revealed limited confusion about what a mental health crisis is and which types of emotional distress are most appropriate for TLR. Perhaps this can be made clearer to potential guests, while allowing for necessary flexibility in these guidelines. Clarifying the difference between a crisis and an emergency may provide some guidance.

Hobbs (1984) defined mental health crisis as a state in which an individual becomes overwhelmed, and their usual coping mechanisms are not adequate, which leave them with disorganized thoughts and life processes. This crisis state is not considered an emergency, which is a risk of harm to oneself or others; however, if a crisis state is not properly treated, the condition can quickly escalate, leading to a mental health emergency. Callahan (2009) describes a mental health emergency as a situation that includes potential suicide, danger to others, and confusion or functional decline that creates an imminent risk for injury, which requires immediate intervention. Unfortunately, many communities lack effective community mental health resources for both crises and emergencies, leaving a visit to the ED as the only solution in a time of need. Without appropriate care, persons cannot regain equilibrium. Our findings suggest that TLR, where individuals access services that is guided by peers, is an appropriate setting for persons experiencing mental health crisis and emergency.

Peer support and peer-provided services were supported by the findings of our study. In a study similar to our own, conducted using consumer-managed mental health settings, Greenfield et al. (2008) concluded that individuals in mental health crisis "who are not deemed a danger to others, the less restrictive crisis alternative, together with available community outreach, is at least as effective as standard care" (p. 142). By establishing services provided by peers, mental illness and recovery can be positively changed in institutions, providers, and clients (Macneil, 2002). Although the study reported here did not examine treatment effectiveness, our findings suggest that guests did indeed feel better after their visits to TLR. In addition, although we did not study the economic cost savings of TLR visits, it is likely that if these guests went to a local hospital ED instead of TLR, the cost of the ED visit would have been much higher. This could be a fruitful and useful area for further research. In addition, further research could examine inpatient admission rates from alternative care environments, replicating studies such as Howard et al. (2008).

The findings from our study have several implications. Individual providers, whether in alternative treatment environments, community mental health centers, inpatient psychiatric units, or hospital EDs can look to these findings for understandings and insights into what persons in emotional distress experience as helpful and unhelpful, in both the structural and interpersonal environments. The ground of the experience of TLR was experience in EDs and inpatient psychiatric units for persons in emotional distress. Although the focus of our study was TLR, our study may have implications and some relevance to organizational units, such as hospital EDs. For example, most EDs are not equipped to handle persons in emotional distress, and because of the ED structure, those persons deemed in greater need, get care first. Judgment and triage is inevitable in this system. Perhaps TLR-type space could be incorporated into existing EDs with these spaces separate from the medical ED and non-clinical in appearance. Migdole et al. (2011) supports the use of peer counselors in ED-type settings. The area also could be staffed with trained mental health nurses, counselors, and peer counselors who are experienced in crisis intervention and de-escalation techniques, which can provide clients the time and space to talk through their difficulties and an opportunity to provide for health care needs.

Although our findings are important because they help fill a gap in the literature about alternative treatment programs, there are some methodological issues that should be considered. Limitations of the study include possible self-selection bias in that only persons with extremely positive experiences may have volunteered to participate in the study. In addition, participants may have expressed overly positive views of TLR because they could have thought that future funding was tied to the study results or because their contextual experiences of hospital EDs were so negative and that by comparison, TLR overwhelmingly provided a better experience. That said, our study findings are trustworthy and dependable because we adhered to our phe-

nomenological approach, we presented preliminary findings to two participants for feedback during the data analysis stage of the study, and all members of the team reviewed, analyzed, and discussed the data. More research on TLR and other alternative treatment environments is needed to evaluate effectiveness. Research on the economic impact of treatment programs such as TLR on Medicaid and Medicare dollars saved by diverting individuals from hospital EDs to more appropriate settings also would be beneficial.

CONCLUSION

Findings from this qualitative study of a recovery-based alternative to hospital EDs for persons in emotional distress are supported by anecdotal and empirical evidence that suggests that non-clinical care settings are perceived as helpful and positive. Our analysis also reveals that persons in emotional distress welcome care and support by registered nurses, counselors, and peer counselors in non-clinical, safe, and comfortable settings. Those mental health and other health care providers who are immersed in community mental health settings and other settings where they see persons who are in crisis, may not be surprised by these findings because many individuals have experienced hospital EDs like our study participants. Providers in hospital EDs also may not be surprised by our findings because they are often given a seemingly insurmountable task—to provide appropriate, compassionate care with competing tensions, in a sometimes frenetic and chaotic environment. The time is ripe for changes in psychiatric emergency care and care for persons in emotional distress. Developing, supporting, and funding alternatives to hospital EDs is just one answer. More needs to be done to alleviate emotional suffering and to improve mental health care.

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