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Self-Reliance and Belonging: Guest Experiences of a Peer Respite

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Objective: A peer respite is a voluntary, short-term, overnight program that provides community-based mutual support to people experiencing a mental health crisis. This qualitative study of guest experiences at 1 peer respite examines its role in fostering recovery and wellbeing. **Method:** Conventional content analysis of interviews with 20 peer respite guests resulted in a thematic framework containing 7 “clusters” of themes with related subthemes. **Results:** The following themes emerged from the analysis and include both positive and negative experiences: belongingness, confidence and hope, crisis self-management, experiencing mutual support, freedom and responsibility, linking to community, and conflict and confrontation. Some guests endorsed the peer respite as a temporary break from stressful life situations, a homelike space for mutual support and community, and a preferred alternative to traditional crisis services. Others struggled with the unstructured environment and expectations for shared responsibility and self-reliance. **Conclusions and Implications for Practice:** Peer respites strengthen self-reliance and social connectedness and offer a viable alternative to traditional crisis services for some people some of the time. The results suggest potential “key ingredients” for peer respites, including a homelike environment, voluntary and self-determined supports, and peer support staff who possess the capacity for developing healing and genuine connections with guests while also promoting shared responsibility and self-reliance. Future research should further develop this theory of change and establish peer respite fidelity criteria based on program elements that seem to contribute to positive outcomes.

Impact and Implications

Findings suggest “key ingredients” for peer respites: A homelike environment, voluntary and self-determined supports, and peer staff who possess the capacity for developing healing and genuine connections with guests while also promoting shared responsibility and self-reliance. This work contributes to a theory of change for peer respites: By providing a “break” from stressful life situations alongside mutual support, peer respites offer a viable alternative to traditional crisis services.

Keywords: peer respite, peer support, mutual support, crisis alternatives

A peer respite is a voluntary, short-term, overnight program that provides community-based, nonclinical crisis support to help people—referred to as “guests” – find new understanding and ways to move forward (Peer Respites, 2018). Peer respites are staffed and

operated by people with psychiatric histories or who have experienced extreme states (Ostrow & Croft, 2015). There are currently 33 peer respites in the United States, up from 17 in 2014 and 22 in 2016 (Ostrow & Pelot, 2018). This qualitative study of guest experiences of one peer respite adds to the growing literature exploring their implementation and impact. The central research question involves whether and how the peer respite fostered recovery and wellbeing for its guests.

Peer Respites

Peer respites fill a gap in the service system between outpatient and emergency services for people experiencing psychiatric crisis. Peer respites are staffed and operated by people with psychiatric histories who offer nonclinical peer support (National Action Alliance for Suicide Prevention, Crisis Services Task Force, 2016; Ostrow & Croft, 2015). Mutual support is based on individuals

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providing support to each other, self-advocating for independence, and empowering others to participate in their communities (MacNeil & Mead, 2003; Ostrow & Croft, 2015). Many peer respites offer intentional peer support (IPS), a theory-driven, manualized approach developed by peers that thousands of people have been trained in worldwide (Mead, 2014). IPS uses the principles of respect and shared responsibility in which individuals help themselves and others, through support and advocacy (Ostrow & Croft, 2015).

Evidence Base

Although peer respites have a modest evidence base (Croft & Ísvan, 2015; Fletcher, Barroso, & Croft, 2020; Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008), there is a substantial evidence base for peer-provided services generally (Bellamy, Schmutte, & Davidson, 2017; Chinman et al., 2014) and for residential crisis diversion programs more broadly (Thomas & Rickwood, 2013). Studies of crisis residential programs have found an improvement in symptoms, mental health-related functioning, quality of life, and higher satisfaction with crisis residential services compared to inpatient services (Fenton, Mosher, Herrrell, & Blyler, 1998; Hawthorne et al., 2005; Rakfeldt et al., 1997; Sledge et al., 1996). To date, there are two quantitative, outcomes-oriented published studies of peer respites. The first was a randomized trial that documented higher satisfaction and greater improvement in symptoms, social functioning, and self-esteem for peer respite guests compared with individuals receiving services in a locked inpatient facility (Greenfield et al., 2008). The second, a quasi-experimental study, found a significant reduction in emergency and inpatient service use among guests compared with a propensity score-matched group of nonguests with similar demographic, clinical, and service use characteristics (Croft & Ísvan, 2015). In addition to these two studies, a recent study of a crisis diversion program with a substantial focus on peer support and peer-driven services suggests similar reductions in emergency services use and cost savings (Bouchery et al., 2018).

A qualitative study of peer respite guest experiences explored research questions similar to those taken up in the present study (Siantz, Henwood, McGovern, Greene, & Gilmer, 2019). Through interviews with 27 respite guests, Siantz and colleagues found the peer respite provided temporary relief from stressful life situations, and that guests reported building peer-to-peer relationships while avoiding some of the problems of the traditional mental health system. Two additional qualitative studies have examined organizational dynamics (Fletcher & Barroso, 2019) and integration with the public mental health system (Fletcher et al., 2020) through interviews with peer staff. The authors documented challenges related to role clarity and program sustainability within the context of overall system resource scarcity and disconnection from social services.

Current Study

This study used qualitative data collected for an evaluation of one of the first peer respites in the United States. The program had capacity for up to six guests who could stay up to 14 days, with an average length of stay of 8 days. All staff completed the IPS training program and participated in regular group supervision

meetings throughout the study period. In terms of size, capacity, and operational policies, the peer respite was similar to many other peer respites in the United States (Ostrow & Pelot, 2018).

The evaluation employed a mix of quantitative and qualitative methods with a participatory approach that emphasized collaboration with program staff and other community stakeholders at all stages. The quantitative evaluation involved guest surveys administered by peer interviewers (Croft, Ostrow, Italia, Camp-Bernard, & Jacobs, 2016) and an examination of whether the program was successful in meeting its objectives to reduce emergency hospitalizations (Croft & Ísvan, 2015). The qualitative component involved a process evaluation examining how the program was integrated into the public mental health system (Fletcher et al., 2020) and the present study, an exploration of guests' experience of peer respite.

Method

The study was conducted between June 2012 and August 2014. Interviews were semistructured using a guide that was developed based on the research aims and included questions about the guests' experience and whether and how the respite fostered recovery and wellness. The interviews took place either during or after the guests' stays at the respite and lasted between 30 and 75 min. Guests were given \$10 for their participation. All interviews were audiotaped, transcribed, and loaded into qualitative analysis software (NVivo 10). The study was reviewed and approved by the Human Services Research Institute's Institutional Review Board.

Recruitment and Sampling

We recruited guests using a combination of convenience and purposive sampling (Palinkas et al., 2015). During site visits, all current guests were invited to be interviewed, and these guests made up the convenience sample. The remaining guests were purposively sampled in the following way: During one site visit, we recruited guests with the highest and lowest scores on a survey of experience, the Perception of Care section of the Adult National Outcome Measures Survey. During another site visit, we recruited guests with high rates of inpatient and emergency service use to understand dynamics associated with more intensive service needs. This combination of sampling methods resulted in three guests being interviewed twice. In total, we conducted 23 interviews of 20 guests. Interviewees were majority female (65%; $n = 13$) and ranged in age from 27 to 67 years, with an average age of 44 years. Most interviewees were White (85%; $n = 17$), and six interviewees (30%) identified as Hispanic.

Data Analysis

We used conventional content analysis (Pope, Ziebland, & Mays, 2000) to organize and understand the interview data. First, we read through all transcripts and developed a preliminary coding framework. Next, each researcher applied the framework through line-by-line coding of six interviews. The coders then met and discussed areas of convergence and discrepancy, leading to further refinement of the framework. We independently coded the remaining interviews and met to revisit and discuss discrepancies. Themes were collapsed, expanded, or eliminated as appropriate.

Once all interviews were coded, we revisited the codebook and identified core themes. These themes were then organized into seven “clusters,” each with related subthemes.

Two primary methods strengthened integrity of the analytic process. For all themes, disconfirming cases were sought out to provide a full range of guest experiences (Mays & Pope, 2000). A draft article was reviewed by three peer respite staff to determine whether the findings resonated with their experiences and observations during the study period (Flick, 2007). Overall, these staff members affirmed the accounting was accurate, also noting that the peer respite has continued to develop and change in the years since the study.

Results

Seven theme clusters related to guest’s experiences emerged: belongingness, confidence and hope, crisis self-management, experiencing mutual support, freedom and responsibility, linking to community, and conflict and confrontation. Each cluster included subthemes related to the cluster’s main context. Themes, subthemes, and representative quotes are summarized in Table 1.

Theme 1: Belongingness

For many guests, *belongingness* emerged as an important element of staying at the peer respite. Subthemes of belongingness

Table 1
Themes, Subthemes, and Representative Quotes

Theme and subthemes	Representative quotes
1. Belongingness	
Belonging to a community	“I felt like I was kind of joining this temporary family . . . I realized I didn’t need to be locked in, I just needed people around me so that I could talk when I needed to, and they could just kinda surround me with love and support.”
Having been there	“[The hospital doctors] are just guessing . . . They just went to school and learned about this crap. You come here, and these people have lived it . . . Like I said, these people are me!”
Homelike ambiance	“[The peer respite is] just like being at a friend’s nice house. It had this comfy fluffy down comforter like I have at home and a comfortable bed and a big clean room . . . I don’t like being anywhere but my own bed, but I was just completely cozy and safe, and I felt really happy there.”
Feeling safe	“I come here, and I can breathe. I come here, and I have people who love me . . . I don’t know why I would choose any other place but here.”
2. Confidence and hope	
Motivation and independence	“I feel internally motivated to get better. It really motivates me, it’s an internal motivation that I don’t experience at those other places [inpatient and crisis services].”
Moving forward	“[Staff] wanted me to . . . do house hunting, look for an apartment and things like that. Ask for solutions, going to places, how to get up and go on with my life, not just isolate.”
3. Crisis self-management	
Minimizing life disruption	“I could come and go as I please. I think if I had been in the hospital, it’s an all or nothing thing, so I’m either locked in or I’m discharged.”
Taking a rest	“I was really stressed out where I was living at. I went there to take a break because I was pretty stressed out.”
Getting stable proactively	“Before I was here I was just spinning and spinning and spinning . . . [The peer respite staff have] given me a new perspective to try to work towards not doing the same thing over and over . . . Changing, and really accepting my symptoms as they come up and being able to work through them and not have to do the same thing over, go to the same place.”
4. Experiencing mutual support	
Taking time to talk	“They make time to talk with you . . . and help you out. ‘Hey how’s your day going? How are you feeling today? Are you feeling better?’”
Engaging in mutual support	“It is not like a one-way talking. When you’re talking . . . to a therapist or psychiatrist or something like that, you’re just talking to them. They’re not disclosing anything about themselves. [At the peer respite] it is a two-way relationship and communication, and it’s really genuine.”
5. Freedom and responsibility	
Being treated as an equal	“There is a profound respect for . . . your ability to know what you need and you leading the way in how you’re going to get better.”
Self-determining the program experience	“I feel like they encourage us to and direct us to try and make our own decisions.”
Setting expectations	“I think there was just a high expectation of me and like so much respect that I wanted to . . . do my best. And I was just trying really hard to keep myself together and live up to what everyone thought of me, which was a lot.”
6. Linking to community	
Accessing resources	“They connected me with a lot of places and really gave me the tools so that when I left I could feel like I was not only a functioning member of society but also in control of myself.”
7. Conflict and confrontation	
Growing through conflict	“It was hard . . . because I’ve never really been confronted about something like that that I had done. I was like, wow, okay, they’re trying to get me to take responsibility for what I’ve done.”
Feeling judged	“Last time I was there, [a staff person] was pigeonholing people. Like ‘some are like this, and some are like that and some come here because of this, and some come here because of that.’ . . . just going on and on categorizing.”

included “belonging to a community,” peer respite staff “having been there,” the peer respite having a “homelike ambiance,” and “feeling safe.”

Belonging to a community. The concept of community frequently came up in interviews, with multiple guests remarking on its value in the peer respite. Guests noted how the staff encouraged community-building, both within the peer respite and as part of a guest’s external support base. Community within the peer respite was encouraged in many ways, from contributing to house tasks, activities, and community outings. Staff intentionally developed relationships with guests and worked with guests to strengthen their social networks outside the peer respite.

Several guests described staff encouraging guests to visit after their stay was over, even if they did not need support, just to keep in touch. One guest said, “they encourage you to come back even if you’re doing really well . . . they don’t just want to see you when you’re not so well.” Many guests described how past guests came back as volunteers to help out and support the staff and the guests. One guest said, “I go there because I love their support, and I love them as people . . . I just love being there. So I volunteer there too now.”

Not all guests were pleased with former guests coming back as volunteers, however. Concerns about community at the peer respite included it feeling chaotic with too many staff, volunteers, and guests. One guest raised a concern about social cliques being formed between staff and guests and the difficulty of negotiating these dynamics. Another complained that many guests and staff had preexisting relationships and, sometimes history of conflict with one another. One guest noted, “I didn’t know who was working there and who was staying there. . . [You] might be telling somebody a whole bunch of stuff about their best friend. And you wouldn’t know.”

Two guests described concern that the role change from guest to volunteer could lead to uncomfortable relationships, particularly when current and former guests have outside relationships and histories with one another. One guest remarked,

Having volunteers working with people that are staying there is not a good idea. Because it creates social problems. Like I shared a room with someone, and we got along together just fine and didn’t have any problems. Now [they are] volunteering [here], and like cut off from me emotionally because [they have] to stay professional . . . It’s like I’ve lost a friend.

Another guest raised a similar concern because they had an ongoing personal conflict with one of the volunteers and did not know how to negotiate the conflict: “If you’re going to a respite house, you’re obviously trying to get away from something. [If] the person you’re trying to get away from also volunteers there, then there’s bias.”

Having been there. Guests appeared to have an easy time establishing a connection with the respite’s peer staff due to staff having personally experienced periods of life disruption and/or because they had experienced receiving service through the publicly funded mental health system. Through this shared experience, guests reported feeling more connected to the staff in contrast to their experiences in more traditional mental health treatment settings.

Peer respite staff were seen by guests as having more credibility than clinical staff because they had “actually lived” experiences

similar to those of the guests, which translated to greater credibility for some. For example, one guest said, “when [staff] say things, it weighs different, because they have actually lived it, instead of [having] just consumed the theory out of literature.”

Homelike ambiance. Many guests described the peer respite as a comfortable, home-like place that felt appealing to visit and enhanced their sense of belongingness. Guests contrasted the peer respite ambiance with the more sterile environments of psychiatric hospitals and crisis centers.

While most interviewees positively endorsed the environment, others expressed discomfort with the house’s open floor plan and its lack of private space for conversations. For example, one guest noted,

I do not like how the office is so open. . . [If] you want to have a private conversation you should be able to close the door. You know, if it’s something serious you do not want the whole house knowing your damn business.

Feeling safe. Multiple guests described the peer respite as their “safe space,” a place where they could go to take refuge during a personal or emotional crisis instead of going to a traditional psychiatric crisis center.

A smaller number of guests, however, noted that the program atmosphere was occasionally disrupted for them when other guests were in crisis. They gave examples of times when other guests intruded on their personal space, leading to personal discomfort and occasionally causing them to leave the peer respite prematurely. A few interviewees expressed concern about allowing other guests in deeper stages of crisis to stay. One guest stated, “[They are] taking people in who are full-blown crisis who really need the hospital but are [here] instead.” Guests discussed times when they had wished for more staff support when dealing with problems with other guests. One guest described peer respite staff encouraging them to “work it out on my own” with another guest. That guest was not comfortable doing that and so decided to leave the peer respite early instead.

Theme 2: Confidence and Hope

Guests spoke about how staying at the peer respite increased their hope for the future, enhanced personal growth, and supported independence from the mental health system. Subthemes in this cluster include “motivation and independence” and “moving forward.”

Motivation and independence. Guests reported developing a drive to pursue wellness and take responsibility for their own wellbeing after staying at the peer respite. One guest remarked about how the staff support increased their motivation to do things independently, “It’s really got me motivated to start searching for myself, doing things for myself. If I had a question or ran into a problem, there would be someone there to help me.” For some guests, this motivation translated to increased independence and fulfillment: “[The peer respite] has helped me to become much more independent . . . I’m living on my own now, and I’m much happier in my life.”

Moving forward. Guests spoke about how staff framed recovery as personal growth and focusing on the future, instead of managing or eliminating symptoms. One guest noted that staff members “try to get you . . . out of your comfort zone to try to

explore new ideas of how to create what you want to create in your life.”

One guest emphasized that encouragement from peer respite staff was done in a respectful, thoughtful manner. “[There] is so much thought that is put into what is being said . . . so that you can move forward together.” Notably, this guest identified moving forward as a mutual process, something that occurs together with the staff and guest rather than by the guest alone.

Theme 3: Crisis Self-Management

Guests described the peer respite as a place where they could remain connected to their communities while taking a break from day-to-day responsibilities and stressful situations. Themes in this cluster include “minimizing life disruption,” “taking a rest,” and “getting stable proactively.”

Minimizing life disruption. Guests discussed the positive experience of being able to engage in outside activities, appointments, and relationships while staying at the peer respite. They emphasized that the peer respite was unique in that it afforded them a break from their day-to-day lives while allowing them to stay connected to outside responsibilities. One guest stated, “The flexibility [allowed me to] have a break and some safety, but also . . . keep up with my family obligations and just get back on my feet a lot quicker.” In this sense, staying at the peer respite was less “dramatic and demoralizing” than an inpatient stay and enabled guests to recover from crises more quickly.

Taking a rest. Guests described staying at the peer respite as a place to take a break from stressful or toxic life situations. One guest described the peer respite as “a place . . . to gather things together . . . to heal and do things that you need to do for yourself and regroup.” Several guests described using the peer respite as a way to take a break from undesirable living conditions, including guests who were experiencing conflict with family members or with roommates.

Getting stable proactively. Guests spoke about how staying at the peer respite increased their confidence to take care of themselves in the future when mental health issues might arise. This dynamic appeared to be particularly important for guests who had used crisis and inpatient services repeatedly in the past and saw the peer respite as a means to break that cycle. These guests described how the peer respite helped them to proactively avert the need for a hospitalization by gaining, or regaining, a sense of stability. A few guests described a need for more linkages to clinical supports while staying at the peer respite. One guest remarked that having a psychiatric medication prescriber and a psychotherapist on site would be useful, “if [the peer respite] had that and the peer support, that would be like golden really.”

Theme 4: Experiencing Mutual Support

Many guests spoke about the value of mutual support at the peer respite. Subthemes of mutual support included interactions with staff and the concept of mutuality.

Taking time to talk. Several guests spoke positively about peer respite staff members being available to spend time with them. They said they appreciated that staff seemed to take interest in how they were feeling, and voiced appreciation that staff were available at all hours of the day and night, and that staff seemed willing to make time to talk despite other responsibilities.

Not all guests appreciated the staff’s attention; some guests preferred to use their time at the peer respite to be alone, reflect, and not engage in discussion. One of the guests described the mutual support approach as intrusive: “[It] gets kind of old . . . talking your problems through over and over and over again . . . I just need some space.”

Engaging in mutual support. Many guests voiced that, at the peer respite, mutual support was expected and flowed in both directions between staff and guests. One guest noted, “[There’s] no stigma . . . everybody is just there to be together and to support each other.” Guests stated that this mutuality was what opened up the space for powerful connection, and they contrasted these dynamics with other clinical settings. One of the guests stated, “It’s like a friendship instead of a very closed, cold-hearted professional support . . . There’s real connection. There’s no connection with people at the hospital.”

In contrast to other mental health treatment settings, guest noted that staff members are open about their moods and personal stressors. One guest said, “[Staff] are people that have been through the same things I’ve been through, and they’re still dealing with it . . . they’re trying the best they can.” Another guest spoke positively about being able to give support to a staff member who was experiencing distress: “[I was] able to actually ask them if they needed support from me [even though] I was a guest here.”

Theme 5: Freedom and Responsibility

Guests said the peer respite staff expected guests to be independent, self-sufficient, and accountable for their personal decisions and actions. Subthemes of freedom and responsibility included “being treated as an equal,” “self-determining the program experience,” and “setting expectations.”

Being treated as an equal. Several guests described how the program promoted a sense of dignity, humanity, and respect for the guests to direct their own recovery. One guest observed, “I don’t feel less than in this environment. I feel like across the table we’re all equals.” Guests frequently described staff as treating them as experts in their own lives, and having faith in guests’ internal capacity to change their lives for the better.

Self-determining the program experience. Guests highlighted the freedom and flexibility they experienced at the peer respite. They said the flexibility offered by the program supported them in self-determining their own experience. One guest stated, “You get freedom. Like you can take your own damn meds. You’re responsible for yourself.” Other guests spoke about being able to make their own decisions and how staff supported them to do so.

Yet this level of flexibility and self-determination was not perfect for all guests. Some voiced a desire for more structured activities and more staff involvement. One guest noted, “In the hospital . . . they feed you your meals, which can be really valuable and useful when you’re struggling. . . [Sometimes] it is hard . . . to try to take care of yourself.”

Setting expectations. Several guests described how the peer respite entry process included a discussion of expectations for the stay, including what the guest wanted to work on while staying at the peer respite and what the guest hoped to get out of the stay. One guest reflected, “[The staff asks] in the beginning how [they can] make my stay a success . . . I think it is totally appropriate that

they [ask] it at the beginning.” Guests noted that staff had high expectations of them, and that they experienced this faith in their abilities as both respectful and motivating.

Other guests described the increased responsibility as being something that might not be appropriate for a person experiencing an acute crisis. One guest reflected, “They expect you to stay out of your room. And it’s just too much for me sometimes.” Some guests interpreted expectations as “telling me what to do” and “putting me on the spot.” Another guest said, “[Staff member] really pressured me while I was there to do things, and I don’t respond well [to] someone being like, ‘you need to do this.’ It’ll make me not want to do it.”

Theme 6: Linking to Community

Guests described the peer respite’s focus on connecting guests to external resources and promoting community integration during their stay.

Some guests highlighted the peer respite’s emphasis on making new or renewed connections to the community. Several guests mentioned how the staff helped them search for, connect to, and strengthen connections with community resources including housing, employment, and relationship supports. Guests described this process as supporting them to develop lasting community connections that would promote long-term health and wellbeing. One guest noted, “They . . . encourage community involvement a lot here, which is huge . . . because that’s really where all your supports are going to come from when you leave.”

A few guests wished the staff had initiated communication with members of their mental health treatment team as part of this push for external community involvement. One guest stated, “I think that that [more contact with people on your team] could be encouraged a little bit more . . . that’s something that could be better.”

Theme 7: Conflict and Confrontation

The last cluster of themes that arose during interviews described occasional discord and conflict with staff. Sometimes guests felt judged or pushed for no reason, while other times these confrontations were considered as useful or cathartic. Two subthemes for this cluster include “feeling judged” and “growing through conflict.”

Feeling judged. Two guests said that staff were too judgmental and unfairly characterized them in certain ways. One was concerned that staff were “pigeonholing” guests who came to the peer respite, making generalizations rather than treating each guest as an individual. Another guest felt that staff looked down upon guests who took psychiatric medications as not being as advanced in recovery as those who chose not to take medications.

Growing through conflict. Some confrontations between guests and staff appeared to foster responsibility for oneself and one’s relationships with others and promote positive personal growth. These guests described conflict as both challenging and transformative. One guest reflected, “[Sometimes staff] would challenge me to try to work through what was going on and not . . . avoid it. Because they want to try to have something different happen instead of the same thing over and over again.”

Other guests were not as appreciative of staff challenging guests to take more responsibility. Describing a relationship with one of

the staff members, a guest said, “[They were] really adamant about me doing more things [and it] made me feel kind of awkward. I felt like I had to.”

Discussion

The findings presented here capture the unique experiences of 20 guests during the early years of one of the nation’s first peer respites. We display a range of perspectives and views, some positive and some negative. Experiences reported here may or may not be generalizable to the experiences of other guests staying at this peer respite, or of guests at peer respites in other communities. Nevertheless, we offer a window into the peer respite experience and provide descriptive evidence of how peer respites offer a unique alternative to traditional services for people experiencing crisis or distress.

These findings add to the literature on peer respites in several ways. The crisis self-management mechanisms described by guests may shed light on peer respites’ association with reduced inpatient and emergency service use (Croft & Ísvan, 2015). Other positive outcomes endorsed by guests may also explain less reliance on inpatient and emergency services. These include strengthened community networks, increased hope, and having an alternative option when in or headed toward crisis. Our findings resonate with Siantz and colleagues’ (2019) observations of the peer respite as a temporary escape from stressful life situations and a space for mutual support and community to develop.

Guest experiences reveal a challenge in striking a balance between promoting both self-reliance and social connectedness. When the approach works well, guests report strengthening their ability to self-manage crisis while also having an increased sense of belonging. However, guests also reported dissonance between the two concepts of self-reliance and social connectedness, feeling pushed to connect when they want to be alone, or feeling pressure to take responsibility for themselves when they feel they need someone to care for them. The extent to which guests and staff were able to strike this balance depended on multiple factors, including the strength of connection between guests and staff (a cornerstone of mutual support, specifically IPS), and the unique needs and life circumstances of guests and staff. These results highlight the challenge of designing an intervention that draws its contribution from being a community setting, while being flexible enough to accommodate individual preferences for contact with others, access to other services, boundaries between community members, and attitudes toward conflict resolution. Notably, these challenges are not unique to peer respites. Any congregate setting, particularly one designed for people in crisis, is likely to present challenges related to interpersonal conflict.

Guest experiences recounted here also draw a contrast with experiences of inpatient and emergency settings, where practices such as forced medication, seclusion, and restraint and emergency department wait times can be traumatizing and countertherapeutic (Donat, 2005; Frueh et al., 2005; Madan et al., 2014). These contrasts may inform efforts to establish best practice, particularly regarding the role of peers in all aspects of peer respite service delivery and organization. Guests endorsed the “homelike” environment of the respite as critical and contrasted it with the colder institutional ambiance of clinical settings, particularly inpatient settings. Guests also noted having the freedom to self-determine

one's experience—including the freedom to come and go from the premises—helped make their stay less disruptive for daily life. Mutuality is a common thread in many themes and appears to be another “key ingredient” in the peer respite approach. The IPS model, which emphasizes shared responsibility and negotiating conflict and growth through connection, appears to have contributed to experiences of the peer respite as a positive, hopeful, and warm place. Organizations like the peer respite that facilitate participation and decision making by service users and staff members can create a more empowering culture than those with hierarchical management characteristics (Campbell, Teague, Johnsen, Yates, & Sonnefeld, 2006; Holter, Mowbray, Bellamy, MacFarlane, & Dukarski, 2004; Segal, Silverman, & Temkin, 2013). In addition to pointing to possible fidelity elements for peer respites, these contrasts may provide useful information for traditional settings, particularly for practitioners of psychiatric rehabilitation.

Some guests described a preference for greater linkages to and integration with the traditional clinical mental health system. However, including a clinician on staff (as one guest suggested) would run counter to the ethos and orientation of peer respites as an intentional community space for people with shared experiences. Nonetheless, there may be opportunities to further tailor the level of collaboration with traditional providers based on individual guests' preferences. This may include more in-depth collaboration and communication with traditional providers in some cases.

Some of the negative experiences of guests suggest a need for additional training and support for staff and for volunteers. It appears critical that staff possess the capacity to read and respond to guests' unique circumstances and preferences for connection versus time alone, level of support, and expectations for shared responsibility and self-reliance. And finally, echoing the findings from Siantz and colleagues (2019), role clarification—particularly for staff and volunteers—appeared to be important for creating a safe and healing environment that feels safe for guests to engage in healthy conflict.

Conclusion and Implications for Practice

Altogether, these findings and those of previous research contribute to a theory of change for peer respites: By providing “break” from stressful life situations alongside mutual support, peer respites strengthen self-reliance and social connectedness and offer a viable alternative to traditional crisis services for some people some of the time. The provision of mutual support in an environment that fosters mutuality and equality between guests and peer staff may improve quality of life and enhance social connections while also preventing the need for more costly and undesirable inpatient and emergency services. Additionally, for many individuals, the peer respite can facilitate the experience of a psychiatric crisis as an opportunity for inter- and intrapersonal growth.

Study findings also suggest there are some “key ingredients” for peer respites, including a homelike environment, voluntary and self-determined supports, and peer staff members who possess the capacity for developing healing and genuine connections with guests while also promoting shared responsibility and self-reliance. Future research should continue to develop this theory of change and establish fidelity criteria for peer respites based on

those program elements that seem to contribute to positive outcomes.

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