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October 3, 2023

The Honorable John Velis
Chair, Joint Committee on Mental Health, Substance Use and Recovery
24 Beacon Street, Room 519
Boston, MA 02133

The Honorable Adrian Madaro
Chair, Joint Committee on Mental Health, Substance Use and Recovery
24 Beacon Street, Room 33
Boston, MA 02133

Dear Chair Velis, Chair Madaro, and members of the Joint Committee:

**Re: H.3602/S.1238, An Act establishing peer-run respite centers throughout the Commonwealth**

On behalf of the Massachusetts Association for Mental Health (MAMH), thank you for strong and steadfast leadership in advancing the health of people with behavioral health conditions and their families across the Commonwealth. I am writing to submit this testimony **in support of H.3602/S.1238, An Act establishing peer-run respite centers throughout the Commonwealth**, heard yesterday by the Joint Committee. These bills will help ensure that individuals experiencing mental health crises have access to voluntary, community-based, peer-driven services.

Formed over a century ago, MAMH is dedicated to promoting mental health and well being, while preventing behavioral health conditions and associated disability. We are committed to advancing prevention, early intervention, effective treatment, and research for people of all ages. We seek to eliminate stigma and discrimination and advance full inclusion in all aspects of community life. This includes discrimination affecting not only people with behavioral health conditions, but also people who face unequal burdens and barriers to the protections and benefits of citizenship due to their race, ethnicity, gender identity, or disability status. MAMH has a demonstrated track record of furthering its mission by convening stakeholders across the behavioral health and public health communities; disseminating emerging knowledge; and providing subject matter expertise to inform public policy, service delivery, and payment methodologies.

***Bill establishes a statewide network of peer run respites***

MAMH supports the requirement in **H.3602/S.1238** for the creation of a minimum of 14 peer-run respites, including two LGBTQIA+ peer-run respite pilots. The respites would be funded and regulated by the Department of Mental Health, which also would be required to report annually regarding implementation.

***Peer-run respites offer voluntary, community-based, trauma-informed care provided by people with lived experience in a home-like environment***

Peer respites, as defined in the bill, are voluntary, short-term residential programs that provide community-based, trauma-informed, person-centered support and prevention on a 24/hour basis in a homelike environment to adults experiencing emotional or mental distress. At these respites, peer supporters would offer peer support and peer respite services. Peer respite services are designed to promote individual freedom, be culturally competent, and focused on recovery, resiliency, and wellness. The respites themselves would be operated by peer-run organizations.

Peer-*run* respites, as defined in the bill, are peer respites operated by "a non-profit entity that is controlled and operated by individuals with psychiatric histories and/or have faced and navigated other life-interrupting challenges and which provides a venue for support and advocacy for individuals who experience similar struggles."

The first clearly peer-run respites in the United States opened in New Hampshire in 1997, followed by one in New York in 2001.[1] Today, peer respites are spreading across the United States and internationally.[2]

***The bill would establish 14 peer-run respites filling a gap in our continuum of care and providing geographic equity***

Massachusetts currently has three peer-run respites, but they are unable to meet demand or serve all geographic regions. Our peer-run respites, contracted by the Department of Mental Health, are located in: Northampton (Afiya House, run by Wildflower Alliance, with three bedrooms); Worcester (Karaya, run by Kiva Centers, with six-bedrooms); and Bellingham (Juniper, run by Kiva Centers, with four-bedrooms). The remainder of the state has no peer-run respites.

To be useful as a diversionary tool, peer respites must be geographically accessible. Individuals often bring themselves to these locations and often do not have the resources to travel beyond one's local region. Otherwise, respites cannot serve as alternatives to hospital-based care.

[1] Washington State Health Care Authority, Peer Respites (Jan. 2023), https://www.hca.wa.gov/assets/program/peer-respites-factsheet-2023.pdf.
[2] Lauren Spiro, *Peer Respite: Why It Should be Everyone's Concern*, MAD IN AMERICA (Oct. 19, 2021), https://www.madinamerica.com/2021/10/peer-respite/.

Further, the concept of peer respites is that these homes are located in the community in which the person lives, allowing guests to remain connected to community-based supports and services. This is particularly important given that peer respites are not locked facilities, but homes which people may freely leave, in the course of stay, to engage with their community and meet ongoing responsibilities.

For these reasons, it is essential that we locate respites where people live, work, and receive care. Establishing respites across the Commonwealth would help reach that goal.

***Peer respites serve to divert people from hospital emergency rooms and psychiatric units***

Peer respites fill a gap in our state's continuum of care for people with mental health needs. Peer respites are places that people can go when experiencing a mental health crisis, where they can be empowered to explore themselves and develop new, healthier ways of relating with others. Peer respites may be used as a diversion from hospital emergency rooms and inpatient psychiatric units. Peer respites offer a non-coercive, home-like, trauma-sensitive setting in the community where individuals may be assisted through the crisis. Typically, stays are for up to 7 days.

***This bill fills a gap in services for people who identify as LGBTQIA+***

This bill would establish two peer-run respites for people who identify as LGBTQIA+, filling a substantial need.

4.5% of the U.S. population identifies as lesbian, gay, or bisexual[3] and, of those, 39% reported having a mental illness in the last year.[4] Research suggests that LGBTQ+ individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBTQ+ persons has been associated with high rates of psychiatric disorders, substance abuse, and suicide.[5]

The risk for people who identify as transgender is even more substantial. Forty-eight percent of transgender adults report that they have considered suicide in the last year, compared to 4 percent of the overall US population.[6]

Wisely, this bill would require that the LGBTQIA+ peer-run respites be managed, operated, and controlled by individuals identifying as members of the LGBTQIA+ community who also have psychiatric histories or related lived experience.

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[3] Lisa F. Platt *et al., Patterns of Mental Health Care Utilization Among Sexual Orientation Minority Groups*, JOURNAL OF HOMOSEXUALITY (2017), https://sci-hub.se/10.1080/00918369.2017.1311552.
[4] Newport, F. (2018, May 22). In U.S., estimate of LGBT population rises to 4.5 percent. Gallup. https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx.
[5] Office of Disease Prevention and Health Promotion, Lesbian, Gay, Bisexual, and Transgender Health (2016), https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health.
[6] National Center for Transgender Equality, The Report of the 2015 U.S. Transgender Survey (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

***Research shows the substantial benefits of peer respites***

A growing body of research shows benefits in diverting individuals in crisis to peer respites, both in terms of improved well-being and reduced cost of care.[7]

A number of studies show improved personal outcomes. A 2002 study using a random design investigated outcomes for 265 participants having or not having access to a New York State peer respite, the Crisis Hostel. Researchers found that respite guests experienced greater improvements in self-esteem, self-rated mental health symptoms, and social activity functioning compared to individuals in inpatient facilities.[8]

A 2008 randomized controlled trial found improvements in self-rated mental health functioning and satisfaction for peer respite users as compared to users of psychiatric hospitals.[9] The researchers found statistically significant improvements in healing, empowerment, and satisfaction.

A 2011 study evaluated the impact of a peer-run hospital diversion program on mental health consumers' recovery, comparing the consumers' experience of environment, services, and staff with a non-peer-run acute inpatient program and assessing their evaluation of services received in both settings. A sample of 39 mental health consumers rated the quality and type of services they received in the peer-run versus non-peer-run programs, and their beliefs about the impact of these services on their recovery and life satisfaction. The results indicate that services at the peer-run programs were more client-centered and less restrictive than services at non-peer-run programs. Peer staff were viewed as more respectful. Respondents reported feeling decreased stigma due to mental illness after receiving services from the peer-run programs, as well as good life satisfaction and social involvement levels.[10]

A 2018 qualitative study involved interviews with 27 respite guests at two peer respites near the end of their stay and at 2–6 months following their stay. Most participants appreciated the lived experience of the respite staff and often found the respite staff to be good role models for

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[7] For a comprehensive list of research, see https://livelearninc.net/respite-research.

[8] Findings From a Consumer/Survivor Defined Alternative to Psychiatric Hospitalization. Adapted from the NASMHPD Research Institute Conference Presentation by Jeanne Dumont, Ph.D. and Kristine Jones, Ph.D. February 13, 2001, Outlook (Spring 2002), https://legislature.vermont.gov/Documents/2018/WorkGroups/House%20Health%20Care/Bills/S.133/S.133~Wilda%20White~Findings%20from%20a%20Consumer-Survivor%20Defined%20Alternative%20to%20Psychiatric%20Hospitalization~4-7-2017.pdf.

[9] T.K. Greenfield *et al*., *A Randomized Trial of a Mental Health Consumer-managed Alternative to Civil Commitment for Acute Psychiatric Crisis*, AMERICAN JOURNAL OF COMMUNITY PSYCHOLOGY (2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2782949/.

[10] Michael J. Bologna & Richard T. Pulice, *Evaluation of a Peer-run Hospital Diversion Program: A Descriptive Study*, AMERICAN JOURNAL OF PSYCHIATRIC REHABILITATION (2011), https://sci-hub.se/https://doi.org/10.1080/15487768.2011.622147.

recovery.[11] A 2021 qualitative study of the experiences of 20 peer respite guests found that peer respites strengthened self-reliance and social connectedness and offered a viable alternative to traditional crisis services for some people some of the time. The results suggest potential "key ingredients" for peer respites, including a homelike environment, voluntary and self-determined supports, and peer support staff who possess the capacity for developing healing and genuine connections with guests while also promoting shared responsibility and self-reliance.[12]

Other studies have shown cost savings. The 2008 study by Greenfield and colleagues cited above found that average psychiatric hospital costs of $3187 were reduced to $1057 for people who used peer respites.[13]

Additionally, an evaluation of stays between May 2011 and December 2014 at Second Story, a peer respite in Santa Cruz County, California, found that 70% of respite guests were less likely to use emergency or hospital inpatient services than those in the comparison group. The researchers further concluded that peer respites could lead to a reduction in overall service costs as well as decrease the reliance on more coercive modes of treatment.[14]

Likewise, a 2013 study tested the hypothesis that peer-run respites lower system costs through reductions in inpatient and emergency care by comparing 141 individuals who used peer-run respites with a comparison group who did not, over a two-year period between May 2011 and June 2013. Findings suggested that the peer-run respite model may be an effective alternative to traditional crisis services. The researchers concluded that

> Expanding the availability of the peer-run respite model in community mental health systems could lead to reductions in overall service costs, particularly through the decreases in the use of costly inpatient and emergency services. Respites may have the potential to reduce costs while also increasing meaningful choices for recovery and

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[11] Elizabeth Siantz *et al*., *Peer Respites: A Qualitative Assessment of Consumer Experience*, ADMINISTRATION AND POLICY IN MENTAL HEALTH AND MENTAL HEALTH SERVICES RESEARCH (2018), https://sci-hub.se/10.1007/s10488-018-0880-z. Some respondents were uncomfortable receiving services from peers, and several guests did not want to leave after their stay leading researchers to suggest a "need to clarify and add structure to the roles of peer providers delivering care in community mental health settings … [and] a need to create and clarify ground rules at the beginning of a given groups' respite stay, as has been done by consumers of previous peer-based services previously. Service providers who connect consumers with peer respites should also be clear on what respites are, so that potential respite guests know what to expect, and whether a respite would be a therapeutic place for them. Id.

[12] Bevin Croft *et al*., *Self-reliance and Belonging: Guest Experiences of a Peer Respite*, PSYCHIATR. REHABIL. J. (June 2021), https://pubmed.ncbi.nlm.nih.gov/32597667/. The researchers noted that some guests endorsed the peer respite as a temporary break from stressful life situations, a homelike space for mutual support and community, and a preferred alternative to traditional crisis services, while others struggled with the unstructured environment and expectations for shared responsibility and self-reliance. *Id.* Hence the recommendations for "key ingredients" for respites to be successful.

[13] Greenfield *et al., supra* note 9.

[14] Human Services Research Institute, Mixed Methods Evaluation of a Peer Respite Program, https://www.hsri.org/project/mixed-methods-evaluation-of-a-peer-respite-program.

decreasing the mental health system's reliance on more coercive, less person-centered modes of service delivery.[15]

Finally, an October 2018 study of peer-staffed respites in New York State examined the effect of respite use on emergency department visits, hospitalizations, and Medicaid expenditures. The researchers used Medicaid enrollment and claims data for the period January 2009 through April 2016 and included a study sample of 401 peer respite guests and 1,796 members of the comparison group. The study found that Medicaid expenditures were an average of $2,138 lower per month, and there were 2.9 fewer hospitalizations for peer respite guests than for the comparison group.[16]

The use of peer-run respites are well-supported in clinical literature. They are working in Massachusetts already, diverting people in behavioral health crisis from our overburdened inpatient hospital system. However, our need vastly outstrips our number of beds. For all the above reasons, MAMH urges you to report these bills out favorably.

Thank you for your consideration.

Sincerely,

Danna Mauch, Ph.D.
President and CEO

c: Rep. Lindsay Sabadosa
Rep. Smitty Pignatelli
Sen. Joanne Comerford

[15] Bevin Croft *et al*., *Service Use Implications of a Peer-Run Respite Program*, Human Services Research Institute (2013), https://power2u.org/wp-content/uploads/2017/01/Croft-APHA-110513.pdf.
[16] Ellen E. Bouchery *et al*., *The Effectiveness of a Peer-Staffed Crisis Respite Program as an Alternative to Hospitalization*, PSYCHIATRIC SERVICES (Oct. 2018), https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201700451.