Peer Respites: A Research and Practice Agenda

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Peer respites are voluntary, short-term residential programs designed to support individuals experiencing or at risk of a psychiatric crisis. These programs posit that for many mental health services users, traditional psychiatric emergency department and inpatient hospital services are undesirable and avoidable when less coercive or intrusive community-based supports are available. Intended to provide a safe and homelike environment, peer respites are usually situated in residential neighborhoods. These programs are starting to spread across the United States, yet there is very little rigorous research on whether they are being implemented consistently across sites and which processes and outcomes may lead to benefits for persons experiencing psychiatric crises and for overburdened mental health systems. This Open Forum outlines implementation and research issues that peer respites face.

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Psychiatric emergency services exceed capacity and contribute to overall mental health service system costs (1,2). Peer respite programs support mental health service users in preventing and overcoming psychiatric crises by providing peer support in a setting intended to be supportive and enhance community connections. Peer staff have professional crisis support training to build mutual, trusting relationships. These programs potentially reduce costs and provide community-based, trauma-informed, person-centered support.

THE NEED FOR RESEARCH ON PEER RESPITES

With 16 peer respites operating nationwide and four more concretely planned, the growth of peer respites outpaces any evidence of their effectiveness. Although there is a substantial evidence base for peer-provided services (3,4) and acute residential crisis alternatives (5), only one randomized controlled trial (RCT) of peer respites has been conducted; it documented improvements in self-rated mental health functioning and satisfaction for respite users compared with involuntary psychiatric hospitalization (6).

IMPORTANT CONSIDERATIONS FOR PEER RESPITE PROGRAM DESIGN

Peer respites are voluntary, short-term residential programs designed to support individuals experiencing or at risk of a psychiatric crisis. Peer respite mission statements thus far typically aspire to provide a supportive environment while effecting system change. Core peer support values of mutuality and equality may be particularly important in crisis support when people are feeling vulnerable or unstable. Peer respites are a peer-to-peer resource with peers in leadership and practitioner roles, a design that departs from the traditional mental health system by creating alternative service delivery paradigms. Peer respites also act as dynamic communities where peers can volunteer, connect with others, and seek and receive informal supports. Because they are often programs within larger organizations, peer respites may enhance the availability of community self-help resources such as the Wellness Recovery Action Plan, suicide or hearing-voices support groups, and wellness-oriented activities (7).

Implicitly or explicitly, most peer respites work to mitigate psychiatric emergencies by addressing the underlying cause of a crisis before the need for traditional crisis services arises. Many function as hospital diversion or "prevention" programs, serving people who are struggling with emotional, psychological, or life circumstances that may be precursors to suicidality or psychosis. Some peer respites do not serve people who are actively suicidal or considered a danger to themselves or others. Programs excluding individuals in extreme states may not reach those who would benefit from the service; on the other hand, accepting individuals in extreme states carries risks that peer respites may not be equipped to manage because of staffing and funding constraints.

Some peer respites require guests to have stable housing prior to admission, whereas others accept individuals who are currently homeless. Refusing to accept unstably housed guests presents an ethical dilemma: many of these individuals would likely benefit from services, yet staff must discharge guests "to the street" once they have reached their maximum length of stay. Peer respites accepting those without stable housing risk acting as proxy homeless shelters in the absence of clear policies distinguishing respite from temporary housing.

Organizational features have critical implications for financing and sustainability, and careful consideration is needed to align financing with program mission. Organizational structures range from fully peer run and autonomous to peer operated and embedded within the traditional mental health system. Peer-run respites operate as part of larger peer-run organizations that are independent nonprofits with boards of directors comprising at least 51% peers (8). Peer-operated respites have peer directors and staff, but the board does not have a peer majority, and these respites often are attached to a traditional provider. Peer-operated services within traditional provider organizations or well-established peer-run organizations may have more access to financial resources and infrastructure, including information technology and third-party billing capacity. Further, Medicaid funding may not cover peer support services in some states (8).

Because traditional mental health treatment has a hierarchical treatment and billing structure, peer respites must purposefully interact with the rest of the mental health system. Psychiatrists who provide consultation for respites should be selected carefully for commitment to recovery principles and offered training in shared and supported decision making. Peer respites need to have a clear protocol for outreach and education activities to increase program access. This includes establishing guidelines with traditional providers regarding whether and how they provide outreach to potential guests through formal referrals and through raising community awareness.

EVALUATION ISSUES

Implementation complexities are mirrored by the challenges of measuring processes, outcomes, and costs of peer respites. Future research should identify target outcomes and best practices and explore whether peer respites reduce emergency hospitalizations for psychiatric crises and foster recovery and wellness. Equally important, research should examine the impact of the program at the level of the behavioral health system, including cost, stakeholder perceptions, and processes of care. Below we discuss some specific considerations in evaluating peer respites along research domains.

Outcomes and Costs

Peer respite goals are wide ranging and include primary goals of fostering wellness, increasing meaningful choices for recovery, and creating and maintaining mutual and supportive relationships. Secondary goals include reducing emergency hospitalizations and system costs.

Short-term, individual-level domains that could lead to benefits for the service user include quality of life, housing stability, and development of social relationships and natural supports. Although explicitly nonclinical, peer respite participation may result in measurable improvements in clinical domains such as mental health functioning and symptom severity. Long-term outcomes include employment, education, and community and civic engagement, which are addressed by measures of recovery (9). Peer respites are not designed to substitute for inpatient hospitalizations; comparison of the cost of a respite day with the cost of a hospital day is therefore incongruent. Nonetheless, peer respites may avert escalation of an event to a psychiatric crisis and may therefore be associated with decreases in costly inpatient and emergency service use, including crisis support teams, crisis residential programs, and hospitalization. Understanding these relationships requires a detailed examination of cost and utilization data. Because inpatient and emergency services are financed through multiple means, accurate cost estimates may not be available in a central administrative database.

The relationship between peer respite and other mental health services use is also unclear. As respite guests experience greater stability, self-determination, and awareness of treatable conditions, they may become more engaged with services and supports, which could translate to increased short-term service utilization. Cost and service-utilization analyses should link with data on other recovery outcomes when possible.

Census within the program is critical for cost-effectiveness research and long-term sustainability. Without an adequate number of people in the program at one time, the fixed costs outweigh the variable costs, and hence the value to the community or funder. Measuring census and keeping programs at capacity through referrals and outreach contribute to defining costs. These analyses should account for additional costs and benefits, such as linkages to a larger organization or additional services (such as a drop-in center or "warm-line" telephone peer support).

Processes of Peer Support

Intentional Peer Support is a trauma-informed, peer-delivered training and supervision model used in many peer respites. Based on a detailed peer-developed training program, Intentional Peer Support uses reciprocal relationships to redefine help; practitioners aim to build community-oriented supports rather than create formal service relationships (10). Early work by the authors is under way to develop a set of core competencies and may be a first step toward documenting fidelity in peer respite programs.

Most peer respites' quality improvement strategies focus on the use of satisfaction measures to understand guest perceptions. However, future quality assurance and improvement activities could more closely examine experiential components, such as promoting choice, mutual decision making, a recovery view, and human rights.

Research Design

Mixed methods are appropriate for studying peer respites (11). Qualitative approaches, such as in-depth interviews, enable exploration of complex relationships between respite use and outcomes that may not be apparent through quantitative analyses of cost, service use, and survey data alone. The infusion of qualitative approaches is particularly warranted because of peer respites' emphasis on self-defined outcomes and the need to understand guests' perception of services and the

relationship between the peer respite and other traditional crisis services. Because peer respite research is in its infancy, qualitative approaches contribute a theory of change to help in interpreting measurement. Formative process evaluations should accompany any exploration of outcomes to document challenges and lessons learned and facilitate charting program fidelity (12).

Control or comparison groups are critical for understanding what would have happened had individuals not stayed at a peer respite. Observational methods, such as asking guests to predict where they would have gone otherwise and what might have happened, are subject to reporting and recall biases. RCTs remain the gold standard for ensuring group equivalence; when an RCT design is not feasible or ethical, quasi-experimental methods also may be used (13), including propensity score matching or dynamic waitlist control designs. Longitudinal designs also are critical to understand short- and long-term impacts and to capture dose-response effects to assess whether and how peer respites affect individuals in the long term.

Peer respite research may present ethical issues or concerns. Because peer respite guests arrive in distress, primary data collection may be experienced or perceived as intrusive or may present an undue burden to guests and staff. Just as peer respite staff members work to ensure that their practices reflect the program mission, researchers, too, should ensure that activities with the program are in concordance with the ethos of mutuality and shared power. Adopting participatory research methods may help accomplish this and help to ensure that feedback from peer staff and guests informs research design, interpretation, and dissemination of results (14). This approach may present a challenge if research-funding priorities and standards in the current scientific paradigm are at odds with those of the community.

CONCLUSIONS

Researchers must engage this small but diverse and growing population of peer respite programs in some form of standardized evaluation. Research can aid quality improvement and program modifications, assist funders in understanding the benefits and costs, and build an evidence base for new and existing programs. In the traditional mental health system context, where power between providers and consumers is infrequently shared, peer respites have the potential to create space for transformative growth, not just for peers but also for providers and policy makers.

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