Peer Respites
a national perspective

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September 13, 2016
Milwaukee Mental Health Task Force
Outline

I. Defining terms

II. Context: Peer support

II. Peer Respite Essential Features Survey

III. Evidence for peer respite effectiveness

IV. Next steps for peer respite
Research questions for peer support

- **Individual-level outcomes**
  - Local evaluations documenting effectiveness: *Does the intervention work?*

- **Program/Service-level fidelity**
  - Measurement of structure and processes: *How does the intervention work?*

- **System-level developments**
  - Growth, innovations, relationship to systems: *What are the larger trends?*
Defining peer respites
What are peer respites?

**voluntary, short-term, overnight programs**

operate 24 hours per day in a homelike environment

provide community-based, trauma-informed, and person-centered crisis support and prevention

staffed and operated by people with lived experience of the mental health system (peers)
How do peer respites work?

- Peer staff engage guests in mutual, trusting relationships.
- Foster relationships in which individuals help themselves and others through mutual support.
- Engage in advocacy to empower people to participate in their communities.
Why are there peer respites?

Psychiatric emergency services...

traumatizing and counter-therapeutic, and do not build capacity to avert future psychiatric crises

internalized and social stigma, disruptions in relationships, and loss of meaningful opportunities

can be avoided if less coercive or intrusive supports are available in the community
Crisis diversion theory

Psychosocial Stressors → Psychiatric Crisis

Labeled/Living with Mental Health Problem

PEER RESPITE

Psychiatric Crisis → Psychiatric Emergency Services

Crisis diversion theory
Context of peer support
Peer Support

People with lived experience creating mutual relationships based on respect, shared responsibility, and agreement of what is helpful

Increasing attention nationally and locally on implementing, evaluating, and regulating peer support practices
Evidence for peer support

Studies have looked at the role of peers both as providers and as “add-ons” to existing mental health interventions.

Studies are conducted in peer-run organizations and peer supports in traditional mental health settings.

Consistent findings demonstrating the use of peer supports as beneficial in reducing hospitalizations.

Evidence for promoting recovery outcomes such as community tenure, empowerment, and self-efficacy.

National Survey of Peer-Run Organizations (2012)

380 non-profit organizations or programs in 48 states & DC

Controlled and staffed by people with lived experience

Mutual support and advocacy to promote community-building and empowerment

[Map of the United States with numbers indicating 99 in the West, 100 in the Midwest, 106 in the Northeast, and 75 in the South]
## Willingness to be a Medicaid Provider

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 316</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, willing</td>
<td>52</td>
<td>16%</td>
</tr>
<tr>
<td>Yes, but have concerns</td>
<td>106</td>
<td>34%</td>
</tr>
<tr>
<td>No</td>
<td>87</td>
<td>28%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>71</td>
<td>22%</td>
</tr>
</tbody>
</table>

Value-Based Concerns about Medicaid

- Conforming to medical model
- Detract from mission
- Medical necessity
- Commitment to advocacy

Legend:
- Problem
- Not a problem
- Don't know
Practical Concerns about Medicaid

- Financial staff: Problem (70%)
- Keeping records for claims: Problem (60%)
- Computer systems: Problem (50%)
- Application process: Problem (40%)
- Auditing: Problem (30%)
- Performance measurement: Problem (20%)

Legend:
- Blue: Problem
- Orange: Not a problem
- Gray: Don't know
The mechanisms of peer support

92% of peer-run organizations engage in advocacy, not just peer support

Peer-run organizations that are more “lateral”, participatory, and democratic have shown greater improvements in empowerment and stigma-reduction compared to those that are more hierarchical

“Do peer support services work?” AND “Under what specific conditions do peer support services work?”

Conclusions

Peer support and peer specialists are a way to increase system and workforce capacity

Provide opportunities for economic self-sufficiency, empowerment, and social equality

New policies to reimburse peer specialists and peer-run organizations risk medicalizing peer support

Financing systems for health care challenge the foundation of peer support in social justice advocacy
Peer Respite Essential Features Survey

California
Georgia
Massachusetts
Nebraska
New Hampshire
New Jersey
New York
Ohio
Pennsylvania
Vermont
Wisconsin
Peer Respite Growth

2010
N=11

2012
N=10 (12)

2014
N=17 (19)

2016
N=22 (33)
Minimum criteria defined by consensus panel

**Staffing**
- 100% of staff have lived experience of extreme states and/or the behavioral health system

**Leadership**
- All leaders have lived experience, and the job descriptions require lived experience of extreme states and/or the behavioral health system

**Governance**
- The peer respite is either operated by a peer-run organization OR has an advisory group with 51% or more members having lived experience of extreme states and/or the behavioral health system

*Consensus panel members:*
- Darby Penney, The Community Consortium
- Sera Davidow, Western Massachusetts Recovery Learning Community
- Chris Hansen, Intentional Peer Support
- Sally Zinman, California Association of Mental Health Peer-Run Organizations
- Bevin Croft, Human Services Research Institute
- Laysha Ostrow, Live & Learn
Peer Respite Essential Features Respondents

N=22

Included in Analysis 67%

Excluded 33%

Criteria Not Met:

- leadership, governance & staff, 9%
- leadership, 3%
- governance, 6%
- leadership & staff, 6%
- leadership & governance, 9%

Map of Survey Respondents

Number of Responding Peer Respites

1 2 3 4 5
Annual operating budgets

- $500,000 or more
- $450,000 - $499,000
- $400,000 - $449,000
- $350,000 - $399,000
- $300,000 - $349,000
- $250,000 - $299,000
- $200,000 - $249,000
- $150,000 - $199,000
- $100,000 - $149,000

Orange bar = 2014
Blue bar = 2016
Proportion of funding from each source

- State: 46%
- County: 35%
- Managed Care contract: 7%
- Federal: 3%
- Guest: 3%
- Donations: 1%
- Medicaid: 0%
- Other: 4%
- Foundation: 1%
- Other: 4%
Training of peer respite staff

- Certified Peer Specialist Training
- Intentional Peer Support
- Wellness Recovery Action Planning
- Suicide Prevention and Response
- Other (Harm Reduction, Motivational...)
- Crisis Support
- Physical Wellness
- Trauma-Informed Supports
- In-House Respite Training
- Train-the-Trainer (IPS, WRAP, and...)
- CPR/First Aid/Safety
- Hearing Voices Network
- Cultural Competence/Diversity
- Substance Use Issues
Policy on suicide

- **2014**
  - No restriction: 8
  - Restriction on people who have a plan: 6
  - Other suicide policy: 3

- **2016**
  - No restriction: 16
  - Restriction on people who have a plan: 3
  - Other suicide policy: 3

Legend:
- **Blue**: No restriction
- **Orange**: Restriction on people who have a plan
- **Gray**: Other suicide policy
Policy on homelessness

- Prohibits people without housing
- Other policy
- No restriction
- Prohibits people without housing unless they have a place to go after
- No restriction unless housing is the only reason for wanting to stay*

<table>
<thead>
<tr>
<th>Year</th>
<th>Prohibits without housing</th>
<th>Other policy</th>
<th>No restriction</th>
<th>Prohibits without housing unless place to go</th>
<th>No restriction unless housing is only reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>4</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>9</td>
<td></td>
</tr>
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</table>
Conclusion

Local governments tend to be the largest financial supporters of peer respites.

There are an array of professional trainings required.

Peer respites continue to refine house policies.
Evidence for peer respite effectiveness
Experimental: *Consumer-run hospital alternative efficacy study*

<table>
<thead>
<tr>
<th>Design</th>
<th>Results</th>
<th>Conclusions</th>
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</table>
| • Randomized control trial comparing peer respite to inpatient hospital | • Significantly greater service satisfaction than the hospital comparison group  
  • Nonsignificant difference in symptom ratings in consumer-run alternative | • The study authors concluded that this alternative was “at least as effective as standard care” and a “promising and viable alternative.” |

Quasi-experimental: 2nd Story Evaluation

Results

Likelihood of PES use

Respite guests were 70% less likely to use inpatient and emergency services

But likelihood of PES use increased with each additional day of respite stay

Hours in PES

Respite days were associated with significantly fewer inpatient and emergency service hours

But the longer the stay, the more PES hours the guests were likely to use
Observational: *Los Angeles County and Rose House, NY*

**LA County Department of Mental Health Innovations Study**
- 98% of guests agreed that they liked coming to the program
- 94% agreed that the program helped them feel empowered to make positive life changes

**Evaluation of Rose House in NY**
- Guests reported peer respite supports were more client-centered and less restrictive, staff were more respectful, and that the respite felt less stigmatizing
- Survey of 10 Rose House guests found that 7 had not used psychiatric inpatient hospitals since becoming involved with the respite
“The wholesale co-optation of genuine peer support into peer-staffed positions within mainstream programs is a shining example of what we don’t want to see happen with peer-run respites.”

Next steps
Research questions for peer respites

- **Individual-level outcomes**
  - Do peer respites improve outcomes for guests? For staff? For communities?

- **Program/Service-level fidelity**
  - What processes are happening in peer respites? What is effective about peer respites?

- **System-level developments**
  - How do peer respites fit in the service system? What are the trends?
Lack of commitment to robust evaluation of peer respites

"Has your peer respite been evaluated?" (2016 PREF)

<table>
<thead>
<tr>
<th>Evaluation status</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-evaluation only</td>
<td>8</td>
<td>36%</td>
</tr>
<tr>
<td>External evaluation only</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Both self- and external</td>
<td>8</td>
<td>36%</td>
</tr>
<tr>
<td>Neither</td>
<td>4</td>
<td>18%</td>
</tr>
</tbody>
</table>

Interviews with and surveys of peer respite programs reveal important evaluation and program design considerations.

By Laysha Ostrow and Bevin Croft
November 2014
Comparative Effectiveness of Peer Respites: What Works?
Conclusion: An agenda for peer respites and peer support

How do developments in policy and program innovation impact sustainability and effectiveness?

How do we apply or adapt gold-standard research methodologies in this context?

What is unique and non-redundant about peer support?

*What are we talking about when we say “peer support” or “peer respite” are effective?*
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Visit www.PeerRespite.net for:
• Directory of peer respites
• Compilation of research studies
• Resources to start and sustain peer respites
• Information on staff training
• Evaluation technical assistance

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