

Results from the 2016 Peer Respite Essential Features Survey



By Laysha Ostrow from [Live & Learn, Inc.](#) and Bevin Croft from [HSRI](#)

The 2016 Peer Respite Essential Features (PREF) survey was an attempt to document and understand important characteristics of peer respites in the United States. Researchers from Live & Learn, Inc. and the Human Services Research Institute (HSRI) created this survey to provide public information for planning, funding, and sustainability of current and future peer respites. This is the third report of its kind, and it builds on previous survey efforts by the team in [2012](#) and [2014](#).

What are peer respites?

Peer respites are voluntary, short-term, overnight programs. They provide community-based, trauma-informed, and person-centered crisis support and prevention 24 hours a day in homelike settings. Peer respites are staffed and operated by people with lived experience of the mental health system.

Peer respites were designed as psychiatric hospital diversion programs to support individuals experiencing or at risk of a psychiatric crisis; the premise behind them is that psychiatric emergency services can be avoided if less coercive or intrusive supports are available in the community.

Imagine experiencing emotional crisis as an opportunity for growth and change. Imagine a homelike place where you can safely explore that opportunity. Imagine people there for you when you need their support. Imagine they understand and believe in you because they've been where you are.

Peer Respite Mission Statement

Peer respites engage guests in mutual, trusting relationships with peer staff. Peer support involves a process of mutual helping based on the principles of respect and shared responsibility.¹ Peer support includes interactions in which individuals help themselves and others through fostering relationships and engaging in advocacy to empower people to participate in their communities.

Crisis, in our program, is not defined as a negative experience but rather as an opportunity for growth, even in the midst of overwhelming situations.

Peer Respite Mission Statement

Defining 'peer respite' for the purpose of this study

People who have personally experienced the mental health system have been providing one another crisis support in informal settings for decades. However, funded peer-to-peer crisis supports – peer respites – are a relatively new concept. In fact, most of those in the United States have opened only in the past five to ten years. In the past two years in particular, many new programs have opened, and many more are being planned. With so many programs opening so quickly, it was important for the 2016 PREF survey to cast a wide net for recruitment so that we could be sure to reach new programs we did not know. (You can read more about PREF recruitment and data collection in the [Data Collection Methods](#) section of at the end of this report.)

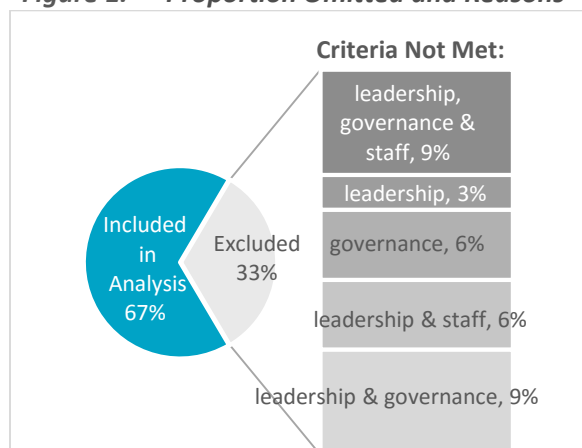
¹ Mead, S. (2003). Defining peer support. Available at: <http://www.intentionalpeersupport.org/wp-content/uploads/2014/04/Defining-Peer-Support.pdf>

In total, 33 programs responded to our survey, and, as expected, there was a great deal of variation in how they operated. Because of this, we found it necessary to define a minimum criteria for “peer respite.” To do it, we convened a [panel of experts](#) in peer support research, training, advocacy, and program administration. This consensus panel examined program structures and policies and considered the tradition and history of the consumer/survivor movement in creating and operating alternatives to traditional mental health services independently of clinical providers. They developed the following specific criteria – the purpose of which are to prevent the cooptation of peer respites by making sure that people with direct experience of the mental health system and extreme states hold operations and decision-making roles:

- **Staffing:** 100% of staff have lived experience of extreme states and/or the behavioral health system
- **Leadership:** All leaders have lived experience, and the job descriptions require lived experience of extreme states and/or the behavioral health system
- **Governance:** The peer respite is either operated by a peer-run organization OR has an advisory group with 51% or more members having lived experience of extreme states and/or the behavioral health system

Of the 33 responses to the PREF Survey, 22 met all three criteria. Figure 1 shows the proportion excluded from the analysis and the reasons why.

Figure 1. Proportion Omitted and Reasons

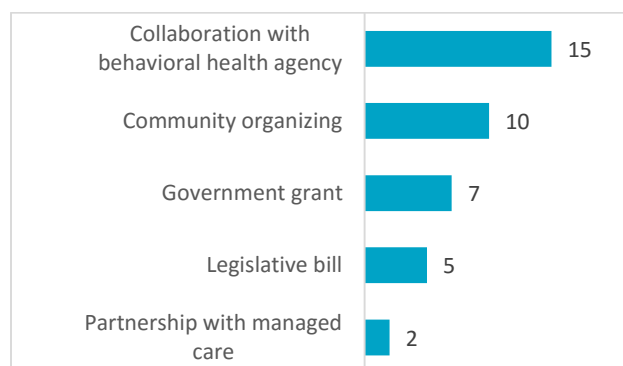


Basic Characteristic of Peer Respites

The 22 peer respites were located in 11 states throughout the country. The majority operate as part of independent peer-run organizations.

We asked respondents to identify the types of activities that contributed to their founding and the initial funding sources for their programs. These are depicted in Figure 2.

Figure 2. Founding Activities



Many of the peer respites were created either as part of a collaboration with a behavioral health agency or through community organizing, suggesting the importance of capitalizing on partnerships locally or within a state.

Funding

We asked the peer respites to report their operating budgets. Figure 3, on the following page, compares respondents’ budgets in 2014 and 2016. Since 2014, the number of peer respites with budgets in the highest category (over \$500,000) has increased by two programs, or 50%. There are five peer respites operating with less than \$300,000 per year.

We also asked programs about their funding sources. Figure 4, also on the following page, shows *on average* how much funding comes from each source for all peer respites combined. From the total operating budgets and the percentage of funding received from each source, we calculated an estimate of how many “peer respite dollars” across the country are coming from each funding source. Figure 4 provides an idea of how many dollars are coming from each funding source across the country to run all of the peer respites.

The number of peer respites receiving funding from various sources remained about the same (given that there were fewer programs in the survey in 2014). One exception is that in 2016 one program reported receiving Medicaid managed care funding. In 2014, no programs were funded by Medicaid or managed care dollars. This may reflect the expansion of insurance funding into behavioral health as part of the Mental Health and Addictions Parity & Equity Act and the Affordable Care Act.

Figure 3. Annual Operating Budget, 2014 vs. 2016

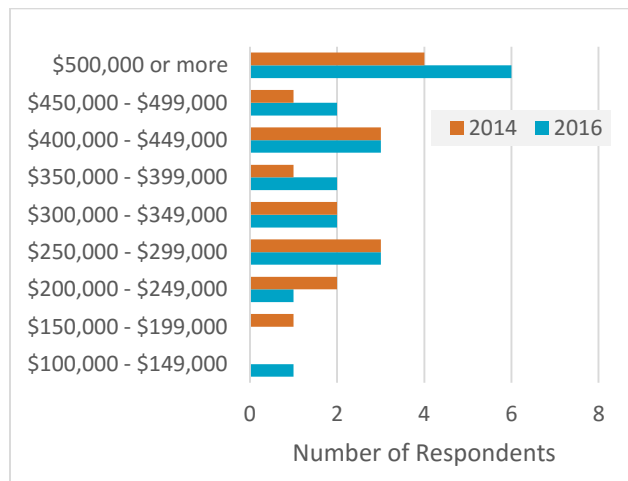
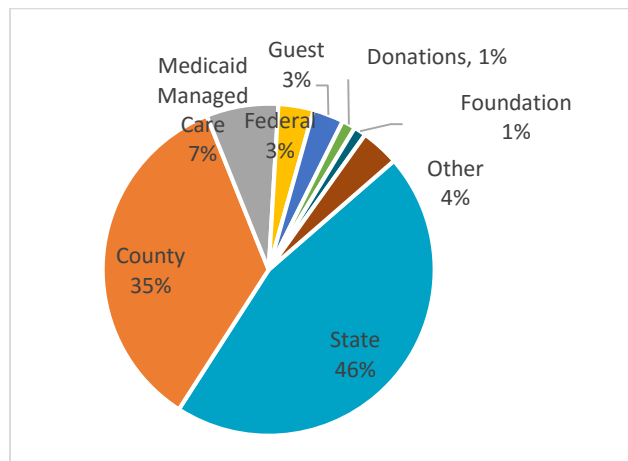


Figure 4. Average Distribution of Funding Sources



Staffing

Peer respites reported the full-time equivalents (FTEs) they employ:

	Mean	Range (Min-Max)
Paid staff FTEs	8.76	5-20
Volunteer staff hours/week	8.85	0-112

They also reported the number of staff available at certain times to support people in the house. Between 2014 and 2016, the number of people available on weekdays, weekends, and nights did not appear to change substantially:

	2014 (n=15)		2016 (n=22)	
	Mean	Range	Mean	Range
Number of Staff Per Shift				
Weekdays	2.12	1-4	2.68	1-7
Weekends	1.76	1-3	1.86	1-3
Nights	1.18	1-2	1.50	1-7

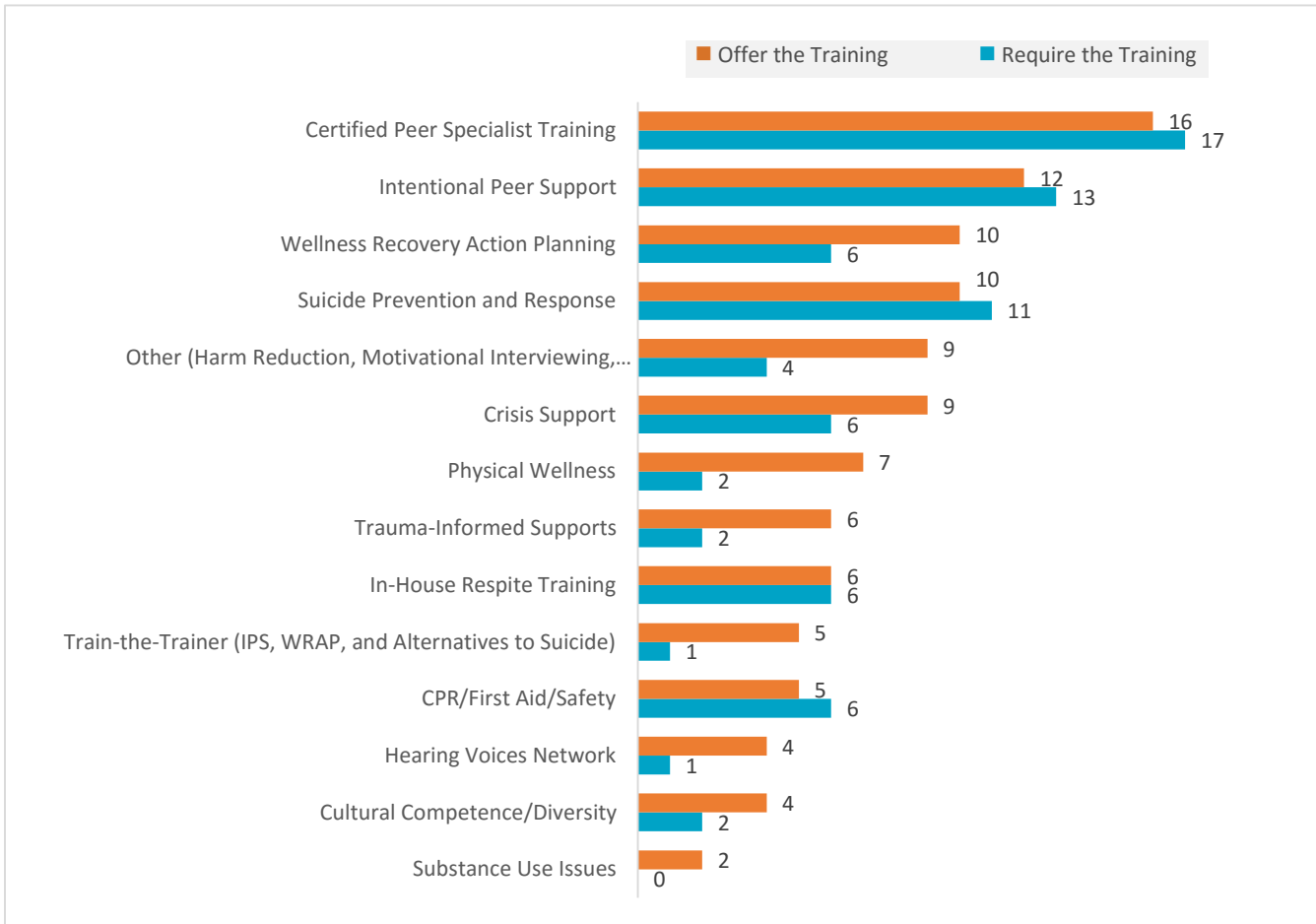
Training of Peer Respite Staff

We asked the peer respites to report the staff trainings they offered and those that were required for staff to work at their peer respite. (Respondents typed their answers into a free-text field, and the research team grouped them into the categories shown in Figure 5. Crisis support trainings included [Emotional CPR](#) and [Mental Health First Aid](#).)

The two most popular training modalities were certified peer specialist training and Intentional Peer Support (IPS).

- Certified peer specialist trainings vary from state to state; you can find out more about peer specialist training and development from the [International Association of Peer Supporters](#).
- Intentional Peer Support is a framework for creating relationships where both people learn and grow together. IPS was developed for use in peer respites and includes modules related to supporting people through challenging times and treating crisis as an opportunity for positive growth and change. You can learn more about IPS at <http://www.intentionalpeersupport.org/>.

Figure 5. Staff Training



Guest Stays

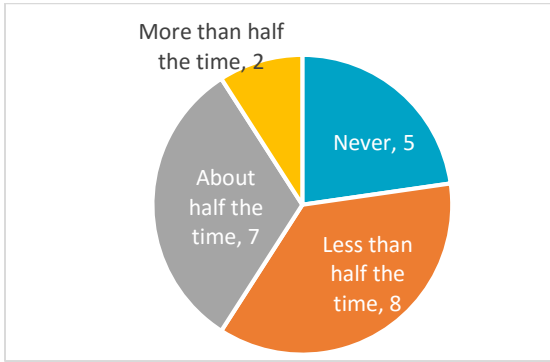
Respondents also reported on the number of people who can stay at the peer respite at any one time, the number of days people stay on average, and the maximum number of days that people are allowed to stay. These figures remained relatively unchanged from 2014 to 2016:

	2014 (n=15)		2016 (n=18)	
	Mean	Range	Mean	Range
Number of guests accommodated at once	4	2-8	4.1	2-8
Average length of stay (days)	5.9	0-11	5.5	0-14
Maximum length of stay (days)	9.0	5-29	8.4	5-29

Of the 22 peer respites that responded to our survey, 21 did not require guests to be public health clients. However, mental health providers may play a role in initiating guest stays. The frequency with which this occurs varied by program, as shown in Figure 6. All but five respondents reported that providers initiate at least some guest stays, though only two said that providers initiate guest stays “more than half the time.”

We also asked if guests were required to be assessed by clinical providers before coming to the respite. No respondents indicated that an assessment was required, but two said that guests were “sometimes” assessed by a clinical provider before coming to the respite.

Figure 6. Provider-Initiated Stays



Activities

A number of organized activities take place at the peer respites we surveyed. The ten most common are listed below, followed by the number of respondents that reported offering them.

- Artistic Pursuits, 19
- Exercise, 19
- Wellness Recovery Action Planning, 18
- Meditation/Mindfulness, 16
- 12-Step Group, 14
- Other Mutual Support, 13
- Hearing Voices Network, 12
- Suicide-Related Support, 7
- Physical Wellness, 6
- Social/Recreational, 6

Only one program specifically required guests to participate in organized activities, and one program indicated that there are no organized activities at the house. All other programs offered activities but did not require participation.

Many respondents noted that activities are organized based on the preferences and interests of the guests, and several noted that staff support guests to find activities of interest in the community if they are not offered at the house.

We believe in diversity, acceptance, advocacy and empowerment while encouraging people to transform their lives.

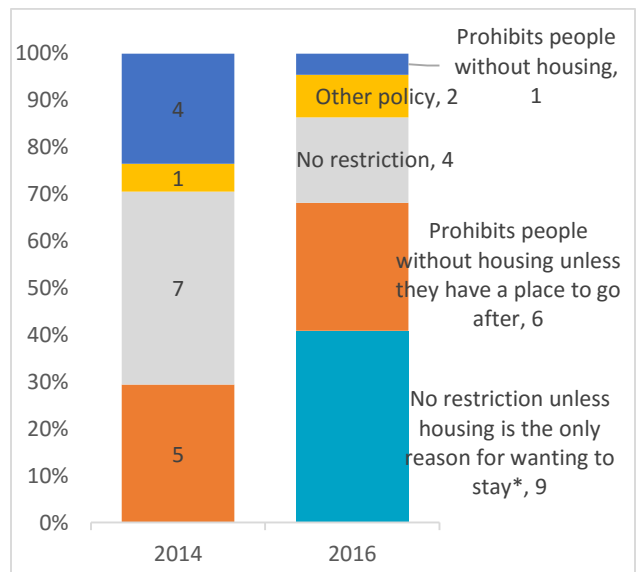
Peer Respite Mission Statement

Program Policies

We asked the peer respites to report their program’s policies on a range of issues, including homelessness, suicide and self-harm, curfews, the possession of illegal substances, and intoxication at the house.

Figure 7 depicts the policies on homelessness in 2014 and 2016. In 2014, 41% of programs surveyed had no restriction based on a person’s housing status, compared to 18% in 2016. However, 41% of programs have no restriction unless housing appears to be the *only* reason a person wants to stay. Just 5% of programs prohibited people without housing, down from 24% in 2014; 27% reported that, to stay at the respite, they require that people without housing have a place to go once they leave; 9% indicated they had some other policy, including one program that responded “We do not have a hard policy on housing status, but have found through experience that guests seem to share they get the most benefit when housing is not the only or primary reason for their stay.”

Figure 7. Policy on Homelessness



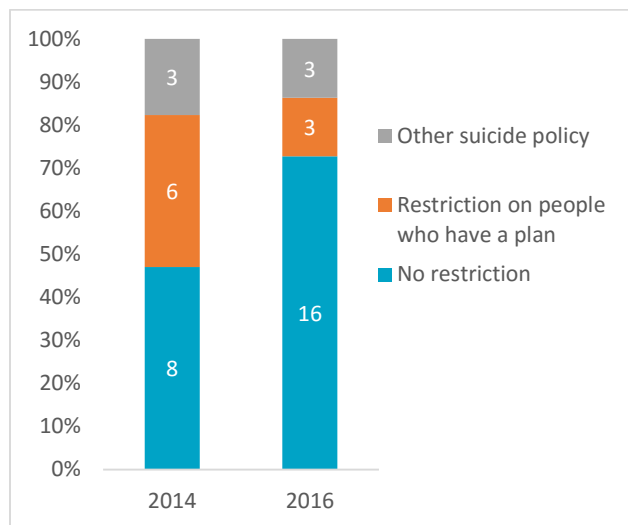
* New category in 2016

Figure 8 on the next page depicts policies on suicide. In 2016, 16 programs reported they had no rule or policy to prohibit guests who’d expressed thoughts of suicide. Describing their approach, one respondent wrote, “We discuss how they are going to maintain their safety here at the house. They are free to discuss thoughts and feelings related to

suicide; however, if they do not feel they can keep themselves safe or if they begin to act on those thoughts, we discuss how they can stay safe and the possibility of a higher level of care such as the hospital. In most cases, the trained staff is able to talk with the guest and they are able to stay at the house and maintain their safety.”

An interesting development is that there are 25% more programs in 2016 than in 2014 that have no restrictions on suicide-related thoughts or behaviors, as shown in Figure 8 below.

Figure 8. Policy on Suicide



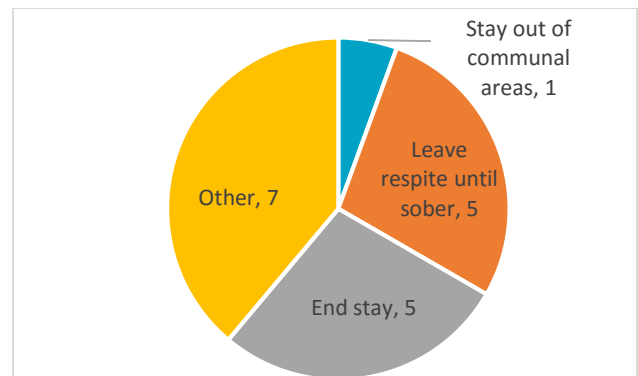
This year, we also asked about policies related to self-injurious behavior while at the house. A majority of programs (n=17) reported they had no restriction related to these behaviors, and four respondents reported having a restriction related to engaging in self-injurious behavior while in the house.

Of the 22 respondents, 11 reported that they implemented a formal curfew policy, and another 8 reported an informal expectation that guests check in with staff if they are away from the house after a certain time in the evenings. The remaining 3 reported that the house did not have a curfew of any kind.

Respondents reported their programs’ policies related to intoxication and possession of illegal substances. Figure 9 presents program policies related to intoxication. Five programs had a “zero tolerance” policy, while six require guests to either stay out of common areas (n=1) or leave the house

until they became sober (n=5). The remaining seven respondents reported having another type of policy in place. Some descriptions of these other approaches reflected behavioral or harm reduction approaches: “The only thing we address is behavior, not presence or absence of intoxication. If they cannot conform behavior to required expectations, they will have to leave.” Respondents also used harm reduction approaches: “If someone is intoxicated we will monitor along with them to ensure that the community isn’t impacted by their intoxication.” In terms of the possession of illegal substances in the house, most (n=12) had a policy that if found with illegal substances, guests are required to remove those substances immediately, and six programs required guests to end their stay if they were found in possession of illegal substances.

Figure 9. Policy on Intoxication at the House



At the end of this report, under “Additional Findings,” we present information on [peer respites’ policies for welcoming guests back](#) after they are required to end their stay.

Evaluation

As shown in the following table, a large proportion of peer respites had been evaluated – either using external evaluators, self-evaluation techniques, or both. If you are interested in learning more about how peer respites may be evaluated, you can download the [Toolkit for Evaluating Peer Respites](#), which shares perspectives on evaluation and methods used by peer respites in 2014.

<i>Evaluation status</i>	<i>N</i>	<i>%</i>
Self-evaluation only	8	36%
External evaluation only	2	9%
Both self- and external	8	36%
Neither	4	18%

Many peer respites used recovery measures (n=5), measures of functioning (n=5), utilization of hospitals (n=5), qualitative interviews (n=5), and measures of relationships at the peer respite (n=5). Other measures used in evaluation included: social connectedness (n=4), quality of life (n=4), program environment (n=4), symptoms (n=2), and program costs (n=1).

The most popular type of measurement used was satisfaction measures (n=6). It is important to remember that in healthcare, service users tend to rate services high on satisfaction measures somewhat universally. As a result, there is little variation between and within programs when it comes to satisfaction. These measures also tend to not be as valued by policymakers compared to other, less biased and more objective measurements. Because these measures are somewhat limited in their usefulness, we recommend that peer respites that are considering the use of satisfaction measures in evaluation consider other options. You may request a free hour of evaluation technical assistance with Live & Learn, Inc. and Human Services Research Institute using this form: www.PeerRespite.net/t-a

Summary

Peer respites continue to evolve and grow around the country. It is important to document and disseminate data such as these that describe organizational-level policies and structures. Additionally, Live & Learn, Inc. and HSRI are working toward research on program fidelity and effectiveness of peer respites in promoting stronger



Visit PeerRespite.net, a site we established for up-to-date information-sharing. It includes:

- A [Directory](#) of peer respites
- A compilation of [Research](#) studies
- [Resources](#) to start and sustain peer respites
- And information on staff [Training](#)

You can also request free [technical assistance](#) on creating an evaluation or data collection plan.

relationships and communities while reducing psychiatric emergency services use.

Additional Findings

In addition to the previously reported findings, the following findings may be of interest to those looking for an in-depth understanding of peer respite policies.

Missions and Codes of Ethics

Most of the peer respites that responded to our survey have a code of ethics and a mission statement (n=16). Only two had neither. Two had a mission statement but not an ethics code; and two had an ethics code but not a mission statement.

Mission statements for peer respites tended to be informed by program staff (n=11) and/or program management (n=9) and/or a governing body (n=8). Some used a mission statement from an umbrella program (n=6) or amended it (n=3). One peer respite sought the input of guests.

Many peer respites use the code of ethics from their umbrella organization (n=8), and only three peer respites amended that umbrella organization's code. Many also developed a code of ethics with input from program management (n=8) or program staff (n=8). Fewer solicited input from guests (n=4), a governing body (n=3), or used another peer-run program's (n=3). Unlike mission statements, ethics code are less likely to need to be highly unique to a specific program, and so it is logical that these would more frequently be adopted or adapted from existing sources than mission statements.

Meals

At almost all of the peer respites, guests are involved in preparing meals (n=21), and at many of these staff (n=17) and/or volunteers (n=4) also contribute to meal preparation. A majority of programs organized communal meals. However, most of those only held communal meals on special occasions, with guests responsible for preparing their own food at other times. Four programs (18%) organized communal meals each day. In eight programs, guests were expected to bring their own food. However, most of these respondents indicated that they provide food for guests if they cannot bring it. For the remaining programs, food

was supplied through the program budget. Several programs obtained food from other sources, including food banks, donations, and even gardens tended by staff and guests. For example, one respondent noted: “We receive a weekly allocation from a food bank of ‘staples’ and guests are invited to bring their own food. In the summer we have a garden and share the harvest.”

Welcoming Guests Back

We also asked peer respites whether they had policies about welcoming people back after they are required to end their stay because of a violation of program policies. Of the 22 programs, 18 (86%) had some kind of policy in place for welcoming guests back. Of these, 10 had policies that involve conversations between guests and staff, usually involving the program director; 3 also noted that staff and directors have their own separate conversations to come to an agreement about whether to welcome a person back. Five programs described a requirement that individuals wait for a set period of time (often 30 days, though some programs negotiated the length of time with the guest) before being allowed to come back. One program had a requirement that guests return to visit or attend groups before being able to stay overnight. Five programs stressed that these situations must be handled on a case-by-case basis: “We treat each stay individually and understand that recovery is not a linear process.”

Data Collection Methods for the PREF Survey

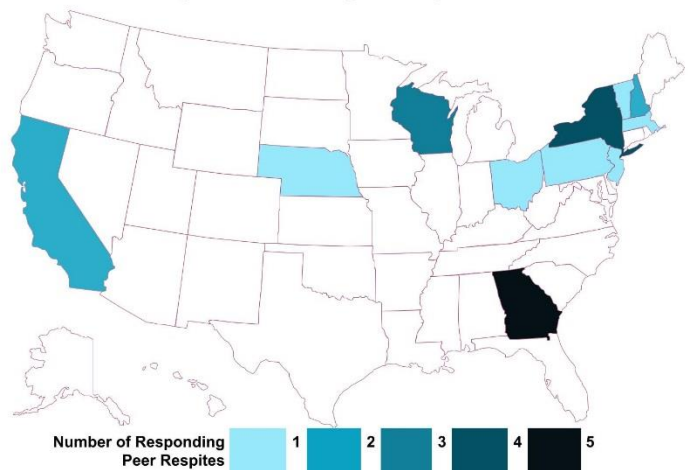
The PREF survey built on previous survey efforts by our team in [2012](#) and [2014](#). Based on the data and feedback from the 2014 survey, as well as developments in the field, we developed more questions about the policies and structures of peer respites. The survey then underwent expert review

and testing with eight individuals knowledgeable about peer respites and peer support.

Recruitment Strategy

In 2012 and 2014, survey recruitment was limited to a targeted group listed in the National Empowerment Center’s crisis alternatives directory. Because of the rapid growth and expansion of peer respite programs around the country, in 2016 we conducted open recruitment for anyone who identified their program as a “peer respite.” Recruitment notices were actively disseminated by the research team through Facebook, Twitter, and the email lists of the National Coalition for Mental Health Recovery, Doors to Wellbeing Technical Assistance Center, the National Consumers’ Self-Help Clearinghouse, the International Association of Peer Supporters (iNAPS), and Live & Learn. Potential participants and other interested stakeholders were directed to [PeerRespite.net](#) (a website dedicated to information and resources regarding peer respites in the US), which had 2,000 unique visitors during the two months of PREF data collection. In total, 33 organizations responded to the 2016 PREF in the period January – February 2016.

Map of Survey Respondents



Acknowledgements

Survey development and review:

- Shery Mead, Chris Hansen, and Steven Morgan [Intentional Peer Support](#)
- Sera Davidow, [Western Massachusetts Recovery Learning Community](#)
- Adrian Bernard, [2nd Story Respite House](#)
- Darby Penney, [The Community Consortium](#)
- Yana Jacobs, [Foundation for Excellence in Mental Health Care](#)
- Lauren Jessell, [New York University Silver School of Social Work](#)

Consensus panel on inclusion criteria:

- Darby Penney, [The Community Consortium](#)
- Sera Davidow, [Western Massachusetts Recovery Learning Community](#)
- Chris Hansen, [Intentional Peer Support](#)
- Sally Zinman, [California Association of Mental Health Peer-Run Organizations](#)

The wholesale co-optation of genuine peer support into peer-staffed positions within mainstream programs is a shining example of what we don't want to see happen with peer-run respites.

Special thanks to Keris Myrick of SAMHSA's Center for Mental Health Services for her input on the implications for this project of SAMHSA's research on Consumer-Operated Service Programs.

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[National Empowerment Center](#) (SAMHSA Consumer Technical Assistance Center)

The Peer Respite Essential Features Survey and this report were created by [Laysha Ostrow](#), PhD, of Live & Learn, Inc. and [Bevin Croft](#), MPP, PhD candidate, of the Human Services Research Institute (HSRI).

