PEER RESPITE

Missouri Peer Respite Crisis Stabilization Initiative: First Year Findings

FY24 Report

University of Missouri-St. Louis
Missouri Institute of Mental Health
Addiction Science Team

UMSL | Addiction Science Team
University of Missouri–St. Louis

Missouri Department of MENTAL HEALTH

Table of Contents

Introduction

In 2023, the Missouri Department of Mental Health (DMH) awarded one-time funding to establish several Peer Respite Crisis Stabilization pilot programs across the state to help fill a need in the current system of care for individuals in early recovery from substance use disorder (SUD).

Providers applied to receive funding through the State Opioid Response (SOR) grant and SAMHSA's Substance Abuse Prevention and Treatment Block Grant, administered by DMH.

The role of the Addiction Science Team at the University of Missouri-St. Louis, Missouri Institute of Mental Health (UMSL-MIMH) is to collect program data on behalf of DMH, provide technical assistance to providers, and evaluate this innovative program model.

This report is intended to help spread awareness of a new and innovative model for supporting individuals with SUD to find long-term recovery.

Background

The peer respite model is an accessible modality of care designed to support individuals experiencing, or at risk of experiencing, a psychiatric crisis. Often termed a "hospital diversion program," the model aims to offer an alternative to inpatient hospitalizations or reliance on emergency rooms as points of access to care by providing participants with rapid, low-barrier access to resources and peer support.

Emerging in the early 1990s, peer respite has grown in response to the limitations of traditional crisis care. While their impact is increasing, such programs remain relatively scarce nationwide.

Although the peer respite model was originally developed as an intervention for individuals experiencing a mental health crisis, Missouri was able to utilize state funding to implement an adapted version of the model to provide targeted care specific to individuals with SUD. Through this initiative, providers established crisis stabilization centers staffed by peers with lived experience to provide empathetic care and support to program participants.

Peers have been successfully integrated in SUD recovery programs throughout the United States and their support as people with lived experience has demonstrated positive recovery and quality of life outcomes.[1] The success seen in behavioral health peer respite programs, coupled with the high need for an intermediary between active use and abstinence-only recovery housing, led to the development of pilot SUD peer respite crisis stabilization programs in Missouri.

Peer respite centers are currently located in St. Louis, Branson, Columbia, and Kansas City but may serve anyone from the state of Missouri.

1. REIF, S., BRAUDE, L., LYMAN, D. R., DOUGHERTY, R. H., DANIELS, A. S., GHOSE, S. S., SALIM, O., & DELPHIN-RITTMON, M. E. (2014). PEER RECOVERY SUPPORT FOR INDIVIDUALS WITH SUBSTANCE USE DISORDERS: ASSESSING THE EVIDENCE. PSYCHIATRIC SERVICES (WASHINGTON, D.C.), 65(7), 853–861. HTTPS://DOI.ORG/10.1176/APPI.PS.201400047

Peer Respite in Missouri

Peer Respite Crisis Stabilization is a voluntary, short-term, overnight program that provides community-based, non-clinical crisis support for individuals experiencing a SUD or co-occurring mental health disorder. Operating 24/7, it is a peer-led, trauma-informed environment that utilizes a social recovery model. Through peer support and connection to resources, the program empowers individuals to take control of their recovery journey, improve their health and wellness, and envision a new path forward.

Social Recovery Model:

- Empowers individuals to engage in personal and collective responsibility in promoting health, safety, and success in recovery. Peer leadership and participatory decision-making are also crucial to success in this environment.

"I've dealt with a specific type of pain and suffering for 8 long miserable years due to my drug addiction. I've lost relationships, jobs, my children, my freedom, I even lost myself along the way. It didn't matter who or what I lost or gave up, all that mattered was getting high. I used the things and or people I lost as an excuse to get and stay high 24/7. I was lost, hopeless, depressed, and I knew I would never amount to be anything better than a worthless drug addict. That all changed when I went to Respite. My whole outlook on life changed. I began to find myself, my worth started to shine through. Respite made me realize that I am worth the fight. The program and the people at Respite saved my life."

-Program Participant

Key Tenets of Successful Peer Respite Programs

1 Low-Barrier

- Immediate access and support
- Welcomes individuals experiencing homelessness
- No payment required
- 24/7 staffing
- Supports residents who experience a recurrence of use
- Does not require a period of abstinence

2 Self-Determined

- Voluntary engagement in services
- Residents can initiate their own discharge
- No mandated length of stay, SOR-funded stays are capped at 30 days but some sites allow for longer periods of housing through alternative funding
- Choice of services and assistance with personal recovery goals
- Promotion of self-sufficiency, self-advocacy, and broader recovery community engagement
- Connection to or continuation of medication for opioid use disorder (MOUD) for those choosing MOUD as part of their recovery plan

3 Peer-Led and Communal

- Non-clinical, home-like living spaces
- Empathetic support based on lived experiences
- Respectful relationships and shared responsibility
- Residents engage in household tasks, decision-making, and problem-solving
- Support from certified peer specialists
- Peer staff are certified, background-checked, and continuously trained

4 Trauma-Informed and Anti-Stigma

- Staff assist residents in crisis with trauma-informed care
- Peer staff trained in crisis response and de-escalation
- Respectful, validating, non-judgmental communication
- Clear guidance on house rules and expectations
- Respect for residents' personal and cultural identities
- Free naloxone and overdose education awareness offered

Why is Peer Respite Needed?

Bridging the Gap of Care

Oftentimes, individuals experiencing homelessness, SUD, and other co-occurring disorders need a place to stay but may not be ready to integrate directly into a recovery housing program, which usually requires a period of abstinence. Whether awaiting a bed for treatment or having experienced a recurrence of use leading to program discharge, individuals in these situations may need a place to go until they can assimilate back into their initial program or transition to another one. This is where peer respite plays a crucial role, filling a gap in the current system of care.

When individuals have an insecure living situation or are feeling overwhelmed by the stress at home, peer respite can be a stabilizing environment to "press pause" and focus on building the foundational steps to their recovery.[1] Additionally, peers providing mutual support and community connections can be a less traumatic and coercive experience than traditional emergency services.[2] The accessible and low-barrier nature of peer respite can lead individuals to be more willing to access services and begin working on their relationships to substances in a non-judgmental and empathetic environment.

> *"While [peer respite] is fast proving to be more cost effective than traditional crisis services, the intent of the service is built on recovery, passion, improved humane care and a level of quality service delivery that is extremely effective in helping people see crisis differently in order to avoid hospitalization".*[6]

The Evidence is Promising

Although peer respite specifically for substance use disorder is an emerging and understudied model of care, existing peer respite models demonstrate efficacy in reducing hospital admissions and symptoms and creating a non-stigmatizing and supportive environment.[3–6]

Peers have been used in recovery support services as key to fostering mutual understanding, eliminating stigma, and empowering individuals to build important skills like coping and self-advocacy.[7–8]

1. Croft, B., Weaver, A., & Ostrow, L. (2021). Self-reliance and belonging: Guest experiences of a peer respite. Psychiatric Rehabilitation Journal, 44(2). 124–131. https://doi.org/10.1037/prj0000452
2. Ostrow, L., & Croft, B. (2015). Peer Respites: A Research and Practice Agenda. Psychiatric Services (Washington, D.C.), 66(6), 638–640. https://doi.org/10.1176/appi.ps.201400422
3. Bouchery, E. E., Barna, M., Babalola, E., Friend, D., Brown, J. D., Blyler, C., & Ireys, H. T. (2018). The Effectiveness of a Peer-Staffed Crisis Respite Program as an Alternative to Hospitalization. Psychiatric Services, 69(10), 1069–1074. https://doi.org/10.1176/appi.ps.201700451
4. Croft, B., & Isvan, N. (2015). Impact of the 2nd Story Peer Respite Program on Use of Inpatient and Emergency Services. Psychiatric Services, 66(6), 632–637. https://doi.org/10.1176/appi.ps.201400266
5. Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A Randomized Trial of a Mental Health Consumer-Managed Alternative to Civil Commitment for Acute Psychiatric Crisis. American Journal of Community Psychology, 42(1–2), 135–144. https://doi.org/10.1007/s10464-008-9180-1
6. Bologna, M. J., & Pulice, R. T. (2011). Evaluation of a Peer-Run Hospital Diversion Program: A Descriptive Study. American Journal of Psychiatric Rehabilitation, 14(4), 272–286. https://doi.org/10.1080/15487768.2011.622147
7. Siantz, E., Henwood, B., McGovern, N., Greene, J., & Gilmer, T. (2019). Peer Respites: A Qualitative Assessment of Consumer Experience. Administration and Policy in Mental Health and Mental Health Services Research, 46(1), 10–17. https://doi.org/10.1007/s10488-018-0880-z
8. PEOPLe, Inc. (2011) Hospital Diversion Services: a manual on assisting in the development of a respite/diversion service in your area. Optum Health. https://power2u.org/wp-content/uploads/2018/01/OH-Hospital-Diversion-Manual.pdf

Diverting from Emergency Care

Individuals experiencing behavioral health crises often cycle in and out of emergency services.[1] Hospitals are acute forms of care that can be stigmatizing towards individuals suffering from SUD, particularly in an overwhelmed healthcare system. Peer respite, alternatively, is a more cost-effective and specialized approach to supporting individuals in crisis from behavioral health or SUD. In fact, longer stays at peer respite are associated with fewer hours of inpatient and emergency services.[2] Individuals that are already struggling with housing security can benefit from avoiding a costly trip to an emergency room and/or inpatient hospitalization, while partially alleviating the strain on hospital systems.

Better Outcomes with Peers

A randomized control trial found that a locked, inpatient psychiatric facilities had higher levels of follow-up dropout, poorer short-term improvement for psychiatric symptoms, and less reported satisfaction for patients civilly committed to this setting compared to those assigned to a crisis residential program entirely staffed with peers who were currently receiving mental health treatment.[3]

Reduced Medicaid Expenditures

Among Medicaid enrollees, clients who utilized peer respite housing were associated with reduced overall Medicaid expenditures and hospitalizations in contrast to a matched group (based on demographics and medical record characteristics) without peer respite utilization.[4]

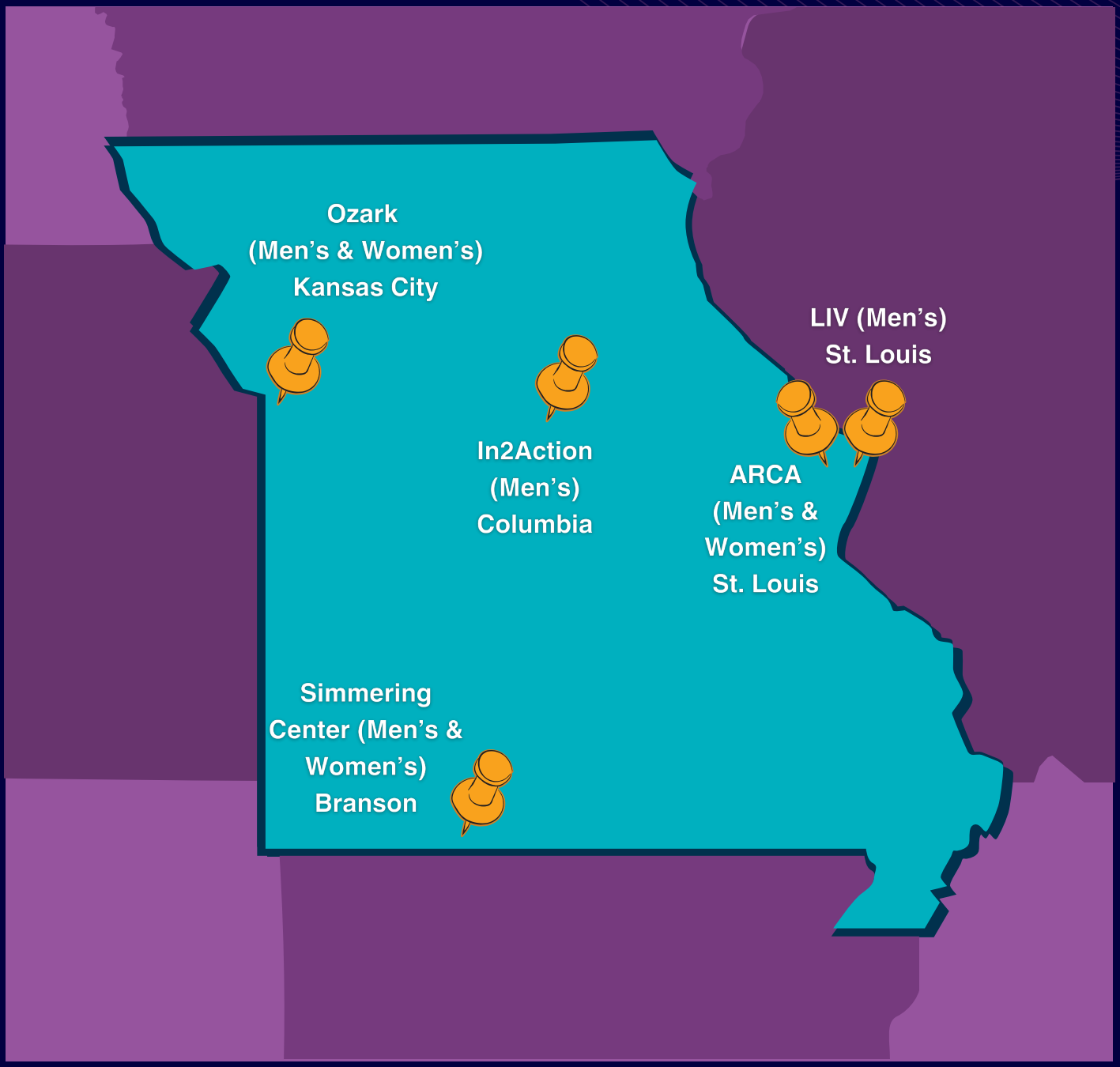
Reduced Hospital Utilization

Additionally, among guests at one peer respite, longer stays were related to fewer hours of (costly) inpatient and emergency services utilization; this effect plateaued starting after day 9 or 10, suggesting short-term stays maximized potential benefits of peer crisis /stabilization residency.[2]

1. PEOPLe, Inc. (2011) Hospital Diversion Services: a manual on assisting in the development of a respite/diversion service in your area. Optum Health. https://power2u.org/wp-content/uploads/2018/01/OH-Hospital-Diversion-Manual.pdf
2. Croft, B., & Ísvan, N. (2015). Impact of the 2nd Story Peer Respite Program on Use of Inpatient and Emergency Services. Psychiatric Services, 66(6), 632–637. https://doi.org/10.1176/appi.ps.201400266
3. Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A Randomized Trial of a Mental Health Consumer-Managed Alternative to Civil Commitment for Acute Psychiatric Crisis. American Journal of Community Psychology, 42(1–2), 135–144. https://doi.org/10.1007/s10464-008-9180-1
4. Bouchery, E. E., Barna, M., Babalola, E., Friend, D., Brown, J. D., Blyler, C., & Ireys, H. T. (2018). The Effectiveness of a Peer-Staffed Crisis Respite Program as an Alternative to Hospitalization. Psychiatric Services, 69(10), 1069–1074. https://doi.org/10.1176/appi.ps.201700451

Current Peer Respite Providers in MO

- 5 unique operations spanning rural and urban communities across the state



Current Respite Providers

AGENCY	LOCATION	PHONE NUMBER:
Assisted Recovery Centers of America (ARCA)	10208 W Florissant Ave, St. Louis, MO 63136	314-678-3205
Living in Victory (LIV) **"Transformation House"**	1426 Wright St. Louis, MO 63107	314-667-5255
In2Action **"Just One Respite House"**	2505 Eastwood Columbia, MO 65202	573-514-7596
Simmering Center	360 Rinehart Branson, MO 65616	417-234-1647
Ozark Recovery Housing **"Center for Respite & Recovery Service"**	7505 E 87th Kansas City, MO 64138	816-808-2233

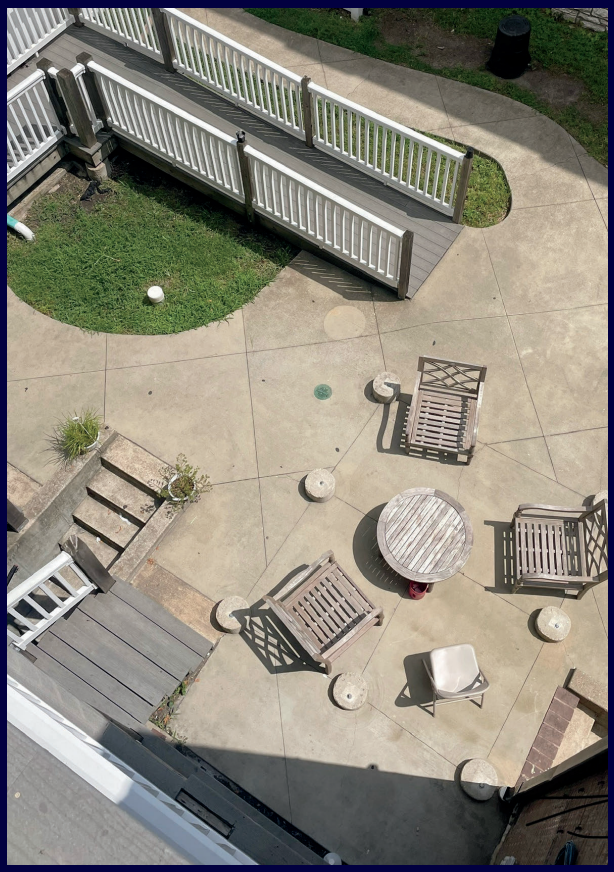
Services Provided:

- Three meals per day
- Laundry/shower
- Peer support
- Assessments
- Connection to treatment, including MOUD
- Connection to medical services or primary care
- Connection to other recovery support services
- Mental health services
- Connection to longer-term recovery housing
- Groups
- Pro-social activities
- Classes
- Employment assistance
- Care coordination/case management

*services vary by organization

A Look Inside

Photos from LIV



What to Expect

THE PARTICIPANT EXPERIENCE

Upon Arrival

Upon arriving at the peer respite center, participants undergo an initial intake process to assess their needs and develop a personalized care plan. This process typically involves completing necessary paperwork and brief assessments. To prioritize safety and well-being, the center implements protocols, including bed bug prevention measures and substance use screenings. Participants are assigned a peer mentor who provides orientation to the facility and its services.

Daily Routine

Participants at most peer respite centers follow a structured daily routine that promotes both stability and recovery. Engaging in group activities and peer support sessions fosters a sense of community and shared experiences. Individualized support from staff is available to address specific needs and goals. To enhance self-sufficiency, participants have opportunities to develop essential life skills through workshops on topics such as financial literacy and technology.

Support Services

The peer respite center offers a range of support services to assist participants in their recovery journey. Staff will assist residents in accessing healthcare such as MA and mental health services. Participants receive support in obtaining essential documents, such as identification and social security cards. Additionally, the center connects individuals with community resources, including housing, employment, and other recovery support services. Case management services are available to help participants develop personalized recovery plans and connect with appropriate resources.

Discharge Planning

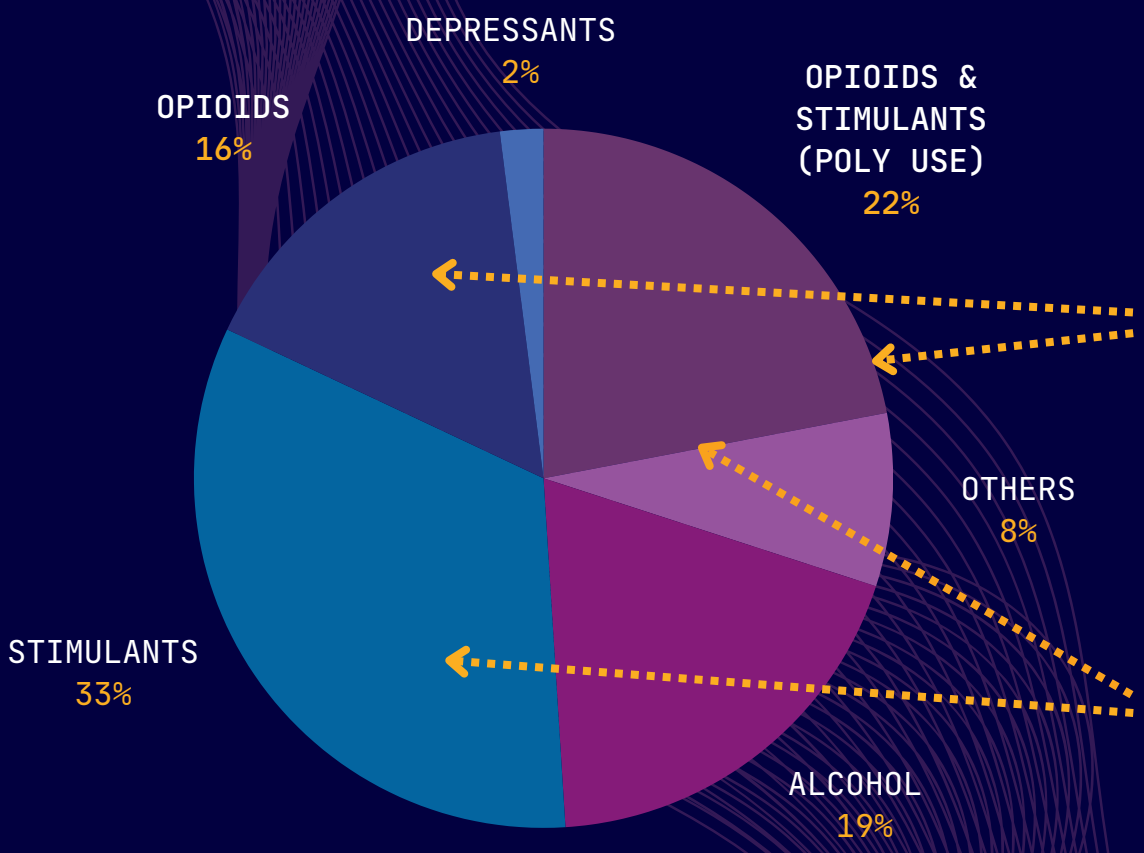
The peer respite center emphasizes a smooth transition to independent living through comprehensive discharge planning. Participants work collaboratively with staff to develop individualized recovery goals and identify suitable housing options. The center provides support in accessing recovery housing and connecting with ongoing recovery support services. By fostering a sense of empowerment and self-sufficiency, the program prepares participants for a fresh start.

Program Outcomes: Year One

Data collected from MO Peer Respite Providers
July 2023 - June 2024

In the first year of program implementation, peer respite providers served **1,401** unique individuals statewide.

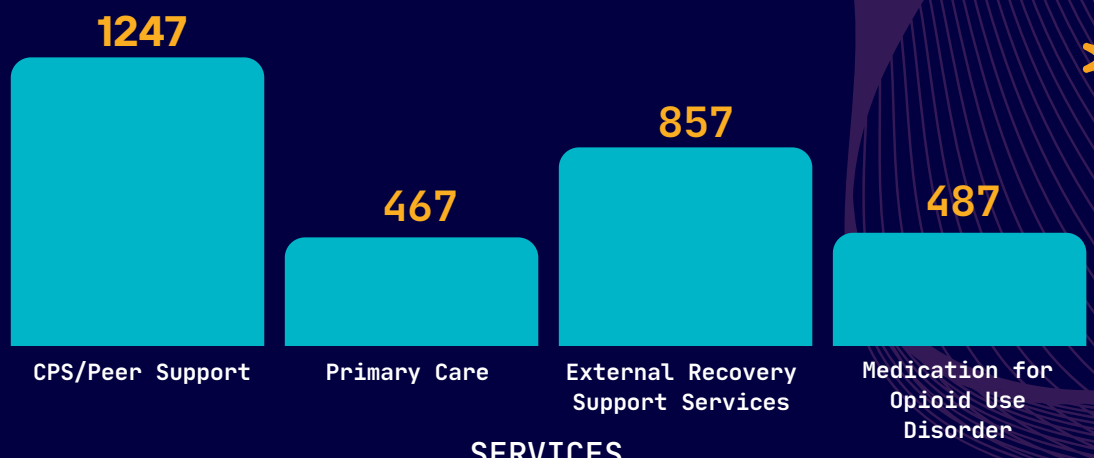
Primary Drug of Use



38%
Of participants said they used opioids

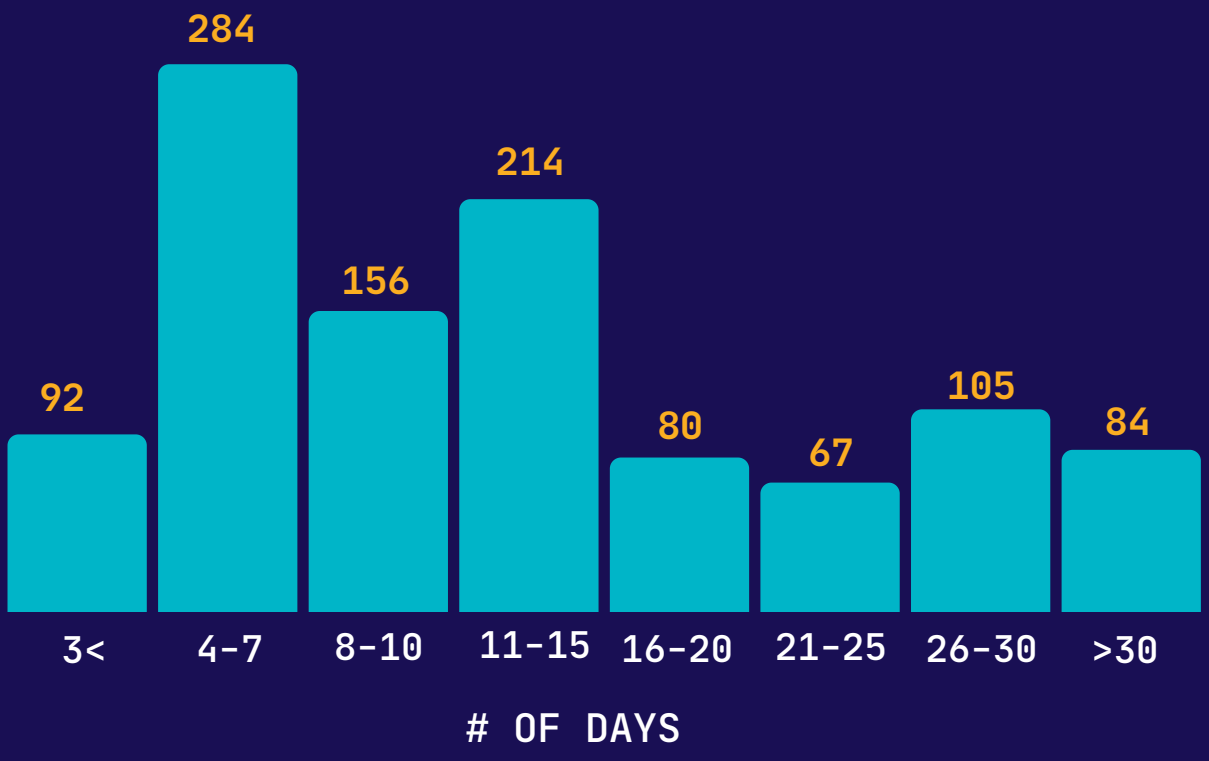
55%
Of participants said they used stimulants

Participants Connected to Services



3,058
connections to service have been made for respite participants

Length of Program Stay



- The most common length of stay in peer respite is between **4** and **7** days
- Two-thirds of residents stayed **15 days or fewer**

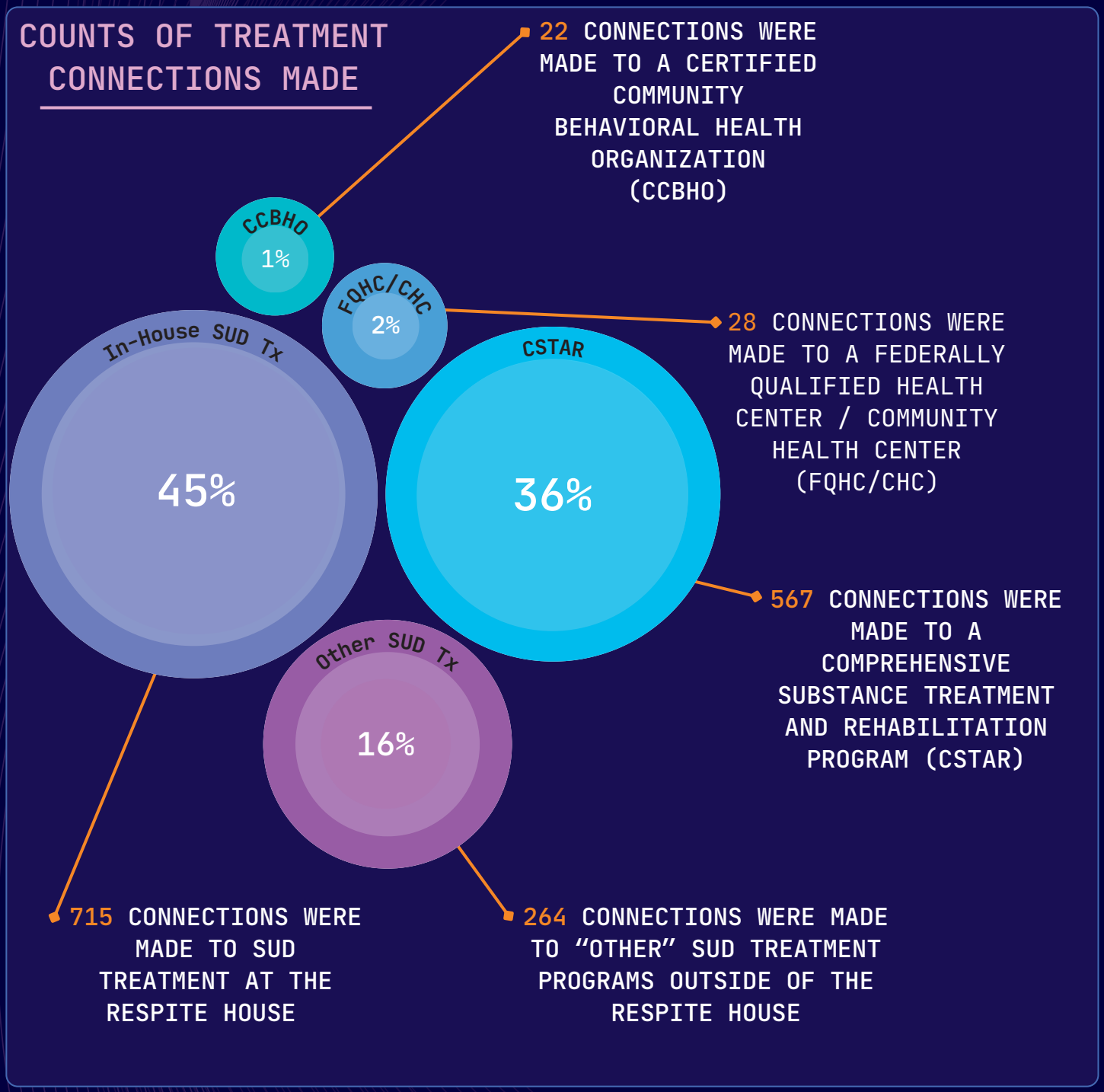
"Respite has helped me by giving me a safe and clean environment for me to focus on my recovery. It helped give me structure, self respect, and a sense of purpose. It gave me an opportunity to get my life on track... I never thought that by coming to this program that it would change my life in ways that it has!"

-Program Participant

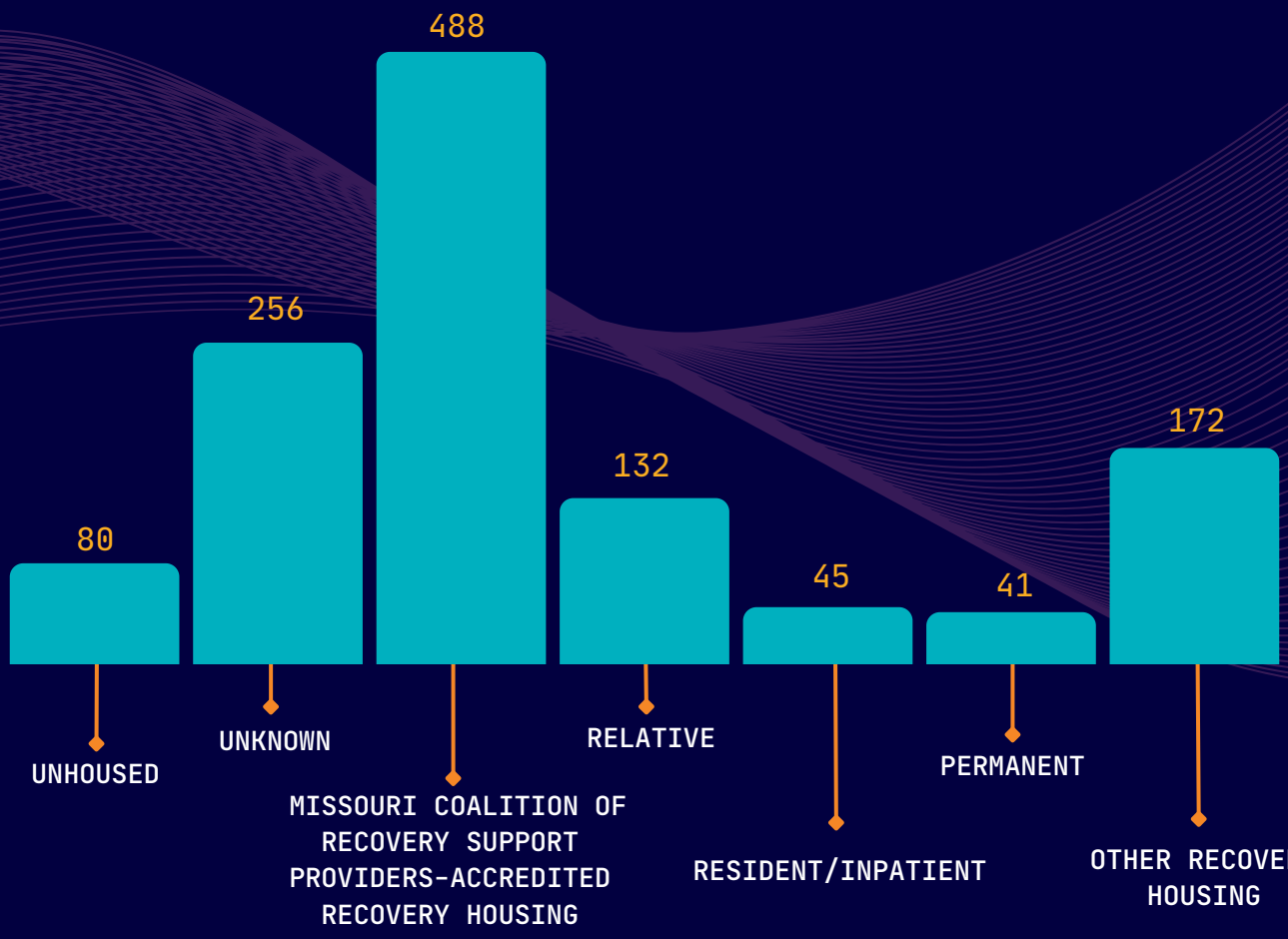
Connection to Treatment

- During their stay, residents were connected to a number of services to assist them in their recovery journey. including services with a Certified Peer Specialist/peer support worker, external recovery support services, primary care, and/or MOUD. Most connections to treatment were in-house at the peer respite center, followed by connections to CSTAR, then "other" SUD treatment.

- **65%** of program participants were connected to at least one service.



Count of Discharge Housing Outcomes



Upon discharge, the **majority of peer respite participants (58%)** transitioned to either recovery housing or treatment. **40%** transitioned to MCRSP-accredited recovery housing and **14%** to other recovery housing.

Over two-thirds of residents transitioned to a recovery house, moved in with a social support, or secured permanent housing of their own.

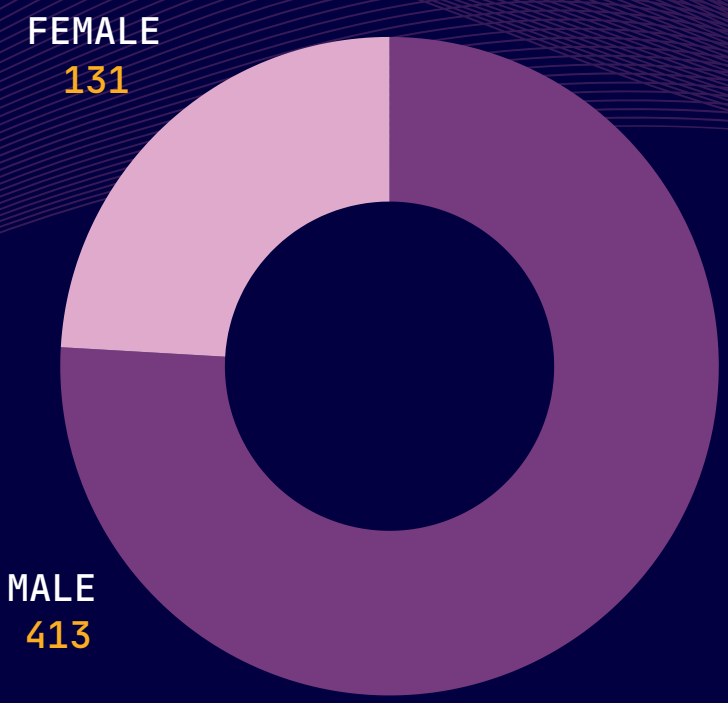
"Without Respite I would still be using and I wouldn't have the relationships with my family and I'd still be homeless."

-Program Participant

Client Demographics

Demographic data collected from April 2024-June 2024

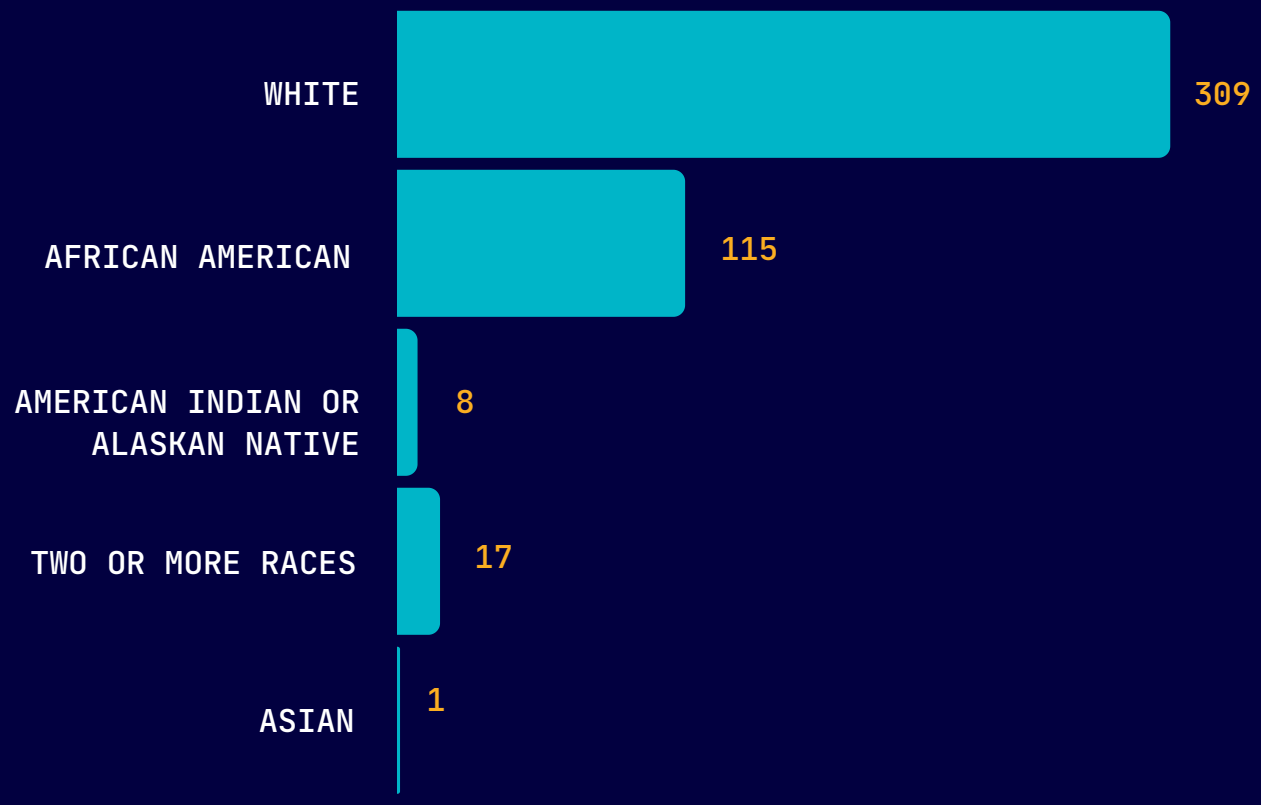
Count of Gender Receiving Services



Clients obtaining services span age, race, gender, drug of use, and previous housing status. Peer respite programs offer their services to those who need support, regardless of their identification.*

*LIV and In2Action are men only facilities

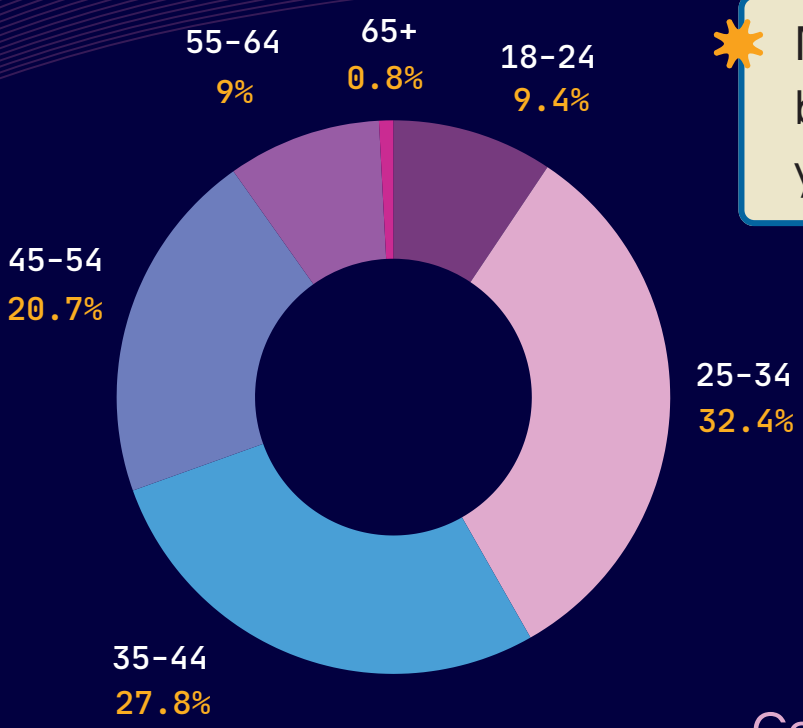
Count of Race Obtaining Services



Client Demographics

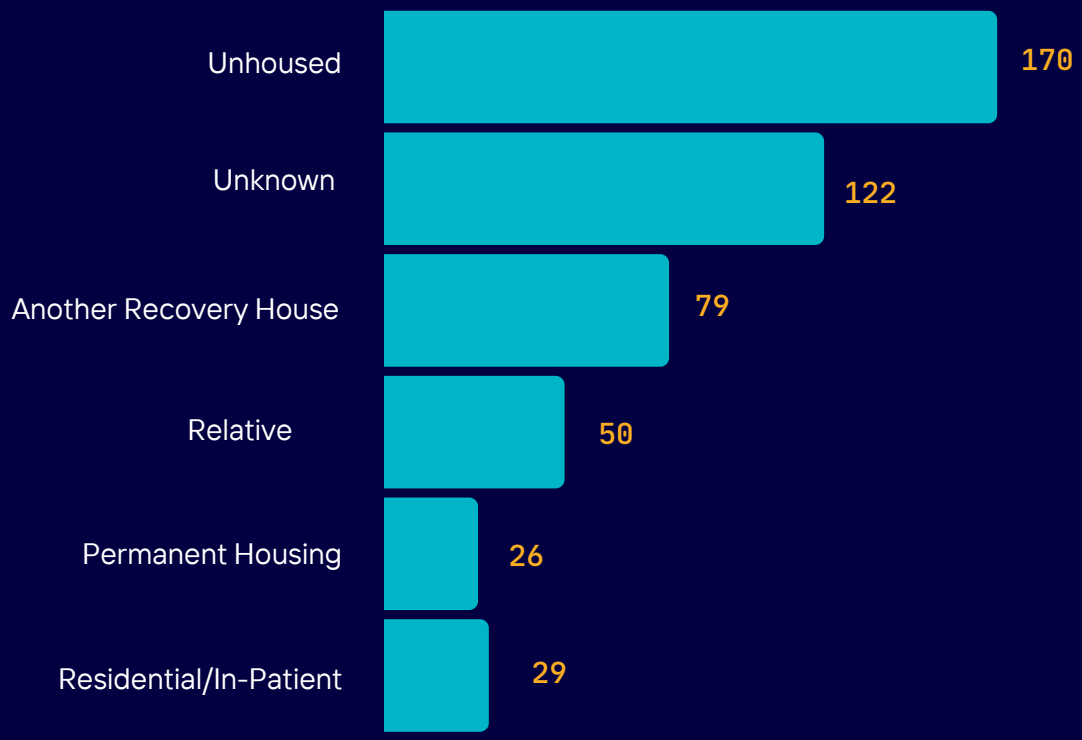
Demographic data collected from April 2024-June 2024

Count of Age Receiving Services



More than **80%** were between 25 and 54 years old.

Count of Prior Housing Status



35.7% of residents who received care from peer respite were previously unhoused

Moving Forward

In just one year, Missouri's Peer Respite Crisis Stabilization programs have demonstrated remarkable success in supporting individuals early in their recovery from substance use disorder.

Although originally funded as a one-time pilot initiative, due to positive outcomes from early findings and many stories of success, the state plans to continue funding to sustain these five vital programs through the State Opioid Response 4.0 grant, administered through DMH, and the Cannabis Tax Fund, through partnership with the MO Department of Health and Senior Services (DHSS).

Moving forward into the next fiscal year, the UMSL-MIMH Addiction Science Team will continue partnering with DMH, DHSS, and providers to further evaluate the effectiveness of these programs. Although there is still much to learn about how these programs are being implemented and delivered, so far they have shown tremendous promise as an innovative model of care for this population. As awareness and support of peer respite continues to grow, we anticipate expanded services and improved outcomes for individuals in crisis.

WE THANK OUR PARTNERS AT **ARCA, LIV, OZARK, IN2ACTION, AND SIMMERING CENTER** FOR THEIR ONGOING WORK IN SERVING OUR COMMUNITIES!

Acknowledgements

UMSL-MIMH Addiction Science Team staff:

Lindsey Vondras, MSW
Lindsey Pawlowski, MSW
Kyle Vance, B.A.
Nico Ruiz, B.A.
Maria Paschke, MPP
Brittany Blanchard, MPH, RN
Brandon Park
Rachel Winograd, Ph.D.

A special thank you to Rosie Anderson-Harper, Jesse Crum, and the Missouri Department of Mental Health

University of Missouri-St. Louis
Missouri Institute of Mental Health

1 University Blvd,
St. Louis, MO
63121

www.mimhaddisci.org

September 2024