be aged ≤64 years, with an identified and acknowledged relationship problem. Exclusion criteria were psychosis, organic brain disease, intellectual disability, and acute medical conditions.

Two groups of 20 patients were assigned to either ICIT or TAU. Data were collected through a series of tests (eg, Burns Relationship Satisfaction Scale and the Firestone Assessment of Self-Destructive Thoughts) on relationship satisfaction, emotional regulation, destructive thought processes, and relapse. One-way analysis of variance was used to perform statistical analyses. A *P* value < .05 was considered statistically significant.

CIT therapy sessions consisted of 6 hour-long modules presented over 2 days. A follow-up appointment took place 6 weeks after discharge. Except for one Latino patient, the ICIT group was all white, as were the TAU patients. The average age range of the ICIT group was 40 to 49 years, compared with 30 to 39 years in the TAU group.

The data showed no statistically significant differences in relationship satisfaction or emotion regulation (depression and anger scales) between the groups. The only significant difference was on the Burns Brief Mood Survey, Anxiety Scale ($P = .047$), indicating that the therapy may be particularly helpful for patients experiencing anxiety. Although the majority of patients in both groups had a reduction in symptoms, those in the ICIT group showed greater improvement than their peers in the TAU group.

Community Crisis Respite Centers Provide Cost-Saving Alternatives to the ED for Patients in Crisis

Written by Nicola Parry

Michelle Heyland, MSN, APN, Rush University College of Nursing, Chicago, Illinois, USA, shared fiscal year 2014 results from a community crisis respite program called The Living Room. This program offers a cost-saving alternative to the emergency department (ED) for individuals in crisis.

According to Ms Heyland, approximately 12.5% of all ED visits in the United States involve a mental health or substance abuse diagnosis, and these are more than twice as likely to result in hospitalization than visits without such a diagnosis [Owens PL et al. *Agency for Healthcare Research Quality Statistical Brief #92.* 2010]. These patients tend to receive inappropriate care, for reasons including ED overcrowding, lack of priority triage, and the absence of trained psychiatric professionals to help with crisis de-escalation [Shattell MM, Andes M. *Issues Ment Health Nurs.* 2011; Clarke DE et al. *Int J Ment Health Nurs.* 2007]. Studies have shown that individuals in crisis want to visit a place where they feel safe and respected, and can talk to trained psychiatric professionals who understand their needs [Agar-Jacomb K, Read J. *J Mental Health.* 2009; Clarke DE et al. *Int J Ment Health Nurs.* 2007].

Table 1. Demographics of Guests Visiting The Living Room in Fiscal Year 2014

Demographic	Percentage
Age, y	
18–40	35
41–60	58
≥60	7
Sex	
Men	39
Women	61
Presenting problem	
Suicidal ideation	18
Homicidal ideation	3
Anxiety	28
Depression	25
Other	26

Ms Heyland described a community crisis respite center called The Living Room as one alternative to the ED for providing service to people in crisis. This was named after the familiar home space, and is offered free of charge to clients who are referred to as "guests," in an attempt to emphasize its nonclinical environment. It provides an inviting atmosphere that is warm, welcoming, and without excessive stimuli. The layout allows for guest privacy with a separate area for rest and relaxation.

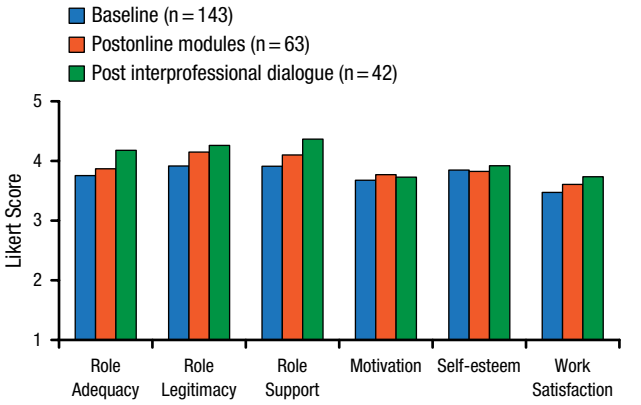
Staff members are trained psychiatric professionals, and include a therapist and a psychiatric nurse; there are also peer counselors who have a mental illness but have recovered enough to be able to offer help to others in need.

Guests who visit The Living Room are triaged by the therapist to obtain some basic demographics (Table 1), determine the nature of the crisis, and assess the guest's levels of distress, risk, and safety. They then meet with the psychiatric nurse, who establishes the guest's vital signs and also addresses any issues they may have regarding medical conditions or medications, for example.

Guests also meet with a peer counselor for in-depth discussion of the nature of the crisis, and to help identify coping skills the guest can use to decrease distress. Ms Heyland emphasized that, due to their own experiences, peer counselors are uniquely positioned to offer support and empathy and to advocate for guests.

According to Ms Heyland, initial results of this program have been positive. In the 2014 fiscal year, of 262 total visits to The Living Room, guests were deflected from attending the ED on 258 visits (98.5% deflection rate), with an average decrease of 2.44 points on the subjective units of distress scale. Since the average cost of a visit to The Living Room is $269, compared with $2500 for a visit to the ED for a psychiatric reason, the 98.5% ED deflection rate represents an estimated savings of approximately $2231 per visit, for a total annual cost savings of > $575 000 to the State of Illinois. Importantly, guests who visit The Living Room are also receiving more appropriate psychiatric care, she concluded.

Figure 1. Alcohol and Alcohol Problems Perception Questionnaire Results



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Online Interprofessional Education and Practice for Health Care Professionals Improves Substance Use Treatment Capacity

Written by Nicola Parry

Kathryn R. Puskar, DrPH, RN, and Ann M. Mitchell, PhD, RN, University of Pittsburgh School of Nursing, Pittsburgh, Pennsylvania, USA, shared results from an online interprofessional project demonstrating the effectiveness of interprofessional collaborative practice (IPCP) and its impact on substance use health care in rural areas.

According to Dr Puskar, substance abuse represents an enormous public health problem, and its comorbidity with mental disorders is well recognized. Early screening by health care personnel has been associated with reductions in health care utilization and in criminal and other societal costs [Cuijpers P et al. *Addiction.* 2004; Wells-Parker E, Williams M. *J Stud Alcohol.* 2002; Gentilello LM et al. *Ann Surg.* 1999]. Nevertheless, she noted that many people need specialty treatment for substance abuse problems but do not receive it.

To address this issue in rural areas, Dr Puskar and colleagues aimed to create an easily accessible, 100% online education intervention for the health care workforce. They established a nurse-led interprofessional collaboration to enhance substance use treatment capacity in rural areas. This ongoing project aims to prepare all health professionals to collaborate, with the common goal of building a better, safer patient-centered and community- or population-oriented health care system in the United States. Its approach reemphasizes the importance of teamwork and communication within and among teams.

More than 230 rural providers are currently enrolled in the project. This involves public health professionals, nurses, and behavioral health professionals in a variety of community-based organizations, predominantly in Pennsylvania, Ohio, and West Virginia.

This interprofessional practice process comprises 7 steps, 1 of which involves online educational modules. Within 1 module, providers learn the reliable, evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach. The screening component comprises a short set of questions that can be used within a health visit to identify risky or hazardous substance abuse or dependence. Other modules cover issues such as the continuum of substance use, motivational interviewing strategies, and practicing IPCP. Providers also have access to online case study examples and interprofessional dialogue sessions. Pre- and posttest questionnaires are performed online to determine the effect of the education. These include the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ) and the Drug and Drug Problems Perception Questionnaire (DDPPQ) [Watson H et al. *Addiction.* 2007].

Dr Puskar shared data obtained to date, showing changes in the questionnaires' subscale scores from baseline to the postonline module and postinterprofessional dialogue steps. Significant ($P < .05$) score increases were seen in the subscales of role adequacy, role legitimacy, and role support in the AAPPQ (Figure 1) and role adequacy and role support in the DDPPQ (Figure 2).