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Financing Peer Crisis Respites in the United States

SAMHSA
Substance Abuse and Mental Health Services Administration

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Executive Summary

Peer crisis respites are an effective component of the behavioral health crisis system of care. Peer crisis respites offer voluntary, short-term overnight stays in a homelike setting. They are predominantly peer led and help people address their immediate challenges and move beyond their current crisis.

Peer crisis respites are associated with positive outcomes, including increased post-crisis participation in community-based treatment and recovery supports, reduced emergency room visits, and less inpatient hospitalization. While there is growing evidence of the benefits of these programs, as of 2024 there were only 36 known peer respites across the United States (U.S.). Due to their scarcity, limited information is available regarding financing and sustainability of peer crisis respites, which is important information for expanding the availability of these programs nationally.

The purpose of this study was to:

1. Highlight the benefits of peer crisis respites within the continuum of care; and
2. Identify common components, operations, and funding of peer crisis respites in a national sample of programs across the U.S.

To better understand peer respite operations and funding, the study team identified a national sample of peer respites, starting with the 36 programs listed in the National Empowerment Center directory of peer respites. An online search for additional peer crisis respites was conducted for every state and territory. Programs that self-identified as peer crisis respites were included and added to the list. A total of 82 programs were invited to provide information for this report and this report includes information on 27 peer crisis respites that met inclusion criteria.

Most peer crisis respites reported having the capacity to provide crisis care and overnight stays to five or fewer people per night, an average length of stay between 6-10 days, and an annual budget of $250,000 - $499,999. Almost all respondent peer respites were peer-run with leadership who self-identified as peer specialists with lived experience. The primary source of peer respite funding came from states and very few respites reported billing Medicaid for their services. Long-term funding stability was the biggest financial challenge and 80 percent of peer respites reported that they often operated at capacity and with wait lists.

Overall, peer crisis respites provide valuable and needed services within the crisis care system. Peer respites rely heavily on state funding and face substantial challenges for sustained funding. Investments should be made to support existing efforts to identify core components of peer respites, develop relevant measures of effectiveness that are sensitive to recovery-related outcomes, assess peer crisis respite cost-effectiveness, and expand sustainable funding streams.

CHAPTER 1

Introduction

In most communities, when someone experiences a mental health or substance use crisis, immediate facility-based care options are often limited to emergency rooms, locked crisis stabilization centers with stays of under 24 hours, or inpatient services.[1,2] However, not every crisis requires a high-acuity medical setting. In a growing number of communities, peer crisis respites provide effective care for many people as part of a comprehensive continuum of community-based crisis services.

Peer crisis respites provide voluntary, non-clinical and community-based overnight care that addresses the needs of some people experiencing mental health crises and substance use concerns.[3] They provide stays of varied lengths in a homelike setting that is open 24 hours per day. Peer crisis respites help people find new ways to understand and cope with their immediate challenges and move past their current crisis.[4] They also connect people with community resources and supports.

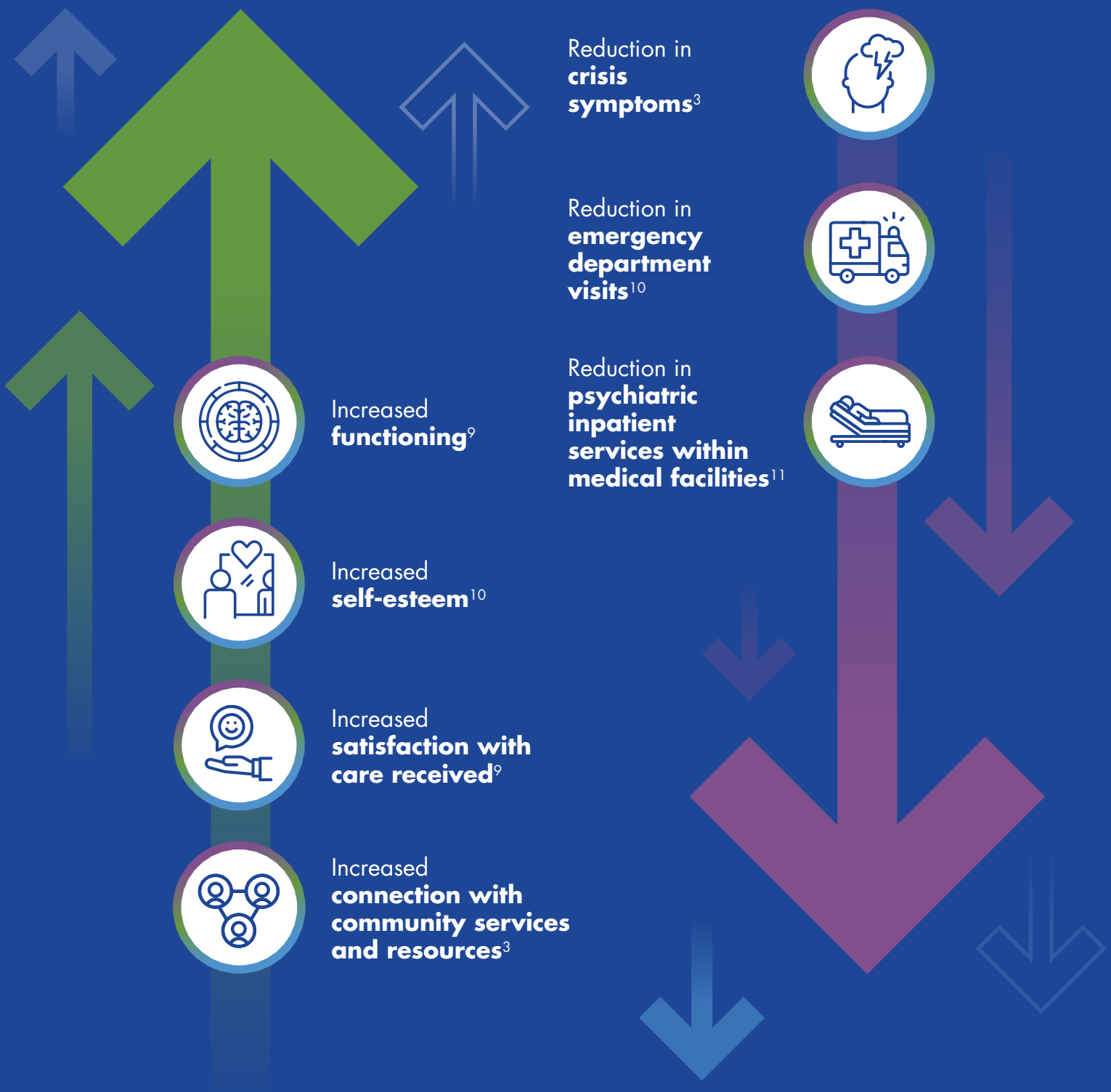
Peer crisis respites are peer-run, meaning that staff and leadership are predominantly, if not all, peer specialists. Peer specialists are individuals with lived experience who have sustained recovery from a mental health or substance use condition, or both.[5] These peers are often trained and certified at the state level as peer support specialists. They model recovery, promote shared decision making, focus on strengths, offer self-help strategies, and provide practical information and resources.[5]

Characteristics of Peer Crisis Respites

Peer respites vary in the services they offer, enrollment criteria and staffing. Currently there are no universal models or core components that define these programs. However, most peer crisis respites aim to:

- Prevent worsening of the current crisis.[6]
- Offer crisis management, crisis resolution, and/or follow-up.[6]
- Provide an alternative to psychiatric emergency department visits and inpatient hospitalization in certain circumstances.[7]
- Focus on individual goals and preferences, rather than on diagnosis or symptoms[6]
- Offer person-centered, recovery-oriented, trauma-informed care[3]
- Strengthen engagement in treatment and improve outcomes for individuals experiencing a crisis.[6]
- Increase the number of days guests report feeling healthier after a stay.[8]

Positive Outcomes Associated With Peer Crisis Respites



Peer Crisis Respites within the Behavioral Health Continuum of Care and Recovery Supports

Peer crisis respites align with national efforts to expand the "continuum of care", particularly as conceptualized within a recovery-oriented system of care (ROSC).[12] ROSC refers to a coordinated network of community-based services and supports that is person-centered and strengths-based.[13] Within this framework, the continuum of care includes a broad set of services available to address people's unique needs in support of mental health and recovery. These include both medical and social services provided in the community and in a variety of locations, including inpatient settings. The behavioral health continuum of care promotes mental health, prevents substance misuse and provides treatment and support to foster recovery. A need for crisis care and support may emerge at any point along the continuum.[2,14]

A behavioral health crisis is a situation where an individual experiences emotional or psychological distress that impairs functioning or the ability to cope with daily life. These crises can manifest in many ways such as acute episodes of mental health conditions, substance use problems, severe stress, suicidal thoughts, or other conditions that require immediate intervention and support.

Peer Crisis Respites Address the Phases of a Crisis Episode

Phases of Behavioral Health Crisis Care	Services Provided by Peer Crisis Respites
Prevention and Early Crisis Intervention	Outreach, community connection, and a safe space for a break from stress
Crisis Services	Short overnight stays to assess needs and support informed decision-making on next steps for care and meeting new or established recovery goals
Post-Acute Recovery Support Services	Short overnight stays after inpatient hospitalization to promote a gentle return to community living and connect with follow-up resources

SAMHSA identifies **three** essential elements of comprehensive behavioral health crisis care:

Crisis Contact Centers
(i.e., "someone to contact or talk to")

Mobile Crisis Teams
(i.e., "someone to respond")

Crisis Stabilization Services
(i.e., a safe place for help or "a place to go")[2]

Peer crisis respites support a comprehensive crisis care system, expanding the options available to individuals in crisis.[2]

Operations, Financing, and Cost-Effectiveness of Peer Crisis Respites

As of April 2024, a directory hosted by the National Empowerment Center (NEC)[15] listed 36 peer crisis respites across 14 states in the U.S. These peer respites are structured in a variety of ways and – though community-driven efforts are underway – there is not yet a standard definition or fidelity tool that outlines core components for peer respites. Data on peer crisis respites largely come from the series of Peer Respite Essential Features (PREF) surveys conducted by Live and Learn Inc every two years from 2012-2020.[16] These surveys showed growing numbers of peer respites over time and varied operating models across respites. For example, the 2020 PREF survey results documented that the daily capacity for peer crisis respites ranged from 2-20 people, and guests usually stayed 1 to 30 days.[7] Most of these programs are staffed by peers and affiliated with peer-run organizations.[7,16,17] Others operate within a larger organization or agency that may be less peer-run.

In 2020, annual budgets were commonly below $500,000 and state funds were the main and often only source of peer respite funding.[7,16,17] No federal discretionary funds are designated for peer crisis respites, but states have leveraged the federal Community Mental Health Services Block Grant (MHBG) with other funds in support of peer crisis respites and warmlines.

Increasingly policymakers are interested in assessing the cost-effectiveness of peer respites. We searched for relevant studies in three research literature databases were conducted: ProQuest, PubMed, and MEDLINE (FirstSearch). A combination of terms was used including: "peer-crisis respite," "peer specialist," "recovery specialist," "lay interventionist," "peer run," "consumer run," and "consumer managed" with the terms "cost benefit" and "cost-effectiveness". This yielded 8,103 articles. An abstract review narrowed the list down to 31 articles related to peer mental health services published since 2008. The study design and methodology of each of the 31 articles were then reviewed. We excluded reports, literature, evidence reviews, and webinars/slides that did not have clear methodology, reported on peer support in general, or did not provide cost data with comparison groups. This resulted in identifying three controlled studies – with a treatment (peer crisis respite) and comparison (acute care) group – that included cost data.

When considering this literature, it is important to contextualize its interpretation and generalizability. There is some overlap in the individuals who can be safely stabilized in each setting. Other study conditions such as follow-up after the intervention can confound outcomes. There were substantial differences between the participants, peer respite conditions, acute care conditions, and designs of these three studies. Results were mixed. Two of the studies[9,11] showed both improved treatment outcomes and some form of cost savings (i.e., reduced hospitalizations, Medicaid savings), and the third showed only improved treatment outcomes.[10]

Three Studies of Peer Crisis Respite with Cost Data

Title, Author, Year	Study Design	Treatment Group	Comparison Group	Cost Outcomes
A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis Greenfield (2008)	Randomized control trial (all participants met commitment criteria)	• Unlocked, six-bed hostel for adults facing civil commitment • Assertive community outreach after discharge	• Locked, 80-bed inpatient psychiatric facility • No community outreach after discharge	• $2,379 average cost savings for initial stay • No significant reduction in total year costs of hospital inpatient services for peer respite
Impact of the 2nd Story peer respite program on use of inpatient and emergency services Croft et al. (2015)	Quasi-experiment (matching)	• 2nd Story, a publicly-funded peer respite program in California • Provides stays up to 14 days in a home-like environment • Support provided by peers trained in Intentional Peer Support	Individuals receiving publicly-funded behavioral health services through the county's system of care (excluding peer crisis respite users)	• 70% lower likelihood of later hospital inpatient or ED use in 2 years after respite stay • Average of 84 fewer hospital hours for respite guests who stayed at least 9 days
The effectiveness of a peer-staffed crisis respite program as an alternative to hospitalization Bouchery et al. (2018)	Quasi-experiment (matching)	• Four peer crisis respites in NYC designed for up to 14-day stays • Majority of staff were peer support specialists • Participants received 24-hour peer support, education in self-advocacy and training in self-help	Medicaid users with hospital stay and psychiatric diagnosis (excluding peer crisis respite users)	• Average annual Medicaid cost savings of $22,000 • 2.9 fewer hospitalizations on average for peer crisis respite users in the year after respite stay

In the absence of more substantial evidence on the cost-effectiveness of peer crisis respites, it is helpful to understand how peer crisis respites are financed and operate. We collected information regarding current financing and sustainability from peer crisis respites across the country. The purpose of this study was to:

1. Highlight the benefits of peer crisis respites within the continuum of care
2. Identify common components, operations, and funding of peer crisis respites in a national sample of programs across the U.S.

CHAPTER 2

Methodology

Survey Data Collection

Identifying a National Sample of Peer Crisis Respites

To identify a national sample of US programs, the study team started with 36 programs across 14 states identified within the National Empowerment Center directory of peer respites.[15]

An online search for additional peer crisis respites was conducted for every state and territory. Programs that self-identified as a peer crisis respite on their website were included. Search terms on Google included "peer respite AND [state name]" and additional related search terms as needed. State directories were also searched including 2-1-1 websites, government inventories of peer programs, and state news releases. For each peer crisis respite, the name, city, state, website address, contact information, and a brief program description were recorded. The list was cross-referenced and further edited by the study team.

The inclusion criteria were purposefully broad to include an array of programs with varying operations and funding streams. A final list of 82 peer respites was identified.

Inclusion Criteria

- Staffed predominantly by peer specialists
- Focused on mental health crisis and substance use intervention (i.e., do not prohibit guests in crisis)
- Allow guests to stay overnight (24+ hours)
- Located in a community-based setting

Exclusion Criteria

- Respite offered in drop-in centers, living rooms, or clubhouses with no overnight or over 24-hour stays
- Not focused on mental health crisis (e.g., peer residential facilities)
- Focused on caregiver respite (e.g., for parents of children with disabilities or for caregivers of older adults)
- Located fully or partly within a hospital or inpatient medical facility

Information Collected from Peer Crisis Respites

The 82 peer respites identified were contacted by People USA, a peer-run mental health nonprofit and partner in this study. The questions were based on the 2020 PREF survey, with permission from the PREF authors. The questions were revised and new questions were added to capture study-specific details. The questionnaire took approximately 10 minutes to complete and was distributed November – December 2023 via People USA using Survey Monkey; follow-up reminders were given periodically by email and in-person. Questions focused on program operations, financial structures, and challenges to sustaining operations. Questions were pilot tested to ensure logical order of items, language clarity, and minimal respondent burden. The final questionnaire contained 40 questions (see Appendix A).

Thirty-five individuals responded to the questionnaire and eight respondents were excluded from analysis for the following reasons: incompleteness, duplicative response from the same program, and did not meet inclusion criteria based on their responses. The usable response rate was 32.9% (N=27). The study team cleaned the data and calculated descriptive statistics, including frequencies, correlations, and crosstabulations, using SPSS (Statistical Package for Social Sciences).

CHAPTER 3

Findings

Survey Findings

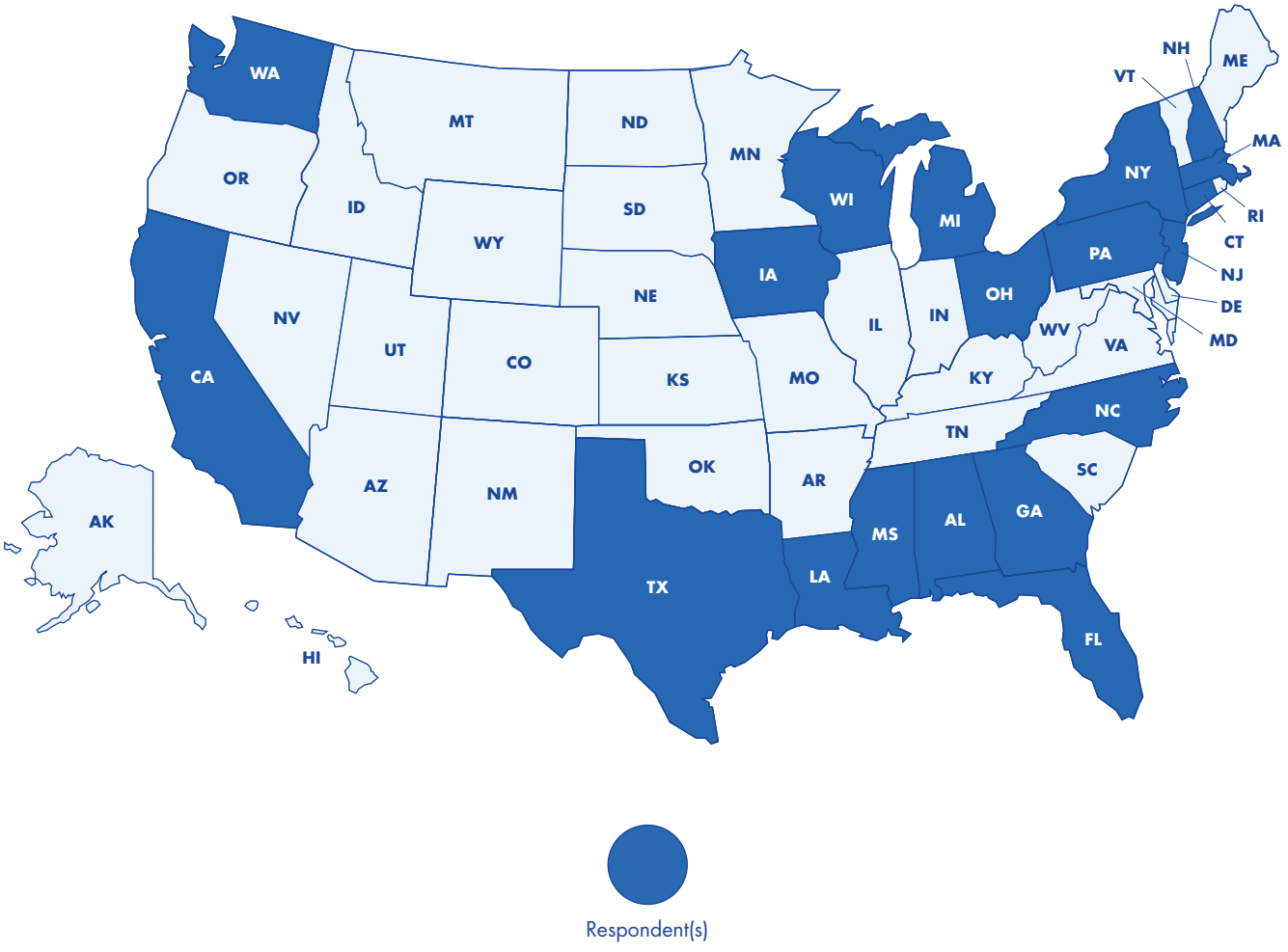
Data from 27 peer crisis respites across 16 states are presented below.

Respite Characteristics

Region

Most responses came from the Northeast and Midwest, with a few from the South and two states on the West Coast. The list of actual programs is not published since respondents answered the questions with promise of anonymity. The number of respondents does not reflect the full number of peer crisis respites in the U.S.

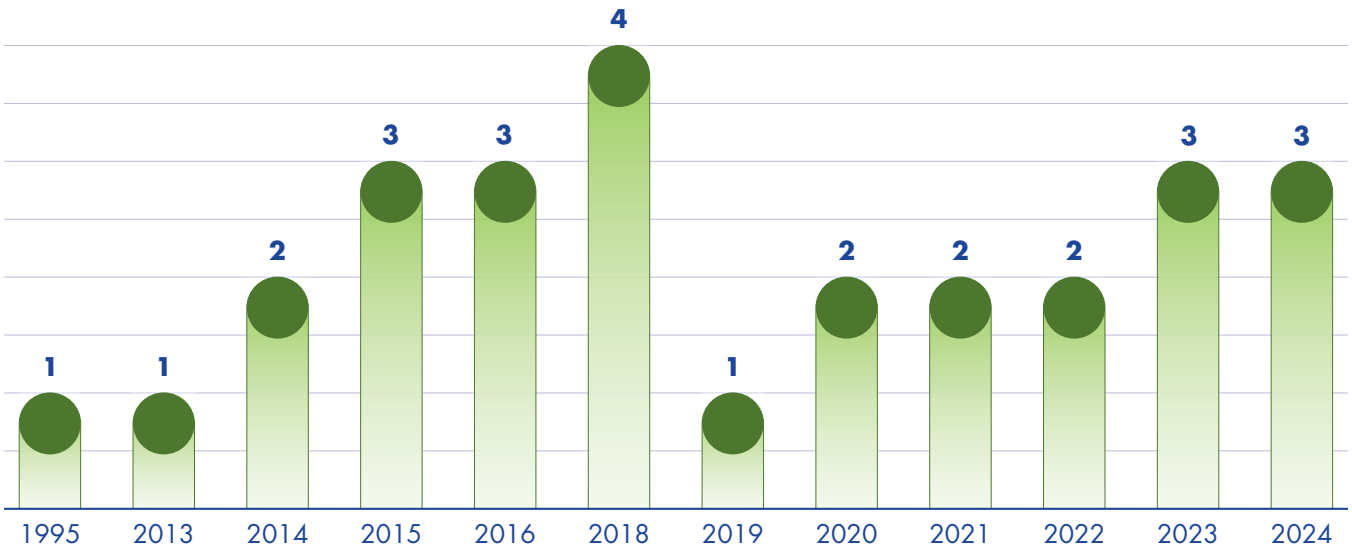
Figure 1. Map of the States with Responding Peer Crisis Respites



Age of Participating Peer Crisis Respites

All but one of the peer crisis respites began serving guests in 2013 or later, with the majority opening in or after 2018. This means most respondent peer respites were operating for 5-10 years. Three programs (excluded from analyses) said they expect to start serving guests in 2024.

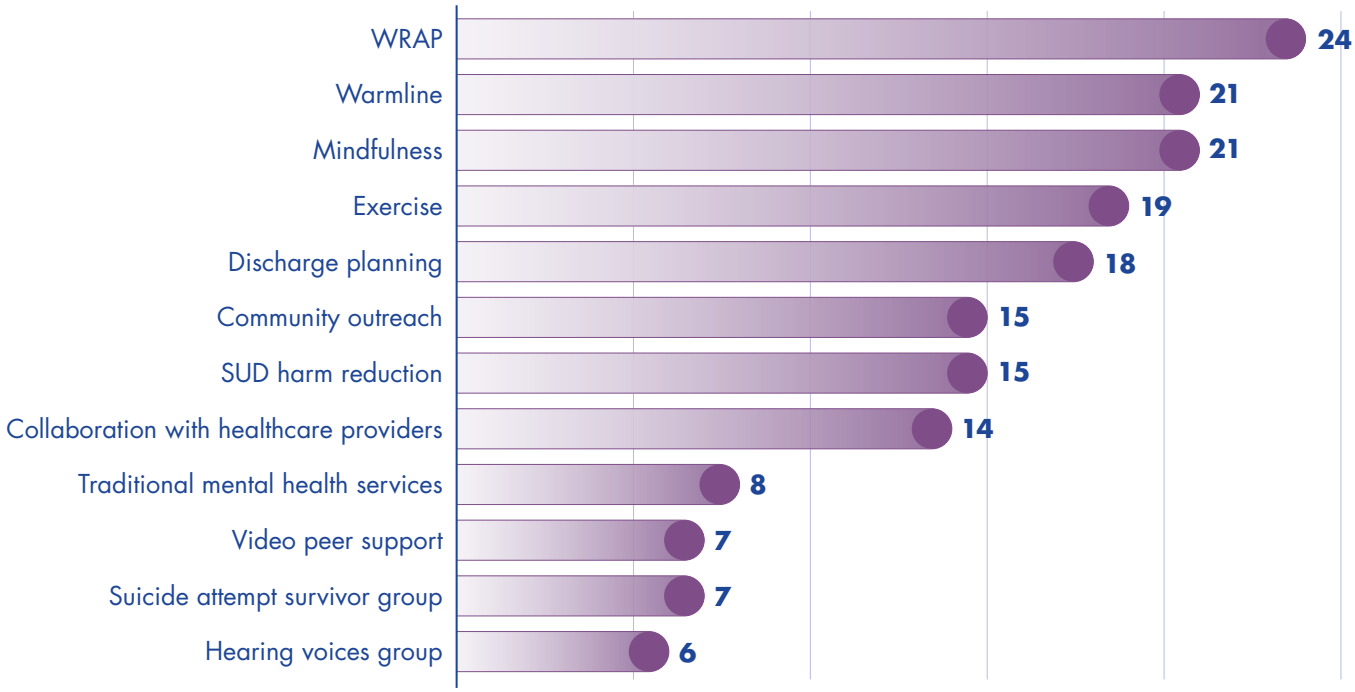
Figure 2. Number of Peer Crisis Respites Opened by Year



Services Provided

Peer crisis respites noted that they provide a variety of services for their overnight guests, with the most common service being Wellness Recovery Action Planning (WRAP), a curriculum used in a peer support group process focused on wellness self-management.

Figure 3. Services Provided to Guests



Peer Crisis Respites at a Glance

STAFFING

96% Respite Director is a peer

100% Majority of staff are Peer Specialists

89% All staff are Peer Specialists

78% Have less than 10 full- or part-time staff

16% Have medical personnel on staff

41% Majority of staff identify as Black, Indigenous and People of Color (BIPOC)

OPERATIONS

63% Affiliated with a peer-run organization

100% Up to 10 beds

70% Up to 5 beds

59% Up to 250 guests served in 2022

57% Maximum length of stay is 6–10 days

30% Maximum length of stay of 11–30 days

78% Waiting list

ENROLLMENT CRITERIA

100% Serve adults 18 years and older

93% Serve individuals with co-occurring physical disabilities

93% Serve individuals with co-occurring substance use conditions

66% Serve unhoused individuals

44% Serve guests expressing active suicidal ideation

GUESTS

48% Serve predominantly BIPOC guests

82% Accept self-referrals

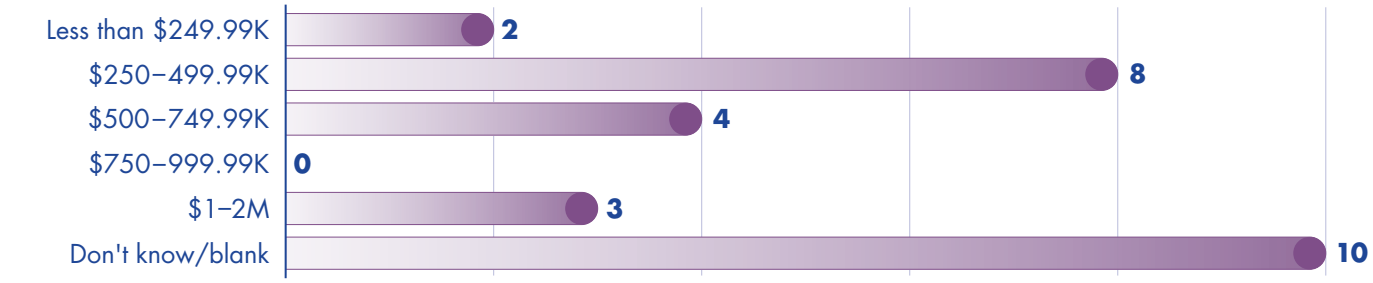
41% Accept referrals from emergency services

Financing

Annual Budget

The majority of the peer respites, 52% (n=12), reported their annual budget ranging from $250k-750k. Ten respites (37%) did not report their annual budget, likely because the respondent was unsure.

Figure 4. Annual Budget

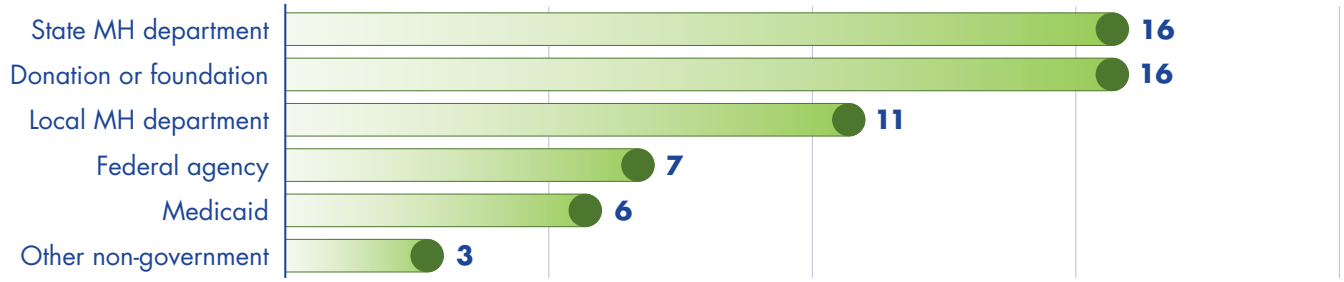


Sources of Funding

Respites indicated that state mental health departments (n=16, 59%), donations and private foundations (n=16, 59%), and local county mental health departments (n=11, 41%) were their most common funding sources. Several peer respites reported that they received funding from donations or private foundation grants, although these were not one of their main funding sources.

1/3 of respites noted they cannot count on current funding levels to continue beyond **5 years**

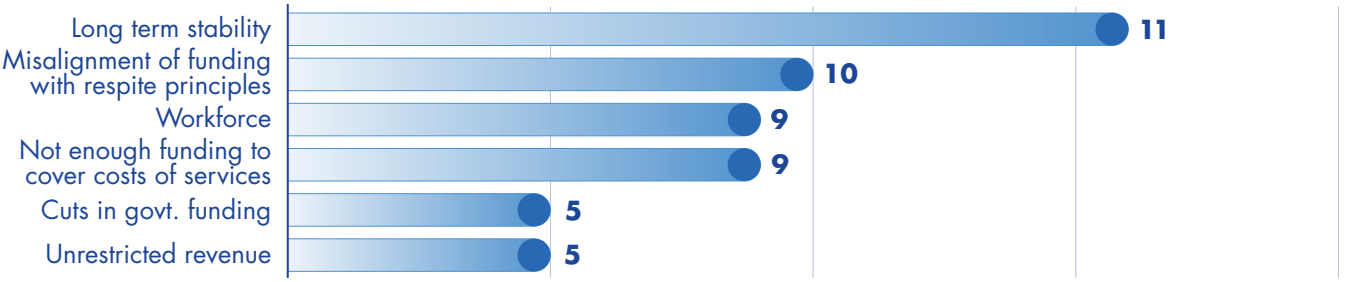
Figure 5. Funding Sources



Challenges to Funding

The most common funding challenges were achieving long term financial stability (41% of peer respites), misalignment of Requests for Proposals or funding priorities with principles of peer crisis respites (37%), workforce issues (33%), and not having enough funds to cover costs of services (33%). Cuts in government funding and raising unrestricted revenue (i.e., funds not earmarked for specific services) were also challenges, though reported about half as often as the others.*

Figure 6. Top 3 Funding Challenges



*Respondents were asked to choose the top 3 challenges, so totals add up to more than 27.

CHAPTER 4

Discussion and Next Steps

This report provides a post-pandemic snapshot of the landscape of peer crisis respites in the U.S. Our search identified 82 peer crisis respites across the country, including three peer respites scheduled to open in 2024. This is a much higher number than totals reflected in the National Empowerment Center (NEC) directory or the Peer Respite Essential Features (PREF) 2020 survey. Admittedly, our working definition of peer crisis respite was broader than for the PREF surveys (e.g., not restricted to 100% peer staff) to capture a broader variety of peer respites. 27 peer crisis respites were included in this analysis. These programs ranged across 16 states, which is slightly more than the 14 represented in the PREF 2020 survey[4] and NEC directory.[15]

Discussion

Peer Crisis Respite Services

Most peer respites reported fewer than 250 unique guests and a similar number of total stays, indicating that repeat guests are uncommon. No peer respites had capacity for more than 10 guests at a time, with most reporting maximum capacity of 5 or fewer.

Self-referrals were by far the most common referral source, consistent with peer respite model principles. Peer support programs and friends/family were top referral sources as well, suggesting that having peer support specialists on staff and in management may lead to strong networks and interconnections between peer support services, peer crisis respites, and close contacts of individuals in crisis. Importantly, peer respite respondents in this study varied in serving unhoused and actively suicidal guests. Ethical challenges with both have been noted in the literature.[3]

Overwhelmingly, peer respites reported having a guest waitlist due to high demand. Given the person-centered, trauma-informed approach and intimate nature of peer crisis respites, there are not nearly enough peer respites nationally to serve all individuals who could benefit from them in a crisis. Notably, peer respites reported that they offered a wide range of 24/7 services both to guests and the broader community, such as warmlines, that would otherwise be unavailable. These were provided despite the substantial financial challenges peer respites reported. This suggests that they provide a unique range of services within the continuum of care – providing far more than only step-down services post-hospitalization.

Additionally, this study is the first known to inquire about diversity in respite guests and staff. We found that 11 respites (41%) reported the majority of paid staff identified as Black, Indigenous, or People of Color (BIPOC) and 13 peer respites reported more than half of guests identified as BIPOC. Further, all but 3 of the peer respites with majority BIPOC guests also had majority BIPOC staff. Not only is this kind of representation important for guest connections, cultural humility, trust, and, ultimately, improved substance use recovery and and mental health, but it also has important implications for funding. Although there is limited information available, studies show that minority-led and minority-serving organizations experience a range of challenges (e.g., smaller organizational budgets, more difficulty accessing financial support from a variety of sources, inequitable access to social networks) that put them at a persistent disadvantage among nonprofits.[18,19]

In this way, the notable strength of peer crisis respites – having leaders and staff represent the communities being served – also poses inherent barriers and challenges to funding that likely all peer respites will need to confront. Funding streams should be modified or created to acknowledge these barriers and allow support for the unique financial challenges associated with diverse representation among peer crisis respite leaders and staff.

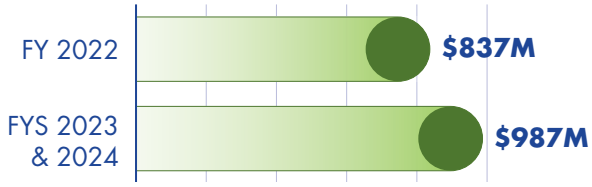
Financing

Financial sustainability was a common concern. The top funding challenge cited was long-term stability, and seventy percent of peer respites either did not know how long current funding would continue or expected it for fewer than five years. Additional funding challenges noted were misalignment of funding announcements with peer respite principles, workforce shortages, and inadequate funding to cover service costs.

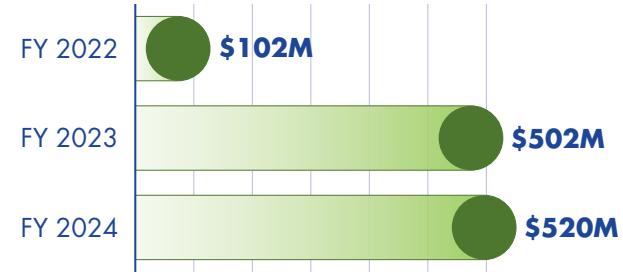
Similar to the 2020 PREF survey results, the primary and often sole funding source was state mental health departments. Private donations or foundations were second most common, in contrast with the 2020 PREF survey, in which they contributed very little to overall peer respite funding. Seven respites reported billing Medicaid and it is unclear how many used funds from the MHBG. It is important to acknowledge that, while billing Medicaid and using other state, county, or federal funding can enhance sustainability, there are important tradeoffs to consider. These funding sources frequently require clinical supervision and can increase administrative burden. For example, one peer respite commented "Current state Medicaid does not have a HCPCS code compatible with this service (daily rate vs. 15-minute unit)" while another commented "we are committed to Non Medicaid funding for peer run respite as it would greatly impact access."

The federal Community Mental Health Services Block Grant (MHBG) funds are allowable expenses that states can allocate towards peer respites and federal funding for the MHBG is increasing.

In 2023 and 2024, federal appropriations for the Community Mental Health Services Block Grants were $987 million, a **$150 million increase** from the 2022 level.[20,21]



Further, federal funding for crisis services has also increased over the past two years; providing $502 million in fiscal year 2023 and $520 million in 2024 for the 988 Suicide and Crisis Hotline, as compared to $102 million in 2022.



Looking Ahead

Communities and states should consider:

- **How to identify the role of peer respites** and embed them within the crisis care system.
- **How to increase the number of peer respites** available nationwide.
- **Improving awareness of peer crisis respite services** among the public, staff at crisis response services (*988, *911, web-based services, etc.), primary care providers, public health departments, mental health and substance use disorder treatment centers, community leaders, law enforcement, and others.
- **Supporting ongoing community-led efforts** to develop consistent definitions and quality standards for peer crisis respites and set criteria for how peer crisis respites fit into individual care plans and care coordination.

Peer crisis respites may not be aware of all the potential funding sources they can use, such as MHBG or opioid settlement funds, or how to take advantage of them. Medicaid can be a dependable source of funding, but there are tradeoffs that can limit accessibility and increase administrative burden. However, broader peer support services have increased in prevalence and use in recent years, and there are current initiatives to develop standardized models for peer support at the federal level that may make it easier to fund peer crisis respites.[22]

Peer crisis respites fill an important niche in the crisis care system and need access to diversified funding streams as well as more dependable, longer-term, tailored and unrestricted funding streams. Despite facing numerous challenges to financial health, peer crisis respites may offer potential cost savings over more restrictive and expensive acute care. Further evaluation and research are needed to fully understand effective implementation of peer crisis respites, trajectories of help seeking and service use, and how peer respites fit into the broader crisis care system.

Looking Ahead

Communities and states should consider:

- **Exploring reimbursement rates** for providers of peer crisis respites.
- **Identifying potential sources of revenue** to foster an increase in the number of peer crisis respite programs.
- **Establishing mechanisms** to process provider claims and pay providers.
- **Providing technical assistance** to peer crisis respites on how to manage billing and reimbursement for services in health-care funded operation/environment.
- **Codifying supervision, care coordination, training/credentialing, and scope of work criteria** for qualifying peer crisis respites.

Payers of Care and the Crisis Care System

Policymakers should consider strategies to adopt and integrate peer crisis respites into the existing continuum of care. Peer crisis respites provide a unique opportunity for individuals to receive support from people who have been through similar experiences. This type of support can be invaluable in promoting recovery, recognizing and responding to trauma, reducing stigma, and fostering a sense of community. For people who could benefit from peer crisis respites, offering them as an alternative to the emergency department or an inpatient hospitalization can reduce stigma associated with mental health and substance use crises.

State governments across the country are increasingly acknowledging mental health crises in their states and funding mental health services, including peer crisis respites, in substantial amounts.[23,24] For example, Wisconsin has several peer crisis respites, including a center for veterans, which receives annual state funding.[24,25] Two additional peer crisis respites recently opened in Michigan and Washington state, which focus specifically on early interventions and preventing crisis escalation.[8,26] Despite interest in creating and funding peer crisis respites, implementation can be slow—even in states with sufficient funding—because of complex regulatory processes and policies.

Limitations

We intentionally crafted a broad working definition of peer crisis respites to include as large a sample as possible, but this appears to have had unintended consequences; potential respondents may have perceived the working definition as an attempt to "water down" the core elements of peer respites, inadvertently discouraging participation. Findings must be interpreted cautiously given that the sample is not generalizable to all peer crisis respites.

Though many findings were consistent with similar questions on the 2020 PREF survey, the PREF cohort was sampled using narrower inclusion criteria, and comparisons cannot be interpreted as change over time.

Peer Crisis Respites as Part of the Crisis Care System

There are active efforts to develop national standards for peer crisis respites rooted in the evidence-based model of authentic peer support, as well as a fidelity framework to measure consistency with peer respite and peer support principles. These efforts and discussions are ongoing, and we were unable to incorporate them in this study. This is a critical step with potential to improve research on peer respite effectiveness and potential cost effectiveness. Future researchers should consider standardizing treatment and comparison groups, defining relevant and respite-sensitive outcomes, and specifying which peer respite features should be measured to understand important variation in implementation/operation.

Peer crisis respites, just like inpatient care, are not the best option for all individuals in crisis. Future research would benefit from a better understanding of the conditions under which peer respites are effective and for whom. Similarly, studies of cost-effectiveness and potential cost savings need to account for the unique model of peer respites and not, for example, measure savings associated with volunteer peer staff. On a related note, an updated inventory of peer crisis respites is needed. Given that peer crisis respites are community- and peer-based, it is critical to think about ways to learn "what works" from communities and successful peer crisis respites and then to disseminate this knowledge in accessible ways.

Looking Ahead

Researchers should consider:

- **Conducting additional effectiveness research** to add to the evidence base on both outcomes and costs. Randomization can be challenging—particularly in voluntary, recovery-based settings; researchers must control the assignment to the treatment group.
- **Examining the effects of variations in the peer crisis respite model.** For example, studies could compare results for peer crisis respites using different staffing models or offering different services.
- **Providing more standardized and detailed cost accounting for peer crisis-run respite services.** Whenever possible, peer crisis-run respites should document per-participant costs.
- **Examining outcomes among diverse participants with different needs and diagnoses.** It is important to determine whether peer crisis respites work more effectively for certain types of crises or based on characteristics of guests.
- **Measuring the impacts of peer crisis respite services on the broader continuum services.** It would be important to look at whether having peer crisis respites in communities reduces the number of individuals who go to the emergency room or are hospitalized due to crises.

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APPENDIX A

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APPENDIX B

Glossary of Terms

988

988 is a crisis line call number that offers 24/7 access to trained crisis counselors who can help people experiencing mental health-related distress, such as thoughts of suicide, mental health or substance use crisis, or any other kind of emotional distress. People can call or text 988 or chat 988lifeline.org for themselves or if they are worried about a loved one who may need crisis support. 988 serves as a universal entry point so that no matter where you live in the United States, you can reach a trained crisis counselor who can help.

Behavioral Health

A key part of a person's overall health, which includes emotional, psychological, and social well-being, and that is just as important as physical health. Conditions that may impact behavioral health include mental health and substance use conditions, and co-occurring mental health and substance use conditions.

Behavioral Health Continuum of Care

An integrated system of care with varying levels of service intensity and settings in response to an individual's behavioral health needs.

Block Grant

A block grant is a grant issued by the federal government to state and local governments to be used in a flexible manner, with few restrictions or requirements, to fund services and activities based on need. The Community Mental Health Services Block Grant (MHBG) is a formula grant available to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and 6 Pacific jurisdictions to provide comprehensive community mental health services limited to individuals experiencing serious mental illness or serious emotional disturbance. The Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) program provides funds to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, the Northern Mariana Islands, Guam, American Samoa, 3 Pacific jurisdictions, and 1 tribal entity to plan, implement and evaluate efforts to prevent and treat substance use.

Clinician/Clinical Provider

Refers to someone who has academic credentials to provide clinical treatment. A clinician has direct contact with patients and may come from a variety of professions, including physicians, social workers, or nurse practitioners, among others.

Consumer

An individual who has a mental health condition and uses mental health services.

Crisis Care

A range of services for individuals experiencing an acute mental health and/or substance use disorder crisis.

Crisis Respite

Short-term, residential facilities that offer a restful, step-down environment with supports for individuals experiencing a crisis.

Emergency Department

A hospital facility that is staffed 24 hours a day, 7 days a week, and provides unscheduled services to patients whose condition requires immediate care.

Evidence-Based Practices

Evidence-based practices are interventions that are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the persons receiving the services, that promote individual-level or population-level outcomes.

Guests

Users of peer respite services.

Grant

A grant is a funding mechanism to provide money to an eligible entity to carry out an approved project or activity that supports a public purpose. A grant is used whenever SAMHSA anticipates no substantial programmatic involvement with the grant recipient during performance of the financially assisted activities.

Grantee

The grantee, also known as the "federal grant recipient," is the organization awarded a grant or cooperative agreement by the funding entity, such as SAMHSA. The grantee is legally responsible and accountable to SAMHSA for the performance and financial aspects of grant-supported projects or activities.

HHS

The Department of Health and Human Services (HHS) is the federal government's principal agency for protecting the health of Americans. It provides essential human services, especially for those who are least able to help themselves. In support of its mission, HHS awards grants for more than 300 programs, making it the largest grant-awarding agency in the federal government. SAMHSA (see below) is an agency within HHS.

Inpatient Care

Health care that a person receives when admitted as an inpatient in a health care facility, such as a hospital, residential treatment center, or skilled nursing facility.

Person with Lived Experience

An individual with personal knowledge gained through direct, first-hand involvement with a behavioral health condition and the receipt of services. Also known as a "peer".

Mental Health Crisis/Emergency

A mental health crisis is any situation in which a person is experiencing intense psychiatric and/or emotional distress that leads to hurting themselves or others, or being unable to care for themselves or function effectively in the community, or all of the above.

Outpatient Care

A structured service setting or program that provides ambulatory (not overnight) care delivered in a specialty facility/hospital/center/clinic or in-home. Care is generally provided for visits of 3 hours or less in duration and 1 or 2 days per week.

Peer Crisis Services

A range of evidence-based peer support services, for individuals experiencing an acute mental health or substance use crisis, or both, provided by trained individuals with lived experience.

Peer Recovery Support Services

A range of non-clinical evidence-based peer support services designed to help people with mental health and substance use conditions pursue recovery, find hope, support self-empowerment, and achieve a self-determined life. to pursue recovery. This can include support groups, recovery housing, supported employment, and more.

Peer Respite

Voluntary, short-term, overnight programs that provide beds and evidence-based peer support services 24 hours a day, 7 days a week in the community for people experiencing or at risk of acute psychiatric crisis. Peer respites differ from other diversion programs such as crisis residential services in that they are staffed and operated by trained peer support staff.

Peer Organizations

Peer organizations may also be referred to as independent community-based organizations and are operated and staffed by peers; these include drop-in centers and recovery community organizations.

Peer Support

An evidence-based practice that consists of giving and receiving nonclinical assistance to achieve long-term recovery from severe psychiatric, traumatic, or addiction challenges. Peer support offers a level of acceptance, understanding, and validation not found in many other professional relationships. Within this report, support is provided by peer support specialists—people who have "lived experience" and have been trained to assist others in initiating and maintaining long-term recovery and enhancing the quality of life for people and their families. Peer support services are inherently designed, developed, delivered, evaluated, and supervised by peers in recovery.

Peer Support Workers (also known as Peer Support Specialists, Peer Recovery Coaches, Peer Advocates, Peer Recovery Support Specialists)

A peer support worker is someone with the lived experience of recovery from a mental health condition, substance use disorder, or both. They provide support to others experiencing similar challenges. They provide non-clinical, strengths-based support and are "experientially credentialed" by their own recovery journey. They assist others by promoting recovery-based approaches. Peers model recovery, promote shared understanding, focus on strengths, offer positive coping strategies, and provide information and resources.

Psychiatric Hospital

An inpatient medical facility specifically designed to provide treatment for individuals with mental health or co-occurring mental health and substance use conditions.

Recovery

A process of change through which people improve their health and wellness, live a self-directed life, and strive to reach their full potential. The four dimensions that support recovery are: health, home, purpose, and community.

Recovery-Oriented Systems of Care (ROSC)

A coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

Strengths-Based Approach

An approach to assessment and care that emphasizes the strengths of the individual, family, and community.

Substance Abuse and Mental Health Services Administration (SAMHSA)

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services (HHS) that leads public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

Trauma-Informed Approach

Services or care based on the knowledge and understanding of trauma and its far-reaching implications. A trauma-informed approach includes six key principles: 1. Safety. 2. Trustworthiness and transparency. 3. Peer support. 4. Collaboration and mutuality. 5. Empowerment, voice, and choice. 6. Cultural, historical, and gender issues.

Warm Line

A peer-operated phone line that individuals can call to receive services that are less intensive than what one would receive when calling a hotline, like opportunities for talking, remote peer support, and referrals to other services.

Wellness

Wellness encompasses: purpose in life; active involvement in satisfying work and play; joyful relationships; a healthy body and living environment; and happiness. Wellness incorporates many dimensions of health, each of which is interconnected within an individual's total well-being. SAMHSA's Wellness Initiative supports embracing the Eight Dimensions of Wellness — emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual — to achieve longevity and improved quality of life. A state of physical and mental well-being.

APPENDIX C

Questionnaire

1. What is the name of the peer respite you are sharing information about here?

2. In what state is your peer respite located?

3. In what year did your program start serving guests? (YYYY)

4. Does the peer respite allow guests to stay overnight?
   - ○ Yes
   - ○ No

5. Is the peer respite focused on guests experiencing a mental health crisis?
   - ○ Yes
   - ○ No

6. Is the peer respite community-based (i.e., located in a home or neighborhood)?
   - ○ Yes
   - ○ No

Guests and Guest Policies

7. Does your program serve any of the following people? (choose all that apply)
   - ○ Age below 17
   - ○ Ages 18-24
   - ○ Ages 25-45
   - ○ Ages 46-64
   - ○ Ages 65+
   - ○ With co-occurring physical disability
   - ○ With hearing impairment
   - ○ With substance abuse problems
   - ○ With a plan for suicide
   - ○ Experiencing homelessness
   - ○ Mothers with children
   - ○ Fathers with children
   - ○ Other (please specify)

8. How many peer respites does your organization operate? (enter number)

9. What is the maximum number of guests your program accommodates at any one time?
   - ○ 1-5
   - ○ 6-10
   - ○ 11-15
   - ○ 16-20
   - ○ 21+
   - ○ Don't know

10. In the calendar year 2022, what was the average number of guests who stayed there at any one time?
    - ○ 1-5
    - ○ 6-10
    - ○ 11-15
    - ○ 16-20
    - ○ 21+
    - ○ Don't know

11. In the calendar year 2022, how many total stays were there? (for repeat guests, count number of visits not individuals)
    - ○ 0-250
    - ○ 251-500
    - ○ 501-999
    - ○ 1,000+
    - ○ Don't know

12. In the calendar year 2022, how many total individuals were served (unduplicated)?
    - 0-250
    - 251-500
    - 501-999
    - 1,000+
    - Don't know

13. What is the maximum length of stay (number of days) for guests in the peer respite?
    - 1-5
    - 6-10
    - 11-15
    - 16-20
    - 21-30
    - 31+
    - Don't know

14. What was the average number of days guests stayed in the peer respite?
    - 1-5
    - 6-10
    - 11-15
    - 16-20
    - 21-30
    - 31+
    - Don't know

15. Does your respite have a waiting list for guests?
    - Yes
    - No
    - Don't know

16. Which percentage of guests identify as BIPOC (Black, Indigenous, or Persons of Color)?
    - None
    - Less than 51%
    - 51% - 99%
    - 100%
    - Don't know

17. Which of the following refer guests to you on a regular basis? Choose the **three** most frequent/ regular sources.
    - Self Referrals
    - Clinical care provider
    - Peer support program
    - Law enforcement
    - Emergency services (emergency room, inpatient, etc.)
    - Housing program or shelter
    - Friend or family member
    - Public outreach (e.g. social media, flyers, etc.)
    - Other (please specify)

Structure and Staffing

18. What type of organization is your program legally/financially affiliated with, if any?
    - None, the peer respite is an independent organization
    - Peer organization (at least 51% of the board; the executive director; and the majority of staff/volunteers have lived experience)
    - Traditional healthcare provider
    - Traditional behavioral health provider
    - Community services agency (non-behavioral health social service provider)
    - State, county, or local government
    - Other (please specify)

19. Which percentage of the governing body that decides policies and procedures for the peer respite has lived experience?
    - None
    - Less than 51%
    - 51% - 99%
    - 100%
    - Don't know

20. What is the current total number of paid full-time respite staff positions?
    - ○ 1-5
    - ○ 6-10
    - ○ 11-15
    - ○ 16+
    - ○ Don't know

21. What is the current total number of paid part-time staff positions?
    - ○ 1-5
    - ○ 6-10
    - ○ 11-15
    - ○ 16+
    - ○ Don't know

22. Does the manager / director identify as having lived experience?
    - ○ Yes
    - ○ No
    - ○ Don't know

23. Is the director / manager / supervisor required to have lived experience?
    - ○ Yes
    - ○ No
    - ○ Don't know

24. Which percentage of paid staff have lived experience?
    - ○ None
    - ○ Less than 51%
    - ○ 51% - 99%
    - ○ 100%
    - ○ Don't know

25. Which percentage of paid staff identify as BIPOC (Black, Indigenous, or Persons of Color)?
    - ○ None
    - ○ Less than 51%
    - ○ 51% - 99%
    - ○ 100%
    - ○ Don't know

26. Does the respite have prescribers, nursing, or medical personnel on staff or under contract?
    - ○ Yes
    - ○ No
    - ○ Don’t know
    - ○ Other (please specify)

Financing

27. What is the current annual budget of your peer respite(s)?
    - ○ Less than $249,999
    - ○ $250,000 - $499,999
    - ○ $500,000 - $749,999
    - ○ $750,000 - $999,999
    - ○ $1 -2 million
    - ○ More than $2 million
    - ○ N/A

28. Please select the sources from which you received funding for your program in the calendar year 2022 (check all that apply)
    - ○ Federal agency (e.g., Substance Abuse and Mental Health Services Administration [SAMHSA], Administration for Community Living [ACL], United States Department of Agriculture [USDA])
    - ○ State mental or behavioral health department
    - ○ County or local behavioral health department
    - ○ Private foundation grant
    - ○ Donations (other than from foundations)
    - ○ Managed care company
    - ○ Medicaid
    - ○ Paid for privately by guests
    - ○ Private insurance
    - ○ N/A
    - ○ Other (please specify)

29. Does your program bill Medicaid for respite services?
    - ○ Yes
    - ○ No
    - ○ Don't know

30. Which of these sources provide the largest amount of funding for your current annual budget? **(Check up to 4 sources)**
    - ○ Federal agency (e.g., Substance Abuse and Mental Health Services Administration [SAMHSA], Administration for Community Living [ACL], United States Department of Agriculture [USDA])
    - ○ State mental or behavioral health department
    - ○ County or local behavioral health department
    - ○ Private foundation grant
    - ○ Donations (other than from foundations)
    - ○ Managed care company contract
    - ○ Medicaid
    - ○ Paid for privately by guests
    - ○ Private insurance
    - ○ Other (please specify)

31. Long-term funding is a concern for many respites. For how long do you expect the current level of funding to continue (i.e., remain the same or increase)?
    - ○ Less than 6 months
    - ○ 6-12 months
    - ○ 12-18 months
    - ○ 18-24 months
    - ○ 2-3 years
    - ○ 3-5 years
    - ○ 5+ years
    - ○ Not sure

32. Please select the top 3 challenges to funding for the respite:
    - ○ RFP/funder misalignment with principles/ models of peer respites
    - ○ Achieving long-term financial stability
    - ○ Raising funds that cover full costs
    - ○ Raising unrestricted revenue
    - ○ Workforce recruitment/retention
    - ○ Not enough funding to meet increasing guest needs
    - ○ Cuts in government funding
    - ○ Cuts in funding from other (nongovernmental) sources
    - ○ Building acquisition or access to physical space
    - ○ NIMBY-ism (i.e., community/resident concerns over having a respite nearby)
    - ○ Other (please specify)

Program Offerings

33. Which services do you offer respite guests? (Check all that apply):
    - ○ Hearing Voices groups
    - ○ Wellness Recovery Action Plan (WRAP)
    - ○ Suicide attempt survivor support group
    - ○ Substance use and/or harm reduction groups
    - ○ Meditation/mindfulness
    - ○ Exercise
    - ○ Art/crafts/music
    - ○ Religious/spiritual
    - ○ Traditional mental health services (e.g. Dialectical behavioral therapy, motivational interviewing)
    - ○ Educational/special interest
    - ○ Warmline (phone)
    - ○ One-on-one video peer support
    - ○ Virtual Support Groups
    - ○ Community Outreach
    - ○ Home visits
    - ○ Collaboration with healthcare providers
    - ○ Social gatherings
    - ○ Discharge planning (e.g., connection to community resources)
    - ○ Alumni group
    - ○ Other (please specify)

34. Do you follow-up with guests after a stay?
    - ○ Yes
    - ○ No
    - ○ Don't know

Evaluation

35. Has your program ever been evaluated? Evaluation could include measuring the outcomes, costs, and processes of your program, or other research techniques.
    - ○ Yes, we conduct our own evaluation or data collection on an ongoing basis
    - ○ Yes, another organization is currently conducting an evaluation
    - ○ Yes, another organization conducted an evaluation in the past
    - ○ No, but we are interested in conducting an evaluation
    - ○ No, and we are not interested in conducting an evaluation

36. Do you collect information on guest satisfaction/experience?
    - ○ Yes
    - ○ No
    - ○ Don't know

37. Do you track hospitalizations of guests after they leave?
    - ○ Yes
    - ○ No
    - ○ Don't know

38. Within 24 hours of staying at the respite, which percentage of guests go to a hospital for **inpatient services**?
    - ○ None
    - ○ Less than 10%
    - ○ 10% - 25%
    - ○ More than 25%
    - ○ Don't know
    - ○ Don't track this

39. Within 24 hours of staying at the respite, which percentage of guests go to a hospital for **the emergency room**?
    - ○ None
    - ○ Less than 10%
    - ○ 10% - 25%
    - ○ More than 25%
    - ○ Don't know
    - ○ Don't track this

40. What else would you like us to know about your program?

Center for Financing
Reform and Innovation

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

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