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Characteristics of Peer Respites in the United States: Expanding the Continuum of Care for Psychiatric Crisis

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Objective: Peer respites are recovery-oriented services where people who identify as having lived experience of extreme mental health states (peers) support individuals experiencing, or at risk of, crises in a homelike environment. This brief report describes data from the Peer Respite Essential Features survey, conducted biannually from 2014 to 2020, which explores the peer respite model and program challenges. ***Method:*** Peer respites nationwide were invited to participate if they met specific guidelines, resulting in 32 programs across 14 states in 2020. ***Results:*** Results focus on the data collected in 2020 and compare past reports where applicable. Characteristics including funding, guest accommodations and policies, and how the programs were impacted by the COVID-19 pandemic are discussed. ***Conclusions and Implications for Practice:*** More research is needed to understand the relationship between program characteristics and effectiveness of peer respites compared to other crisis diversion services and how to better support these growing programs.

Impact and Implications

This brief report provides an overview of peer respites in the U.S. to further characterize these crisis prevention and intervention programs. Defining the operational components of peer respites is an important step in understanding what these programs do. This informs future research in the development of fidelity measures among peer respites and other crisis diversion programs to investigate how they compare in reducing the use of psychiatric emergency services.

Keywords: peer respites, crisis prevention services, peer support, program evaluation

Peer respites are voluntary, short-term, overnight programs that provide community-based, nonclinical support for people experiencing or at risk of acute psychiatric crisis. They operate 24 hr per day in a homelike environment and may divert from hospital-based psychiatric emergency services (PESs) or provide a "step-down" from those settings. Peer respites allow users (commonly referred to as "guests") to take a break from stressful life circumstances while building community with peers (Siantz et al., 2019).

Peer respites differ from other diversion programs such as crisis residential services in that they are staffed and controlled by trained peer support staff (National Action Alliance for Suicide Prevention, 2016; Ostrow & Croft, 2015). This definition of the program model, developed by the peer support community, is consistent with other definitions of peer-run or peer-operated mental health programs (Ostrow & Hayes, 2015).

These programs may offer a viable alternative to PES for some people some of the time (Croft et al., 2021) and fill an important gap in the mental health service system by helping guests build skills to manage future psychiatric crises. In 2013, Thomas and Rickwood, published a systematic review of acute and subacute residential services defined as voluntary short term, often community-based, accommodations and services that incorporate therapy, peer support, and psychoeducational programs. The review found that these alternatives are generally associated with higher satisfaction, and similar or improved symptoms and quality of life compared with PES (Thomas & Rickwood, 2013). The evidence base for peer-provided services generally (Bellamy et al., 2017; Chinman et al., 2014, 2017) and for peer-staffed (but not controlled) crisis diversion programs (Bouchery et al., 2018) suggests peer respites may operate at similar levels of effectiveness, but more research is needed.

Only two quantitative, outcomes-oriented studies of peer respite are published. The first found gains in the quality of life-related outcomes such as empowerment and satisfaction (Greenfield et al., 2008). A quasi-experimental study found a 70% reduction in inpatient or emergency services use, and reduced PES service hours (Croft & İsvan, 2015). Qualitative studies have found peer respites strengthen self-sufficiency and social connectedness (Croft et al., 2021), and high program satisfaction (Siantz et al., 2019).

The Peer Respite Essential Features (PREF) survey, first conducted in 2014 and repeated every 2 years, reports the characteristics of peer respites nationwide. This article describes survey results, explores the peer respite model, and discusses the challenges faced by peer respites.

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Method

Data were gathered from identified peer respites in the U.S. using Qualtrics. The PREF Survey was used each year with minor alterations to its 50 questions. This brief report is focused on 2020 results, with comparisons for meaningful changes from previous years.

The survey asked about funding, program policies, staffing, guest accommodations, and program evaluation. The 2020 version included questions on the impact of the COVID-19 pandemic.

Eligible Peer Respite Programs were determined using a set of implementation guidelines as follows (Ostrow & Croft, 2016): (a) All staff have lived experience; (b) program's job description for management positions require lived experience; (c) the peer respite is either operated by a peer-run organization or has an advisory group of at least 51% of members having lived experience; and (d) the program's mission is consistent with the above definition of a peer respite.

The list of peer respites was created from two directories maintained by organizations embedded within the peer support community: Live & Learn, Inc. (https://www.peerrespite.com/peer-respite-directory) and the National Empowerment Center (https://power2u.org/directory-of-peer-respites/). This list was validated by the National Network of Peer Respite Leaders who reviewed and updated program information. In 2020, there was a 100% response rate from 32 peer respites in 14 states—up from 31 in 2018, 22 in 2016, and 17 in 2014.

Results

Most programs were part of peer-run organizations (84%, $N = 27$), the remaining five were either part of, State, county, or local government (9%, $N = 3$); traditional mental health provider (3%, $N = 1$); or community service agency (35, $N = 1$).

The most frequently reported program operating budget, with 25% ($N = 8$) of peer respites, was the $400,000–$499,000 range and 16% ($N = 5$) in each of the ranges $200,000–$299,000 and $300,000–$399,000. This is consistent with previous years where at least half of peer respites report budgets between $200,000 and $499,000 (56% in 2020, $N = 18$; 50% in 2018, $N = 15$; 65% in 2016, $N = 13$; 71% in 2014, $N = 12$).

More than half (53%, $N = 17$) received funding in the last fiscal year from only one source, and the remaining from two to three sources. Using aggregated percentages of funding across programs, state behavioral health agencies were the largest funding source, providing an average of 53% of funding for all programs (36% in 2018, 46% in 2016; Figure 1). County/local behavioral health agencies only contributed 28% of total funding for all peer respites in 2020, down from 45% in 2018 and 35% in 2016.

Peer respites reported the required peer staff trainings. In 2020, 38% ($N = 12$) required staff to complete Intentional Peer Support training. Peer specialist training was required by 50% ($N = 16$), and Wellness Recovery Action Planning was required by 28% ($N = 9$).

As shown in Table 1, peer respites accommodate a range of 2–20 guests at one time ($M = 4.6$, $SD = 3.3$, $Mdn = 4$). Only one program did not have a maximum number of days guests can stay; others ranged from 5 to 30 days ($M = 8.5$, $SD = 4.6$, $Mdn = 7$; $N = 31$).

The plurality of programs (56%, $N = 18$) had no formal policy restricting guests who were experiencing suicidal ideation. This lack of restriction is consistent over time (58% in 2018, $N = 18$; 73% in 2016, $N = 16$; 47% in 2014, $N = 8$). In 2020, the number of programs with restrictions on guests who had a plan for suicide (38%, $N = 12$) increased from 2018 (19%, $N = 6$).

As shown in Figure 2, 34% of programs ($N = 11$) did not restrict guests from staying if they did not have permanent housing. This has varied over time (26% in 2018, $N = 8$; 18% in 2016, $N = 4$; 41% in 2014, $N = 7$).

For 78% of peer respites ($N = 25$), at least half of guest referrals came from clinical providers and other peer programs. Public outreach was a significant source of referrals for 71% ($N = 22$)

Figure 1
Overall Distribution of Funding From All Sources

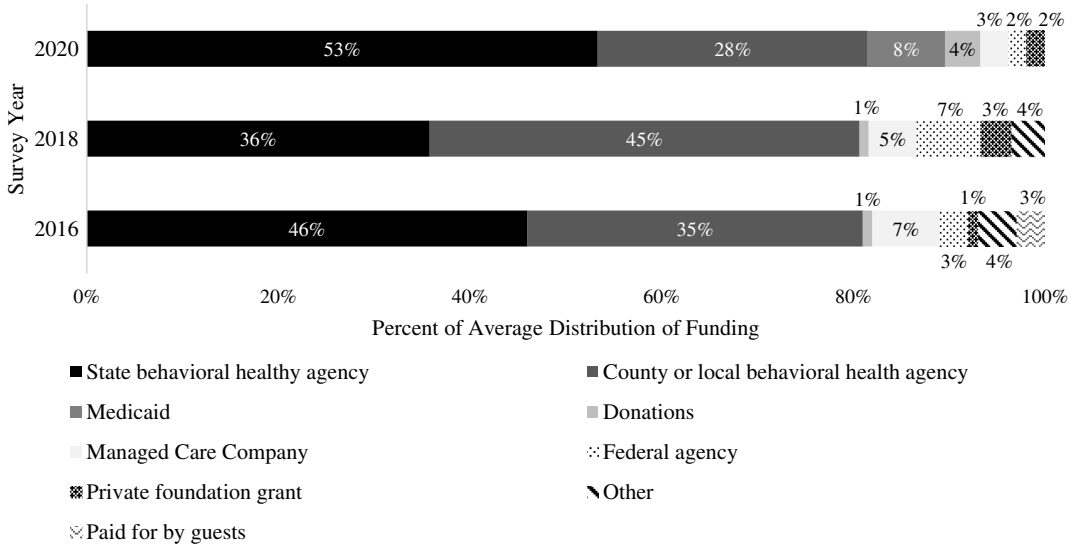


Table 1
Guest Accommodations

Accommodation variable	Minimum	Maximum	*M*	*SD*	*Mdn*
Maximum guest capacity	2	20	4.6	3.3	4
Maximum length of stay (in days) [a]	5	30	8.5	4.6	7
Average length of stay in last fiscal year (in days)	0	15	6.3	3.4	5.5
Average number of guests at one time in last fiscal year [b]	0	7	2.4	1.7	2
Number of people served in last fiscal year	0	203	91.2	47.8	94
Total number of stays in last fiscal year	0	876	163.5	249.5	85

[a] $N = 31$, one peer respites did not report having a maximum length of stay for guests. [b] $N = 27$, one missing value and four were excluded from analysis as the number reported exceeded the reported number of beds for the corresponding program.

of peer respites, as were referrals from family members/friends for 69% ($N = 22$).

In 2020 all peer respites ($N = 32$) reported completing a program evaluation with 66% ($N = 21$) responsible for their own evaluation. Program evaluation has increased; only 84% of programs had been evaluated in 2018 ($N = 26$). The most common evaluation tools used were recovery and guest satisfaction surveys (81%, $N = 26$), quality of life (75%, $N = 24$), social connectedness (72%, $N = 23$), qualitative interviews with guests (72%, $N = 23$), environment measures (69%, $N = 22$), and relationships between staff and guests (66%, $N = 21$). Only 50% ($N = 16$) of programs asked about guests' hospital and other service use and 31% ($N = 10$) included the measurements of guests' symptoms.

All programs reported making changes in response to the COVID-19 pandemic. Common changes included the following: 72% ($N = 23$) of programs implementing new cleaning protocol, 72% ($N = 23$) using personal protective equipment (PPE), and 59% ($N = 19$) reducing guest capacity. In addition, one program (3%) reported being closed indefinitely since April, 16% ($N = 5$) closed to the public but offered virtual support, and 41% ($N = 13$) closed briefly but continued in-person services when able. Some provided alternative supports as follows: 88% ($N = 28$) operated telephone warmlines, 72% ($N = 23$) offered virtual support groups, and 69% ($N = 22$) offered one-on-one video support.

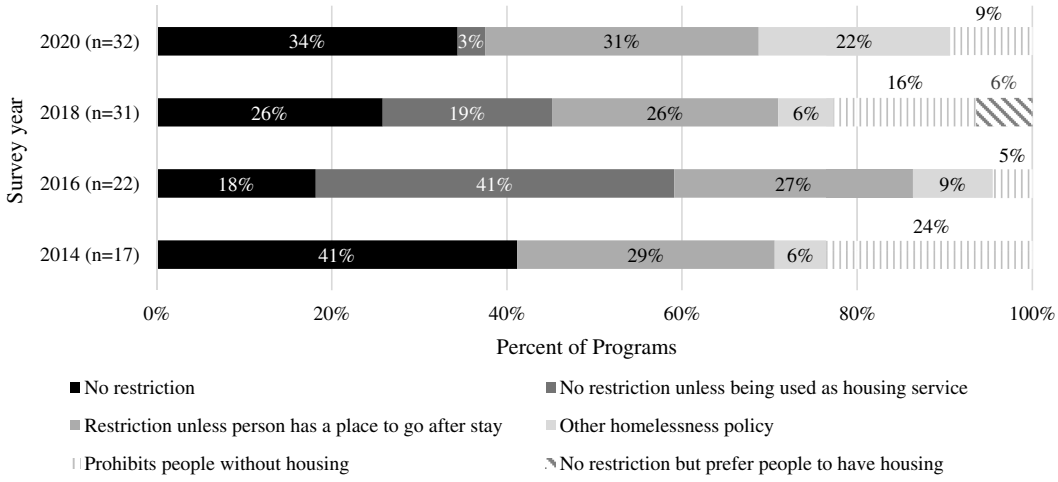
Half of programs ($N = 16$) reported that COVID-19 did not impact their funding. Alternatively, 16% ($N = 5$) reported financial hardships from decreased funding, the cost of cleaning and PPE products, or implementing Health Insurance Portability and Accountability Act (HIPAA)-compliant virtual services. Five peer respites (16%) received assistance with additional pandemic-related expenses.

Conclusion

The PREF survey includes all operating peer respites in the U.S. to provide information for planning, funding, and sustainability. The expansion of peer respites in recent years reflects increased calls for person-centered crisis alternatives among service users and their families, advocates, and behavioral health administrators (Brister, 2018; Centre for Public Impact, 2019; Hepburn, 2017; National Action Alliance for Suicide Prevention, 2016; Pinals & Fuller, 2017).

Peer respites are peer-run programs that value nonhierarchical communities of shared power and responsibility to prevent escalating crises, but the PREF survey results show they are formal programs with substantial investments from state and local

Figure 2
Peer Respites' Policy on Guests' Housing Status Over the Years



government, required staff trainings, and policies that define suitable users for their services. Nevertheless, the flexibility they offer is essential to filling the crisis prevention gap in the mental health system. As one respondent to our survey said, "We are placing several restrictions and requirements for both team members and guests … These restrictions could be reminiscent of more medical or clinical settings." This statement expresses the niche that peer respite services offer, where flexibility is prioritized.

Of all the policies, guest housing-related restrictions have fluctuated the most, speaking to the need to restrict service users without permanent housing from using the peer respite as a substitute for homelessness services. Few have restrictions on suicidal ideation, but some are increasingly restricting guests who have a plan for suicide. These policies may reflect their continuing integration into the service system while trying to avoid mission creep.

One positive outcome of the pandemic on peer respites is many were able to broaden the array of virtual services or introduce this to their practice, such as adding warmlines. Some programs commented that they were able to reach more individuals with these new options.

Within a context of resource scarcity and a lack of integrated, holistic services, institutional constraints of traditional service providers may limit a peer respite's ability to uphold recovery values, creating a need for organizational restructuring and an investment in infrastructure. A case study of one peer respite's experience integrating into a county service system found numerous barriers to agencies employing peer support staff, challenging integration of these "alternative" program models (Fletcher et al., 2020). More infrastructure investment and outreach—such as understanding the mission and services of peer respites—may be needed to reduce systematic constraints on these programs' success (Centre for Public Impact, 2019). Most importantly, although peer respite programs continue to grow across the nation, there is little evidence for their effectiveness in using less coercive and intrusive support to reduce PES use. Half of peer respites' program evaluations did not ask guests about other service use which may be a missed opportunity to better understand what other services are available and for research to support the crisis diversion theory of peer respite services. Notably, the peer respite stakeholder community maintains the definition of "peer respite" based on structural criteria (i.e., controlled by people with lived experience) versus operational criteria, but research is needed that compares program features and connects model fidelity to outcomes.

Implications for Practice

Although crisis diversion programs can provide a safe alternative to PES, research is needed to compare the effectiveness of different models of crisis diversion services on outcomes that matter most to service users and their families, and to explore how these services may be tailored to meet needs and preferences. Specifically, research studies on this topic should be designed to investigate service user experiences of and compare the effectiveness of peer respite to traditional crisis residential in reducing PES use, user engagement/activation, empowerment, social connectedness, quality of life, and mental health-related functioning. Fundamentally, this will require the development of fidelity measures of various models of crisis diversion and support that can be used to document and evaluate differences in core components of peer respite and crisis residential.

Because of the voluntary nature of these services, a randomized controlled design—the gold standard in intervention research—may be logistically and ethically inappropriate. Guest stays are voluntary, but multiple referral channels from clinical providers, the program's public outreach or other peer programs, law enforcement or emergency rooms, housing programs, or through family or friends are common. Instead of a randomized design, observational methods for addressing differences in nonrandomly selected groups are more likely to preserve the core principles that make diversion programs a unique contribution to the system and make results of such a study generalizable to real-world programs.

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