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Peer Respites: A Research and Practice Agenda

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Abstract

Peer respites are voluntary, short-term, residential programs designed to support individuals experiencing or at-risk of a psychiatric crisis. They posit that for many mental health services users, traditional psychiatric emergency room and inpatient hospital services are undesirable and avoidable when less coercive or intrusive community-based supports are available. Intended to provide a safe and home-like environment, peer respites are usually situated in residential neighborhoods. These programs are increasing in number across the United States, yet there is very little rigorous research on whether they are being implemented consistently across sites, and what the processes and outcomes are that may lead to benefits for persons experiencing psychiatric crises and to overburdened mental health systems. In this Open Forum, we present an agenda outlining implementation and research issues faced by peer respites.

Introduction

Psychiatric emergency services exceed capacity and contribute to overall mental health service system costs [1, 2]. Peer respites programs support mental health service users in preventing and overcoming psychiatric crisis 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 while providing 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 the evidence. Though there is a substantial evidence base for peer-provided services [3, 4] and acute residential crisis alternatives [5], only one randomized controlled trial (RCT) has been conducted and documented improvements in self-rated mental health functioning and satisfaction for respite users compared to users of psychiatric hospitals [6].

Important Considerations for Peer Respite Program Design

Existing peer respite mission statements typically involve providing 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 and/or unstable. Peer respites are a peer-to-peer resource with peers in leadership and

practitioner roles, changing the culture of the traditional mental health system through alternative service delivery paradigms. Peer respites also act as dynamic communities where peers can volunteer, connect, seek and receive informal supports. Often as programs in larger organizations, peer respites may enhance the availability of community self-help resources such as WRAP, 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 in “pre-crisis” 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 self or others”. Programs excluding individuals in extreme states may not reach individuals 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, given the voluntary nature of the service.

Some peer respites require guests to have stable housing prior to admission, while others accept individuals experiencing homelessness. 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 a proxy homeless shelter in the absence of clear policies distinguishing the respite from a temporary housing program.

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, independent non-profits with boards of directors that are at least 51% peers [8]. “Peer-operated” respites have peer directors and staff, though the board is not majority peer, and are often 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 interface with the rest of the mental health system. Psychiatrists used for consultation should be selected carefully and offered training in shared/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 outreach to potential guests through formal referrals and community awareness-raising.

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 include quality of life, housing stability, and development of social relationships and natural supports. Although explicitly non-clinical, 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, community and civic engagement, which are addressed by measures of recovery [9]. Peer respites are not designed to substitute inpatient hospitalizations; it is therefore incongruent to compare the cost of a respite day to the cost of a hospital day. Nonetheless, peer respites may avert the escalation of a psychiatric crisis, and may therefore be associated with decreases in costly inpatient and emergency service use, such as 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 service use is also unclear. As guests experience greater stability, self-determination, and awareness of treatable conditions, respite guests 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.

Program census is critical for cost-effectiveness research and long-term sustainability. Without adequate capacity, 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. Additional costs and benefits should be accounted in these analyses, such as linkages to a larger organization or additional service provision (i.e. “drop-in” center or a telephone warm line).

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 underway to develop a set of core competencies is underway and may be a first step towards 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 choice, mutuality, and the promotion of recovery and rights.

Research Design

Mixed methods are appropriate for studying peer respites [11]. Qualitative approaches like indepth interviews explore 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 need to understand guest 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 understand measurement and interpretation. 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 what they would have otherwise done, are subject to reporting and recall biases. RCTs remain the gold standard for ensuring group equivalence; when not feasible or ethical, quasi-experimental methods may also be employed [13], including propensity score matching or dynamic wait-list control designs. Longitudinal designs are also critical to understand short- and long-term impacts and capture dose-response effects to assess whether and how peer respites impact individuals in the long-term.

Peer respite research may present ethical issues or concerns. Because peer respites guests are distressed, primary data collection may be experienced or perceived as intrusive, or present an undue burden to guests and staff. Just as peer respite staff 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. Participatory research methods may help accomplish this, ensuring 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 our current scientific paradigm are at odds with those of the community.

Conclusion

Researchers must engage this small but diverse and growing population of 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 providers and policy-makers.

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