Differences in approaches to emotional crisis response: Conventional psychiatric crisis compared to peer-run respites

Domain	Psychiatric crisis response	Peer-run respite approach
How emotional crisis is understood	Emotional crisis is viewed by narrowly focusing on presenting crisis behaviors or symptoms as an indication of a disturbed, diseased, or chemically imbalanced mind. Crisis response behaviors are considered evidence of pathology or psychiatric illness. Underlying causes, risk factors and inequities of emotional crisis/distress are not considered in the context of the current presentation.	Emotional crisis is understood to happen when circumstances exceed a person's current capacity to effectively cope, including a lack of accessibility to appropriate resources and the adaptations needed for them to thrive. Crisis response behaviors are often seen as having important meaning for the person's life and may be related to risk factors, trauma and/or social inequalities such as socioeconomic status, education, physical environment, employment, social support networks and access to healthcare. Risk factors for many common mental disorders are heavily associated with social inequalities.
Goal of crisis response	The goal of the crisis response is to reduce or eliminate symptoms, making the person easier to manage and conform to dominant cultural norms. It is believed that the person in crisis does not know what is best for themselves. The focus is on stabilization, modifying the persons behavior, and helping them to accept that they have a "mental illness".	The goal of crisis response is to create a mutually respectful space where compassion is offered and individual choice is honored. Thus, a foundation is set for the person to realize they are not alone, they are in a safe environment where they are gently invited to find meaning in their crisis experience, to reclaim their power, and to determine their next steps. The focus is to help the person to practice ways to maintain emotional balance and enhance wellness.
Self-determination	The provider is expected to tell the person what is best and promote compliance and reliance often on intervention and programs that sometimes do not meet needs nor align with the person's values.	The supporter assists the person to consider what options are available and to identify and practice new skills to meet their needs, care for their body and align their life with their values. Examples of how self-determination plays out in conventional vs. peer run respites could include choices between cafeteria food options in a psychiatric hospital vs. option to bring food for home, or going grocery shopping nearby and make one's

		food at the peer respite kitchen; e.g. forced medication in an involuntary commitment vs. a lock box in a private "guest" room for self-administered medication.
Power dynamic	Decision making uses a power over structure that is guided by or imposed by professionals whose expert knowledge is unquestioned. Focus is on compliance, approach is often coercive, which is often experienced by the person in crisis as a violation. In response, the person in crisis may withdraw, comply, or act out in anger in reaction to the coercion and not being seen, heard, nor understood.	Decision-making uses a power with structure guided by the person in crisis, whose knowledge of themselves and their situation is honored. Focus is on creating a safe space by listening, exploring the person's experience and perspective, and supporting them in thinking and feeling their way through the crisis, even if it means going into the unknown and tolerating uncertainty.
Being with versus doing to	The professional's goal is to evaluate the person and either minimize or eliminate behaviors, feelings, or ideas considered problematic, primarily using psychopharmaceuticals. Impact: The person in emotional crisis may respond with a need to protect or defend self, due to being pressured to accept the definition of their experience as a chemical imbalance / mental illness, and to accept the diagnosis and treatment imposed on them.	The supporter's goal is to create a safe "being with" space by listening to the person in crisis, exploring together literal or symbolic meaning within the crisis, and supporting the person to move towards meeting their expressed needs and desires. The supporter is aware of the impact of their own words and actions ensuring that the person in crisis feels listened to and authentically validated. Impact: Invites openness in the person in emotional crisis and fosters the capacity to look at their inner experience. Allows the person to move through the crisis and consider their hopes and intentions for the future.
Trauma	Problematic behaviors, emotions, and/or ideas are often understood to be caused by brain chemical imbalances or genetic problems. There may be some consideration to trauma, but not as an underlying cause. Often staff do not use a trauma-informed approach, thus, re-traumatization occurs. Little consideration is paid to the	There is an understanding that trauma may be involved in any life interrupting crisis. Trauma could be individual, intergenerational, community and/or historical and include the traumas of racism, sexism, poverty, and other forms of systemic oppression that impact peoples' lives and are often perpetuated by the behavioral health, education, political, and criminal justice systems.

	traumatization of staff, other patients, and others witnessing. The use of psychopharmaceuticals may mask and compound the trauma.	The person in crisis is supported to trust their wisdom, come to their own understanding about their experience, and determine their next steps.
Trauma-informed approaches and environments	Sometimes people are forced against their will into a psychiatric crisis services. Inpatient environments are generally sterile and structured around safety and risk management and strategies to ensure physical and emotional safety are often coercive and demeaning. Sometimes violent interventions are used up to and including lethal force which impacts not only the person in crisis but witnesses, families, and the entire community.	Stays are completely voluntary. Staff focus on embodying trauma-sensitive approaches to engage the person, including consideration for physical, environmental, and emotional safety. Peer respites provide a familiar setting typically in a single-family home in the community where people (often referred to as guests) have privacy, feel safe and have access to a kitchen, living room, bathroom(s), and other spaces conducive to relaxation and recovery.
Relationality	Staff maintain a professional distance with the person in crisis focusing on symptoms stabilization and compliance. The relationship does not focus on creating interpersonal safety nor focus on exploring values. Impact: Without an awareness nor a willingness to be present and resonate with the person in distress this limits a relational experience for both the staff and the person in crisis. This may result in the staff unawarely saying or doing something that hurts or re-traumatizes the person in distress.	Peer staff are trained and supported to practice attunement - a feeling of spaciousness and presence - that enhances their capacity to be more sensitive and effective in their ability to interact, to communicate, and to resonate with other people and with life. The attunement skills of staff support the guest (if the guest wishes) to practice responding in ways that better serve them so that they may improve the guest's ability to create a life that is more aligned with their deeper intentions, values, and vision. Impact: Practicing the deep listening/attunement process reinforces the guest feeling cared for and listened to and may enhance the guest's ability to tap into an inner resource for finding calm and feeling included in relationship and with life. Lastly, there is the potential that in the spaciousness of the relationship there is a recognition of our potential not only for healing but for co-creating the relationships and the collective spaces one envisions.

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