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PEER RESPITE POLICY BRIEF

Massachusetts lacks sufficient voluntary, non-clinical community behavioral health options for individuals experiencing mental or emotional distress. One solution to this problem is to establish peer respites throughout the state. SD.832/HD.539 would do just that, placing a peer respite in each county of the Commonwealth while establishing two respites devoted to the Black/Brown, Indigenous, and People of Color (BIPOC) community and two respites devoted to the LGBTQIA+ community. Peer respites reduce costs, promote recovery, and conserve crucial resources of an overburdened mental health system. This brief explains what these facilities are, how they operate, and why they are needed to address the current mental health crisis confronting this state.

What are Peer Respites?

Peer respites are a form of crisis intervention that provide safe and supportive environments for individuals experiencing emotional or mental distress. They provide individuals with voluntary, short-term lodging and nonclinical, trauma-informed, person-centered emotional support in a non-coercive, homelike environment. These centers are easily accessible and operate on a 24-hour basis—there is no need for prior-authorizations, and other gatekeeping functions are limited. Peer respites serve individuals who do not or cannot get their needs met in a traditional, clinical mental health setting.

Peer support and peer respite services are based on the commonsense notion that individuals who have personal experience with mental health issues, navigating mental health and other systems, and related challenges are uniquely qualified to assist others confronting similar struggles. Such connections and services have been shown to promote hope surrounding the possibility of recovery,

personal strength, and choice.ⁱ This is in part attributable to the peer respites' focus on helping individuals maintain long-term recovery past acute crises. Key components of this model include empowering and involving consumers of behavioral health services in shaping their own care and the integration of peer providers into the workforce supporting recovery and resilience.

Each peer respite is completely staffed and operated by “peer supporters” who are formally trained in the provision of peer support and respite services, and each of whom has psychiatric histories and/or have faced and navigated similar emotional crises.ⁱⁱ These individuals provide assistance that promotes engagement, socialization, recovery, self-sufficiency, self-advocacy, resiliency, wellness, and the development of skills necessary to confront and overcome mental and emotional challenges in the future. This paradigm allows individuals to receive emotional support and practical assistance from peers with similar lived experiences in an environment that fosters personal growth and recovery, while avoiding hospitalization and other invasive and life-disrupting interventions.

Why Peer Respites?

Peer respites work. They save lives and cut unnecessary health care spending while promoting recovery and self-determination. They have also been recognized as a cost-effective alternative to inpatient psychiatric hospitalization by clinical experts,ⁱⁱⁱ the Substance Abuse and Mental Health Services Administration,^{iv} the Centers for Medicare & Medicaid Services,^v the World Health Organization and United Nations,^{vi} and the Massachusetts Department of Mental Health.^{vii} And while the services they offer are non-clinical in nature, the research shows that the use of peer respites leads to better clinical outcomes. Peer respites improve users' self-esteem and confidence,^{viii} empathy and acceptance,^{ix} sense of control and ability to bring about changes in their lives,^x quality of life and life satisfaction,^{xi} empowerment and hope,^{xii} community engagement,^{xiii} engagement and activation in treatment,^{xiv} and social functioning.^{xv} In addition, peer respites use has led to decreased

hospitalization,^{xvi} use of inpatient services,^{xvii} and self-stigmatization among individuals experiencing emotional or mental struggles.^{xviii}

The Need for Peer Respite

Effective solutions are needed to combat the mental health crisis confronting the nation. Approximately 1 in 5 adults in the United States (46.6 million people in total) experience life-interrupting emotional or mental distress each year; suicide is the 10th leading cause of death in the United States, and the 2nd leading cause of death for people aged 10-34.^{xix} There simply are not enough outpatient facilities to meet the needs of individuals experiencing mental and emotional distress. This leads to overcrowded psychiatric emergency rooms, a lack of inpatient beds, and emergency room boarding of individuals for days on end.

Yet, most individuals experiencing acute mental or emotional distress do not require inpatient hospitalization. For many individuals, traditional psychiatric emergency room and inpatient hospital services are undesirable and avoidable when less coercive or intrusive community-based supports are available. Nevertheless, many individuals who do not require or will not benefit from emergency care end up in hospital emergency rooms due to the lack of accessible non-coercive community behavioral health options.^{xx} This process is costly and ineffective and results in overutilization of limited hospital resources, invasive pharmacological interventions, and unnecessary involuntary commitments.^{xxi}

Unfortunately, there are only three operational peer respites^{xxii} in the entire state, and none focus on serving the LGBTQIA+ community. There is a distinct need for such facilities. LGBTQIA+ youth report significantly higher rates of attempting suicide.^{xxiii} In 2022 alone, 41% of LGBTQIA+ youth in Massachusetts reported seriously considering suicide, including 51% of transgender and nonbinary youth; and 11% and 15% of such individuals attempted suicide, respectively.^{xxiv} More than half of LGBTQIA+ youth reported experiencing symptoms of depression, and over 70% reported

experiencing anxiety.^{xxv} These figures were even higher for youth identifying as transgender and nonbinary, with 64% reporting experiencing symptoms of depression and 78% reporting anxiety.^{xxvi} The creation of additional peer respites will provide individuals experiencing mental or emotional distress with a safe place to go to and enable them to receive effective nonclinical support from trained peers who themselves have overcome similar struggles. The establishment of LGBTQIA+- and BIPOC-focused peer respites will additionally provide members of this community with a unique, supportive resource and temporary refuge from harmful situations.

There is No Better Time to Invest in Peer Respites

Legislation or appropriations are needed for the purpose of establishing additional peer respites throughout the state. The attached legislation will accomplish this end. This bill will establish fourteen additional peer respites throughout the Commonwealth, including two LGBTQIA+-specific and two BIPOC-specific facilities. If signed into law, this bill will ensure that each county has at least one peer respite facility available for individuals in crisis. It will also ensure that the existing peer respites and relevant stakeholders have a say in how these new peer respites are operated.

The peer respite legislation is a unique opportunity to establish a system devoted to the principles of self-determination, individual autonomy, and sustained recovery. Peer respites empower individuals to seek assistance for their needs without fear of having their liberty deprived through involuntary hospitalization or their autonomy subverted with the forcible administration of psychiatric drugs. This legislation will help establish a true nonclinical, voluntary behavioral health option for such individuals, and will simultaneously reduce waste and free up hospital beds for individuals who require a higher level of care. It is a win for all parties involved.

ⁱ Individuals who utilize peer respite services have been found to have statistically significant improvements in healing, empowerment, and satisfaction, and use of peer respites has been found to reduce inpatient hospitalization utilization. *See* Greenfield, Thomas K., et

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- al. (2008). “A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis.” *American Journal of Community Psychology* 42.1: 135-144.
- ⁱⁱ For example, Peer Supporters employed by Afiya Wildflower, located in Northampton, MA, are certified and trained in intentional peer support and trauma informed peer support.
- ⁱⁱⁱ For example, researchers of a 2015 study found that the likelihood of respite users using emergency services was 70% lower than for non-respite users. Croft, Bevin & Isvan, Nilufer. (2015). “Impact of the 2nd story peer respite program on use of inpatient and emergency services.” *Psychiatr Serv.* Jun; 66(6):632-7, available at https://www.researchgate.net/publication/273066832_Impact_of_the_2nd_Story_Peer_Respite_Program_on_Use_of_Inpatient_and_Emergency_Services; see also Greenfield, Thomas K., et al. (2008). “A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis.” *American Journal of Community Psychology* 42.1: 135-144 (finding the average psychiatric hospital costs were \$1,057 for respite guests compared with \$3,187 for non-guests).
- ^{iv} Substance Abuse and Mental Health Service Administration (SAMHSA). (2017). “Peer Support. Bringing recovery supports to scale.” Technical Assistance Center Strategy (BRSS TACS); SAMHSA presentation by Fisher, Daniel et. al. “Peer-run respites: an effective crisis alternative.” available at <https://www.nasmhpd.org/sites/default/files/Peer%20Run%20Respite%20slides.revised.pdf>.
- ^v Centers for Medicaid & Medicare Services (CMS). (Aug. 15, 2007). *State Medicaid Directors Letter: Using Peer Support Services Under Medicaid*. Baltimore, MD: HHS, available at <https://downloads.cms.gov/cmssgov/archived-downloads/SMDL/downloads/smd081507a.pdf>.
- ^{vi} World Health Organization & United Nations Human Rights Office of the High Commissioner, *Mental health, human rights and legislation: Guidance and practice*, at 64, 92 (2023), available at https://waps.ohchr.org/sites/default/files/documents/publications/WHO-OHCHR-Mental-health-human-rights-and-legislation_web.pdf
- ^{vii} For example, the Massachusetts Department of Mental Health funds two peer respites in the state—Afiya Wildflower and Kiva Centers. These peer respites have operated for years and have helped thousands of people to recover from crisis.
- ^{viii} Davidson, Larry, et al. (1999). “Peer support among individuals with severe mental illness: A review of the evidence.” *Clinical psychology: Science and practice*, 6(2), 165-187; Salzer, Mark. (2002). “Consumer-Delivered Services as a Best Practice in Mental Health Care Delivery and The Development of Practice Guidelines: Mental Health Association of Southeastern Pennsylvania Best Practices Team Philadelphia.” *Psychiatric Rehabilitation Skills*, 6(3), 355-382.
- ^{ix} Coatsworth-Puspokoy, Robin, et al. (2006). “Peer support relationships: an unexplored interpersonal process in mental health.” *Journal of psychiatric and mental health nursing*, 13(5), 490-497.
- ^x Davidson, Larry, et al. (2012). “Peer support among persons with severe mental illnesses: a review of evidence and experience.” *World Psychiatry*, 11(2), 123-128.
- ^{xi} Bologna, Michael J. & Pulice, Richard T. (2011). “Evaluation of a peer-run hospital diversion program: A descriptive study.” *American Journal of Psychiatric Rehabilitation*, 14, 272- 286; Stastny, Peter, et al. (1995). “Consumers as peer specialists on intensive case management teams: Impact on client outcomes.” *Psychiatric Services*, 46, 1037-1044.
- ^{xii} Cook, Judith A., et al. (2010). “Developing the evidence base for peer-led services: Changes among participants following Wellness Recovery Action Planning (WRAP) education in two statewide initiatives.” *Psychiatric Rehabilitation Journal*, 34, 113-120.
- ^{xiii} Min, So-Young, et al. (2007). “Peer support for persons with co-occurring disorders and community tenure: A survival analysis.” *Psychiatric Rehabilitation Journal*, 30, 207-213.
- ^{xiv} Druss, Benjamin G., et al. (2010). “The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness.” *Schizophrenia Research*, 118, 264-270; Short, Robert, et al. (2012). “The impact of forensic peer support specialists on risk reduction and discharge readiness in a psychiatric facility a five-year perspective.”

International Journal of Psychosocial Rehabilitation, 16, 3-10; Bellamy, Chyrell D., et al. (2012). “*Giving back and getting something back: The role of mutual-aid groups for individuals in recovery from incarceration, addiction, and mental illness.*” Journal of Groups in Addiction & Recovery, 7, 223-236.

^{xv} Walker, Gill & Bryant, Wendy (2013). “*Peer support in adult mental health services: A metasynthesis of qualitative findings.*” Psychiatric Rehabilitation Journal, 36, 28-34.

^{xvi} Davidson, Larry, et al. (2012). “*Peer support among persons with severe mental illnesses: A review of evidence and experience.*” World Psychiatry, 11, 123-128.

^{xvii} Chinman, Matthew, et al. (2014). “*Peer support services for individuals with serious mental illnesses: Assessing the evidence.*” Psychiatric Services, 65, 429-441; Sledge, William H., et al. (2011). “*Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations.*” Psychiatric Services, 62, 541-544; Min, So-Young, et al. (2007). “*Peer support for persons with co-occurring disorders and community tenure: A survival analysis.*” Psychiatric Rehabilitation Journal, 30, 207-213.

^{xviii} Corrigan, Patrick W., et al. (2013). “*The impact of self- stigma and mutual help programs on the quality of life of people with serious mental illnesses.*” Community Mental Health Journal, 49, 1-6.

^{xix} National Alliance of Mental Illness. (June, 2022). “*Mental health by the numbers.*” available at <https://www.nami.org/mhstats>.

^{xx} Peer respites differ from Community Behavioral Health Centers (CBHCs) and serve different purposes. Unlike CBHCs, peer respites offer nonclinical interventions that are neither dependent upon remuneration from insurance providers nor constrained by diagnostic labels. Peer respites do not form partnerships with local law enforcement and/or Emergency Medical Services or facilitate involuntary hospitalization. Rather, they focus on helping individuals turn crisis into an opportunity to grow, build resiliency, and find ways to navigate their issues in the least restrictive, most autonomous manner possible.

^{xxi} For example, the financial burden of psychiatric care in the United States amounts to approximately \$193 billion in lost earnings per year. See National Alliance of Mental Illness. (June, 2022). “*Mental health by the numbers.*” available at <https://www.nami.org/mhstats>.

^{xxii} They are: Afiya Wildflower, located in Hampshire County; and Kiva Centers, located in Worcester County.

^{xxiii} The Trevor Project. (Dec. 15, 2022). “2022 National Survey on LGBTQ Youth Mental Health by State.” at 125, available at <https://www.thetrevorproject.org/wp-content/uploads/2022/12/The-Trevor-Project-2022-National-Survey-on-LGBTQ-Youth-Mental-Health-by-State.pdf>.

^{xxiv} *Id.* at 123.

^{xxv} *Id.*

^{xxvi} *Id.*