

Persons in recovery from life disruptions caused by mental health challenges often experience episodic crises, resulting in frequent visits to hospital emergency rooms and voluntary or involuntary stays in locked, in-patient psychiatric hospitals. Based on research conducted over a period of nearly three decades, there is a strong evidence base for the efficacy of peer-run hospital diversion programs (AKA peer-run respite services) that provide a much needed supplement to the existing system of care in communities around the nation. Studies of early, experimental models of peer respite crisis care began to establish the evidence for reducing the number of unnecessary hospitalizations and over-utilization of emergency rooms by people experiencing psychiatric crises that could be more appropriately served in a respite model facility.^{1 2}

Throughout the 1990's and into the 21st century, the peer-run respite center model was replicated and researched across the United States, and the evidence base began to solidify.³ For example, a 2008 research report about a peer-run respite program in Sacramento, CA demonstrated that peer-served participants experienced significantly greater improvement on interviewer-rated and self-reported recovery outcomes than did participants in the psychiatric locked facility; service satisfaction was also dramatically higher in the peer-run service.⁴

In 2011, the United States Substance Abuse and Mental Health Services Administration (SAMHSA) recognized peer-delivered respite services for individuals experiencing a psychiatric crisis as an evidence-based practice. According to SAMHSA, peer-run crisis programs emerged as alternatives to the coercive or abusive practices experienced by some people in traditional crisis services and psychiatric hospitals in the 20th century. The model has proven to be effective at preventing emergency hospitalizations, providing alternative support to individuals throughout their crisis period, and serving as a step-down program for individuals recently released from psychiatric hospitals. SAMHSA reported that rigorous national research demonstrated that peer-run respite services are associated with significantly decreased stays in restrictive and expensive psychiatric settings, both short- and long-term.⁵

As of November 1, 2017, there are now 16 peer-run respite centers operating in 11 states across the nation.⁶ The peer-run respite model has evolved from an experimental practice, to a promising practice, to an evidence-based practice. Peer-run respite services have been proven to be a cost-effective model of care and a superior methodology for supporting individuals' recovery and wellness as compared to in-patient treatment in locked psychiatric hospitals.⁷

¹ Galanter, M. 1988. Zealous self-help groups as adjuncts to psychiatric treatment: A study of Recovery, Inc. *American Journal of Psychiatry*, 145(10), 1248-1253.

² Kennedy, M. (1990). Psychiatric hospitalization of GROWers. Paper presented at the Second Biennial Conference on Community Research and Action. East Lansing, Michigan.

³ Mead S. 2011 Peer Support and Peer-Run Crisis Alternatives in Mental Health. Plainfield, NH, Shery Mead Consulting.

⁴ Greenfield, 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*. Volume 42, issue 1-2, pp 135-144.

⁵ Substance Abuse and Mental Health Services Administration (SAMHSA). 2011. *Consumer-Operated Services: The Evidence*. HHS Pub. No. SMA-11-4633, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

⁶ National Empowerment Center's Directory of Peer Respite Centers. <http://www.peerrespite.net/directory>.

⁷ Shattell, M. *et al.* 2014. A Recovery-Oriented Alternative to Hospital Emergency Departments for Persons in Emotional Distress: "The Living Room" *Mental Health Nursing*. Volume 35, Issue 1.