



The Key

ASSISTANCE REPORT

FOCUS ON PEER-RUN CRISIS RESPITE SERVICES

National Mental Health Consumers' Self-Help Clearinghouse

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Until recently, John Tedesco had been hospitalized at a local facility several times every year. Diagnosed with schizoaffective disorder, he thought his options were limited: that the hospital was the only place he could go during a difficult period. Then a nurse told him about Rose House, a peer-run center that some people in his community were using as an alternative to hospitalization.

"It wasn't for several months that I actually went there and tried it out but, when I did, boy, did I like it!" Tedesco recalled. "The atmosphere is more accepting [than the atmosphere in a hospital], and your life doesn't come to a screeching halt. When I'm there I can relax and meet with peers and talk things through with people who really care." For Tedesco, part of the appeal is the sense of personal autonomy. "When things start to get stressful and I need a break, I can prepare to go and pack my bags instead of being committed."

A TRUE ALTERNATIVE

A peer-run crisis respite (PRCR) is a place where people can live for a while during a mental health crisis. Run by likeminded people who have "lived experience" of a mental health condition and are working toward



recovery, PRCRs offer a nonmedical, trauma-informed environment that approximates the feeling of being at home. In fact, PRCRs are usually located in houses in residential neighborhoods, rather than on distant and sprawling hospital campuses.

Editor's note: In a peer-run crisis respite center, peers administer, staff and operate the center at all levels, and at least 51 percent of the board members identify as peers. In another model – the "hybrid" – although the respite is attached to a traditional provider organization and/or fewer than half of the board members are peers, the respite's director and staff do identify as peers.

For Steve Miccio, who was hospitalized in 1994, the psychiatric ward was not a

good place for managing his emotional distress. "There was no discussion of hope or recovery or wellness when I was there," he said. "For me, a seed was planted during this experience, and that made me want to change things."

A year later, Miccio started his journey to recovery and, several years later, spent some time working in a hospital as an emergency room screener, which gave him more insight into how the system worked. When he became the executive director of PEOPLE (Projects to Empower and Organize the Psychiatrically Labeled) Inc., he saw it as a chance to find and develop an alternative.

"At that time," Miccio continued, "Shery Mead [a peer consultant] was doing something in New Hampshire

with respite. I contacted her and got her advice. We had an opportunity, through some monies that were made available through the New York State Office of Mental Health, to create our own respite – but we called it hospital diversion because we wanted it to be clear that it wasn't just a place to go to relax; it was a genuine way to keep people out of the hospital."

Miccio's vision led to the founding of Rose House, a PRCR in Milton, N.Y., in 2001. Since then, Miccio has helped craft the place to better serve the people who use it. "It has certainly evolved over the years as we have developed more effective guidelines and policies for running it," he said.

In the fourth year of Rose House, Miccio began to collect data and found that the PRCR had a 90 percent success rate in keeping people out of the hospital, breaking the cycle of recidivism and "learned helplessness." In 2010, he opened a second Rose House, in Carmel, Putnam County, N.Y. He is currently working on developing other houses and has consulted on new PRCRs in Nebraska and the Netherlands.

Like Steve Miccio, Daniel Fisher, M.D., Ph.D., had an early traumatic experience with psychiatric hospitals. He was involuntarily hospitalized several times in his twenties and diagnosed with schizophrenia. Ironically, he was a biochemist working at the National Institute of Mental Health on the neurochemistry of schizophrenia at the time.

"It was the '70s," Dr. Fisher said. "I was a hippie and I was sent to the Naval Hospital and it was a horrible culture clash. They cut my hair and things went downhill from there. I was prohibited from receiving visitors and I felt like a prisoner." The only good thing to come out of the experience, he said, was that he left the hospital determined to become a psychiatrist and improve the situation for others: "I didn't feel anybody should be subjected to involuntary treatment."

That led to his involvement with the burgeoning rights movement organized

by individuals with psychiatric diagnoses, where he has been instrumental in a number of different initiatives to promote a recovery-oriented system. Dr. Fisher now serves as executive director of the National Empowerment Center in Lawrence, Mass. One of his projects has been to help establish a PRCR called Afiya in Western Massachusetts. "We know that peer-run alternatives provide hope, and that's what people need," he said.

THE MODEL

While peers have been providing crisis support to one another for decades, the current PRCR model is a relatively recent one. At a PRCR, trained peer staff

"PRCRs are a growing service because they just make sense and they already have good science behind them to show that they work."

can help individuals develop a recovery plan and work toward their goals. Individual goals might include stress reduction, finding short-term solutions for emotional situations, and developing living and coping skills that may reduce the chance of future crises. The PRCR might offer its own resources, such as support groups, individual meetings with a peer specialist, WRAP (Wellness Recovery Action Plan) training, and access to recreational or wellness activities as well as unstructured time.

"There are three components of a peer-run hospital diversion program that are integral to its success," Miccio said. "One is the absolute belief in the values behind recovery and wellness. All of the staff here wholeheartedly

believe that people can and will live a better life if educated and supported. The second is environment: people should feel at home here. In fact, they don't have to come to our House; we can deliver our services to their home. But a homelike environment is going to be a healthier place. We keep musical instruments, art equipment, books and comfortable furniture around.

"The third piece," Miccio continued, "is engagement and mutuality: how we speak to one another, share our experiences and listen. We want people to feel validated, respected and comfortable talking, because that sense of connection is very important."

Participating in peer-run crisis respites is voluntary. Some respites restrict access to include only people who have not been deemed a danger to themselves or others, while others include individuals who are suicidal or who might harm or have harmed themselves in some way. Some PRCRs even request an initial intake *before* a time of crisis to ensure that personal relationships and an environment of trust are established early on. Others accept residents on an as-needed, immediate basis.

The respite will often take care of guests' personal needs, such as pet care, bill paying and anything else that will help them maintain their life in the community. Respites can also be used as a transition for people who are coming out of jail and looking to reestablish themselves.

PRCRs dovetail with the ideals of the recovery movement. The hands-on personal attention of peers not only creates an atmosphere of dignity, respect and personhood, it promotes communication and connection between individuals. Spending time at a PRCR can even reduce the trauma of a past involuntary hospitalization.

Just as important, Dr. Fisher said, is the continuity of outside life. "Your caregivers, family and friends can still visit and be part of your day-to-day routine, which doesn't happen in a hospital. You are more empowered because you are making your own decisions and not having your whole

day dictated to you. And, unlike in a hospital, where you are often given very negative messages about your future – perhaps even told that your disease will be lifelong and that you will always need to take medication – here you are given hope when you see that others have been through similar experiences.

“These things make all the difference to someone who is in an extreme emotional state,” Fisher said. “Rather than a tragedy, your situation is viewed as an opportunity for growth.”

THE EVIDENCE

There are some in the psychiatric community who continue to resist the idea of PRCRs as an acceptable alternative. “There is still skepticism out there that people with lived experience can actually help others in a crisis situation,” Dr. Fisher said.

He added that many respites are funded by county and state dollars, but there could be more PRCRs if insurance and Medicaid could fund them. “The worry is that insurance and Medicaid funding is medical, and that, in order to have any adequate reimbursement, we would be forced to medicalize the model,” he said.

There is not yet a large body of research examining PRCRs but, so far, studies have shown that peer-run respites have multiple advantages over psychiatric hospital wards. They have been found to promote greater improvement and satisfaction in people who use their services; reduce the incidence of self-harm and violence; and save money that would otherwise be needed to pay for police, ambulance, emergency room and/or hospital costs. A 2008 study showed that the cost of PRCRs averaged \$211 per day per individual, versus \$665 per day per individual for hospitalization. By promoting recovery, peer-run respites can also save money in reducing future visits and services.

“It’s clear that this model is more conducive to recovery,” said Peggy Swarbrick, Ph.D., an advocate, peer and researcher at the University of Medicine and Dentistry of New Jersey Department of Psychiatric Rehabilitation and Counseling Professions. Dr.

Swarbrick and her colleagues are familiar with the available research about PRCRs and report that there is compelling evidence that favors them.

“The supportive environment, the routine, the wellness strategies of getting people to sleep and eat better, instead of simply focusing on medication, are all helpful,” Dr. Swarbrick said. “For many people, hospitals are chaotic environments where their rights are taken away. They approach a peer-run center with a different mindset.”

“If they’ve been to a hospital before, people are often surprised when they come to a respite to find out that no one is telling them what to do,” Dr. Fisher said. “The outcomes have shown us that being able to make one’s own decisions can help them come away with greater self-esteem and a sense of control over their future.”

THE FUTURE

No wonder, then, that interest in developing PRCRs at the county and local level is simmering. There are currently 12 such centers around the country, in Massachusetts, New York, New Hampshire, Vermont, West Virginia, Ohio, Nebraska and Georgia; and those that work in the field say that people in other states are looking into this model and beginning the process of grassroots organizing. (There are also two hybrids: one in California and one in Maine.)

Miccio sees crisis services being taken to the next level. “I can imagine a different kind of diversion or wellness approach that is more preventative, so that people won’t even need to come to a house in a time of crisis,” he said. “They will get the support they want and deserve in the community.” He added, “PRCRs are a growing service because they just make sense and they already have good science behind them to show that they work.”

Rose House made sense to Erme Maula, program manager of Consumer Recovery Investment Funds Self-Directed Care, a project of the Mental Health Association of Southeastern Pennsylvania. “Steve gave me a tour, and I thought it was great,” Maula said.

RESOURCE LINKS

National Empowerment Center: Crisis Alternatives
<http://www.power2u.org/crisis-alternatives.html>

Hospital Diversion Services: A Manual on Assisting in the Development of a Respite/Diversion Service in Your Area
<http://www.power2u.org/downloads/OH-Hospital-Diversion-Manual.pdf>

Peer Support Wellness Respite Centers, SAMHSA-HRSA Center for Integrated Health Solutions: March 30, 2011
<http://www.integration.samhsa.gov/images/res/PDF,%20PSWRC.pdf>

Peer-Run Crisis Respite Centers
<http://blogs.psychcentral.com/channeln/2011/08/peer-run-crisis-respite-centers/>

A Case Study of the Peer-Run Crisis Respite Organizing Process in Massachusetts
http://ncmhr.org/downloads/Ostrow_Groundhogs-case-study.pdf

“It really incorporated the peer aspect of recovery, and was a safe haven for people to deal with their crises.”

The average stay at Rose House is three to five days, Maula noted. “It’s able to address a crisis and get you back into the community quicker than I think a lot of medical-model crisis respites can do.”

She was also impressed by the fact that the program was available 24 hours a day. “If you are having a crisis at two in the morning, you can call right then. Even if it doesn’t mean that you’re coming to stay there, you can talk to someone who is trained to handle crises but is also a peer.

“It’s one of the things I wish I had had when I was in college,” she said. “I just wanted somewhere to go to be in a safe place and have food, where I could focus on what I needed to focus on without having to go to a hospital.” ■



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by location, type of organization, and targeted clientele, and serves as a free resource for consumers, program administrators and researchers.

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