Peer-Run Crisis Respites

A review of the model and opportunities for future developments in research and innovation

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Abstract: Peer-run crisis respites (PRCR) are an emerging form of acute residential crisis services for people with psychiatric disorders. PRCRs are an alternative to psychiatric inpatient hospitalization, and are completely staffed and operated by other people with lived experience of mental illness (i.e. peers). Only recently have PRCR programs in their current form come into existence, and we need to better understand how they operate, their effectiveness, and disseminate information about them. The aim of this article is to structure and formalize the body of knowledge that we do have, in order to inform future development and analyses of PRCR. The paper utilizes published literature where available, unpublished documents by the consumer movement, and comments by experts in the field. This paper will describe what a PRCR is, the operations of the existing PRCRs, and review some of the evidence of effectiveness and cost of PRCRs.

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INTRODUCTION

Peer-run crisis respites (PRCR) are an emerging form of acute residential crisis services for people with psychiatric disorders. They are completely staffed and operated by other people with lived experience of mental illness (i.e. peers). Only recently have PRCR programs in their current form come into existence, although peers have been providing crisis support to one another in their homes for several decades (Chamberlin, 1978). Peer-run crisis respites are usually located in a house in a residential neighborhood. They provide a safe, homelike environment for people to overcome crisis. The intended outcomes are diverting hospitalization by building mutual, trusting relationships between staff members and users of services, which facilitate resilience and personal growth.

There has been interest from peers and the recovery movement in implementing and studying PRCRs nationwide, as well as internationally. Much of what we know about PRCRs is unpublished work by consumers in the movement. The aim of this article is to structure and organize this body of knowledge to inform future design and implementation of PRCRs, and to inform the development of an evidence-base. The paper utilizes published literature where available, unpublished documents by the consumer movement, and comments by experts in the field collected for this paper. The paper will describe what a PRCR is, the existing PRCRs, and review some of the evidence of effectiveness and cost of PRCRs.

PEER-RUN CRISIS RESPITE: VISION AND VALUES

The National Coalition for Mental Health Recovery (NCMHR), a driving force behind the establishment of peer-run crisis respite services nationwide, has described PRCRs as a place for people in crisis to process stress, explore new options for short-term solutions, increase living and coping skills, and reduce susceptibilities to crisis in an environment that provides support and social connectedness (Mead, Hilton, & Curtis, 2001; NCMHCSO, 2008). The goal of PRCR is to encourage less dependence on the mental health system and help consumers avoid the trauma that often occurs during emergency room visits and inpatient psychiatric hospitalization (NCMHCSO, 2008; Stefan, 2006). Trained peers use compassion and a supportive approach to enable people to start the recovery process (Stefan & Poole, 2009). The expected outcomes are recovery-related outcomes, reduced emergency room utilization, and decreased use of mental health services in the future (MPOWER, 2008).

PRCRs are part of a transformed system of care because their philosophy emphasizes responsibility, recovery, and person-centered care, rather than “top-down” care in hospitals that often do not provide the opportunity for person-directed decisions. Groups and statewide consumer networks are working on developing, fundraising, and lobbying for PRCRs in their states. Below are the principles of care developed by consensus by a group of peers in one state:

Safety and acceptance through connection

Hold hope for others when they cannot hold it for themselves

Use everyday language to describe one's experiences

Self care and personal responsibility

Encourage mastery and power over one's own life

These principles demonstrate the value that PRCRs, and the consumer movement which is developing them, place on individual and shared responsibility for the experience of crisis and recovery in it. The first (safety and acceptance through connection) indicates that PRCRs encourage relationships in an environment where consumers feel accepted by their peers and can provide a sense of safety that traditional authoritative approaches do not. The collaboration that went into consensus on these principles demonstrates the power of the grassroots movement, which is happening nationwide, but occurring in state and local contexts.

OPERATIONS OF PRCRS

INTAKE PROCESS

The intake process at PRCRs varies between programs, and there is no one approach that is agreed upon by all members of the consumer movement. Some PRCRs require an initial interview when someone is well in order to be able to provide better services, should they encounter a crisis. A respite that has this process describes the purpose of the interview as **"**allow[ing] participants and peer staff to form a relationship that will be useful during a future time of respite. Many times in a hospital setting, we are surrounded by strangers" (GMHCN, 2011). This approach is differentiated from the approach of emergency rooms, where people may not trust providers because they have not expressed what their individualized needs are in a crisis, as is done in the pre-crisis interview.

Other PRCRs have a less formal intake process, where consumers may call when they are in crisis and arrange for a stay immediately. Although this approach is similar to an emergency room or hospital, where a consumer can start participating in services without prior relationships, the intake focuses on building a relationship with the consumer. It is described by one respite as a: "dialogue" [that] is no more than an informal conversation, but it is a time to explore things more fully with you, to get to know you and your needs and to form a view about whether a stay might help be a support to you" (Voices of the Heart, 2011).

ADMISSION REQUIREMENTS

PRCRs advertise themselves as hospital diversion and alternative. This means that PRCRs are restructuring our understanding of the psychiatric crisis experience. Some respites do advertise that people who are a danger to self or others are not qualified to enter the respite (GMHCN, 2011). Some have less clearly defined admission requirements and take a more individualized approach, but acknowledge that not everyone can be accomodated with these services (Voices of the Heart, 2011). However, PRCRs can provide an alternative to hospitalization for many consumers – and we have begun to see their potential. The model has the potential to change the traditional system's perspective on crisis, which evaluates need for hospitalization on a reactionary basis when it often may not be warranted. By diverting people from hospitalization, PRCRs can help people break a cycle of recidivism where they have become accustomed engaging in unsafe behavior and thinking in order to get access to services (PEOPLe, 2011).

SERVICES PROVIDED AT PRCR

PRCRs use self-help strategies, self-determination, and peer-support to address the needs of people experiencing suicidal thoughts, altered perceptions of reality, and heightened fears and anxieties with the goal of enhancing their participation in their life and community. The services that have been identified as occurring at a PRCR are support groups, individual time with a peer specialist, WRAP training, educational activities, and recreational activities. There is also unstructured time to explore independent and communal interests. Group or individual time may address building social supports, learning about recovery, and access to mutual understanding and connection. Recreational activities are art groups, exercise groups, and other activities that are therapeutic to people in crisis but not explicitly a "therapy." At the Georgia Peer Support and Wellness Center, the activities offered include: cooking/nutrition groups, Wellness Recovery Action Plan (WRAP), gender specific trauma-informed peer support, Double Trouble in Recovery (DTR), acting group, aromatherapy, creative writing, activities centered around spirituality, Pathfinder's Employment Group, sports and swimming, computer skills training, and social group activities (Legere, 2009). The Georgia respite is able to offer all of these activities because the respite is embedded in a larger peer-run organization. It is not uncommon to be able to provide these activities. Other PRCRs, such as those in New York, are also embedded in larger peer-run organizations. PRCRs that are embedded in, or connected to, a larger peer support organization have the ability to offer more activities, which may be a more ideal circumstance.

MODELS OF PRCRS

There are two models of PRCRs: peer-operated and peer-run. Peer-run indicates that the board of directors is at least 51% peers. Peer-operated indicates that although the board is not a majority peers, the director and staff are peers. Both of these models are being considered across the country. In peer-operated models, the parent organization is not peer-run, but the respite under its control has a director and staff members who are

peers (National Empowerment Center, 2009). This means it is attached (financially and legally) to a traditional provider, and is not an independent 501(c)(3) non-profit organization. In a peer-run model, peers staff, operate, and oversee the respite at all levels (National Empowerment Center, 2009). It is not attached to a traditional provider, and has no on-site or contractual ability to offer psychiatric or medical services. The following quote is from a consumer working with the state to develop a PRCR, where a peer-run model is preferred. It illustrates how peers view peer-operated versus peer-run models:

> *[A peer-operated respite] does not offer much separation from conventional services…[It] exists under a large clinical provider often within a medical building. The atmosphere is clinical, the doors are locked, and security guards man the area…While this model can work when leadership of both the respite and the larger organization are in agreement, there is nothing in the model to ensure that the priorities of the peer respite are consistently followed… [Peer-run respites] are peer-directed, not programs of a large, traditional provider organization. Implementation of a peer respite underneath the umbrella of a traditional provider organization inhibits the ability to fully operationalize any truly peer and recovery-oriented principles.*

Whether a peer-operated model or a peer-run model works best is dependent on the culture of the consumer movement in the state/locality, how independent the consumer movement is from traditional providers in that state, and how the traditional providers operate. For instance, in some states or localities, there are already consumer-operated organizations that are independent non-profits and can operate a respite under the umbrella of that organization (for instance in Georgia and New York). Some feel that if it is necessary to run a peer-operated model, the umbrella organization would need to demonstrate that it shares the values of peer-operated services and recovery.

EXISTING PEER-RUN RESPITES

There are currently twelve PRCRs operating in the United States. There are also PRCRs in other countries, such as New Zealand, Germany, and England. The respites are listed in the table below. This table presents the names of the PRCRs, the state in which they are located, their funding source and budget, number of staff on shift, capacity for guests, average or range of typical length of stay (LOS), and their variation on the model.

Characteristics of Existing Peer-Run Crisis Respites in the U.S.

PRCR Name	State	Funders	Annual Budget	Peer staff	# of Guests	LOS (days)	Model
Stepping Stone Peer Support & Crisis Respite Center	NH	NH State General Funds and Federal Block Grant	$353,180	1	2	1-7	Peer-run
Sweetser Peer Support & Learning & Recovery Center	ME	Sweetser and their Endowment of Mental Health and United Way	$308,500	1	3	3.5	Peer-operated
Georgia Peer Support and Wellness Center	GA	Georgia's Department of Behavioral Health and Developmental Disabilities (GBHDD)	$354,000	2	3	Up to 7	Peer-run
Peer Support, Wellness, and Respite Center of Bartow County	GA	GBHDD	$325,000	2	3	Up to 7	Peer-run
Peer Support, Wellness, and Respite Center of White County	GA	GBHDD	$325,000	2	3	Up to 7	Peer-run
Rose House Hospital Diversion Program by PEOPLe Inc. (Milton House) Serving Orange and Ulster Counties	NY	Orange County	$270,00	1-2	4	1-5	Peer-run
Rose House Hospital Diversion Program by PEOPLe Inc. (Putnam House)	NY	Putnam County	$290,000	1-2	3	1-5	Peer-run
Voices of the Heart, Inc.	NY	NYS Office of Mental Hygiene, Warren and Washington County and Private supporters	$150,000	2	2	1-3 days	Peer-run
Foundations: A Place for Education and Recovery	OH	Stark County Recovery Services Board (Canton)	$160,000	3	3	3-5	Peer-run
Keya House	NE	State Division of Behavioral Health	$266,000	2	4	Up to 5	Peer-run
2nd Story Santa Cruz County	CA	SAMHSA Mental Health Transformation Grant	$478,650	2	8	8	Peer-operated
Alyssum	VT	State of Vermont	$369,000	2	2	14 +/–	Peer-run

TRAINING

Intentional Peer Support (IPS) is the most common training used in PRCRs. Persons trained in IPS attend a 5-day training. IPS is a form of peer support, but is different because it teaches both the principles of "intention" and "mutuality" (Mead, 2008). According to the developer of IPS, "intention is to purposefully communicate in ways that help both people step outside their current story" (Mead, 2008, pg. 10). IPS operates with the understanding that when people are in crisis, their view of their circumstances, opportunities, and challenges may become narrowed. When peers trained in IPS work with consumers, they also must re-examine their own experience of crisis and their perceptions of the person they are interacting with in order to provide support in a way that is unique to that relationship and experience. Mutuality is defined as "re-defining help as a co-learning and growing process" (Mead, 2008, pg. 10). In contrast, many other peer support practices are uni-directional, where the peer helps the person served, but does not engage in a reciprocal process. IPS teaches the ability to be non-judgmental, "just be with people" and not try to "fix" them, which often happens in traditional mental health services (Mead & Hilton, 2003). This uses some of the same principles of mutual support because of the natural reciprocity of the relationship, but differs because peer staff is trained in the IPS service delivery model to provide help to those in crisis. IPS teaches the importance of building relationships and trust, and the value of being comfortable with emotional distress and discomfort in order to "exist" with a person in crisis. According to the creator of IPS (Mead, 2007, p. 211) services provided by peers trained in IPS:

> *…operate from a completely different set of assumptions than traditional services. Where traditional services diagnose and treat illnesses, trauma informed peer run crisis alternatives focuses on the construction of meaning people have made of their experience, building mutually responsible relationships, and creating "new stories." [Peer run crisis alternatives] establishes no real hierarchy (patient/expert), no particular framework for interpreting experience, and best of all can happen (with a little groundwork laid) in community.*

Many PRCRs have found IPS training to be helpful in working with guests through crisis, and PRCRs continue to train staff in IPS. Below is a quote from an existing respite director, whose staff has been trained in IPS:

> *When your action (or reaction) is fear based, others pick up on it immediately, and their reactions become fear based as well. Then you have two people scared of a situation that they are expected to "handle." But staying calm and focusing on the relationship works very well. Using IPS is a highly effective way to deal with "risky" situations. That has been my experience.*

The evaluation of the IPS training in one state showed that peers who were trained valued the approach the training takes towards appreciating others' points of view, even when they are in crisis, and that they believed that the training provided them with skills that would be useful in working in a PRCR. The comment from one peer was:

> *I appreciated the value of worldview in relationships. I thought that the role-plays were a great practice. I really found that the difficult role-plays were especially helpful even though they were difficult for the group… I also like the mutuality and „learning vs. fixing".*

Role plays include difficult situations that may arise in a PRCR, such as suicidality. During role plays, trainees are expected to use the principles of IPS, such as mutuality, to engage in a relationship in which peers use co-learning to understand the others' point of view and build a shared experience of growth.

COORDINATION WITH TRADITIONAL PROVIDERS

In both peer run and peer-operated models, coordination with guests' providers is important. In peer-run models, this may be more complicated because there are not psychiatrists on staff or connected to the respite through a traditional provider organization, but respites may determine the best collaborative relationship to ensure continuity of care.

Some PRCRs may have consulting psychiatrists who provide medication management. As has been done in some respites, consumers can continue to see their regular psychiatrist if they wish. There is general consensus in the consumer movement for PRCR that guests should be able to continue their relationships with their regular providers, as this provides continuity of care and normalizes the crisis episode (National

Empowerment Center, 2009). In PRCR, consumers do continue to take medication; however, they bring their own and they are kept in a locked box to which only the guest has the key (they are not held by staff). In peer-operated models, there is more capacity for peers to work with clinicians who are part of the same umbrella agency.

ENGAGING CONSUMERS IN RELATIONSHIPS TO REDUCE RISK

One of the most clearly identifiable risks of using a PRCR instead of traditional services is that persons who are in crisis may be feeling unsafe and be a danger to themselves or others. Consumers have acknowledged that people (including consumers, providers, and government) may be afraid that PRCR cannot handle crisis situations because the system operates in an "illness paradigm" where services focus on safety and symptom reduction. As discussed above, our system is used to reacting impulsively to perceptions of dangerousness, and overusing language related to illness to describe extreme mental and emotional states in order to de-humanize the crisis experience and distance ourselves from the individuals experiencing it. PRCR services focus on person-centered recovery instead. They do accept people in states of psychosis or suicidality, but emphasize trust and mutuality to build relationships to diffuse crises. Building hopeful relationships with people who have experienced their own recovery increases safety and security for guests and peer workers. This enables respites to work with people who otherwise might have ended up in a locked ward. As demonstrated in some of the evidence presented here, relationships with guests that focus on hope, understanding, and trust enable persons to make self-directed choices about their behavior – even in a state of crisis. It has been shown that people in locked units demonstrate increased physical violence toward others by 11% and self-harm by 20% compared to those in unlocked facilities (Van Der Merwe, Bowers, Jones, Simpson, & Haglund, 2009). PRCRs have rules about appropriate behavior to which guests agree. Guests understand that they can be asked to leave if they engage in threatening behavior.

Stories regularly emerge that testify to the potential of PRCRs to manage crises in the respite by engaging consumers in a dialogue about their behavior and the rules regarding this behavior. Relating to others through a perspective of respect and mutuality allows peers working in respites to diffuse crises without force or coercion. PRCRs will not accept guest involuntarily because this violates the value of choice, but police and emergency service personnel do bring consumers to respites. These individuals can often be served, but the following story attests to how PRCRs communicate with guests to make the respite a safe place for peer staff and other respite guests:

> *Last year, we had a respite guest who brought a gun into the house, along with an ounce of marijuana, and bragged about how he was able to pass through security at [the] hospital the night before. Drugs and weapons are forbidden at the [respite], and anyone who brings them in has to leave the premises. I knew I would be the one to ask this person to leave, knowing he was high and had a gun. I remember being grateful that I had already formed a relationship with him. I was scared, but my faith in our relationship was stronger than the fear. Instead of focusing on the drugs and weapons, we focused on the recovery that the Center stood for. We talked about the trauma-informed environment, and we both shared some of our trauma history. By the time I asked him to leave the premises, he was in complete agreement, and he gave everyone hugs goodbye.*

This story demonstrates that PRCRs can manage acute crises and "unsafe" situations with guests, even if consumers cannot be served. PRCRs are able to set reasonable limits on guest behavior by using relationship skills, rather than force or coercion, to come to agreed upon solutions. PRCRs can be coordinated with traditional care, and in some areas, police and providers do refer consumers, and PRCRs can connect consumers with other services.

There is potential for an increase in demand for crisis services if PRCRs are implemented. This demand appears because PRCR is a more attractive alternative to some consumers than traditional inpatient care. Therefore, there may be a subsequent increase in crisis service utilization. Some consumers may have avoided crisis services including emergency rooms and inpatient facilities because they can be so unpleasant. Findings from a consumer/survivor defined crisis hostel study showed that people used the crisis hostel alternative for a number of different reasons, not always as a substitute for the hospital (Dumont & Jones, 2002). A recent survey of 4 peer-run respites, with aggregate of 27,000 bed days revealed 3 instances in which guests

had to be asked to leave due to aggressive behavior (none of which resulted in bodily harm or hospitalization) and no instances of suicide (Fisher, manuscript in preparation). Liability insurance is not required because these are not classified as clinical services, although some PRCRs do invest in it.

EVIDENCE FOR PEER-RUN CRISIS RESPITES

Evidence for the effectiveness of PRCRs is being built. One randomized controlled trial of a PRCR has been conducted (Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008). This study found that the average rate of improvement in symptom ratings was greater in the alternative than in the hospital comparison group, and that the peer-run alternative group had much greater service satisfaction. The cost was significantly less: $211 per day versus $665 per day for hospitalization. The study authors concluded that this alternative was "at least as effective as standard care" and a "promising and viable alternative" (Greenfield, Stoneking, Humphreys, et al., 2008).

PRCRs can also increase self-direction, one of the components identified in the SAMHSA National Consensus Statement on Mental Health Recovery (SAMHSA, 2004). What follows is a story from a respite worker at a PRCR:

> *Just yesterday a former respite guest came into the Center saying he was thinking about suicide and that he wasn't "safe." After getting to the untold story, we realized that he wanted someone to talk to and validate his feelings about a living situation he was currently experiencing. He proceeded to call the crisis center, who came to the [respite] to talk with him. Our staff stayed with him for extra support, but his calling the crisis center was what he did for himself, and we supported him. I remember thinking, "Wow, he came to us first and handled everything his way. That is self direction."*

As the above quote illustrates, PRCRs can integrate traditional crisis services and support guests in accessing them. This allows them to be embedded in the mental health system in an integral manner. The guidance peers provide through a crisis promotes self-direction which can promote independence from the mental health system, and create healthy relationships with traditional providers and the system, as well as the PRCR itself.

The one-year qualitative evaluation of the Sweetser program in Maine showed that the PRCR helped people change how they thought about themselves, their illnesses, and their recovery journey. Specifically, the PRCR encouraged "redefinition" or new learning about four areas of experience (Macneil, 2002):

Oneself : The PRCR demonstrated the ability to help people to discover new meaning in experiences that have been defined by diagnostic labels and illness-based interpretations.

Crisis: The PRCR has been shown to teach people to redefine crisis through a trauma-informed lens. New understandings and responses to trauma were developed.

Rituals: The PRCR allowed people to grow into new rituals or patterns of care. Peers reported that they learn how to better manage their emotional distress and how to avoid hospitalization.

Relationships: The PRCR demonstrated ability to help people to respectfully treat others, and how this is influencing the way they think about themselves and their relationships.

This evaluation of the Sweetser PRCR is evidence that guests can learn new ways to deal with and thrive in the critical domains of self-definition, crisis, rituals/patterns of care, and relationships (Macneil, 2002). These are all essential elements of wellness promotion and crisis aversion.

An evaluation of the Rose House in New York conducted in 2009 showed higher guest satisfaction with the PRCR than traditional inpatient services. Specifically, the evaluation demonstrated that services at Rose House were more client-centered and less restrictive, staff were more respectful, and that the respite felt less stigmatizing (Legere, 2009). In addition, consumers who had used the respite felt more socially involved and that the respite increased this social involvement (Legere, 2009). A survey of ten users of Rose House also found that 7 had not used psychiatric inpatient hospitals since becoming involved with the respite (Legere, 2009).

There are limitations to the research that has been done, and there is not sufficient research yet. Evaluating PRCRs is an important next step in their development and implementation. The number of PRCRs funded by local and federal funds is continuing to rise. Rigorous evaluation is needed to determine the effectiveness of respite services in a number of different domains. PRCRs must be evaluated for cost, outcomes, and cost-effectiveness. To date, there has not been large scale, multi-site, quantitative evaluation of organizational processes, utilization, outcomes, or costs. This type of evaluation would assist in determinations about the expansion of the model. Other, less rigorous, evidence to support the effectiveness of PRCRs as a promising alternative to traumatic, costly, and behaviorally constricting hospitalizations continues to emerge. However, more evaluations need to be conducted, with both quantitative and qualitative components. Until we can spur more research, we are relying on practice-based evidence and the research that we have to determine the best ways to implement the programs.

CONCLUSION

PRCRs are a promising alternative to emergency room and inpatient hospitalization because they act to both provide a secure place when individuals are experiencing crisis, and as an intervention to prevent the further development of crisis in times of stress. The national movement toward PRCRs must be supplemented and supported by peers in the states and counties. Because mental health systems are locally run, it is essential that there be grassroots organizing at the local level. Organizing must be strategic, taking into account the existing mental health systems in which the PRCRs will be embedded, while maintaining the vision of peer-run, recovery-oriented services.

The general sentiment in the health care field is that “it is no longer sufficient for treatments to be effective; they must also be cost-effective” (Sledge, Tebes, Wolff, & Helminiak., 1996, p. 1074). The needs of mental health consumers need to be met by choosing services that are effective in reducing negative outcomes of mental illness at a feasible cost. A study of non-consumer-operated crisis respite found that “hospitalizing most voluntary patients with uncomplicated psychiatric distress cannot be defended on the grounds of either effectiveness or cost” (Sledge, Tebes, Wolff, & Helminiak, 1996, p. 1079). PRCRs are an alternative to hospitalization because they use an approach to individuals in crisis, or at risk of crisis, that is based on relating to others as peers and forming mutual bonds based on a shared understanding of the experience of crisis and recovery. Because of this approach, and the fact that they attempt to prevent the further development of crisis, they are not a substitute for hospitals, but rather a true alternative for many of those that are currently placed in locked inpatient settings. PRCR also reduce the retraumatization caused by involuntary hospitalization. PRCRs present an opportunity for the system to focus on the personhood of all individuals – even those in crisis who have been brought to emergency rooms against their will – which then allows individuals to be treated with the respect and equality that promotes a type of communication that can diffuse crisis, rather than exacerbate it. If the system is to transform, we must step outside our current, myopic view of crisis that places individuals who require support on a continuum of dangerousness, rather than assessing their needs for connection and safety. We must ask the right questions, provide alternatives and choices, and adapt services to promote recovery, rather than remain stagnant in our understanding of crisis and our current financially and emotionally costly services.

As a movement of peers, we need to carefully track successes and report them to others who are attempting similar strategies. There are more lessons to be learned from the implementation of PRCRs as they grow and connect to the mental health system. The experiences of individual PRCRs in providing services to persons in crisis are invaluable to future PRCRs. More outcome and implementation research is needed, as well as evaluations that compare this approach to others.

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