Peer Respite

Central Maryland Feasibility Study Recommendations Report

September 2023

Behavioral Health System Baltimore

Acknowledgments

This document was produced for Behavioral Health System Baltimore, Inc. (BHSB) by On Our Own of Maryland, Inc., Promise Resource Network, Inc., and TBD Solutions, LLC with funding from the Behavioral Health Administration (BHA), Maryland Department of Health (MDH).

Appreciation

The authors would like to express their profound gratitude to the hundreds of Marylanders, peer support professionals, and peer respite operators across the country who shared their time, talents, and thoughtfulness with us throughout this study. We are continually inspired by your visionary leadership and dedicated service toward our collective recovery.

Recommended Citation

Behavioral Health Services Baltimore. (2023). *Peer Respite: Central Maryland Feasibility Study Recommendations Report.* Author.

Table of Contents

Executive Summary

In Fall 2022, Behavioral Health Systems of Baltimore (BHSB) released a Request for Proposals to conduct a feasibility study on developing and incorporating peer-run respite into the behavioral health crisis continuum of the Central Maryland region as defined to include Baltimore City, Baltimore County, Carroll County and Howard County.

On Our Own of Maryland (OOOMD), Maryland's statewide, peer-run education and advocacy organization, was awarded the consulting contract, and partnered with two organizations with particular subject matter expertise: Promise Resource Network (PRN) regarding peer support services and peer respite operations, and TBD Solutions (TBDS), regarding clinical crisis services design and delivery. This collaboration is referred to as the PRS Project Team in this report.

The study included a landscape analysis of the current array of crisis services and access to care, including data analysis of crisis service utilization, cost, and outcomes; a robust stakeholder engagement process to solicit community feedback through structured interviews, focus groups, community presentations, and on-site visits to regional service providers; and industry research on best practices in peer respite operations, including site tours of five peer respites in three states.

Stakeholders in the Central Maryland region were found to generally hold a positive view of the effectiveness, importance, and feasibility of peer respite. This mindset may stem from decades of progress in raising awareness and expansion of peer support practices and programs through a longstanding network of independent peer-operated organizations, a recognized statewide peer support certification credential, recent expansion in the role of peer support specialists in clinical settings, and increased need for non-clinical and/or non-licensed professionals to provide help amidst increased demand and behavioral health workforce shortages.

Based on the information gathered through the feasibility study, the PRS Project Team recommends the development of 5 peer respites across the Central Maryland region over the next 10 years, starting in Baltimore City. With full implementation, these peer respites may ultimately achieve a potential cost savings of up to $36M through effective hospital diversion of up to 2,000 individuals each year across the region.

Feasibility Considerations

The Central Maryland region demonstrates multiple favorable indicators for feasibility for peer respite:

- The region has sufficient demand and unmet needs for additional and alternative crisis-responsive services such as peer respite, as evidenced by population density, ED/crisis services use, and hospitalization rates.
- Stakeholders of diverse perspectives within the behavioral health system support peer respite, as shared in survey responses, focus groups, and key informant interviews.

- Operator capacity exists thanks to long-standing peer-operated organizations and a well-developed peer workforce.
- Peer respites can address state and regional goals, such as strengthening crisis response and reducing reliance on 911, law enforcement, and emergency departments.

However, several challenges to immediate implementation were also recognized:

- Lack of familiarity with the peer respite model and its non-clinical approach to crisis support will require extensive education and engagement of stakeholders throughout and beyond the behavioral health system to build trust, partnership, and promotion of peer respite services.
- Securing appropriate and sustainable funding will require visionary leadership and strategic advocacy, particularly considering Maryland's projected structural state budget deficit and other needs, projects, and priorities within the public behavioral health system.
- Peer-operated organizations in Central Maryland are under-resourced and over-stretched, and will require investment in capacity building before adding peer respite to their operations.

Key Components for Peer Respite Success

Peer respite is not simply a service, but a paradigm-shifting way of thinking about and being in relationship with people who are experiencing emotional distress. Peer respites should only be developed at the speed at which champions can be identified and supported, capable operators can be developed and equipped, sufficient and sustainable funding can be secured, ideal properties can be obtained and curated, and well-qualified staff can be hired and trained. All elements of the peer respite must be consistent with a healing and restorative approach, minimizing hierarchical structures and embracing holistic healing.

System Integration: Peer respite should be understood as a critical but complementary component of multi-service and multi-system engagement. Respites should be located within an array of peer-operated and/or peer-staffed recovery support services like warmlines, drop-in Wellness & Recovery Centers, and other services that support the individual in their full recovery. The number of peer respites and total beds in any community or jurisdiction should be responsive to unmet needs for behavioral health crisis support and local capacity considerations (ex: zoning, operating entities).

Location and Amenities: Property features and location should be identified with the same intention of a homebuyer, with a building design and property style that aligns with the peer respite values of hospitality, dignity, peace, and community. Respites should have adequate private bedrooms and communal space, be easily accessible by public transportation with adequate parking for guests and staff, and reasonably near to community resources such as health services and retail businesses.

Community Engagement: Effective peer respite development requires a committed group of champions in each community where they are built, with a torch carrier equipped with passion, knowledge, and resources to build lasting relationships and navigate challenges with stakeholders. Neighborhood relationships are critical, and so implementation plans must allow adequate time for introductory meetings with neighbors and community partners to establish relationships, learn about the neighborhood, and educate them about peer respite and its intended benefit for the community.

Access: As a low-barrier resource, considerations for respite guest stay requests should be modeled on a "yes, and" approach, with the goal of welcoming guests through voluntary, self-directed access and with sensitivity to guests who may face barriers or be unable to access other types of crisis support services.

Operator Capacity: Independent, nonprofit, peer-operated organizations with an existing program array are the preferred provider type for respite programs, as their structure ensures consistency of mission, capacity for service delivery, and accountability to lived experience at every level of operation. Entities wishing to open peer respites must balance the values and ethics of peer support with the realities of 24/7/365 business operations.

Key Performance Indicators (KPI): Aligned with respites' intentionally small size and focus on quality at the individual level, KPIs should be focused on the guest experience, with surveys and feedback mechanisms to gauge ease of access, feelings of safety and comfort during the stay, impact on intensity of emotional distress and future hopefulness, successful connection(s) to community-based recovery support resources, and likelihood for future use for self or as recommended to others. Population-level impact and estimated cost savings can be calculated based on reported successful diversion from hospital-based services or other crisis programs.

Funding: Peer respites are able to function most effectively when funded outside of a 'medical model' framework, which typically requires process elements (ex: assessments, diagnosis) that are antithetical to peer respite values and operating principles. Developing a blended funding stream of public and private funding provides flexibility for the operators and acknowledges the benefit of peer respite to multiple service systems and the community at large.

Project Overview

In 2021, the Maryland Health Savings Cost Review Commission (HSCRC) awarded a $45 million, 5-year Regional Partnership Catalyst Program grant to the Greater Baltimore Regional Integrated Care System (GBRICS) Partnership convened by Behavioral Health System Baltimore (BHSB), which serves as the Regional Administrative Manager for the project. The mission of the GBRICS Partnership is transforming behavioral health crisis services and infrastructure across Baltimore City and Baltimore, Carroll, and Howard Counties, aiming to expand access and reduce unnecessary Emergency Department (ED) use and police interaction of people experiencing a behavioral health crisis.

Aligned with this goal, BHSB published a Request for Proposals in Fall 2022 for a feasibility study exploring how peer respites could be added to the array of crisis prevention, diversion, and response to individuals experiencing a behavioral health related crisis in the Central Maryland region. On Our Own of Maryland, in partnership with Promise Resource Network and TBD Solutions, was selected to conduct a multi-faceted analysis, including:

- evaluating how various peer respite models can reduce reliance on law enforcement, 911, and EDs;
- conducting a needs assessment including stakeholder engagement, environmental scan, and services utilization data; and
- submitting a subsequent set of recommendations for peer-run respite, inclusive of a model business plan for implementation in the Central Maryland region.

Study Partners (PRS Project Team)

On Our Own of Maryland (OOOMD) is a statewide peer-operated behavioral health advocacy and education organization which promotes equality, justice, autonomy, and choice about life decisions for individuals with mental health and substance use needs across Maryland. For more than 30 years, OOOMD has coordinated a network of affiliated, independent, peer-operated nonprofits which provide direct peer support and resource navigation services in diverse communities across the state. Other OOOMD projects include training, technical assistance, public education, and advocacy initiatives.

Promise Resource Network (PRN) is a peer-operated organization based in North Carolina that offers 18 programs, including a 24/7 peer-run respite and a 24/7 peer phone, text and chat line. In addition to providing direct services to people experiencing mental health and substance use related distress and/or crisis, the agency provides consultation, training and technical assistance and advances social justice through statewide, national, and international policy efforts.

TBD Solutions (TBDS) is a behavioral health consulting, training, and research firm serving a national clientele of public and private agencies at the provider, payer, and administrative levels. TBDS specializes in assessing and enhancing behavioral health crisis services, promoting person-centered, accessible, and outcomes-driven care.

Study Methodology

This report includes the project methodology and all relevant activities conducted from December 2022 – June 2023. The PRS Project Team employed a multimodal approach to gather and analyze quantitative and qualitative data, including:

Stakeholder Engagement: Virtual and in-person focus groups, survey, interviews, and presentations educated 300+ stakeholders about the peer respite model and solicited insights from a variety of perspectives.

Industry Research: Literature on peer respite models and effectiveness dating back to 2009 was reviewed for applicability to the Central Maryland region. Stakeholders from across the region joined the PRS Project Team for site visits to 5 respite programs on the East Coast: Miele's Respite of Transitional Services New York Inc. in Queens, NY; Community Access in Manhattan, NY; Kiva Centers' Karaya Respite in Worcester, MA, and Juniper Respite in Bellingham, MA; and Promise Resource Network's Retreat at the Plaza in Charlotte, NC.

Landscape Analysis: The region's crisis continuum was compared to nationally-defined best practices. The PRS Project Team reviewed and analyzed population demographics and public health data, insights from key informant interviews, and regional behavioral health crisis and emergency psychiatric services utilization, readmission, cost, and satisfaction rates.

Environmental Scan: The region's network of peer communities, peer support services, and peer-operated organizations were surveyed. Relevant workforce development factors, findings from recent studies on peer services, and recent expansion toward Medicaid reimbursement for crisis response and peer support services were considered.

Feasibility Assessment and Recommendations: Capacity building strategies and a model business plan for development of peer respite programs in the region are provided via this final report.

Peer Respite Model Overview

Peer Respite Model Overview

Peer respites are short-term, low-barrier, voluntary crisis alternatives that offer 24/7 peer-delivered, non-clinical, non-coercive support services in a homelike setting.

While individuals experiencing any type or intensity of behavioral health crisis will benefit from respite, they are uniquely well-positioned to serve individuals who are not eligible, not well-served, or rejected by traditional programs. Peer respites help address a gap in crisis care through their capacity to serve people with multiple behavioral health and concomitant needs through extraordinarily highly trauma-informed supports and settings.

Access to peer respite can prevent and avoid unnecessary psychiatric hospitalization of people at risk of or experiencing a behavioral-health-related crisis, regardless of diagnosis or insurance status.

Key Characteristics

Compared with other types of crisis residential programs, important distinguishing characteristics of peer respite include the following, with each component explored in greater detail in this section:

Access: Using a respite is necessarily voluntary and non-coercive; an involuntary or forced respite stay is unacceptable. Individuals can self-refer or may be connected to the respite through relationships with community organizations, outpatient providers, or crisis services. These supporters act as messengers to share information about the option of respite, not gatekeepers with the right or responsibility to refer. Determining fit for the respite is centered in the individual's self-defined state of crisis, their agreement to respect the space and uphold a safe and healing-centered environment for self and others, and their ability to manage their personal care during the respite stay. Eligibility is not based on diagnosis, symptom assessment, medical necessity, insurance, or socioeconomic status. The process of exploring and accessing respite involves clear communication of mutual expectations and collaborative agreement between the respite staff and the individual guest. There is generally no direct cost to the individual.

Length of Stay: Length of stay can range from 3 to 28 days, with a national average of 7 to 14 days. Length of stay is determined by the individual and can be ended early if desired or extended if warranted, subject to the operating guidelines of the particular respite and any extenuating circumstances. Guests have the freedom to come and go within and outside of the respite at their preference.

Location and Amenities: Respites typically operate in a house-like residential building within a neighborhood, and are fully furnished akin to a vacation rental property. Common areas located inside and outside the home are designed with trauma-informed principles and feature comfortable and soothing decor. Each guest has a private bedroom that can be locked from the inside, which may be equipped with features like a minifridge or room safe for personal belongings.

Staffing: Peer respites are staffed and operated by people who themselves are survivors of suicide attempts, psychiatric commitments, behavioral health crises, and other trauma-related experiences, and who are specially trained (often certified) to offer individualized peer support services to respite guests. Staff have personal experience and receive intense training in peer support skills and tools, particularly around trauma, suicide, and hearing distressing voices. Respite staffing patterns do not include clinically-licensed or medical providers.

Services: Peer support services are the heartbeat of the respite, and are typically practiced in 1:1 or small group support sessions within the respite. Additional services might include self-help skill development (using peer-developed models such as Wellness Recovery Action Planning), wellness and nervous system regulation practices (e.g. journaling, walking, yoga, drumming), and community resource navigation to support guests in the next step of their healing journey. Respites should be integrated into a continuum of peer support services in the local community, which allows guests to access an array of programs such as drop-in centers, warmlines, virtual offerings, housing access, employment support, etc. While peer respites often maintain strong relationships with clinical service providers for bi-directional linkages, active collaboration with clinical services during a respite stay is only and always at the sole choice and direction of the individual being supported.

Safety through Mutual Accountability: The most common question asked about peer respite is how safety can be maintained with individuals experiencing heightened states of emotional or mental health distress without the use of locked spaces, medication requirements, or search-and-seizure protocols for items often considered 'dangerous' (e.g. sharps, shoelaces, belts, etc.). Safety is maintained collectively by all the people at the respite, using peer support strategies to work through distress, conflicts, and solutions. Features that support respite culture include both the quality of the physical environment (pleasing, comfortable, and peaceful), and the presence of 24/7 peer support that upholds individual autonomy and choice with non-hierarchical mutuality between staff and guests. 'Safety risks' like the expression of suicidal or self-harm thoughts, anger and frustration, or beliefs and experiences of alternate realities are reframed as opportunities for connection, mutual support, and exploring personal meaning-making through the crisis experience.

History and Evidence

Practices of mutual aid and shared healing have been alive and well for the whole of human history, and intentional communities of retreat, rest, reflection, and reconciliation have emerged in multiple religious, cultural, and secular communities.

The recognized origins of two models of modern crisis alternatives — peer respite and residential crisis services — date back to 1971, when psychiatrist Loren Mosher founded the Soteria Research Project. The cornerstone of this research was Soteria House, a therapeutic housing community that served people between the ages of 18 and 30 who had recently been diagnosed with schizophrenia. The house was designed as a calming space informed by the values of autonomy, shared and personal responsibility, minimization of hierarchy between persons serving and persons served, and a reframe of psychiatric medication from being viewed as essential to an option. During the research project, individuals were randomly assigned to a psychiatric hospital or to Soteria House, which was staffed primarily by artisans and paraprofessionals with a penchant for connection and a high distress tolerance. Medications were prescribed to only 12% of the individuals at Soteria, yet treatment outcomes were superior to those that were assigned to the hospital setting.

Accounts of peer respite variations within indigenous communities have also been dated back to the 1970s. As with many culturally-centered practices, knowledge of their existence has been passed down verbally but has not been widely included in historical accounts. Similarly, unofficial houses of refuge for LGBTQ+ individuals have been operated by and for this community in many cities in response to family rejection, social oppression, and targeted violence.

Within the behavioral health service system landscape, the first widely documented precursor to peer respite in the United States was The Crisis Hostel, founded in 1993 in Ithaca, NY. Although not peer-run, The Crisis Hostel represented a significant departure from the way mental health crisis is viewed and people experiencing it were understood and treated. Established “to provide individuals with a consumer-controlled option for managing or working through a crisis while they live in community with others,” the program design maximized individual power and personal responsibility within a supportive environment guided by a non-hierarchical model of mutual aid.

Guiding Principles of The Crisis Hostel (1993)

- People ought to be able to experience a crisis situation with the least possible disruption to their daily routine and existing support system.
- People, even in crisis, are capable of making decisions and choices for themselves.
- There are decision making, negotiating, and living skills which can be taught, modeled, and/or supported while people are living through a crisis.
- Help is best received when there is reciprocity between help givers and receivers.

In 1995, the first truly peer-run respite, Stepping Stones, opened in Clairmont, NH under the leadership of renowned international recovery pioneer Shery Mead. Building on the values of The Crisis Hostel, Stepping Stones was designed, operated and led entirely by people that had been directly impacted by labels of mental illness who had also experienced psychiatric hospitalization and other service system involvement. In 2001, the peer-operated organization People USA launched their first Rose House respite program in New York, which has inspired subsequent replication across the United States and internationally.

Over the last two decades, peer respites have expanded largely in communities with a socially progressive approach to caring for their citizens and/or a strong network of peer advocates and peer support services, such as southern California and along the East Coast (New Hampshire, Massachusetts, New York, New Jersey, Georgia). Some are fully peer-operated, and others run in partnership with other organizations.

Several studies from the past 20 years reveal the substantial benefits of peer respite, including decreased use of inpatient and emergency services, improvements in empowerment and satisfaction, improved self-esteem and self-rated behavioral health symptoms, and reduced future treatment utilization and costs.

- A 2008 randomized trial found greater improvement in self-rated and interviewer-assessed outcomes and higher satisfaction with services for individuals utilizing a peer-managed crisis residential program in contrast to those placed in a locked, inpatient psychiatric facility. Conclusions included that such programs are "a viable alternative to psychiatric hospitalization for many individuals facing civil commitment."[1]

- A 2015 study revealed that peer respite guests were 70% less likely to use inpatient or emergency services than a control group, and that a respite stay under 14 days was associated with fewer hours of inpatient and emergency services use. Peer respites were considered to "increase meaningful choices for recovery and decrease the behavioral health system's reliance on costly, coercive, and less person-centered modes of service delivery."[2]

- A 2018 study found lower hospitalizations and lower Medicaid expenditures in the 11 months following an individual's stay in a peer-staffed crisis respite center, suggesting that such programs "can achieve system-level impacts."[3]

[1] Greenfield, T. (2008). A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis." American Journal of Community Psychology

[2] Croft, B., and Isvan, N. (2015). Impact of the 2nd Story Peer Respite Program on use of Inpatient and Emergency Services. Psychiatric Services

[3] Bouchery, Ellen, et al. (2018) The Effectiveness of a Peer-Staffed Crisis Respite Program as an Alternative to Hospitalization. Psychiatric Services.

These outcomes are particularly encouraging when the comparatively low cost of peer respite programs is considered. The daily cost of respite operations has a national average of $250 per night per guest, only a fraction of the cost of a hospital Emergency Department bed.

Despite the model's documented success, peer respite remains underutilized, with only approximately 40 peer respites existing across 15 states. However, plans for additional peer-run respites are rapidly forming in several other communities, states, and federally through the Substance Abuse and Mental Health Services Administration. This trend is consistent with the National Action Alliance for Suicide Prevention's Crisis Service Task Force that concludes in its *Crisis Now: Transforming Services is Within Our Reach* report, "ideally, there should be one respite alternative in every crisis care system."[4]

Guiding Values and Principles

Speaking broadly, crisis response has historically viewed containment as necessary and sufficient for safety, but common practices used in these environments have resulted in trauma and negative impacts for both individuals in distress and for those who aimed to provide support.

Individuals who have experienced high intensity crisis services (both voluntary and involuntary) have shared experiences of being physically and chemically restrained[5], stripped and searched, and having their choices of how and when to sleep, wake, eat, shower, dress, speak, read, write, touch, and move significantly limited. Violations of bodily integrity, forced isolation, and restriction of autonomy induce panic, anger, grief, and dissociation – the very opposite of safety, and a recipe for poor outcomes.

In contrast, the approach of a peer respite is centered in dignity, human rights, connection, and healing, where people are allowed and encouraged to embrace intense emotions and distress, rather than to simply numb, medicate, or avoid them. In 2014, a group of peer leaders began work to draft a Peer Respite Charter. While not yet formally recognized by any national entity, several of the items help to illuminate the unique voice of peer respite in the crisis response landscape.

Peer Respite Charter (2014 Draft):

- "Illness" is not assumed and a wide variety of ways of making meaning of distress and various unusual or difficult experiences are welcomed and may be openly discussed.
- There is openness to the idea that what often gets called a "symptom" (e.g., self-injury, etc.) can be a way of coping with or adapting to difficult life experiences.

[4] National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Education Development Center, Inc.

[5] Such as seclusion in a 'quiet room,' use of arm or leg restraints, forced or unwanted emergency medication, etc.

Peer Respite Charter (2014 Draft): *Continued*

- Routine person-specific paperwork is minimal and, where it exists, led largely by the individual seeking support.
- There is an emphasis on not talking about people without them present, even when releases have been signed legally enabling someone working at the respite to do so.
- Tasks that are likely to create or enhance power imbalances, such as handling medications or money, are avoided.

Today, while each peer respite may have some variation in the way the model is operationalized, there are fundamental values, principles, and characteristics that most respites fiercely proclaim and protect:

Support Through Shared Experiences: Peer respites are spaces to heal through distress and do not utilize involuntary, forced, or coercive approaches. Safety and healing requires trust, vulnerability, and hope. As survivors of life-disrupting emotional distress and behavioral health-related crises, peer respite staff are uniquely sensitive to avoiding "power over" approaches and instead practice authentic validation, being with, active listening, seeking to understand, mutuality, learning together, and co-creative, shared decision-making means.

Self-Direction and Personal Responsibility: The gold standard is for potential guests to access a peer respite directly without the need for clinical assessments, referrals, or authorizations. Rather than being centered on rules and controls, peer respites intentionally value, promote, and expect shared responsibility for the environment, self, culture, and relationships. Each person is respected as the expert on themselves, supported to make their own decisions without judgment, threats, or advice-giving. The dignity of risk is upheld.

Non-Clinical Healing Environment: Rather than being viewed simply as symptoms of an illness, guests explore their own understanding and meaning of their distress, which may be rooted in trauma, poverty, marginalization, and survival rather than pathology. The guests' wisdom about their own experiences and truth are uplifted and honored. Peer respites maintain an environment of retreat and sanctuary where self-expression, bodily autonomy, privacy, voice, and self-exploration are valued without judgment. The layout and amenities of physical space, language used, and interventions practiced are thoughtfully chosen to promote healing and avoid retraumatization. Friendliness, generosity, engagement, and comfort are active ingredients to the respite environment.

Homelike Hospitality: Peer respites are often located in a home and in a neighborhood rather than on or a part of a unit, a clinic, or on the grounds of a hospital or institution. Guests typically have their own private bedroom with linens, and are offered food, games, and activities to enjoy on their own or with other guests. Current guests collectively determine whether or not visitors will be permitted in the respite at any given time. Likewise, guests have privacy within their own bedrooms and can choose who may come into their bedroom space, including people who work at the respite. The entire respite operates on an "unlocked" basis, where the choice to use security features (exterior locking doors, locking bedroom doors) is at the discretion and direction of the guests staying at the respite.

Community Connections: The peer respite model intentionally offers minimal disruption to a guest's daily life in recognition that the ability to maintain employment, school, family and friendships can be critical to the recovery process. Guests choose which community connections they would like to maintain (or not) during their stay. Guests have the freedom to create their own schedule and make decisions about continuing or changing their typical routine while at the respite.

Operational Components

While peer respites share common values and characteristics, adaptations to the model occur based on sources of funding, available resources, and local and state specific gaps and needs.

Organizational Structure

Perhaps the most critical component of a peer respite is the entity which governs and guides its day-to-day operations and annual goals, staffing and funding arrangements, and long-term vision and mission. While there is significant variety in the language used to indicate authenticity (e.g. peer-driven, peer-developed, peer-delivered, peer-staffed, peer-led, peer-run, peer-operated), for the purposes of this report the following definitions are offered:

- **Peer-Operated (Peer-Run) Respites** refer to those programs which are operated by organizations intentionally led and staffed by persons with lived experience of behavioral health challenges. Typically, this includes a codified requirement that board of directors be composed of at least 51% of people that have been directly impacted by psychiatric labels and/or system involvement; some provision or practice that the majority, if not all, of organizational leaders and employees are also people with lived experience; and centrality of peer support values in the guiding documents such as mission statements.
- **Peer-Staffed Respites** refer to programs which are operated under or by other types of agencies (e.g. traditional behavioral health organizations, community-based agencies) whose executive leadership and board of directors are not explicitly people with lived experience. In such cases, respite program directors' staff are generally — but not always required — to be people with lived experience.

Some peer-staffed respites test the limits of the model. Sometimes referred to as crisis respite centers, they are operated by and located on the grounds or campus of traditional behavioral health service providers. Among the national debate on peer-run respites is serious concern that the reputation and milieu of the model is impacted when set within or alongside a traditionally medical or clinical environment. Concerns about “co-optation” of the peer respite model are heightened in response to Requests for Proposals for peer respite programs that include requirements such as being located in a mental health facility and requiring minimal peer support experience from staff, which mental health advocates say is incompatible and even harmful to the integrity of the model.[6,7]

[6] Fitch, Marc E. (2023) “Connecticut Moves to Create Peer Respite House, But Mental Health Advocates Cry Foul,” Connecticut Inside Investigator

[7] State of Connecticut Department of Mental Health and Addiction Services. (2023). Evidence Based Practice Peer Respite Program Request for Proposals (DMHAS-EBP-Peer Respite Program-2023)

Much debate exists within the national peer community about peer-operated vs. peer-staffed approaches, and efforts to establish national standards on the organizational structure, values, and operations of what earns the designation of peer respite is currently underway. However, any given entity's capacity and preparation to operate a peer respite program with fidelity will need to encompass a few major areas of consideration.

Administrative Capacity

Running a 24/7/365 health-related operation with a residential component requires navigating multiple overlapping legal requirements (e.g. zoning restrictions, building codes, labor laws, ADA, HIPAA, etc.) and significant financial pressures. These are frequently accompanied by regular reporting requirements and compliance audits, and the need for in-house expertise in particular subject areas, use of professional consulting services, or both. Managing the size and scope of these administrative processes is a challenge for smaller organizations, whether peer-operated or not.

With respect to funding opportunities for respite and the potential for using insurance-based mechanisms (such as Medicaid), there are requirements for entity approval and licensure, staff credentialing, service definition and documentation, billing submission and approval, reporting, and auditing, as well as implications for cash flow. Larger organizations with robust administrative infrastructure and financial resources, both peer-operated and not, generally have greater capacity to manage these requirements and maintain a diversified funding portfolio, which allows greater ability to navigate gaps in coverage for certain time periods or programs (whether by design or circumstance).

Values-Driven Priorities

There is inherent tension in maintaining a deliberately small-scale operation when faced with unmet need. To be truly effective on a population basis, multiple respites would be needed within arm's reach of every hospital with behavioral health presentations in the ED and psychiatric admissions. While the cost savings of a respite is easily recognizable on an individual basis (via preventable imminent hospital admission or decreased future services utilization), the total number of individuals served by a respite is often lower than other crisis services. For the operating entity, this can lead to pressure to increase beds, replicate rapidly, or sacrifice important ingredients of hospitality for overall affordability. While these strategies may seem to make sense on paper, their impact for individuals at the respite is a net loss. Far from being unambitious, peer-operated organizations are led by lived experience to prioritize intentional, inclusive, and transformational approaches over raw productivity.

Policies and Practices

The nature of a person-centered healing approach means that many gray areas must be managed responsively. Decisions about respite policies and practices are largely dependent on the operating organization and informed by the community, its resources, and funding streams.

On a practical basis, many traditional human services and behavioral healthcare providers have established policies and procedures that are designed to be as universal as possible and responsive to regulatory, licensure, risk mitigation, or other compliance requirements. In contrast, peer respites need flexibility to respond to each situation as it arises, and to practice mutuality and shared decision making as intrinsic to the experience. This places respites operated by larger multi-service organizations in a difficult position, where they may be forced to break fidelity with the ethics of peer support or the principles of peer respite if in conflict with standard agency protocol.

Notably, the PRS Project Team experienced this subtle shift during a visit to a respite program operated by a traditional provider agency with Medicaid funding. Staff at this program had adopted some of the stigmatizing language (such as referring to repeat guests as “frequent flyers”) heard in provider settings, emphasized documentation procedures, and were faster to identify burnout as a concern. This type of language and framing was not observed at the respites of peer-operated organizations, where staff focused more on accessibility, mutuality, and individualization of support to guests’ unique needs.

Physical Space

Peer respites should offer a well furnished, home-like space in a residential neighborhood, located close enough to community hubs for easy access, but quiet enough to achieve a retreat-like quality.

Location: To be a realistic alternative in times of crisis, respites must be easily accessible for individuals with and without private transportation, and for programs or services that might support voluntary transportation (e.g. Mobile Crisis/Response Team, clinical services providers). The respite should be reasonably close to major community hubs where guests may have current connections (healthcare provider, family, work, school, faith community) or may want to establish new ones (peer support and recovery center, job center, social and recreational opportunities). The surrounding neighborhood should have a culture and climate where individuals from all walks of life will feel comfortable and will be treated with respect.

Building: The building itself should be in good condition and easy to maintain, with appropriate landscaping and exterior features that match or exceed the neighborhood standard. Property features like electrical, plumbing, HVAC, appliances, and internet must be sufficiently rated to support the maximum number of potential occupants at any given time. The building must meet all applicable codes and zoning considerations (fire escapes and evacuation routes, sprinkler systems, etc) as well as appropriate safety features for the wellbeing of guests (locking doors and windows, clear exit pathways, fire extinguishers, first aid kits, etc.). Buildings should be ADA compliant with renovations as needed to best accommodate potential guests.

Floor Plan and Furnishings: Respites need a private bedroom for each guest, large enough to comfortably accommodate at least a full-sized bed and appropriate storage for personal belongings. Common areas should be large enough for the maximum number of guests and staff to have an all-house meeting and to accommodate home-like living spaces: living room, dining room, kitchen, etc. Furnishings and decor should be of high quality and demonstrate obvious intention to create a comfortable, inviting, retreat-like space with care for sensory considerations like smell, texture, color, size, and inclusive language. Exterior common areas should allow for reasonable privacy equivalent to that of private homeowners.

Occupancy and Ownership: The decision whether to purchase or lease a building for a peer respite is subject to the individual circumstances of the operating organization and the dynamics of the local real estate market. While owning a property affords operational control and potential access to funding for acquisition and renovation, it also limits opportunities to respond to changing dynamics (neighborhood relations, utilization trends, funding shifts) and incurs significant financial risk and liability. Organizations choosing to rent a home in which to operate a respite must build a strong relationship with

the property owner, especially if necessary renovations are needed to meet external requirements (ex: ADA, zoning) or change key features to maximize efficient use of the space.[8] Rental arrangements also risk rent increases and/or other issues that might necessitate relocation.

Access

Peer respites have historically focused on primary mental health crises. While some peer respites still narrowly define crisis through a "mental health only" lens, the trend of peer support models has been expanding to include a more personal definition of crisis, which creates broader access for people who may identify as experiencing intense stress in situations involving substance use challenges, subclinical anxiety or depression, passive suicidal thoughts and non-life-threatening self harm, and trauma-related crises like surviving crime, incarceration, interpersonal violence, human trafficking, housing instability or houselessness, financial stress, intense grief and loss, or a combination of challenges. Accepting and embracing an individual's intersectionality of experiences and identities is a key component of peer support, and with that intent, many peer-run respites have endeavored to expand access for people with many different personal experiences and expressions of crisis.

Number of Guests

Peer respites are intentionally small, designed to offer an intimate setting with a high degree of support and hospitality for a limited number of guests. Most respites offer 3-4 private bedrooms for guests, and would not exceed 6 total guests. The number of guests is dependent upon the physical space (i.e. number of bedrooms, layout, square footage, building code and zoning requirements).

Prospective Guests

In general, peer respites operate with a "yes, and" philosophy with respect to access. Eligibility is based primarily on whether the individual can agree to and meet mutual expectations of respect of one another, self, the space and the community during the respite stay:

- **Informed Consent:** 18 years of age or over, able to communicate consent and non-consent with voluntary agreement to uphold respite community guidelines.
- **Self-Sustained Safety:** Able to respect and uphold the physical and emotional safety of other people at the respite, and provide for daily self-care. Guests may use chosen support and assistance (ex: direct aide, visiting nurse) as a reasonable accommodation, so long as it does not conflict with other aspects of the respite program or guests.

[8] Kiva Centers in Massachusetts has an arrangement with a real estate developer who is highly supportive of the model. See Environmental Scan of Peer Services: Model Respite Programs (Site Visits): Massachusetts.

In its ideal form, eligibility for peer respite is intentionally blind to factors used in many other service settings (diagnosis, symptom acuity, income, insurance status, housing status, etc.) and requires no formal assessment as a precondition or determination for length of stay. Respites using insurance-based funding such as Medicaid must find creative ways to substantiate medical necessity while maintaining the integrity of the non-clinical model to the greatest extent possible. Funding contracts may require other eligibility criteria, such as legal residence in the state or jurisdiction.

Importantly, the experience of hearing distressing voices, having thoughts or plans of suicide, practicing self-injury, and other experiences often labeled as 'psychosis' or 'mania' or 'danger to self' are welcomed at a respite, where peer staff have personal same or similar lived experience and specific training in self-directed, non-coersive support practices.

Multiple respites which initially deemed stable housing as a prerequisite for admission out of fear of being used as a shelter program have since amended their policy in the face of reality. Instead, clear communication and mutual commitment to the length of stay limits between staff and guests has resulted in peaceful and voluntary endings of a respite stay in the vast majority of cases. Having robust knowledge of and strong working relationships with local housing programs prepares respite staff to support guests in working through application processes for temporary, transitional, and permanent housing at their preference.

Emerging practices are also developing around substance use during a respite stay. Many respites do not mandate strict abstinence, but instead take some level of a harm reduction approach with policies that non-prescribed substances cannot be used on the premises, out of respect for safety and comfort in a recovery environment. Use of substances which can prompt strong feelings for some people in recovery such as medication-assisted treatment (MAT) and medical marijuana are considered through a trauma-informed lens: what is supportive to the individual without creating a triggering environment for other guests?

In addition to self-referred individuals from the community, some respites also work with individuals through discharge planning from institutional settings (hospital, assisted living, rehab, or incarceration), as re-entry from these circumstances can be a crisis of its own kind with increased risk for overdose and suicide after discharge. [9,10,11]

[9] Hartung, D., McCracken, C., Nguyen, T., Kempany, K., Waddell, E. (2023). Fatal and nonfatal opioid overdose risk following release from prison: A retrospective cohort study using linked administrative data, Journal of Substance Use and Addiction Treatment.

[10] Lyden JR, Xu S, Narwaney KJ, Glanz JM, Binswanger IA. (2023) Opioid Overdose Risk Following Hospital Discharge Among Individuals Prescribed Long-Term Opioid Therapy: a Risk Interval Analysis. J Gen Intern Med

[11] Chung DT, Ryan CJ, Hadzi-Pavlovic D, Singh SP, Stanton C, Large MM. (2017). Suicide Rates After Discharge From Psychiatric Facilities: A Systematic Review and Meta-analysis. JAMA Psychiatry.

Voluntary, Consent-Based, and Non-Coerced

The nature of respite is voluntary, and every aspect of its operation depends on mutual responsibility for the shared experience. Respite staff must engage with each unique individual to eliminate sources of coercion and affirm a voluntary choice and capacity for the full respite experience.

While peer support holds that everyone has the capacity and right to self-determination, respites cannot ignore situations where persons other than the individual seek to exert, influence, or control decision-making, or where the individual themselves is acting coercively toward others, such as in the case of threatening, harassing, or violent conduct. The determination that a guest is not able to use the respite is made rarely and only after great consideration and active communication.

Service provider or caregiver fatigue, capacity limits, or strained relationship with the individual can cause high-pressure situations which result in a person feeling pressured or being forced toward respite. Particularly difficult situations occur when individuals are under court order or legal guardianship and not able to exercise their full agency, or when individuals experience complex medical needs that exceed the support available in the respite environment.

Situations where an individual has expressed or demonstrated that they are not willing or able to uphold shared safety in the respite require staff to sensitively communicate with the individual about why they are not being offered a stay (or are being asked to leave), along with assistance with finding an alternate option. If the person desires, that may include a clinical program.

Entrance and Exit Process

Individuals may self-refer directly or may be assisted in connecting with the respite through a community program, service provider, crisis support service. Most respites have a designated staff position (or small team) who manages the inquiry for a respite stay, and orientation process to ensure consistency and responsiveness to the ever-changing dynamics of the respite environment.

1. **Initial Conversations:** Initial conversations to explore a respite stay can be done either on a proactive basis for individuals interested in planning a respite stay in the future or at the time of an emerging or active crisis. The process always requires direct communication with the prospective guest, and may also involve a written form to be completed by the individual. The goal is to make a human connection with the prospective guest, seek to understand their experience, and communicate essential information about the nature of a respite stay, including but not limited to:
    - Understanding the individual's circumstances and current experience of crisis, including previous and current behavioral health challenges, nature and scope of crisis, current or desired community connections (treatment, housing, employment, etc.), any other involved persons (family member, guardian, clinician), any specific accommodations needed, etc.
    - Explaining what the respite does and does not offer, including guest responsibilities and mutuality of expectations and accountability for the experience.
    - Identifying available/desired support through the respite, including types of peer support/self-help activities and ideal length of stay.
    - Ensuring that the choice to use peer respite is entirely voluntary and that the person is prepared for what it entails.
2. **Interview/Tour:** While the timing is subject to respite capacity (which may include funder-specified eligibility verifications or a waitlist), next steps in the process generally involve a more in-depth conversation and onsite tour of the respite.
3. **Mutual Determination:** A guest's stay happens only if there is mutual agreement between the individual and the respite staff that the respite is a comfortable fit for both parties. The manager or director responsible for making these decisions works to ensure consistency and thoughtfulness about what can best support the individual.
4. **Check In & Orientation:** Individuals in the throes of crisis should not be bombarded with questions as they walk in the door. Instead, orientation may provide a welcome packet with resources for self-reflection and self-help tools, an overview of where to find schedules of planned activities at the respite as well as community events and other peer support opportunities, and the offer of 1:1 peer support.

5. **Check Out:** The expectation that peer respite is a short-term stay is actively communicated throughout the process, and peer respite staff support the individual in exploring and making choices about what ongoing community supports they want to connect with to continue their wellness and recovery. Having a strong connection to local shelter, transitional, service-based, and permanent housing providers can be supportive to guests who experience housing instability. As described below, many respites have established a post-stay 'waiting period' before a guest can return, to maintain integrity to the short-term, crisis-responsive nature of the program and to balance community need with respite capacity. That said, one of the hallmarks of respite is flexibility to negotiate exceptional circumstances in individual cases.

Length of Stay, Waitlists, and Waiting Periods

In most respites, individuals can determine their own length of stay up to the total amount of days allowed. This means that some people opt to stay for a night or two, while others are there for a week or more. The allowed length of stay varies from respite to respite, with some as short as 3 days and others as long as 28 days. The national average is 7 to 14 days. Determining an appropriate maximum length of stay and any post-stay waiting period should consider the number of guest rooms available, required room turnover time, the number of individuals and length of time on any waitlist(s), and relevant local regulations.

Many respites operate a waiting list for individuals who have gone through the initial screening process. Waitlists may range from a few days to multiple weeks, depending on the specific operating conditions of the respite. Given that length of stay is responsive to the needs of the guest, respites must balance predictions about upcoming openings with sensitivity to the real-time needs of the individuals currently being served.

Managing a waitlist can rely on a simple first-come, first-served principle or can allow for priority to be given to individuals with particular types of situations or statuses. In a landscape where there are not enough resources available, any ranking system can result in some inequity. However, organizing waitlists by source of funding is an avoidable disparity.

In general, respites maintaining a waitlist will offer phone support or connection to other resources such as a drop-in Wellness & Recovery Center or peer warmline in the interim. Some respites will ask the individual to call in daily or weekly to confirm their continuing interest; others will proactively reach out on a regular basis.

In addition to waitlists, some respites require guests to wait a predetermined amount of time after their stay before returning. This 'waiting period' can range from 30 days to six months. Such a policy can be helpful in upholding the short-term, crisis-based nature of the respite, and ensuring availability. However, strong connections between the respite and other community services are needed to ensure all guests leave with an array of resources to support them in the next phase of their recovery journey.

The presence of a peer warmline operated in connection with a respite can be invaluable as a source of support and ongoing communication with individuals on the waitlist or during a required waiting period, enhancing its overall impact for effective crisis diversion. Kiva Centers in Massachusetts also developed a 'mobile peer respite team' to support individuals on their waitlist, where peer support professionals may travel to meet with an individual in their home or a community setting for up to 4 hours for intensive peer support in the spirit of the respite model.

Funding

Like other emergency response and crisis services. peer respites must be open 24/7/365, irrespective of how many individual guests may be using the respite at any particular time. As such, baseline funding must be aligned with the full operating costs of the respite and with minimal dependence on service volume. Otherwise, respites will necessarily shape entry requirements, range of included support services, and length of stay to meet budgetary demands instead of maintaining fidelity to the person-centered nature of the respite model.

Historically, most peer-operated respites have been funded through grants and contracts of public funds (e.g. federal, state, or local funding designated for mental health programs) and additional private dollars (e.g. foundation grants, donation campaigns, etc.) as necessary to support operations or special projects. Peer respites in some states are funded through Medicaid, and others have gained interest from managed care organizations and other insurance-based entities. Contemporarily, specialty funding such as the American Rescue Plan Act (ARPA) and Opioid Settlement Funds are also being utilized to launch peer respites in some areas.

Peer respite programs were recently confirmed as eligible programs under the crisis set aside established within federal Mental Health Block Grants. It is uncertain at the time of this report whether standalone federal funding may be established or made available for peer respites as a part of initiatives for crisis prevention and diversion.

When examining potential funding streams and structures for respite, there are two frameworks that have to be considered simultaneously and with a pragmatic lens: eligibility and mechanism.

Eligibility: Medical Necessity vs. Person-Centered Focus

Most healthcare in the United State is paid for on an insurance basis, whether through employer-based group plans, individual plans secured on the private market or through the Affordable Care Act, or publicly funded insurance, namely Medicaid/Medical Assistance (based on income or priority population status) or Medicare (based on age or disability status).

For programs which are intended to serve individuals with limited income or who are deemed eligible under other parameters, Medicaid reimbursement is often explored because it allows states to secure a federal match toward the cost of services. There are a variety of ways that services can be approved for Medicaid, such as being a designated mandatory benefit, added through a State Plan Amendment, or approved under a waiver program. There is tremendous variety in what is covered and how by different states. Some Medicaid-eligible services can also be subject to further enhancement, such as the current 85% match for community-based mobile crisis services.

Medicaid and other insurance-based funding typically operates on a rate schedule with incremental adjustments that may not keep pace with the changing costs of doing business, from basic inflation to local cost of living indexes to shifting market salaries in the context of workforce shortages. While frequently thought of as a cost-saving strategy, adding services to state Medicaid plans could also increase spending to supply a required service, creating more pressure to keep rates low.

No matter whether an insurance-based plan uses public or private dollars, or the particulars of the plan type, payment is rooted in an assessment of 'medical necessity.' In behavioral health, medical necessity criteria generally requires assessment and documentation of a DSM-recognized diagnosis as well as indicators of severity and instability that justify the need for a certain level of care. Additionally, such determinations are typically limited to specifically licensed provider types (e.g. doctors, nurses, clinicians, etc.).

Another facet of insurance-based funding that can cause difficulty is limited procedural standards. While a peer support specialist may possess all the knowledge, skills, and experience necessary to complete certain practical functions during the respite experience, formalization of these tasks in a billing structure may be restricted to individuals with a specific credential (e.g. Bachelors, Masters, certification, licensure). Defining and respecting scope of practice is very important, yet it is not helpful to diminish the significance of a conversation between two people with shared experience ('what would you like support with?") and suddenly require an academic degree and license to accomplish the same end using a prescriptive format (Needs Assessment).

These basic process requirements and the medical model framework are at odds with the open access, person-first, non-clinical nature of the peer respite model. Respites utilizing Medicaid funding, even if run by a peer-operated organization, have to find creative ways to meet requirements for conducting assessments, treatment plans, progress notes, diagnosis, and medical necessity with minimal compromise to the core nature of the respite model.

The following chart illustrates some of the contrasts, challenges, and compromises of funding through a medical model framework vs. a person/community-centered approach with respect to the components of the peer respite model.

Component	Medical Model Funding	Person-Centered Funding
Facility	Subject to approval by an administrative entity and licensing or accreditation bodies.	Per applicable local requirements. (ex: zoning, rental housing, etc.) Subject to approval by respite stakeholders and local community.
Eligibility Criteria	Medical necessity rule outs. Clinical assessments required. Diagnosis-centered.	Voluntary consent and desirable fit, mutually determined by respite and individual.

Component	Medical Model Funding	Person-Centered Funding
Entry Process	Per eligibility requirements, typically with heavy administrative burden. Can be influenced by financial needs.	Per respite operating needs, optimized to assure maximum opportunity for connection with guests.
Length of Stay	Authorized via clinical assessment and medical necessity.	Per individual preference. Mutually determined by respite and individual.
Documentation	Per billing requirements. Treatment plan, goals, progress notes.	Minimal, only as required for communication and safety.
Metrics	Reduction in symptoms. Length of stay. Number of services.	Satisfaction with experience. Increase in hope and self-determination. Quality of life, community connection.

A significant challenge of insurance-based funding is the high level of administrative expertise and processes needed to manage required accreditation and licensing, documentation of services and outcomes, and billing process. Claims may be scrutinized and denied, immediately or retroactively. This can create a cycle of increasing administrative demand while payment is delayed (or its return demanded), all while individuals needing support must still be met with services.

Leaders of peer respites that utilize Medicaid billing speak to the significantly increased administrative burden to their organizations and work diligently with their funders to influence standards that are more compatible with peer support values. Concerns about the compromises needed to fit the medical model framework of insurance-based and managed care funding have led peer-operated organizations to seek other sources of funding such as philanthropy, corporate giving, and earned revenue strategies (ex: contracts for consultation, training, and technical assistance) to sustain or fill in funding gaps. However, these strategies require expanded organizational capacity and a high volume of engagement to net any meaningful amount of funding beyond their associated costs, and so are not an option for most peer-operated organizations.

Payment Mechanisms

Another lens for analyzing funding opportunities is how the dollars are actually disbursed, and whether or not that will practically support the 24/7/365 nature of respite operations. All service providers face similar challenges with respect to the most common funding models:

- **Fee-for-service** models offer the opportunity to scale services at pace with growth (or reduction) in actual utilization, i.e. per person per service per instance. Instances could be as short as a 15-minute interval or as lengthy as a daily rate. Some concerns about fee-for-service models include their lack of flexibility, significant documentation requirements, and the potential to lead to an emphasis on volume instead of quality outcomes.

- **Capitated** models also structure payment around enrolled users, but with greater flexibility than simple fee-for-service. Rates are typically established on a per person per time interval basis (ex: per month), where the payment is made up front and the provider is responsible for providing all necessary services, and are held to certain outcome measures. The flexibility of this model may come with significant financial risk, as the cost of emergency or high-intensity care can rapidly exceed the capitated payment.

- **Cost reimbursement** models generally focus on the cost of providing a set of services instead of a per-person basis. When funded purely via reimbursement, they are highly vulnerable to potential cash flow issues, but can be a good match for established entities with multiple revenue sources, adequate reserves, and access to emergency resources (ex: line of credit).

- **Prospective payment** models provide predetermined, fixed amounts based on classification of service groups. The funding is provided at the onset of services based on an approved budget. These modes often have strong service delivery, quality, and outcome measure requirements. Review and adjustments are typically made on an annual basis and respond to actual costs. Provider types expected to serve any person walking through the door, such as Federally Qualified Health Centers and Certified Community Behavioral Health Clinics (CCBHCs) are funded through this model.

- **Grant funding** typically provides a lump sum payment at the onset of a project (or in predetermined installments), based on an approved budget and project plan. Regular programmatic and fiscal reporting ensure appropriate use of funds and achievement of goals, with degrees of flexibility determined by the funding institution. Public and philanthropic grants are still subject to the overall availability of funds and the ongoing interest and support of the grantmaker. This funding type is also vulnerable to insufficient annual cost adjustments and limitations on capacity as required by the total grant amount.

Integration with Crisis Service Systems

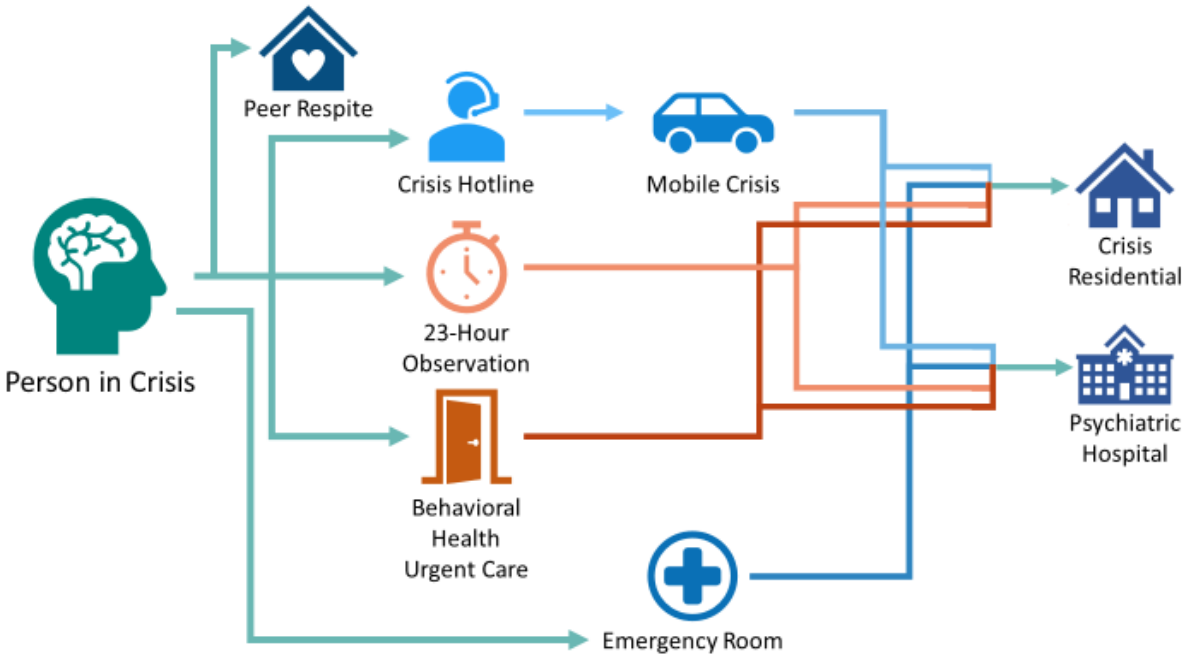
The goal of behavioral health crisis services is to provide effective and timely support to individuals experiencing a mental health or substance use crisis, trauma, and/or a psychiatric emergency. Today's crisis response system was built over the past few decades as communities identified how crises required a distinct set of services and interventions. Other emergency services such as 911, law enforcement, and hospital emergency departments are poorly suited for supporting people in crisis and often lead to expensive and traumatic outcomes such as psychiatric hospitalization or jail.

To avoid these unfavorable outcomes, communities experimented with offering care in an atypical fashion – sending social workers to people's homes or offering mental health support by phone – with the intent of being more helpful, keeping people out of the traditional psychiatric or criminal justice systems, achieving better outcomes, and reducing costs for unnecessary services.

Over the decades, crisis services have expanded, becoming increasingly more defined, better funded, and more widely available. In 2020, SAMHSA published National Guidelines for Crisis Care, outlining a "no wrong door" approach that is available for "anyone, anywhere and any time" through a three-tiered essential service continuum: Someone to Call, Someone to Respond, and Somewhere to Go.[12] The Roadmap to the Ideal Crisis System, written by the Group for the Advancement of Psychiatry and published by the National Council for Mental Wellbeing in 2021, provides a more expansive conceptualization of the crisis continuum and gives specific attention to the role of peer respites.[13]

At every level, services should be designed and delivered in a way that upholds individuals' agency and choice, recognizing they are experts of their experience and ultimately the driver of their care and their recovery. An ideal behavioral health crisis continuum is built on evidence-based practices in crisis care, and includes a variety of services and supports which range from informal, open-access options to high intensity treatment services delivered in a medical facility.

Multiple Pathways for Crisis Support: Someone to Call, Someone to Respond, Somewhere to Go



[12] SAMHSA. (2020). National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit.

[13] Group for the Advancement of Psychiatry. (2021). Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response.

Someone to Call

Warmlines: Designed to serve individuals at any time, at risk of, or experiencing a crisis, these support lines often provide emotional support via phone, text or chat. Some warmlines operate 24/7, while others may have set days and times. Callers may also be connected to other community resources for a wide range of quality of life factors. Warmlines are generally confidential, and most peer-operated lines do not use risk assessments or active rescue, instead supporting callers through a variety of types of emotional distress and crisis situations.

Crisis Hotlines, Helplines, and 988: Designed to assist individuals experiencing a behavioral health emergency through emotional support and referrals to appropriate care. In some communities, crisis call centers can dispatch mobile crisis teams or access next-day scheduling of therapy appointments. Crisis hotlines are typically staffed by trained counselors, utilize risk assessments, and have policies requiring active rescue including police and/or EMS dispatch.

Someone to Respond

Mobile Response, Crisis, or Co-Responder Teams: Provide onsite, real-time support to people experiencing a behavioral health emergency. Teams may consist of at least one clinician, and often include a police officer, peer support, behavioral health clinician, paramedic, or nurse. Mobile teams meet individuals where they are — home, school, grocery store, workplace, etc. — with the goal of stabilizing the crisis and diverting people from higher levels of care.

Somewhere to Go

Peer Respite: An alternative to traditional behavioral health crisis support services, this type of short-term option provides 24/7 non-clinical, healing-centered support delivered by trained peer professionals in a homelike environment.

Behavioral Health Urgent Care: Provides timely access to care for people experiencing a behavioral health crisis. Hours are typically limited to extended business hours based on community need. Prescribers, nurses, clinicians, and technicians typically staff these centers. Some Behavioral Health Urgent Care centers are voluntary and unlocked, while others accept involuntary transport from police. Often, these programs are providing assessment and triage to other levels of crisis services.

Crisis Observation/Stabilization: This level of care represents a facility resembling an emergency department for individuals in a psychiatric crisis. These units can be locked or unlocked depending on the acuity of the individuals served. Units located on the campus of a hospital are often called Psychiatric Emergency Departments or Psychiatric Emergency Services, while freestanding units or units co-located with other behavioral health services may be called Crisis Observation or Stabilization Units.

Somewhere to Go *(Continued)*

Crisis Residential/Residential Crisis Stabilization: Referred to by many different names, this level of care represents a residential alternative to psychiatric hospitalization. Over 600 Crisis Residential Programs exist across the United States, serving as both a diversion and a step down from inpatient hospitalization. Average length of stay can vary from 3 days to 14 days.

Emergency Departments and **Inpatient Psychiatric Hospitals** are long-standing treatment options in emergency psychiatric care. While they still play an important role in the crisis continuum, they should be used sparingly in times when medical conditions or violence to self or others indicate significant risk to safety and a need for the highest level of service intensity.

Peer respite offers significant departure from other services in the crisis response continuum in that it does not rely on clinical assessment to determine appropriateness or authorization, it can be accessed through self-referral without needing to navigate through other services first, and it focuses on the preservation of autonomy as necessary for safety, connection, and healing.

As an accessible, available alternative to unnecessary Emergency Department use or psychiatric hospitalization, peer respite can also help individuals avoid forced interventions through arrest, emergency petition, or admission to a facility which practices confinement, seclusion, and/or restraint. To realize this impact, respites must be cognizant of the mechanics of ED diversion and sufficiently integrated with service systems to meet people where they are and serve them well.

Demystifying Emergency Department Diversion

The term 'behavioral health' is often criticized for being transparent about what it includes, but it contains the key to transforming this dimension of healthcare: behavior. People will act and react in the ways they are expected or compelled to do so, whether by explicit instruction or tacit influence. When every therapist and clinic's voicemail message instructs individuals to call 911 or go to the Emergency Department if experiencing a crisis, emergency responders and hospitals will be jammed with unnecessary and preventable referrals. When individuals in crisis are regarded with stigma and suspicion, they will hesitate to be honest and resist presumptive authority in self-protection. When service providers are reprimanded and rewarded on the basis of regulations and billing standards, they will feel pressure to compromise compassion and creativity for certainty and compliance. When someone is told "that's just the way it is," they will stop believing change is possible.

Most individuals presenting at the ED are not experiencing an idiopathic psychiatric emergency which requires immediate medical intervention. Instead, individuals show up because they are in more distress or despair than they can handle alone, they don't have another accessible option, they have established a routine of going there when in need of support, or they are brought in by law enforcement or family members who can't wait for another service.

As described in a recent article in the American Journal of Managed Care, "The term 'avoidable ED visits' suggests that there is an appropriate and alternative place to care for people… often patients are portrayed as the problem, when really the problem is that the resources they need are not easily available to them, so there is a failure in the system."[14]

Maryland's Health Services Cost Review Commission's *Behavioral Health Emergency Department Wait Times and Service Improvements in Maryland* report acknowledged how "the problem of long ED wait times and hospitalizations with excess length of stay for individuals experiencing a psychiatric crisis is multifaceted and complex… While the bed registry and referral system[15] and related pilot are important tools to address this problem, no single intervention will solve ED wait times and hospital overstays.' Solving this complex problem requires many solutions, including 1) initiatives that help keep people stable in the community, so they do not need acute psychiatric services; 2) increasing the availability of community-based services for people in crisis, which divert people from the ED to other, more appropriate, settings of care, and 3) addressing issues with throughput in the ED."[16]

---

[14] Mulrooney, L. (2022). Reducing 'Avoidable' ED Visits for Mental Health Could Cut Billions in Costs and Improve Patient Outcomes, American Journal of Managed Care

[15]In 2021, Maryland enacted HB 1121 (CH0029) to establish the Maryland Mental Health and Substance Use Disorder Registry and Referral System in the Maryland Department of Health, updating Maryland Code, Health- General § 7.5–801 and § 7.5–801.

[16] Maryland Health Services Cost Review Commission. (2022). Behavioral Health Emergency Department Wait Times and Service Improvements in Maryland: Report at the Request of the House Health and Government Operations Committee. Author.

Options for prevention or diversion services may not be available because of eligibility factors for certain types of service, a dearth of providers, or long waiting lists. Individuals may experience barriers in connecting with services related to financial burden (un- or underinsured), lack of culturally relevant or affirming supports related to their age, gender, race/ethnicity, sexual orientation and gender expression, family status, faith, language, etc., or prior bad experiences (whether personally experienced or learned through agency reputation and word-of-mouth).

- **On a systems level**, the necessary actions to decrease unnecessary ED use for behavioral health include enhancing community-based, peer-driven recovery support programs for prevention, stigma reduction, and sustained wellness; building sufficient trauma-informed and culturally relevant outpatient network adequacy for timely and effective treatment; reforming insurance coverage to real affordability and parity standards; and expanding open-access and on-demand crisis services for acute episodes of need. As no-cost, open access, crisis-responsive, non-medical services, peer respites can help fill gaps across these dimensions of necessary transformation.

- **On a program level**, clinical and community organizations need to equip and support their staff and people served with high quality self-help, stress management, conflict mediation, connection, self-advocacy, and emotional first aid practices.[17] Too many referrals for emergency care (or emergency petition) are made on the basis of fear, uncertainty, risk aversion, discomfort, and doubt on the part of the practitioner instead of from a person-centered, trauma-informed perspective of how a high-intensity or involuntary intervention experience increases stress and self-stigma, breaks trust in therapeutic relationships, and even increases risk of self-harm and suicide.[18] Peer respite operators are well positioned as technical assistance and training providers to help build these skills in teams across the continuum, as well as offering an alternative program option.

- **On an interpersonal level**, individuals and their support networks (including providers) should actively use and promote tools like Wellness Recovery Action Planning (WRAP) and Psychiatric Advance Directives (PADs) to proactively plan and communicate what helps and what harms when a crisis is emerging or erupting. Individuals who have historically frequently used the ED (whether by choice or coercion) can be particularly encouraged to connect with a respite program. In addition to providing a better experience for the person, this type of conversion illuminates the immediate cost-saving impact of respite.

[17] Emotional CPR and Mental Health First Aid are popular and well-vetted curricula.

[18] Golman-Mellor, Sidra (2019). Association of Suicide and Other Mortality With Emergency Department Presentation. Journal of the American Medical Association.

Assuring people in distress are seen, heard, valued, honored, and respected can serve as an antidote to crisis. Even when a respite is not able to immediately offer someone a room, the experience of directly connecting to another person with lived experience and the support exchanged throughout the initial exploration process is markedly different from what most individuals receive from many crisis or emergency services. That understanding and mutuality can bring a sense of relief and a restoration of personal empowerment, which in turn can make it possible for the individual to maintain in the interim instead of going to the hospital. Peer respites may not always be able to provide an immediate place to go during an acute emergency, but their presence in the system of care contributes to the prevention of emergencies in the first place.

Meeting People Where They Are...

While preserving the necessarily voluntary nature of peer respite stays through self-referral, the behavioral health system should take a "no wrong door" approach to informing and supporting individuals to explore respite programs as a viable option. This would include at minimum:

- **988, Hotlines, Warmlines, Helplines, and Peer Lines:** Call center counselors and peer supporters on peer lines/warmlines should be knowledgeable about local respite programs and understand the circumstances under which an individual may seek respite in order to provide connections to the caller.

- **Peer Support Services:** Whether standalone community peer support programs or embedded within traditional service settings, peer support professionals should form a personal connection with any respite program(s) serving their local community. Especially in peer work, direct experience and word-of-mouth are the currencies of engagement, and peer support specialists serve as important credible messengers.

- **Outpatient Services:** Providers should update standard operating procedures to utilize peer lines, warmlines, 988 and mobile response services instead of directing individuals to 911 and the nearest Emergency Room. Individuals at risk or actually using the ED or inpatient facilities should be offered a facilitated connection to the respite program.

- **Crisis and Emergency Services:** Providers should define the circumstances under which they can divert or discharge individuals from their services to support respite access without compromising their own clinical or legal responsibilities. This may include designating the respite as an option for voluntary transport only; respites cannot receive individuals under emergency petition or when the individual declines support. However, respites can welcome individuals released from restricted status (e.g. discharged from crisis stabilization, psychiatric emergency facility, ER, inpatient hospital, detention center, etc.) subject to their own policies..

... and Serving Them Well

Emergency Department diversion can be achieved through a combination of prevention (by receiving timely and quality care), intervention (meeting a person on the path to the ED and offering an offramp or alternative instead), and resolution (providing a healing experience that leads to stability and recovery).

Respites create opportunities for healing through an unshakeable belief that recovery is possible for everyone, allowing great freedom of personal expression and meaning-making in crisis, and focusing on peer-developed, self-directed techniques for processing emotional intensity and restoring self-regulation in healthy and non-invasive ways. There are countless stories of individuals who lived through multiple hospitalizations and labels of major depression, bipolar disorder, schizophrenia, and other 'serious mental illness' who created a profound shift in their lives through peer support that stopped the traumatizing cycle of crisis.

Peer respites are particularly positioned to support individuals who don't fall within priority population criteria for other crisis services, or who are not served well by traditional behavioral health services. Specific groups who would particularly benefit from a respite include but are not limited to:

- **Survivors of Traumatic Experiences:** Many people who have experienced trauma find that anniversaries of particular events or unexpected reminders (triggers) can prompt or heighten behavioral health crises. Inpatient units, which can have highly regimented protocols that violate personal integrity (e.g. being stripped, searched, restrained, watched, coerced to take medications, etc.) can produce experiences that range from uncomfortable to actively retraumatizing. Peer respites offer a calm environment with self-directed activities and active skill-building practices for nervous system regulation. Additionally, a respite stay may be able to be planned in advance in anticipation of difficult anniversaries, depending on the operating conditions of the respite.
- **Self-Harm and Passive Suicidal Ideation:** Individuals who have practiced self-harm as a coping strategy, or who experience passive suicidal ideation, are frequently under- or over-served by crisis services, either by keeping silent about their struggles out of fear or by being subjected to emergency petitioning and/or involuntary admission in the name of safety. Peer respite offers the opportunity to speak openly about self-harming behaviors and suicidal thoughts with peer support professionals who can offer non-judgemental support based in shared experience to work through difficult thoughts and feelings without coercive or unwanted measures.

- **Hearing Voices and High Intensity Experiences:** Experiences labeled as psychosis or mania can have deep personal meaning and transformational impact for the individual living through it, and many medications used for symptom reduction have overwhelming or unpleasant side effects. Peer respite offers people who are having such intense experiences 24/7 peer support in a comfortable, accepting, and safe space in which to process their experiences and reactions, with or without the use of self-administered medication.

- **Not Meeting Medical Necessity:** People presenting in distress at an Emergency Department who don't meet admission criteria are often sent home with few to no resources for immediate support. This can include a range of situations from individuals who fall below certain diagnostic criteria, to individuals who live with multiple diagnosis and challenges and end up in the ED due to caregiver fatigue or some negative interaction that led to Emergency Petition. Peer respite offers a non-medical alternative that builds self-help skills and connection to community support and resources.

- **Underinsured for Behavioral Health:** While Maryland's uninsured rate (6.1%) is below the national average (8.6%), health plans may not have robust and realistic coverage for behavioral health services.[19] As parity laws work to equalize coverage, the reality of too-high costs and too-few in-network providers can prevent individuals of all socioeconomic circumstances from accessing traditional behavioral healthcare as prevention or response to a building crisis. This means that many individuals utilize the ED when experiencing behavioral health distress for lack of other outpatient options or awareness of the crisis service system.
- **Working Professionals:** Peer respite services are particularly supportive to people whose job status would be threatened by missing work due to psychiatric confinement or a behavioral health medical diagnosis, such as first responders, legal services providers, healthcare workers, and public safety professionals. Notably, these professions often deal directly with highly traumatic situations, with a high degree of compassion fatigue, burnout, and secondary trauma.

[19] United Health Foundation. (2022). America's Health Rankings 2022 Annual Report

- **Institutional Trauma:** Institutional trauma can occur when a person experiences harm by systems and services. Examples may include use of restraint, seclusion, forced injectables, rights violations and lack of due process, marginalizing and discriminatory practices related to gender identity, sexual orientation, race, ethnicity, culture, and poverty, historical trauma, disproportionate use of confinement, law enforcement, arrests and incarceration, and harmful treatments. Peer respites offer an option for people that fear system involvement and those who have been "banned" or are unwilling to engage in traditional services and treatments. A peer respite creates a welcoming, affirming, non-judgmental, culturally-relevant alternative.

Innovations in Peer-Led Crisis Support

Peer communities successfully prevent, divert, support, and recover from crisis experiences using a variety of connection-based approaches, whether over the phone, in virtual space, or in person. Two models with particular relevance for peer respite are Peer Lines and Peer-Run Warmlines, and Mobile Peer Respite services.

Peer Lines and Peer-Run Warmlines

Peer support by phone has been practiced for decades, and many peer-operated organizations offer a dedicated phone support option, whether 24/7 or available within certain hours. Unlike many crisis hotlines, peer lines and peer-run warmlines generally seek to avoid any form of involuntary intervention in policy and practice, with a focus on support and connection over risk assessment.

When connected to a peer respite program, a peer-run line/warmline can serve multiple functions:

- provide expert information and referral services for individuals (or other stakeholders) interested in the concept or wanting to stay in a respite
- offer proactive and on-demand telephonic or video call peer support for individuals on a waitlist or in the post-stay waiting period
- support workforce recruitment and retention. Shifts on the warmline can help to onboard new staff, offer additional hours for part-time positions, or provide reprieve for respite workers who need to temporarily step away from in-person services for personal wellness or particular circumstances.

Mobile Peer Respite

Kiva Centers in Massachusetts developed their Mobile Peer Respite team model in response to the high demand for their respite services and subsequent implementation of a waiting list.

In this model, a team of Mobile Peer Respite Advocates are available during extended daytime hours to meet in person with an individual experiencing a crisis, whether in their home, at a program, or in some public place such as a park or restaurant. The interaction can last up to 4 hours, and can repeat multiple days a week, subject to team capacity. Importantly, Mobile Peer Respite is initiated only by the choice of the individual, in contrast to clinically-based Mobile Crisis Teams which may be dispatched by request or as a result of risk assessment. This voluntary-only approach preserves the non-hierarchical, non-coercive nature of the service.

Mobile Peer Respite (Continued)

Mobile Peer Respite offers a compelling solution for real-time ED and hospital diversion when respite houses or beds are limited. A Mobile Peer Respite team operating out of a peer respite program could:

- Meet and provide support to a person in distress prior to any interaction with the ED, particularly if connected through 988 or community hot/warm/helplines.
- Meet with a person currently in an ED waiting to be seen, to offer realtime support, share information about the respite, and support self-advocacy in choosing to voluntarily use inpatient, outpatient, or peer support services.
- Assist with exploration and possible transport to a respite, subject to availability, fit, and operating procedures.
- Provide support to individuals unable to stay at the respite, whether due to capacity limitations or some other circumstance.

Stakeholder Engagement Process

Stakeholder Engagement Process

The Peer Respite Study Project Team (PRS Project Team) conducted a robust stakeholder engagement process with a variety of virtual and in-person opportunities to contribute insights and suggestions, including community forum presentations, focus groups, key informant interviews, and a community survey. More than 350 stakeholders were reached through direct interaction or public presentations, including 160 participants in small group meetings, site visits, or interviews.

Focus Groups and Community Forums

Two in-person stakeholder kickoff meetings in Howard County and Baltimore City were held in February 2023 and attended by representatives from BHA, LBHAs, services providers, and peers active in direct service, training, and advocacy.

Numerous presentations on the peer respite program model and the feasibility study were delivered to stakeholders through existing forums across the region during the study period, including through local LBHA provider meetings and advisory councils, Recovery Oriented Systems of Care (ROSC) networks, and local and statewide opioid-focused working groups.

Four virtual public stakeholder focus groups were held in February and March 2023, and were attended by a total of 109 participants. Participants in these focus groups included:

- Peers, peer support professionals, and representatives of peer-run organizations.
- Clinical/medical service providers, including Mobile Crisis/Response Teams, outpatient providers, and hospital administrators.
- Community organizations in the mental and behavioral health space such as NAMI, Bipolar/Depression Support Alliance (DBSA), Disability Rights Maryland (DRM)
- Government agencies such as Local Behavioral Health Authorities (LBHA), police and fire departments, and representatives from the Baltimore City Mayor's Office and Consent Decree.

Additional targeted virtual focus groups were held to gather feedback from ACT teams, Maryland Early Intervention Program teams, local government agencies, and hospital systems.

Symposium and Conference Presentations

In addition to small-group presentations, the PRS Project Team leveraged large-scale virtual events to reach broader audiences:

OOOMD Virtual Symposium: *Peer Respite: What, How, and Why?* (March 2023): Attended by 54 live participants, the symposium featured short overviews of three successful peer respites from staff representatives (Kiva Centers, People USA's Rose Houses, and Promise Resource Network), and a lively discussion about operational considerations and lessons learned through experience. The recording is posted to OOOMD's YouTube channel for public viewing.

BHA Conference Workshop (May 2023): The PRS team presented an hour-long presentation about the study and its preliminary findings to more than 50 participants. The BHA conference is traditionally attended by representatives from clinical services programs throughout the state.

BHA Peer Summit (June 2023): OOOMD's Executive Director conducted a live interview with PRN's CEO for an audience of over 100 peers, which included an overview of the peer respite program model, the feasibility study, and peer workforce development topics.

Survey

Between February – June 2023, a public online survey was conducted to gather perspectives on the current state of the behavioral health crisis response system and awareness of peer support services in the region. Survey participants were overwhelmingly supportive of peer respite, and the majority were critical of traditional crisis services. The survey was publicized through outreach via the OOOMD network and in every public stakeholder engagement presentation. Ultimately, 80 complete responses were received, with the most engagement coming from Baltimore City, closely followed by Howard County, Baltimore County, and Carroll County.

The survey consisted of 43 questions in 11 sections, with dependent variables including questions just for providers, for peer providers, and for people who have utilized the crisis system. Respondents were asked to self-identify with demographic and stakeholder groups. All questions were optional and frequently used an agree/disagree likert scale of opinion statements about their experiences with services.

A majority of respondents (54%) self-identified as a "person with lived experience with behavioral health challenges, services, or systems," and 48% identified as someone with a "family member of person with lived experience with behavioral health challenges, services, or systems."

63% of participants identified as "white," and 25% as "black, indigenous or a person of color." 29% of participants identified as LBGTQIA (Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual), and 16% identified as a person with a physical disability.

For respondents who identified as users of behavioral health services, the majority (80%) utilized outpatient services. Nearly 40% had used peer support services in the past.

The vast majority of respondents, 86%, said that they were aware of peer services, and 34% had personally used peer support. Those who had used it reported a positive experience, with the majority of respondents agreeing with the statements that "I felt heard and respected as an individual," "I learned about myself from the experience." "I felt empowered and helped by the experience." Other comments included:

- *"Peer services are great assets to the behavioral health system."*
- *"My experience observing peer services is that it has been phenomenal in many areas of their recovery. I want to see that happen too, for people who have severe mental illnesses."*
- *"Every experience that I have had with peer support services have been very positive and beneficial to the population I serve."*
- *"I'm a huge fan of peer support, especially when it can harmonize well with other types of support someone might choose to receive (clinical, somatic, substance use, etc). A non-coercive, open-minded approach is a must."*

Conversely, the majority of respondents who had used behavioral health crisis services either disagreed or strongly disagreed with statements about feeling heard, respected, empowered, and helped by the experience. Responses illustrated the ineffectiveness and trauma that too often results from the framework of the current crisis services system:

- *"I wish I didn't have to sacrifice my dignity, autonomy, or access to community in order to obtain support. I wish it weren't threatening or shaming. I wish it didn't involve threats of violence. I wish it respected my self-knowledge of what I needed. I wish it didn't punish me for having multiple disabilities. I wish it didn't involve seeing me as incapable simply because I was in a lot of pain. I wish support didn't involve taking everything away from me and telling me what I needed to be safe. I wish I were seen as a human being, not just a liability. I wish just once someone stopped and asked me what I needed, rather than forcing me into a hospital. I wish it didn't involve questioning whether my support needs were valid. I wish crisis supports were actually supportive and focused on what I said I needed at that moment in time to reduce my distress."*
- *"I was shamed by staff for using community crisis walk-in, while holding a career with private insurance. I was told I had better access to other options and I needed to leave that service to folks with [Medicare], even though I'd been waitlisted for months by every other service I tried to utilize."*
- *"Treatment was not individualized, it stripped away comforts, and invalidated mental health struggles."*

- *"Crisis services are in desperate need of transformation, and I think mobile crisis with peers is a great start. But in my experience with crisis services, I was not understood, and often ended up lying to protect myself. Suicidal thoughts and behaviors are never taken the time to be understood. I always felt like I was playing defense instead of being able to access care."*

Respondents were also quick to identify how peer respite could provide a better quality of experience for individuals as well as support the behavioral health system at large. Survey respondents were also asked, "What would be the biggest benefit of peer respite in your county?" The most-cited response was hospital diversion, mentioned by 23 out of 77 respondents to the question, and the non-coercive nature of peer support:

- *"I've not found formal peer support programs helpful in places like hospitals, but I think an inclusive, culturally responsive peer respite would be a game changer for me. Mutual peer support rooted in disability justice has allowed me to thrive and helped me feel safe seeking support because I know I can maintain my dignity and autonomy when accessing care that respects my needs."*

- *"I would be so relieved to have access to peer respite and be able to get the support I needed outside of an institutional setting. Being able to get the support I need to get through a crisis without fear that the only option is hospitalization [and] being able to continue to obtain support with my community based therapist in a supportive community-based setting would help so much."*

- *"Providing opportunities to support people experiencing crisis or challenges related to their mental illness without taking away their voice or autonomy. It can also have an impact on the necessity for higher levels or care or decrease the delay in support if beds are not available or if eligibility is not met."*

- *"I work with people in mental health crisis who are usually homeless and unwilling to take medication. If there was a Peer Respite program here I believe it would help a lot of those people to get them inside somewhere comfortable and safe, and be able to build rapport in order to get them stabilized in the right treatment needed."*

- *"I believe countless people who are suffering from mental illness, substance abuse, or both would benefit from having someone who has been there and understands, it may facilitate a dialogue in which a doctor wouldn't have necessarily been privy to because of the mutual understanding."*

- *"There are so many benefits to voluntary, non-coercive, peer support. There will be fewer people stuck in an often retraumatizing system, without legal, financial, or personal consequences for seeking support."*

Key Informant Interviews and Service Provider Site Visits

The PRS Project Team conducted over 30 individual key informant interviews to gain specific insights, feedback, and recommendations from particular stakeholder perspectives throughout the region, speaking with representatives from the following organizations:

- Affiliated Sante Group
- Baltimore County Crisis Response (Affiliated Sante Group & Baltimore County Police Department)
- Baltimore County Department of Corrections
- Baltimore Crisis Response, Inc.
- Baltimore Harm Reduction Coalition
- BMore Clubhouse
- Grassroots Crisis Intervention
- Greater Baltimore Medical Center
- Hearts & Ears
- Helping Other People through Empowerment (HOPE)
- Howard County General Hospital (Johns Hopkins)
- Institutes for Behavior Resources
- Johns Hopkins Hospital
- Johns Hopkins Bayview
- LifeBridge Health
- Maryland Addiction and Behavioral-Health Professionals Certification Board (MABPCB)
- Mental Health Association of Maryland
- National Association of Mental Health (Statewide, Baltimore Metro Area and Carroll County)
- On Our Own, Inc. (Baltimore City & County)
- On Our Own of Carroll County
- On Our Own of Howard County
- Saint Agnes Healthcare
- Sheppard Pratt
- Tuerk House
- University of Maryland
- Maryland Early Intervention Program (MEIP)

The PRS Project team also conducted in-person site visits to several OOOMD-affiliated, peer-run Wellness & Recovery Organizations and longstanding crisis services providers such as Sheppard Pratt, Johns Hopkins Hospital, Baltimore Crisis Response, Inc., Baltimore County Crisis Response System (Affiliated Sante/Baltimore County Police), and Grassroots Crisis Intervention in Howard County.

Across services and stakeholders, interviews and comments revealed a deficiency of choices between mobile crisis and inpatient psychiatric hospitals – SAMHSA's "Somewhere to Go" level of care – in Central Maryland, and recognized the immediate value peer respite would offer to individuals in crisis not currently being served or served well by traditional programs.

Interviewees familiar with peer services shared a positive impression of their role in crisis services but noted a lack of both financial support and awareness about the availability of services. Organizations employing peers or those working closely with peers were generally familiar with the concepts and benefits of peer services, and some were enthusiastic about adding more peer staff to their service lines or partnering with peer-operated organizations.

In conversations with other stakeholders, while no concerns or disparaging remarks about persons with lived experience were shared, there was not a sense of enthusiasm or complete understanding of peer support as an essential component in a crisis continuum.

Peer Supporters and Peer Support Programs

Peer supporters working in peer-operated programs shared a sense of pride in the non-coercive nature of their services and their ability to create mutual support networks. Peer supporters emphasized that they are currently filling a gap for underserved community members: people who don't fit in or qualify for traditional services due to current substance use, gender identity, or immigration status; not feeling welcome or being allowed in programs due to past interactions; having mistrust of authority figures such as doctors or police; or needing emotional supports beyond what family or the medical system provides.

In terms of challenges in the peer support landscape that may have an impact on the success of a peer respite, peer supporters and peer providers spoke of being stretched thin in terms of low wages, staffing patterns, operating budgets, and difficulty navigating the CPRS certification process, particularly finding affordable training opportunities. Peer workers also expressed concern about services being unavailable or inaccessible, overreliance on law enforcement, and inadequate support for transition-aged youth and members of the LGBTQ+ community.

- *"I think it's important that we don't necessarily make peer support about recreating the hierarchy that exists within medical systems, but rather creating networks of mutual support and care." ~ Advocate, Baltimore City*
- *"Training and certification is a major barrier, [and] wages are a major barrier. Peers are not making enough to live, to make going through all of the training worthwhile." ~ Peer, Howard County*

Crisis Services and First Responders

Crisis service providers (e.g. 988 and local crisis call centers, mobile crisis/response teams, and residential crisis stabilization) identified several system shortcomings where peer respites could offer effective solutions and support better outcomes.

Several interviewees shared that residential crisis stabilization programs are currently primarily being used as a step-down from psychiatric hospitals, in contrast to their traditional function of diversion from hospitalization that systems embrace in most other states. Interviewees also spoke of an overreliance on emergency petitions, which they attributed to the perception that few hospitals will admit individuals on a voluntary status.

Representatives of police and fire departments spoke of how they have been forced into mental health crisis services as first responders, and tasked with transporting people experiencing a behavioral or mental health crisis to services. They were highly supportive of a peer respite program to become an approved drop-off destination as an alternative to the emergency department or jail for people in crisis. However, it was noted that because of the voluntary nature of peer support services, police or an ambulance transporting someone to a respite is vulnerable to being inappropriately coercive.

Peer respite was also seen as a potentially valuable support resource for crisis system workers and first responders themselves (whether publicly identifying as 'peers' or not), who are subject to secondary traumatic stress on a regular basis, and who may face employment barriers if they seek inpatient mental health or substance use treatment.

- *"Behavioral and mental health crises represent a significant portion of requests for 911 service. These problems are not easily mitigated and often require broad based and long term collaboration. EMS, as an episodic, reactive life-stabilizing service is not ideally equipped to address the often chronic needs of some of these patients. This contributes to frustration on behalf of first responders AND patients alike." ~ First Responder, Baltimore City Fire Department*
- *"I have been doing mobile crisis for 16 years, and have seen way too many crises that don't need to be treated by emergency petition. We hate doing them, and any alternative would be good." ~ MCT team member, Baltimore City*

Hospital Systems

From frontline staff to CEOs, hospital staff across the region reported frustration around the lack of alternatives to the Emergency Department (ED), as this is not an optimal treatment setting for individuals experiencing behavioral health distress. The concept of peer respite was well-received by representatives from hospitals offering emergency psychiatric services. Several reported serious issues with overcrowding and boarding, and a need for more timely access to mental health support. Many of these providers also operate other outpatient and inpatient behavioral health services, and still acknowledge the unmet and growing need for additional services throughout the continuum of care. Respite was also identified as a potential resource for individuals not being admitted or being discharged from the hospital who need transitional support.

- *"We have 15-25 people coming in [to the ED] with mental health issues a day, and 2-3 psychiatric evaluators per shift. The average stay here is 36 hours. There are always way more patients coming in than designated beds. We have 5 psychiatric spaces in the ED, [and] are frequently functioning at half hospital capacity because psych is taking up beds. 62% of folks are discharged [as not meeting admission criteria] for issues like panic attacks or suicidal ideation." ~ Hospital Administrator, Howard County*
- *"Do we need peer respite? We need anything and everything. The need is so great, and the demand for services will always exceed supply." ~ Hospital Administrator, Baltimore County*

Regional Landscape Analysis

Regional Landscape Analysis

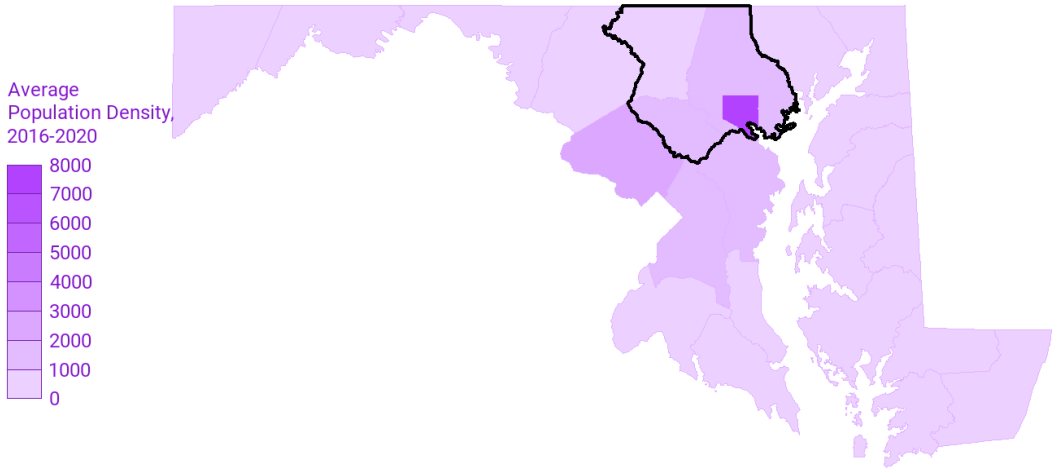
Regional Community Profiles

The "Central Maryland Region" as used in this report includes Baltimore City, Baltimore County, Carroll County, and Howard County, as united under the Central Maryland Crisis Response System.

Population and Population Density

Why It Matters: *Population density impacts how many people can be served in an area with a location-based service. Population density can impact bed capacity or number of services to design to meet community needs.*

While all four areas are considered urban according to the U.S. Census Bureau, in local context, Baltimore and Howard Counties are substantially suburban, and Carroll County, Western Howard County, and Northern Baltimore County considered more rural.[20]



Average population density in Maryland Jurisdictions (2016-2020)

As shown in the figure, Baltimore City has the highest population density of any county region in the state, between 5 and 20 times higher than other counties in the region and over 15 times the state average.[21] It ranks as the 14th most densely populated county, and the 30th most populated city, in the United States.

[20] The U.S. Census Bureau defines a county as "completely rural" if it has a population of fewer than 65,000 people.

[21] Ibid

The jurisdiction of Baltimore City (pop. 602,000) accounts for 10% of the state population, while the surrounding jurisdiction of Baltimore County (828,000) accounts for 14%. The combined four-county region accounts for nearly one third of the entire population of Maryland (6 million).[22]

Demographics and Diversity

Why It Matters: *Cultural considerations must inform community engagement in the chosen location(s) of a peer respite, and respites must be welcoming and affirming spaces for individuals from all backgrounds. Racial, ethnical, and cultural groups have different frameworks for understanding behavioral health challenges and different culturally based recovery practices. Many racial, ethnic, and cultural groups, including BIPOC and LGBTQ+ communities, have historically and presently been subjected to systemic and structural oppression which impacts Social Determinants of Health, subsequently experience disparities in health outcomes, and face ongoing discrimination when seeking health and wellness support services.*

Multiple studies have demonstrated disparities in access, use, quality, and outcomes of healthcare related to racial, ethnic, and cultural identity.[23] Major factors suggested as related to the identification and resolution of these disparities include but are not limited to:

- structural and systemic racism, xenophobia, and homophobia, resulting in intergenerational and institutional trauma, chronic stress, discrimination, misdiagnosis, and maltreatment
- variety in culturally-informed experiences and frameworks for understanding, interpreting, and processing distress, treatment, support, and recovery[24]
- service cost or lack of insurance coverage, which is often related to employment status and household income[25]
- varied participation rates in behavioral health services for the reasons listed above, which is typically a precondition of being included in surveys, research studies, and analysis

Race, Ethnicity, and Culture

The four-county region experiences broad differences in racial, ethnic, and cultural diversity, reflecting the tides of historical population migration trends associated with many Mid-Atlantic port cities and a variety of influences on the accessibility of housing, employment, and other socioeconomic drivers.

---

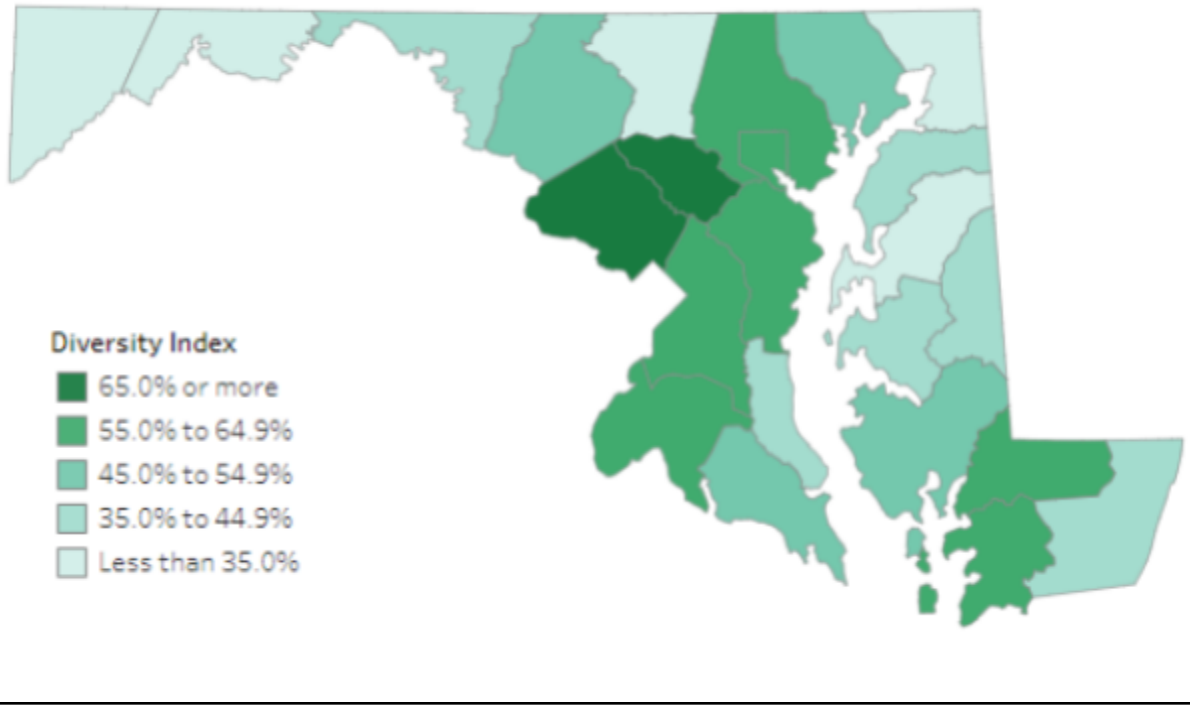
[22] U.S. Census Bureau. (2023). 2016-2020 American Community Survey 5-year Estimates

[23] U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

[24] Gara, M., Minsky, S., Silverstein, S., Miskimen, T., Strakowski, S. (2019). A Naturalistic Study of Racial Disparities in Diagnoses at an Outpatient Behavioral Health Clinic.Psychiatric Services.

[25] Substance Abuse and Mental Health Services Administration. (2015). HHS Publication No. SMA-15-4906: Racial/Ethnic Differences in Mental Health Service Use among Adults.

The US Census Diversity Index measures the probability that two people chosen at random will be from different race and ethnic groups, and Maryland is the 4th most diverse state in the nation.[26] Intrastate comparison of Maryland's 24 counties shows Howard County ranking as the second-most diverse jurisdiction with a 69.6% rating, followed by Baltimore County (4th, 63.2%), Baltimore City (5th, 59.1%) and Carroll County (22nd, 27.4%).



U.S. Census Diversity Index by County: Maryland (2020)

Black/African-Americans make up the largest demographic group in Baltimore City (63.7%), followed by White (32.3%). The other counties have a majority White population (Baltimore County 61.1%, Howard 58.3%, and Carroll 92.7%). Baltimore County has the second-largest Black/African American population (31.6%), followed by Howard County (21.8%) and Carroll County (4.8%). Only Howard County had a substantial Asian population (21.1%). All other racial/ethnic groups counted by the U.S. Census fell below 8% of the population of each county.

In the region, 74% to 95% of households speak only English, 2%-5% speak Spanish, 2%-11% speak Asian and Pacific Island languages, 2%-7% speak other Indo-European languages, and 0%-3% speak other languages. Howard County (74%) has the lowest percentage of people who speak only English, and subsequently their other language percentages are the highest in the region.

[26]U.S. Census Bureau. (2021). Racial and Ethnic Diversity in the United States: 2010 Census and 2020 Census

Gender and Sexual Orientation

Statewide estimates suggest 4.2% of Maryland residents identify as part of the LGBTQ+ community, and this community has a strong presence in the Central Maryland region. Baltimore City hosts multiple social spaces and cultural institutions operated by and for the LGBTQ+ community, some of which have been active since the 1950s.

Over the recent decades, Maryland has passed significant legislation to protect and uphold civil rights related to gender expression and sexual orientation. Marriage equality for same-sex couples was legally recognized in 2013, prior to the federal 2015 Supreme Court ruling, and has protections in place for nondiscrimination and inclusivity in employment, housing, public accommodations, and educational settings.[27] In 2021, legislation established the Governor's Commission on LGBTQ Affairs. Most recently, the Trans Health Equity Act will require Maryland Medicaid to provide coverage for additional gender-affirming treatments beginning in 2024. Unfortunately, these protections can be contrasted with continuing incidents of violence against LGBTQ individuals across the state, particularly transgender women of color.

Not only do LGBTQ individuals face disproportionally high rates of mental health, substance use, trauma, suicide, and negative social determinants of health,[28] but many behavioral health services with a residential component settings are lacking cultural competency with respect to gender-inclusive language and practices, or are segregated along a gender binary (ex: beds or units designated as 'male' or 'female').

Social Determinants & Health Equity

Why It Matters: *Understanding the rates of socioeconomic barriers and general health factors can inform where communities might benefit from building peer respites as no-cost, low-barrier options.*

Income and Cost of Living

The intensity of socioeconomic barriers varies between and within counties in the region, with historically oppressed groups experiencing disparate impact. In considering poverty levels for each county, based on what percentage of people have had 12 months of income below the Federal Poverty Level (FPL), Baltimore City has the highest poverty rate at 20.3%. This is at least twice as high as any other county, and over twice as high as the state average (9.2%).

---

[27] Movement Advancement Project. (2023). Maryland's Equality Profile (LGBTQ)

[28] Multiple studies demonstrate the disparities in access and outcomes for the LGBTQ population. Three examples are: Substance Abuse and Mental Health Services Administration. (2023). "Lesbian, gay, and bisexual behavioral health: Results from the 2021 and 2022 National Surveys on Drug Use and Health" (SAMHSA Publication No. PEP23-07-01-001); Hafeez H, Zeshan M, Tahir MA, Jahan N, Naveed S. (2017). "Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review." Cureus., and Emlet, C. (2016). "Social, Economic, and Health Disparities Among LGBT Older Adults." Generations.

While Carroll County (5%) and Howard County (5.5%) have the lowest poverty rates in the region, both counties still have a significant number of individuals and families struggling with income instability or inadequacy, who may be rendered effectively invisible in social considerations or local policy alongside the presence and influence of high-wealth neighbors.

Another helpful lens for understanding the interplay of income and cost of living is the *ALICE Report* produced by United Ways of Maryland, which measures 'Asset Limited, Income Constrained, Employed (ALICE)' households earning "more than the Federal Poverty Level, but not enough to afford the basics where they live."[29] The most recent ALICE analysis demonstrates how adding these households to Federal Poverty Level statistics illuminates a truer picture of the breadth of socioeconomic barriers experienced across the region: 24% of households in Howard County, 32% in Carroll County, 44% in Baltimore County, and 53% in Baltimore City are struggling or unable to afford basic living expenses.

Health Factors and Outcomes

SAMHSA's working definition of recovery encompasses four major dimensions:[30]

1. **Health:** Overcoming or managing one's disease(s) or symptoms, and making informed, healthy choices that support physical and emotional well-being
2. **Home:** Having a stable and safe place to live
3. **Purpose:** Conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
4. **Community:** Having relationships and social networks that provide support, friendship, love, and hope

The *County Health Rankings and Roadmaps* report analyzes measures of the current Health Factors (e.g. housing quality and severe housing cost burden, air and water quality, food insecurity, access to clinical care, health behaviors, education completion levels, employment rates, living wage, social associations, school and residential segregation) which impact Health Outcomes (e.g. premature death, poor or fair overall health, poor mental health days). The 2022 report reflects Baltimore City as ranking lowest in the state (24th/24th) on both overall scores, with Baltimore County in the middle (15th), and Carroll (4th) and Howard (2nd) counties with the highest scores.[31]

[29] United Way of Maryland. (2021). ALICE in the Crosscurrents: COVID and Financial Hardship in Maryland.

[30] SAHMSA. (2023). Recovery and Recovery Support

[31] University of Wisconsin Population Health Institute. (2023). Maryland County Health Rankings,

Behavioral Health Needs

Why It Matters: *Understanding the rates of behavioral health needs in the region can help justify the need for a peer respite, and forecast any specific trends that may require specialized training or consideration in operating procedures. While frequently siloed in funding, administration, and clinical treatment, mental health and substance use are often co-occurring for people in crisis.*

Mental Health

Mental Health depression statistics for the region reveal that Baltimore City has the highest proportion of adults with depression (20.7%), followed by Carroll County (18.5%), Baltimore County (18.2%), and Howard County (14.8%).

For adults who reported mental health that was "not good" for 14 or more days in a row in 2020, Baltimore City reported the highest incidence rate at 16.2%, followed by Baltimore County (14.5%), Carroll County (13.7%), and Howard County (11.4%).

From 2018 to 2021, suicide rates for the Central Maryland region varied against the statewide average (10.3 per 100,000 population). Baltimore City (9.4) and Baltimore County (10.9) closely mirrored the median, with Howard County (7.5) at 27% below and Carroll County (12.9) at 25% above the statewide average. However, suicide rates in the Central Maryland region are generally lower than counties in both western and eastern Maryland.[32]

Substance Use

Opioids: Within the Central Maryland region there is a striking geographic disparity in the impact of the opioid overdose epidemic. Baltimore City has the highest opioid overdose death rate of any major city in the country,[33] and accounts for the most opioid overdose-related Emergency Department visits in the region at a per capita rate of 71.93 per 10,000 in 2022. In comparison, Baltimore County's rate was 21.98, Carroll County's was 15.79, and Howard County had a striking low rate of 4.18.[34]

Alcohol: Carroll County has the highest proportion of the population who engage in binge drinking (17%), approximately 1 in 6 adults. Baltimore City (16%) and Baltimore County (15%) have similar numbers, and Howard County reports the lowest rate (13%) in the region.

---

[32] Centers for Disease Control and Prevention, National Center for Health Statistics. (2021). "National Vital Statistics System, Mortality 2018-2021" on CDC WONDER Online Database, Data are from the Multiple Cause of Death Files, 2018-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

[33] Baltimore City Health Department. (2023). "Baltimore City's Response to the Opioid Epidemic"

[34] Maryland Opioid Operational Command Center, (2023). Maryland Overdose Data Dashboard.

Cocaine: Maryland has the second-highest per capita rate of cocaine use in the country (2.2%), second only to Washington, D.C. (3.6%). The national average is 1.7%.[35] In 2022, cocaine was a contributing factor in 35% (901) of the total 2,581 drug overdose deaths in Maryland.[36]

Cannabis: Prior to recreational legalization in July 2023, Maryland was in the top 15-20% of states for per-capita consumption, with studies suggesting Marylanders consume about five grams per month more than their counterparts elsewhere in the country.[37] In 2019, a survey from the Centers for Disease Control and Prevention found that between 9 to 11% of Maryland adults reported having used marijuana on a daily basis in the past month.[38,39] With respect to possible impact on the need for peer respite, the National Institute on Drug Abuse notes that "considerable—though not all—evidence has linked cannabis use to earlier onset of psychosis in people with genetic risk factors for psychotic disorders, including schizophrenia, as well as worse symptoms in people who already have these conditions."[40]

Crisis Response Service Systems

Any crisis response system is interdependent with the surrounding behavioral health system, which must have the capacity to prevent crises in the first place, coordinate aftercare, and support recovery throughout and beyond outpatient treatment services. The transformation of crisis services requires multi-pronged approaches which seek to:

- center and be led by the lived experience of people who use the services
- encourage and develop partnerships among community behavioral health providers, specialized crisis service providers, hospital systems, and community organizations
- develop and support a diverse and multidisciplinary workforce
- invest in and leverage technology efficiently

Of particular note to this study, people with lived experience are employed in professional positions throughout the crisis response services system, such as in call centers (as call counselors, not performing a peer support function), on mobile crisis/response teams (with longstanding integration in some areas, and not utilized at all in others), in walk-on and urgent care centers, in Emergency Departments and hospitals, and in administrative entities at the local, regional, and state levels.

---

[35] SAMHSA. 2021 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia), Table 7, page 14

[36] Maryland Opioid Operational Command Center, (2023). Maryland Overdose Data Dashboard,

[37] Wiggins, Ovetta. (2023). "Maryland studied how much marijuana adults consume. It's a lot." The Washington Post,

[38] SAMHSA 2018-2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia)

[39] Maryland refers to the substance as "cannabis" in statute. Some other state governments, the federal Centers for Disease Control, and many researchers use the term "marijuana." Both terms have the same meaning in this context.

[40] National Institute on Drug Abuse. (2023) "Is there a link between marijuana use and psychiatric disorders?"

Maryland's Crisis Response Services Landscape

Crisis services in the state of Maryland have experienced significant growth over the decades, recently accelerated through growing need and enhanced funding opportunities as a result of the pandemic. In 2021, the Behavioral Health Administration convened a new Crisis System Advisory Workgroup to discuss national best practices in crisis care and guide the establishment of a statewide crisis system. The overarching goals of the initiative are to provide immediate, recovery-oriented solutions to support individuals in crisis; avoid unnecessary emergency department visits and hospitalizations; and avoid unnecessary incarceration. Subcommittees within the CSAW are focused on standardization and best practices, data, and financial stability and sustainability.

An initial survey of the current array of crisis services available across Maryland demonstrated considerable variety in the number, type, and model of services available within each of the counties, encompassing crisis call centers, standalone crisis centers, law enforcement Crisis Intervention Teams, Emergency Departments with psychiatric services, Mobile Crisis Teams, mental health and substance use Crisis Residential programs, Safe Stations, and Walk-In/Urgent Care Centers.

Maryland has recently instituted several new initiatives designed to expedite the linkage of people in distress with behavioral health services and resources across the state, with focus on reducing Emergency Department boarding and hospital overstays. BHA's Behavioral Health Hospital Coordination Program features online dashboards reporting in real time the number of available inpatient beds, crisis bed, and walk-in/urgent care facilities. Maryland 211's Behavioral Health Care Coordination program supports hospital personnel to access information about available services by dialing 211, press 4.

A major impending change for crisis services providers in Maryland is that certain services (Mobile Crisis Teams and Crisis Stabilization Centers) will soon be eligible for Medicaid reimbursement. The proposed regulations and rates for these programs continue to be keenly analyzed by potential provider and oversight agencies, who have expressed questions and concerns about the accreditation and licensing process, facility and staffing requirements, cost and payment estimates, and assumed utilization trends which may not match well with the current economic conditions and service trends they navigate every day. These discussions have illuminated similar challenges that peer respite programs would face, exacerbated by the mismatch of a non-clinical model and a medical framework.

Phone/Text/Chat Support: 988, Hotlines, Warmlines, Helplines, and Peer Lines

In July 2022, federal legislation established 988 as the national phone number for suicidal and other behavioral health crisis, revolutionizing access to the longstanding network of National Suicide Prevention Lifeline ("Lifeline") crisis call centers, now administered by Vibrant Emotional Health. Offering 24/7/365 support by phone call, text, and chat, 988 provides free and confidential support from trained counselors, many of whom have personal, familial, or clinical experience with suicide and behavioral health crisis.

While the advent of 988 has increased awareness of and access to the longstanding network of Lifeline call centers, the reception has not been universally positive. Fear of having a mobile clinical team or law enforcement sent out for assessment still keeps some individuals from using 988, particularly in communities who have had poor experiences with discriminatory or harmful treatment by public systems, such as BIPOC communities, LGBTQ communities, and communities of people who have immigrated to the U.S., do not speak English fluently, or do not have visas or citizenship standing. Within the peer community, questions and strong concerns have been expressed about the implementation of 988, particularly around data privacy and use, policies and protocols for involuntary interventions, and the use of geolocation services. Advocates also note the lack of awareness or availability of culturally-responsive supports and services in many areas.

Just prior to the launch of 988, Maryland enacted legislation to establish the 988 Trust Fund, which provides a vehicle for funding to support the development, implementation, coordination, and delivery of the behavioral health crisis response services, including with crisis call centers, mobile crisis team services, crisis stabilization centers, and "other acute behavioral health care services." In 2023, legislation passed to add $12M to the fund in FY 25. While peer respite is not named in the statute, a strong argument could be made for its eligibility as an important component of the crisis services continuum.

Maryland has a total of 8 call centers, including the three major community-based crisis services providers in the Central Maryland region (Baltimore Crisis Response, Affiliated Sante Group, and Grassroots Crisis Intervention). Additionally, many local jurisdictions and agencies (behavioral health providers, peer and family support organizations, and community organizations) operate helplines and/or warmlines that offer support and connection to resources. Previous to 988, Maryland had established 211-press-1 as the statewide crisis hotline, leveraging the use of 211 as a statewide resource for assistance with finding help across multiple life categories (food, housing, employment, healthcare, family service, aging and disability support, etc.). This line, along with many local phone support options, continue to run independently from 988.

Whether crisis-oriented or a community resource, ensuring that call center operators are aware of peer respite and able to refer to callers as a potential resource is an important step toward reaching individuals in distress who would prefer and be well-served by this alternative option.

Community-Based: Walk-In, Urgent Care, Crisis Stabilization, Crisis Residential

Maryland has a long history of community-based crisis service options, and the last few years have brought intentional expansion in the number and type of services available.

Walk-In and Urgent Care Centers currently exist in multiple jurisdictions within the state, offering walk-in services for individuals in emotional or psychological distress. Importantly, the role of peer

support specialists in these settings is actively expanding under a BHA initiative to place peer specialists in these settings in 12 jurisdictions by 2025.[41]

Crisis Stabilization Centers are generally standalone facilities designed to offer an alternative to Emergency Departments and/or inpatient hospitalization, with different regulations and funding depending on whether the focus is substance use or mental health. In 2018, the first substance use-related Crisis Stabilization Center in Maryland (Tuerk House) opened in Baltimore City. It offers 24/7 access for individuals under the influence of drugs and/or alcohol to sober and receive short-term interventions, including medical screening and connection with recovery resources. In the mental health system, Crisis Stabilization Centers are a new provider type for Maryland, envisioned to have 23-hour observation beds and the ability to accept individuals under Emergency Petition.[42] The regulations establishing these types of mental health-focused centers are currently being developed.

Crisis Residential programs located across the state offer short-term residential stays to individuals experiencing or at risk of a behavioral health crisis as prevention or alternative to hospitalization. The organization, funding, and regulation of these programs differs depending on their categorization within the mental health (Residential Crisis Services) or substance use ('crisis beds' typically embedded within ASAM Level 3.7 SUD programs[43]) service systems. Interestingly, mental-health based Residential Crisis programs have an explicit intended purpose to "prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, shorten the length of inpatient stay, or reduce the pressure on general hospital emergency departments."[44]

Emergency Departments: Presentations, Wait Times, and Boarding

The use of Emergency Departments for behavioral health concerns have steadily been rising over the past decade. Between 2016 and 2018, ED visits for behavioral health jumped up by 14% even as all other types of ED visits fell by 10%, according to analysis of hospital claims conducted by the Maryland Hospital Association.[45] The even more rapid increase of Emergency Department visits for behavioral health concerns during the COVID pandemic is alarming and indicative of the need for new

[41] Maryland Department of Health (March 18, 2022) Maryland Department of Health expands child and adolescent behavioral health crisis services, peer recovery services

[42] Currently, individuals petitioned for involuntary evaluation (Emergency Petition, or "EP")may only be transported and evaluated to specifically designated emergency psychiatric facilities, which at present only includes Emergency Departments.

[43] Sometimes referred to as Crisis Beds/SRD (Substance-related Disorders). American Society of Addiction Medicine (ASAM) Level 3.7 is defined as a Medically Monitored Intensive Inpatient Service. American Society of Addiction Medicine. About The ASAM Criteria

[44] Maryland Division of State Documents. COMAR 10.21.26.02 Community Mental Health Programs — Residential Crisis Services Definitions

[45] Wilder Research (September 2019) "Behavioral Health Patient Delays in Emergency Departments Results from the Maryland Hospital Association Behavioral Health Data Collection"

approaches. Maryland Department of Health data indicates that ED visits for mental health rose dramatically to nearly 48% in 202, up from only 11.5% in 2018.[46]

For individuals in emotional or psychological distress, the noise, lighting, pace, lack of privacy, stigma, and disrespect from other waiting individuals and ED staff can further agitate and escalate the crisis. Unfortunately, Maryland has the worst ED wait times in the nation, averaging 228 minutes (nearly 4 hours) according to data from the U.S. Centers for Medicare and Medicaid Services.[47]

"ED Boarding" is generally used to describe the universally unwanted situation where individuals remain in the ED too long. However, this term may be used interchangeably to express frustrations with two different situations:

- **Waiting for Evaluation:** Individuals in distress come to the ED looking for support and medical attention. With EDs frequently overwhelmed and understaffed, the wait time to see a clinical professional or physician may be extensive. Individuals voluntarily coming to the ED retain the option to leave the hospital at any time prior to evaluation, but may become subject to an Emergency Petition if ED personnel suspect risk of harm to self or others. In the case of an Emergency Petition, state regulations dictate that evaluation by a physician should take place within 6 hours of arrival, and that no person should remain in the ED for more than 30 hours, but this is not always achieved in practice and is not sufficient grounds for release.
- **Waiting for Placement:** The more common use of "ED boarding" describes the situation where an individual has been evaluated and found eligible (or necessary) for inpatient admission, but where transfer to a bed is delayed due to
    - scarcity, such is often the case with 'speciality' beds for adolescents or older persons,
    - non-availability, such as when beds are filled with persons ready for discharge to a lower level of care but delayed in transitioning to community placement, or
    - overload of the hospital system, such as when beds are available but processing delays result from shifts being understaffed, procedural requirements, or overall high volume

Peer Respite programs could potentially offer a pathway out of some, but not all, ED boarding situations. For individuals waiting on voluntary evaluation, or who have been evaluated and found not eligible or not necessary for inpatient admission, exploring peer respite may be an option. In those cases, functional considerations include respite availability, screening, and transport processes.

Given the non-clinical nature of a respite program, it seems unlikely that respite would be considered by hospital systems to be a viable alternative for transfer for individuals already in process for inpatient hospital admission. Peer respite could also be a destination for individuals being discharged from the hospital, but great care needs to be taken to ensure that this is directed by the individuals

[46] Maucione, S. (2023) Maryland lawmakers may spend $12M to improve mental health crisis hotline, if bill moves forward. WYPR - 88.1 FM Baltimore

[47] Roberts, Angela. (2023) " 'We can do better': What's behind Maryland's long ER wait times?" Baltimore Sun

and not dictated by pressure from the system of care. Additionally, the current use of crisis residential programs for discharge and step-down from a hospital indicates a need for more diversion options.

Crisis-Adjacent Programs: CCBHC, MEIP, & ACT

While not falling within the commonly understood boundaries of the crisis response system, there are several program types which often work with individuals at higher perceived risk of experiencing crisis. They are included in the landscape analysis of crisis services as high-priority potential partners in promoting and connecting individuals served to explore peer respite.

- **Certified Community Behavioral Health Centers (CCBHC)**: CCBHCs are multiservice entities providing coordinated, comprehensive, open-access behavioral healthcare in the community. Crisis services and peer services are both included within the nine required services to be offered through this model. Updated CCBHC standards indicate centers may establish Designated Collaborating Organizations (DCO) agreements with standalone peer-run organizations for crisis alternatives such as peer-run respites and peer lines/warmlines. While Maryland currently has a limited number of CCBHCs in operation, and only one in Central Maryland (Sheppard Pratt in Baltimore City and Baltimore County), this model presents interesting collaboration opportunities for peer respite.
- **Maryland Early Intervention Program (MEIP):** The MEIP network of specialized programs offer a holistic approach and expertise in the early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults (age 12 - 25) at risk for, or in the early stages of, a mental illness with psychosis. As young adults experiencing diagnostic labels that include psychosis are likely to not only experience emotional distress but potentially a crisis of identity, peer respite offers affirming support from people who personally understand what this journey can be like.
- **Assertive Community Treatment (ACT) and Mobile Treatment:** ACT teams are a community-based service consisting of a multidisciplinary team providing intensive wraparound services to individuals who have been unable to utilize or have not been well-served by traditional services. There are 24 ACT teams currently operating across the state, with planned expansion. “Mobile Treatment” describes a similar service that does not meet the full fidelity standard for ACT as an Evidence-Based Practice.

Central Maryland Crisis Response System (CMCRS) Landscape

This section reviews the relevant stakeholder groups, programs, services, policy initiatives which may influence and impact the feasibility and fit of peer respite in the Central Maryland region.

GBRICS Partnership

The GBRICS Partnership was awarded a five-year Health Services Cost Review Commission (HSCRC) grant in 2021 to expand and strengthen the Central Maryland Regional Crisis System with the overall goal of reducing unnecessary Emergency Department use and police interaction for people in behavioral health crisis in the region. The grant funded four key initiatives to achieve these goals:

1. **Comprehensive Call Center:** Create a regional, integrated call center accessed by 988 that is supported with infrastructure for real-time bed and appointment capacity and referrals tracking, coordinated dispatching of mobile crisis response plus dashboard reporting.
2. **Mobile Response Teams Services:** Expand capacity and set regional standards following national best practices.
3. **Open Access Services:** Support behavioral health providers to offer same day walk-in/virtual services for people in immediate need of behavioral health care.
4. **Community Engagement and Outreach:** Support culture change to increase awareness and use of the 988 as an alternative to calling 911 or using an Emergency Department.

The efforts and investments of the GBRICS Partnership have led to significant expansions and improvements in the Central Maryland Crisis Response System (CMCRS), and peer respite programs have the potential to be integrated into this emerging infrastructure.

As of July 2023, the Regional 988 Helpline launched with a formal partnership among the three regional providers active in the Maryland 988 network. The new data platform is live and richer regional data is being gathered to support improved system management and investment. Several regional Mobile Response Teams have been established using a two person team made up of a clinician and a peer specialist. Open access services are available through several dozen community providers and can be scheduled 24/7 through the Regional 988 Helpline. Community engagement and outreach efforts are ongoing, including direct outreach to thousands of local residents and well-funded paid media campaigns.

Central Maryland Crisis Response System Service Providers

Warmlines: NAMI Maryland, Pro Bono Counseling Project, Native American Lifelines, and many local peer-operated Wellness & Recovery Organizations.

988 Call Centers: Baltimore Crisis Response, Inc, Affiliated Sante Group, Grassroots Crisis Intervention

Urgent Care or Walk-In Centers: Affiliated Sante (Baltimore County), Grassroots Crisis Intervention

MH Crisis Residential Programs: Baltimore Crisis Response, Inc (BCRI), Empowering Minds Resource Center, Sheppard Pratt Health Systems (Mosaic Community Services, Way Station), People Encouraging People, Key Point Health Services Inc. Prologue, Humanim, and Safe Journey House.

SUD Crisis Stabilization Beds: Tuerk House, Mountain Manor

Hospitals Systems: Ascension (Saint Agnes Hospital), Johns Hopkins (Howard County General, Johns Hopkins Bayview Medical Center, Johns Hopkins Hospital and Health Sys.), LifeBridge (Grace Medical Center, Sinai, Northwest, Carroll), MedStar (Good Samaritan, Harbor, Union Memorial, Franklin Square Medical Center), University of Maryland Medical System (UM Medical Center, Midtown Campus, St. Joseph Medical Center), Mercy Medical Center, Greater Baltimore Medical Center.

CCBHCs: Sheppard Pratt

MEIP Programs: Johns Hopkins Early Psychosis Intervention Clinic/Maryland EIP (EPIC/EIP), First Episode Clinic at the Maryland Psychiatric Research Center, Strive for Wellness Clinics at Walter P. Carter Center of the University of Maryland, and UMBC Psychology Training Clinic, Recovery After an Initial Schizophrenia Episode (RAISE) Connection Program at UMMS Midtown Campus

ACT and Mobile Treatment Teams: Grace Medical Center, Johns Hopkins Hospital, People Encouraging People, Sheppard Pratt (Mosaic), University of Maryland PACT, Recovery Center Of Maryland, Transformation Healthcare Inc., UMMS Mobile Treatment Unit, Healthcare Living For Families, Hope Health Systems Inc Mobile, Institute For Healing, Main Street Mobile Treatment Associates, Oasis Health Ventures, Temah Healthcare Services.

Regional Community Priorities: The GBRICS Partnership made community engagement an early priority and has sought to listen to the voices of people with lived experiences in the development of the new regional system. In 2021-22, a survey and series of roundtables were conducted to identify themes in stakeholders' experiences with behavioral health crisis and their attitudes towards the behavioral health system.[48]

The top challenge identified was earning the trust of communities and overcoming skepticism: "Many people shared difficult and painful experiences. Participants reported feeling disrespected by crisis staff or police, or that staff were condescending or dismissive of their situation. This is alarming considering the vulnerability of those in suicidal or behavioral health crisis. Others shared experiences where seeking help made things worse."[49]

Identified barriers included issues with timely connection to helpful services; a lack of high-quality mental health training across the system; inadequate coordination and follow-up between services; a lack of inclusive services for marginalized populations (people with disabilities, non-English speakers, refugees, transgender and nonbinary individuals, and/or youth who feel intimidated talking to an adult about mental or behavioral health challenges); and a need for less reliance on police to provide behavioral health crisis responses. Another recurring theme was that services that were originally designed to be low-barrier often became less so over time as requirements from funders or other entities narrow eligibility criteria, slow referral and intake processes, and overwhelm staff with administrative burden.

Peer respite aligns with many of the needs identified by these 350+ stakeholders, particularly in how it offers voluntary, inclusive services delivered by people with lived experience and expertise in mental health within a trust-based framework of mutuality.

Baltimore City 911 Diversion Pilot Program

In June 2021, a collaborative effort by the Baltimore City Fire Department, Baltimore City Police Department, and behavioral health agencies (Behavioral Health Services Baltimore and Baltimore Crisis Response, Inc.) launched the Behavioral Health 911 Diversion Pilot Program. Through the program, individuals experiencing a behavioral health crisis who call 911 are triaged with the goal of connecting them directly to counselors at BCRI. A secondary phase of pilot co-locates a behavioral health clinician in the 911 call center, which is a practice that has been adopted in several communities across the country with great outcomes. Overall, this program aims to not only produce a right-sized and timely response, but to generally improve awareness and linkage between law enforcement, fire, Emergency Medical Services, and available crisis-oriented resources in the community.

Since launch, as of April 2023, almost 60% of 911 calls routed through the pilot were successfully resolved by connection to 988 only. The other 40% received a co-response, meaning the caller was

[48] GBRICS Partnership. ?(2022). 2021-22 Community Engagement Report. Behavioral Health Systems Baltimore.
[49] Ibid

connected to 988 and a 911 first responder was dispatched. Of the calls routed to 988, only 30% required dispatch of a mobile crisis team. While location data for diverted calls isn't compared to population rates, the highest total number of diverted calls occurred in the Northwestern and Northeastern police department districts.[50]

Baltimore City Consent Decree

In 2017, the City of Baltimore entered into a consent decree with the U.S. Department of Justice to resolve findings that the Baltimore City Police Department had engaged in a pattern and practice of conduct that violated the First, Fourth, and Fourteenth Amendments to the United States Constitution. The Consent Decree requires the Baltimore City Police Department to adopt a number of specific reforms aimed at ensuring effective, safe, and constitutional policing.

Relevant to peer respite, two sections of the decree deal specifically with the City's legal obligation to decrease inappropriate criminal justice involvement for people with behavioral health disabilities or in crisis.[51] The Behavioral Health Gap Analysis Implementation Plan (rev. May 2022) outlines a multi-year approach to reducing unnecessary police encounters with people in crisis, specifically addressing 911 diversion and mobile crisis team response, crisis services integration, peer supports, and social determinants of health. The plan speaks directly to supporting the financial sustainability of peer-run organizations through a variety of funding streams, including partnering with foundations to create pilot grant opportunities for existing peer organizations, providing technical assistance to peer run organizations, and supporting training and employment opportunities related to Maryland's Certified Peer Recovery Specialist credential."[52]

Baltimore City Outpatient Civil Commitment Pilot Project

Peer respites operating in other states frequently work successfully with individuals who have struggled to connect or have been failed by traditional services, and who are targeted for forced-treatment approaches such as involuntary commitment.

In 2017, BHSB launched an Outpatient Civil Commitment (OCC) pilot program in Baltimore City, which represented a dramatic expansion of the use of involuntary commitment beyond Maryland's established use of the state statute for inpatient settings only.[53] While there are some similarities between Maryland's OCC program and what is commonly referred to as "Assisted Outpatient Treatment (AOT)," the difference is fundamental: the Baltimore City OCC program only involuntarily enrolls individuals who are already committed to an inpatient psychiatric hospital, serving as a condition of release. It also offers a pathway for individuals to voluntarily enroll in the program.

---

[50] Mayor's Office of Performance and Innovation (retrieved June 2023) 911 Behavioral Health Diversion Program Indicators and Diversion Map,.

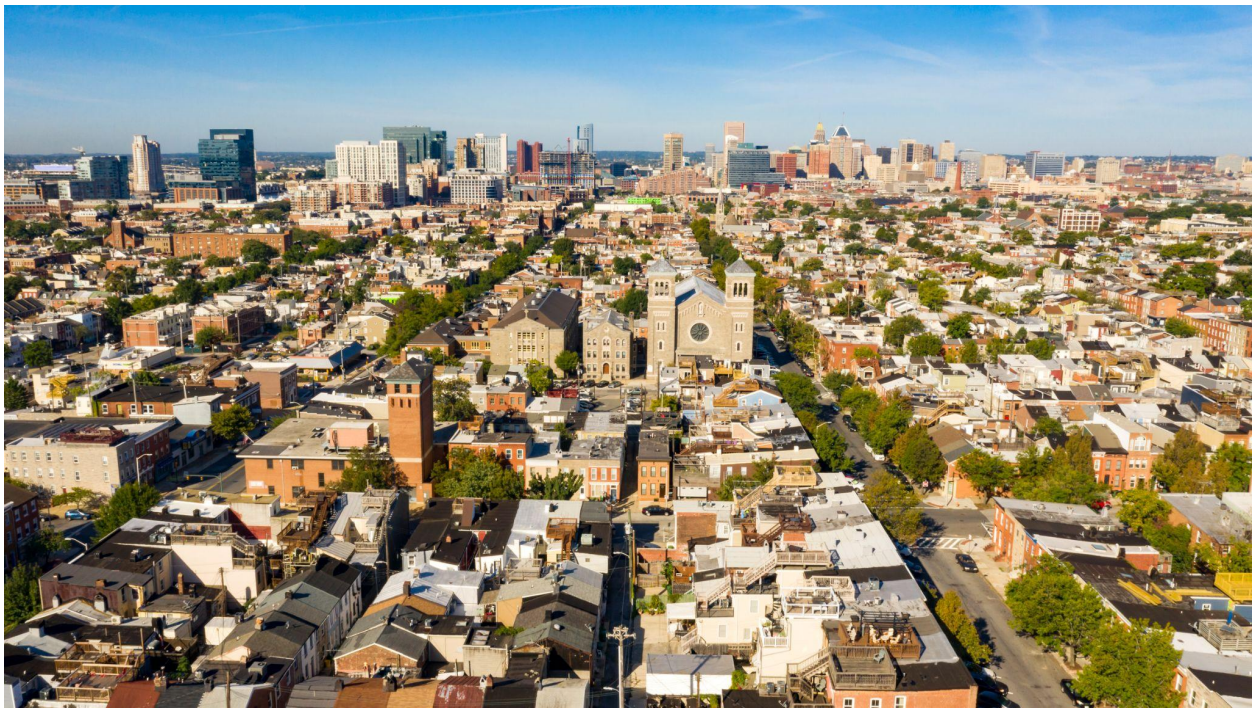
[51] *US v. Baltimore Police*, paragraphs 97-98

[52] City of Baltimore Public Behavioral Health Gap Analysis Implementation Plan 2nd Draft, 2022 pg. 32

[53] Maryland Register, January 6, 2017, "Subtitle 63 Community-based Behavioral Health Programs and Services 10.63.07 Outpatient Civil Commitment (OCC) Pilot Program," Volume 44, Issue 1, Pgs. 43—46

Participants are offered a comprehensive range of community-based and client-centered services and supports, with a strong focus on peer support services.

Note is made in this report of the Baltimore City OCC Program because the individuals enrolled represent Central Marylanders who have not been well-engaged or well-served by the traditional system for a variety of reasons, and who deserve the opportunity and choice of peer respite as a trauma-informed, non-coercive alternative to (re)hospitalization. While peer respite must occur on a strictly voluntary basis, the OCC Pilot program has demonstrated its understanding of the importance and effectiveness of peer support through the integration of these services throughout the program.



Services Utilization Data Analysis

Regional variance in types, availability, and accessibility of services in the four counties are typical of any large geography with varying population sizes, funding sources, and community structures. Within and between those dynamics, there are strong indications of the need and feasibility of peer respite programs to be successful.

Through the data collection and review phase, the PRS Project Team received over 1,700 data points related to the behavioral health crisis continuum. While crisis data queries revealed a vast amount of information, collecting data for the region and the state revealed several challenges for analysis to make educated inferences about system needs, namely:

- **Different Parameters:** Publicly shared data and local and state data from numerous sources were not always available from the same timeframes, making it difficult to compare data sets. For example, Emergency Department visits for a mental health condition were most recently available region-wide in 2017, but the proportion of ED visits for a behavioral health crisis was most recently available from 2019. Data is often siloed between the mental health and substance use systems, and reports from multiple local, state, and county sources use different formats and parameters, exclusions, or considerations for the data.
- **Lack of Comparisons:** While the pandemic created significant fluctuations in utilization of crisis services, data was not provided that included both pre-pandemic and post-pandemic statistics for comparison. The consistency and reliability of data for billable services during the last three years was considered with significant reservations, given the well-publicized challenges experienced with the contracted Administrative Services Organization vendor.

It is also important to note that the majority of available data on behavioral health service utilization informing this analysis represents individuals enrolled in Medicaid or participating in services which are funded through state or federal dollars. Encouragingly, a 2021 analysis by the Maryland Department of Health found evidence for "the long-standing supposition that when All-payer data is not available, Medicaid data can be used as a proxy for the wider population's experience." [54]

Encouragingly, BHA's Crisis System Advisory Workgroup's Data subcommittee is actively working through a two-phase process of standardizing and modernizing data collection across crisis services. With a focus on outcome measures, the new data solution is planned to include real-time collection and reporting, a robust set of data elements synced to national data sets for population-level impact analysis, as well as individual-level data to better track and understand how the crisis system is effectively achieving diversion from hospitals and correctional institutions.

[54] Maryland Department of Health. Transformation of Outpatient Mental Health Clinics to Crisis Stabilization Centers Grant: Data Analysis (2021)

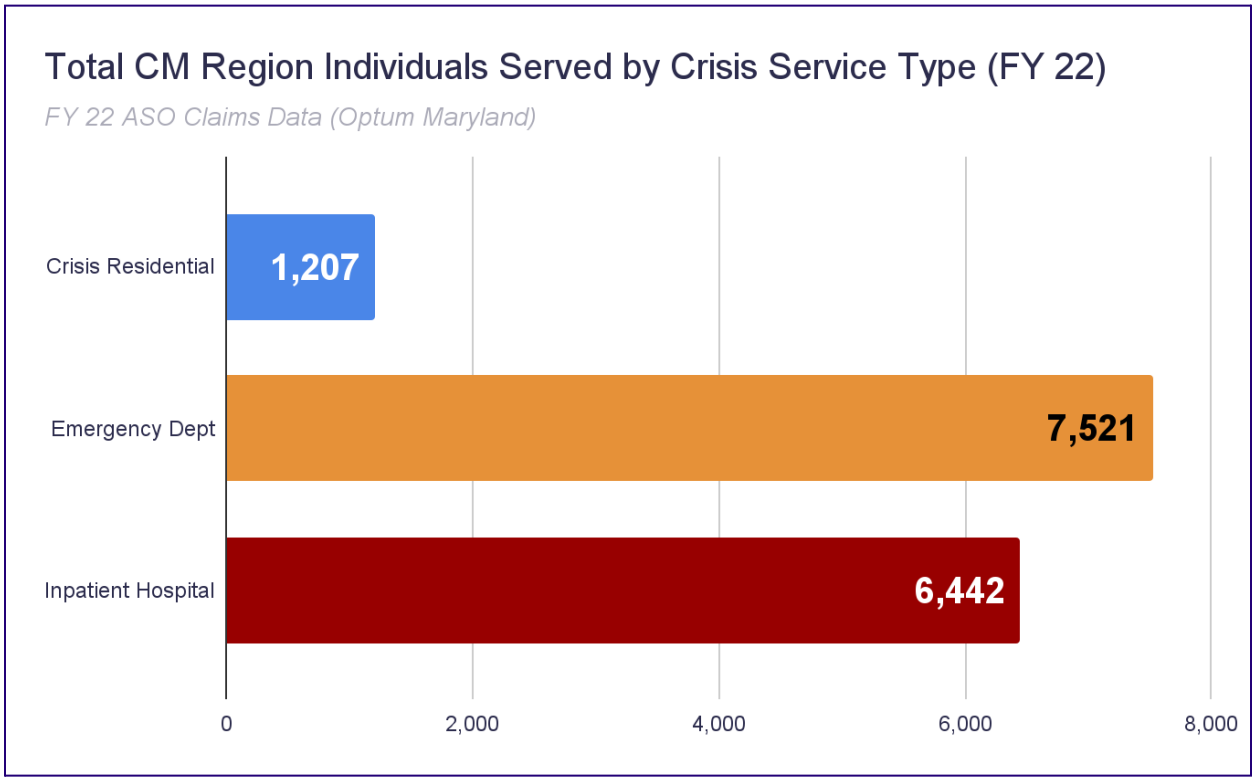
While implementation of the interim and full data management processes will be a significant effort, it opens important new opportunities to align future peer respites' data collection with the statewide system, and truly measure the positive impact and cost savings achieved.

At A Glance: Utilization & Cost of Crisis Services in Central Maryland

Based on FY 22 ASO Claims Data (Optum Maryland)

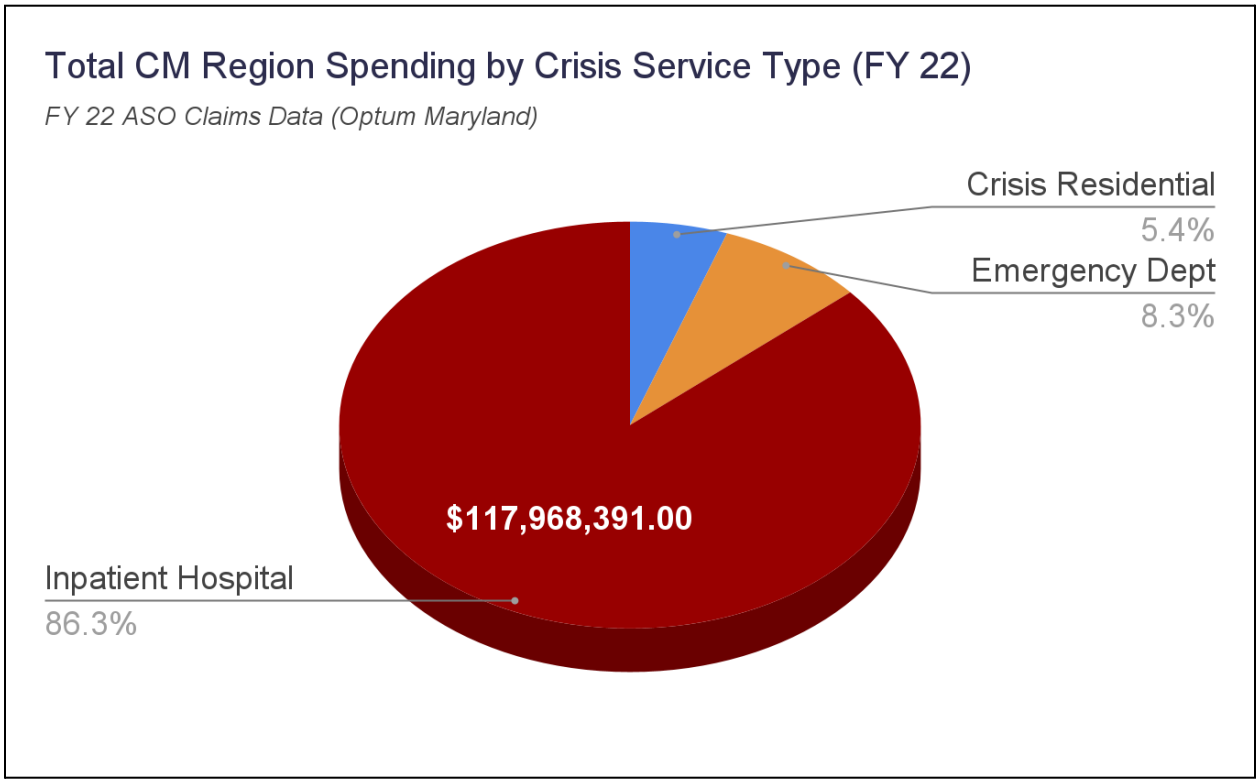
Individual Served

Type of Service	Baltimore City	Baltimore Co.	Howard	Carroll	Total CM Region
Crisis Residential	800	236	95	76	**1,207**
Emergency Dept	4,813	1,849	375	484	**7,521**
Inpatient Hospital	3,754	1,818	338	532	**6,442**



Total Cost of Services

Type of Service	Baltimore City	Baltimore Co.	Howard	Carroll [55]	Total CM Region
Crisis Residential	$3,656,024	$1,209,539	$579,298	$1,961,061	**$7,405,922**
Emergency Department	$8,075,144	$2,176,172	$630,861	$404,255	**$11,286,432**
Inpatient Hospital	$72,038,103	$32,119,032	$9,125,150	$4,686,106	**$117,968,391**



[55] The facilities designated as crisis residential in Carroll County are located on the grounds of the local state hospital, and are restricted to use as step-down programs for individuals discharged from the hospital but 'not ready' or not able to be placed in community settings, resulting in longer lengths of stay and higher costs.

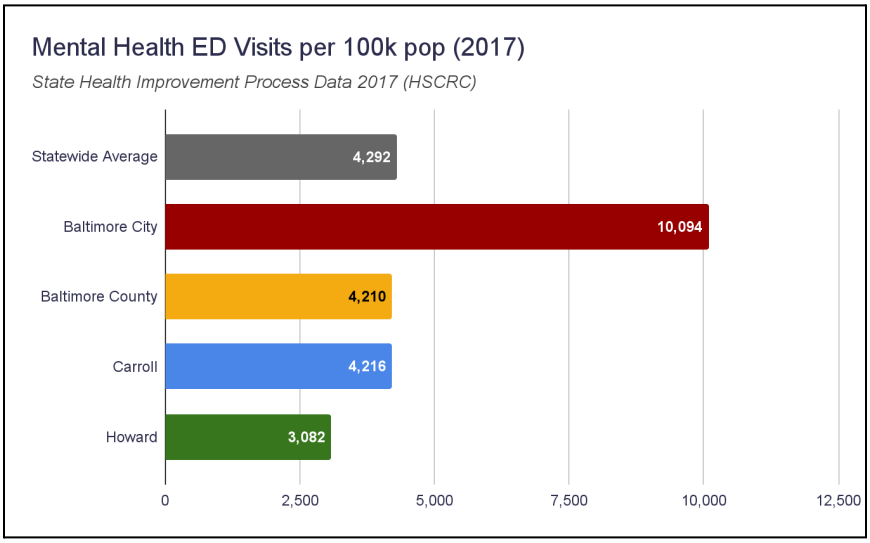
Behavioral Health Presentations in Emergency Departments

Why It Matters: *For many communities, Emergency Departments remain the de facto access point for behavioral health crisis care. Individuals presenting to the ED with emotional distress may be perceived by medical staff to need inpatient hospitalization when a less restrictive and intensive option, if available, could be helpful. If inpatient beds aren't available, persons experiencing a behavioral health crisis can experience "ED boarding;" staying days or even weeks awaiting appropriate placement.*

Interpreting Emergency Department (ED) utilization for behavioral health crises must balance considerations about population density, Social Determinant of Health factors that can be protective or precipitating for behavioral health challenges, the adequacy and accessibility (or lack thereof) of outpatient and community-based prevention, treatment, and support services, and the availability of alternate options for support at a given place and time when crisis may be experienced.

In 2023, Maryland reportedly had the longest ED wait times in the nation, at just under four hours, according to data from the Centers for Medicare and Medicaid Services.[56] However, the issue of long wait times existed well before the COVID-19 pandemic.

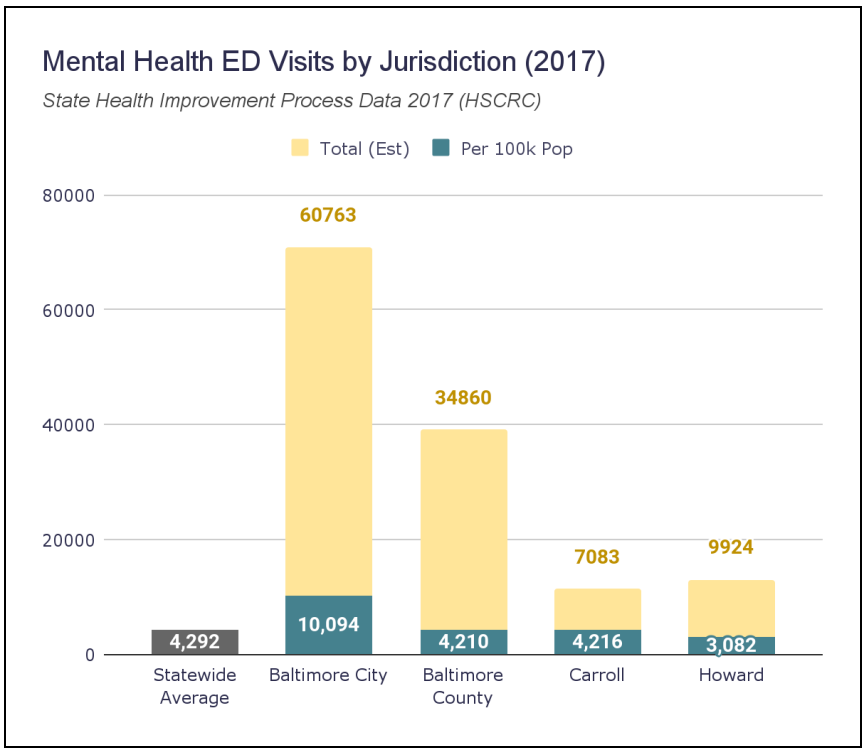
In 2016-2017, the Maryland Hospital Administration undertook a project to understand the causes of increased ED wait times, and found that "one of the primary causes of ED diversions and overcrowding is Maryland's behavioral health crisis… the number of ED visits by individuals with a behavioral health diagnosis rose by 18 percent between 2013 and 2015… One [hospital] CEO reported that on a single day, 75 percent of his facility's ED bed capacity was filled with behavioral health patients."[57]



As shown in the graph, the statewide average of ED visits related to mental health conditions was 4,292 visits per 100,000 people in 2017 according to data available through the Maryland Health Service Cost Review Commission's State Health Improvement Process (SHIP).

[56] Roberts, A. "'We can do better': What's behind Maryland's long ER wait times?". (2023). Baltimore Sun.

[57] Maryland Hospital Administration. Emergency Department Diversions, Wait Times: Understanding the Causes. (2016-2017)



While Baltimore, Carroll, and Howard counties all generally mirrored the statewide rate, Baltimore City experienced more than double the Maryland average.[58]

Given their respective populations, this can be calculated as over 60,000 visits in Baltimore City as compared to fewer than 10,000 visits in Howard or Carroll Counties.

In 2018, mental health accounted for 11.5% of emergency room visits statewide, but ballooned to nearly 48% in 2021 according to information from the Maryland Department of Health.[59] Stress, isolation, trauma, loss, anxiety, and depression related to the COVID pandemic strained individuals, families, and the healthcare system at large.

In 2021, the Maryland Department of Health analyzed the potential for standalone crisis stabilization centers to support ED diversion for behavioral health crises. The report estimated that the vast majority (83%) of persons in mental health- or substance use-related crisis seek and receive care in EDs, "despite these facilities being ill equipped to provide crisis care, resulting in poor health outcomes for individuals, as well as losses in productivity for health care providers, first responders (EMS), and law enforcement."[60]

Included in that 2021 analysis was a finding that 7 hospitals within the Central Maryland region ranked within the 15 Maryland hospitals with highest volumes of behavioral health ED visits in 2019. However, "EDs in Baltimore City saw the highest proportion of persons multiple times a year for [behavioral health] crisis, with nearly 40% of the persons seeking care at an ED for BH-crisis in Baltimore having two or more ED visits in one year," and nearly 5% considered "super utilizers" with more than 10 visits.[61]

[58] Maryland Health Services Cost Review Commission (HSCRC) (2019). SHIP Emergency Department Visits Related To Mental Health Conditions 2008-2017 [Dataset].

[59] Maryland 211. New Program Helps Emergency Rooms Connect Patients To Community Resources. (2022)

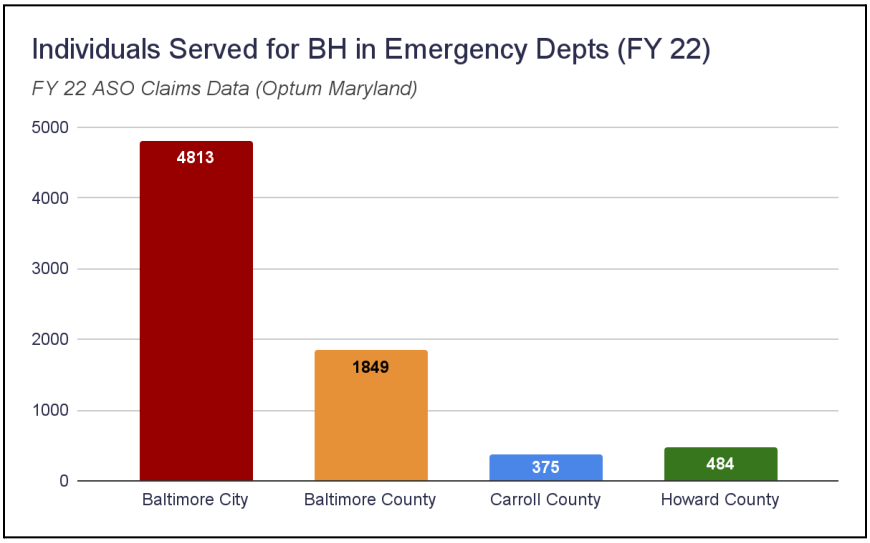
[60] Maryland Department of Health. Transformation of Outpatient Mental Health Clinics to Crisis Stabilization Centers Grant: Data Analysis (2021)

[61] Ibid

With respect to the proportion of substance use-related vs. mental health-related crises, Baltimore City experienced a fairly even split (slightly more than 50% of visits for substance use), Baltimore County had a slight majority for mental health (just below 60%), and Howard and Carroll counties had decidedly higher rates of mental health-related crises (between 60-70%).[62] The report also analyzed potential differences between mental health and substance use with respect to individuals with multiple ED visits, and found "no differences observed, indicating that… equal emphasis should be placed on [substance use] and [mental health] needs among the high-utilizer populations."[63]

Encouragingly, that report also found that up to 56% of behavioral health EMS/911 transports in Baltimore City could be potentially treated at a crisis facility instead, with the other three Central Maryland counties falling in the 35-52% range.

According to a 2019 GBRICS Regional Partnership report, only 23% of the 63,140 visits to a Central Maryland ED for a behavioral health condition were admitted to the hospital or kept longer than 23 hours in the ED.[64] This is a surprisingly low number compared to national averages of 70% inpatient hospitalization rate, and merits further analysis outside the scope of this study.



As shown in the graph, recent data on ED utilization for behavioral health for individuals in the Central Maryland jurisdictions in FY 2022 reveals that while Baltimore City's population makes up only 31% of the entire region, its ED utilization for behavioral health conditions is over 64% of the region's total.

However, an important caveat to note is that data sources track the location of services, not origin of the patient. As the excellence of Baltimore-area hospital systems attracts people from beyond the region, ED utilization for this county may be skewed by indeterminable fractions.

[62] Ibid

[63] Ibid

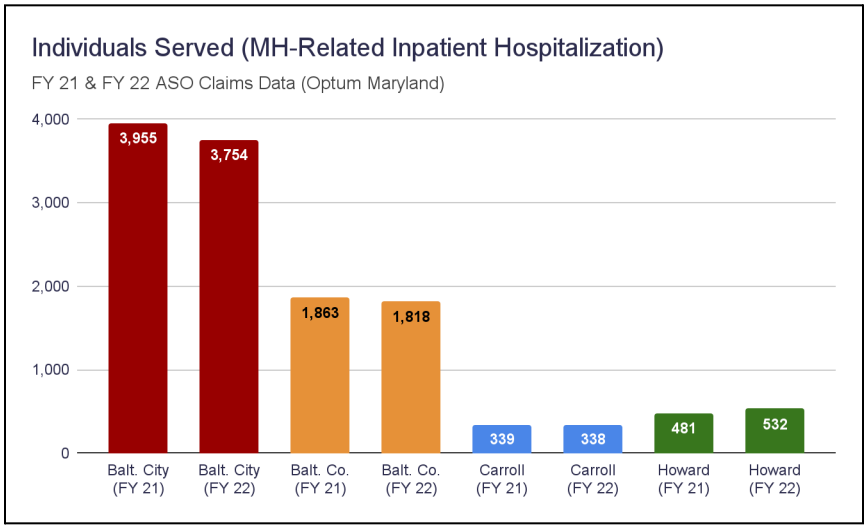
[64] Behavioral Health Services Baltimore. (2023). GBRICS Regional Partnership Report, utilizing data from CY2019 Case Mix IP and Observations

Considering the estimates for possible ED diversion found in BHA's 2021 analysis and the rates of non-admission for individuals presenting in the ED according to the 2023 GBRICS Regional Partnership Report, there are promising indications that between 56-75% of individuals seeking help for emotional distress or behavioral health crisis through the 911/EMS system or an ED could be ideal candidates for peer respite.

Inpatient Psychiatric Hospital Utilization

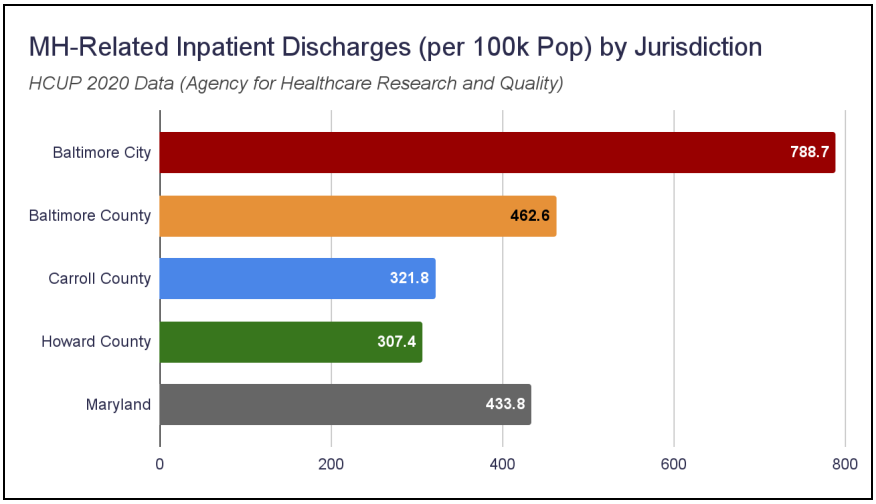
Why It Matters: *The presence and utilization of peer respites in a community has been demonstrated to reduce the use of emergency departments, inpatient psychiatric hospitals, and overall medical spending.[65] However, these are all additional benefits to the primary reason to develop a peer respite: to serve a person in crisis with dignity and respect while maintaining their agency and choice. Peer respites' ability to divert people from a psychiatric hospitalization through earlier intervention may have a considerable impact on hospital discharge statistics. Projected savings actualized from a peer respite visit versus an inpatient psychiatric admission are shown in* **Appendix A: Peer Respite Cost Savings.**

As the most expensive and intensive treatment option in the crisis continuum, inpatient psychiatric hospitals are responsible for a significant portion of a community's overall behavioral health budget. Historically, communities that have an abbreviated continuum of crisis services use inpatient hospitalization to address many of their needs related to individuals experiencing a psychiatric emergency, creating supply issues that lead to ED boarding of individuals in crisis. A dynamic relationship between psychiatric hospitals, residential crisis programs, and peer respites help to assure people receive right-sized treatment in the least restrictive settings.



Inpatient psychiatric beds are available in every county in the region. Baltimore City has 12 inpatient psychiatric units, Baltimore County has 6 units, Carroll County has 2 units, and Howard County has 2 units. In FY 2022, a total of 6,442 individuals experienced inpatient psychiatric hospitalization funded through Maryland's public behavioral health system.

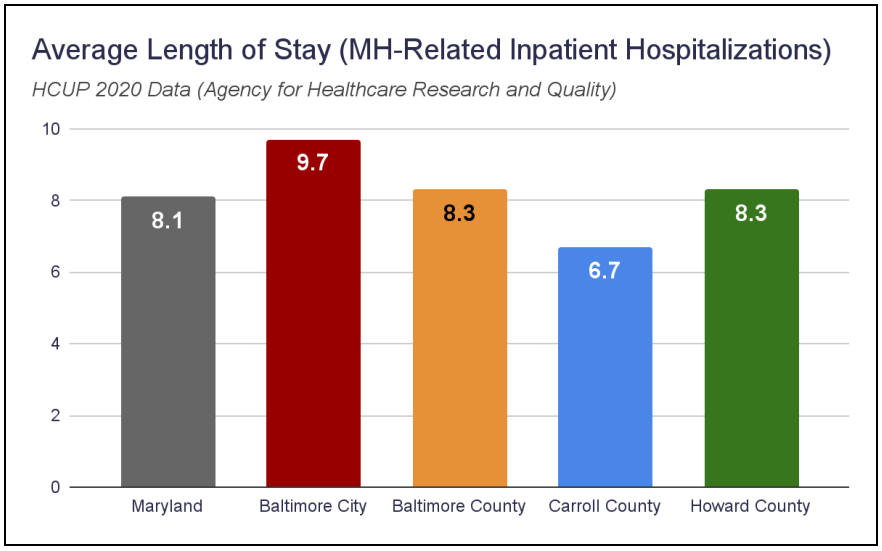
[65] Croft, B., and Isvan, N. (2015). "Impact of the 2nd Story Peer Respite Program on Use of Inpatient and Emergency Services.". Psychiatric Services.



Analyzing discharges per 100,000 population provides a utilization metric that allows comparison between counties as to how often hospitalization is relied upon as a service. The graph shows inpatient psychiatric hospital discharges for each part of the Central Maryland crisis system region in 2020.[66]

While the pandemic may have adversely or uniquely impacted hospital utilization data, vast discrepancies were observed across the region. Baltimore City's inpatient psychiatric hospital discharge rate (789 per 100k population) was 80% higher than the statewide average (434) and 2.6 times higher than the lowest county in the region, Howard County (307). Despite having a developed crisis continuum, Baltimore City's reliance on inpatient psychiatric hospitalization indicates an opportunity to expand its crisis services through a peer respite.

Reviewing the average length of stay (ALOS) for inpatient psychiatric hospitalization illuminates how much time an individual is spending in a locked treatment setting and removed from their community.



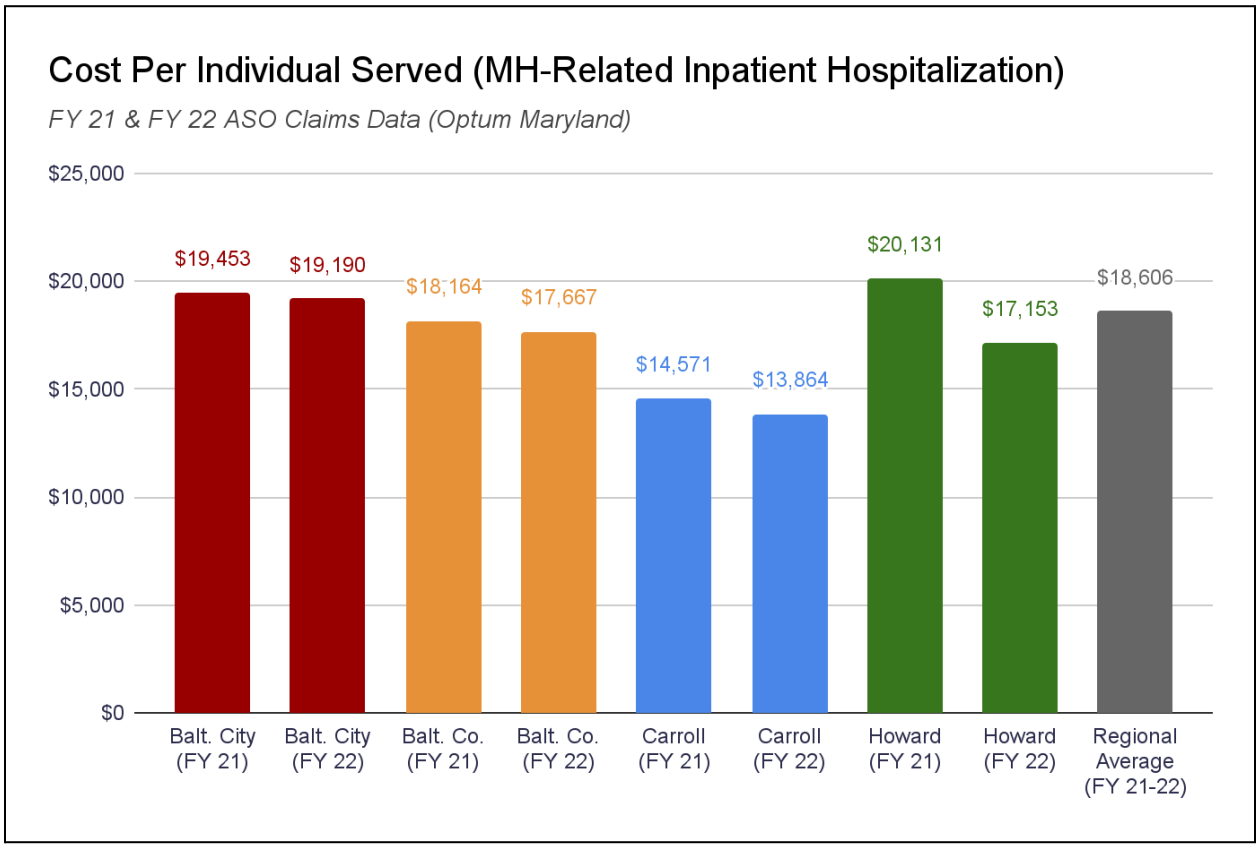
The graph compares the average length of stay (ALOS) for mental health-related inpatient psychiatric hospital visits in the four regions and includes Maryland's overall average length of stay for comparison. Baltimore City's ALOS of 9.7 days is highest in the Central Maryland region and 20% higher than the statewide average.

[66] Ibid.

Both Baltimore County and Howard County are within 2% of the statewide ALOS average, and Carroll County is 17% lower than the statewide average. [67]

The PRS Project Team analyzed utilization, total cost, and cost per individual served for inpatient psychiatric hospitalizations in the region over FY 2021 and FY 2022.[68]

The average cost per individual experiencing psychiatric hospitalization in the region in FY 2021 and FY 2022 ranged from $13,864 to $20,131, with a regional average across both years calculated as $18,606 per individual. Using average lengths of stay and cost per individual served by county reveals a per diem inpatient psychiatric hospital rate just over $2,000 per day.[69,70]

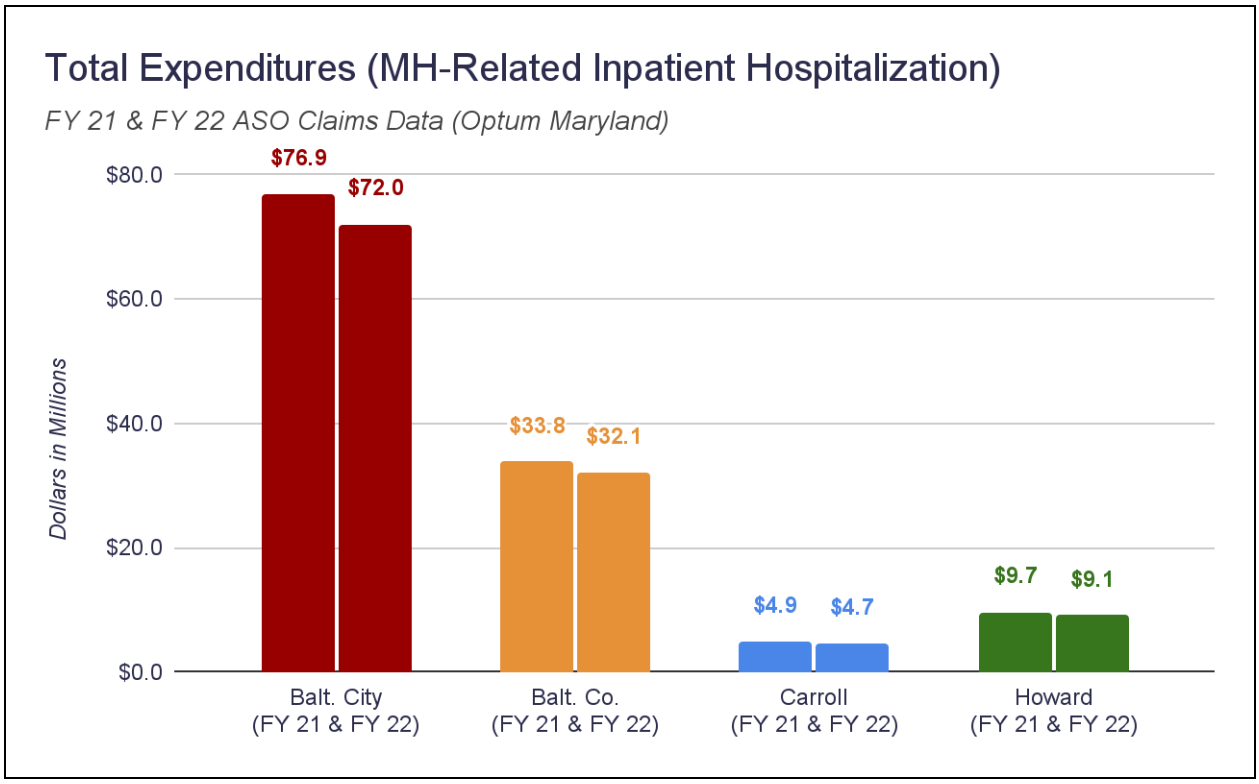


[67] HCUPnet. (2023). Healthcare Cost and Utilization Project, Agency for Healthcare Research and Quality.

[68] Based on ASO Optum claims paid through 02/26/2023. Data for FY 2022 should not be considered complete, as a provider has 12 months from the time of service in which to submit a claim.

[69] Calculations are approximate as data sources originate from different years; average length of stay data is from 2020, while cost and utilization data is from 2021 and 2022.

[70] According to information obtained through on-site interviews, inpatient psychiatric hospitals in Maryland are paid in a Diagnosis Reimbursement Group (DRG), meaning visits are paid based on the presenting condition for the entire length of stay instead of at a per-day rate. This incentivizes the hospitals to deliver high-quality care efficiently so that each stay costs less, compared to a fee-for-service arrangement which may in effect incentivize longer stays.



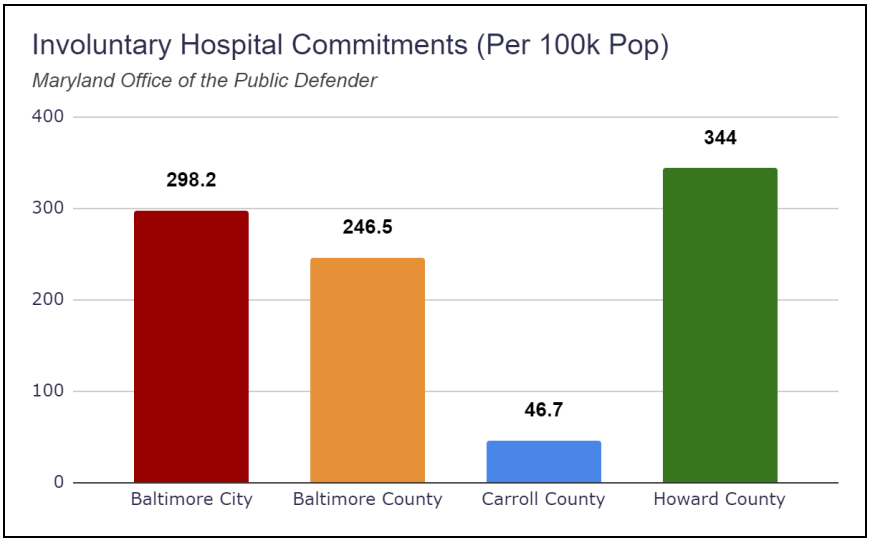
As compared to FY 2021, the total expenditures across the region appear to have experienced a slight decrease (avg. 5.6%) with approximately 200 fewer individuals served. The only county with a notable shift from FY 2021 is Howard County, which saw a 10% increase in individuals served in FY 2022.

FY 22 Inpatient Hospitalization Utilization & Cost					
	Baltimore City	**Baltimore Co.**	**Howard Co.**	**Carroll Co.**	**Total CM Region**
Individuals Served	3,754	1,818	338	532	**6,442**
Per Person Cost	$19,190	$17,667	$13,864	$17,153	**$18,312**
Total Spending	$72,038,103	$32,119,032	$4,686,106	$9,125,150	**$117,968,391**

Involuntary Hospital Commitments

Why It Matters: *Involuntary hospital commitments are responsible for some of the most trauma-inducing services in the crisis continuum. Understanding how a community involuntarily hospitalized its citizens in crisis – as well as its monitoring and commitment to reducing the rates – provides an indicator for their tolerance for hospital alternatives such as peer respite.*

Communities boasting a well-functioning and recovery-oriented crisis continuum strive to keep individuals in crisis in the least restrictive and least intrusive setting possible. The psychological impact of involuntary evaluation (Emergency Petition,"EP"), hospitalization (Involuntary Admission, "IVA"), and/or civil commitment should make these measures a last resort that must be monitored toward goals for minimal use. Similar to restrictions on the use of physical and chemical restraints in healthcare facilities, the consideration of enacting involuntary interventions shouldn't neglect their potential negative and lasting impact.



The graph depicts the involuntary hospitalization rates for the region per 100k population.[71] Carroll County shows a remarkably low rate of involuntary hospitalization, over 7 times lower than Howard County and over 5 times lower than Baltimore County or Baltimore City.

The comparison of national and statewide involuntary commitment information is complicated by the stark state-to-state variations in laws and reporting requirements surrounding the commitment process across the country. Of the 25 U.S. states that collect and report on involuntary commitment data, the average detention rate in 2016 was 309 per 100,000 people, placing Howard County above the 2016 national average, Baltimore City and Baltimore County below average, and Carroll County significantly below average.[72]

The decision to use an involuntary intervention should only come after extensive consideration of all other voluntary options and the potential consequences for the person in crisis. It is surprising that despite this decision-making process occurring in the most vulnerable and volatile of circumstances,

[71] Maryland Office of the Public Defender, Mental Health Division (2023).

[72] Lee, G. and Cohen, D. (2020). *Incidences of Involuntary Psychiatric Detentions in 25 U.S. States*. Psychiatric Services

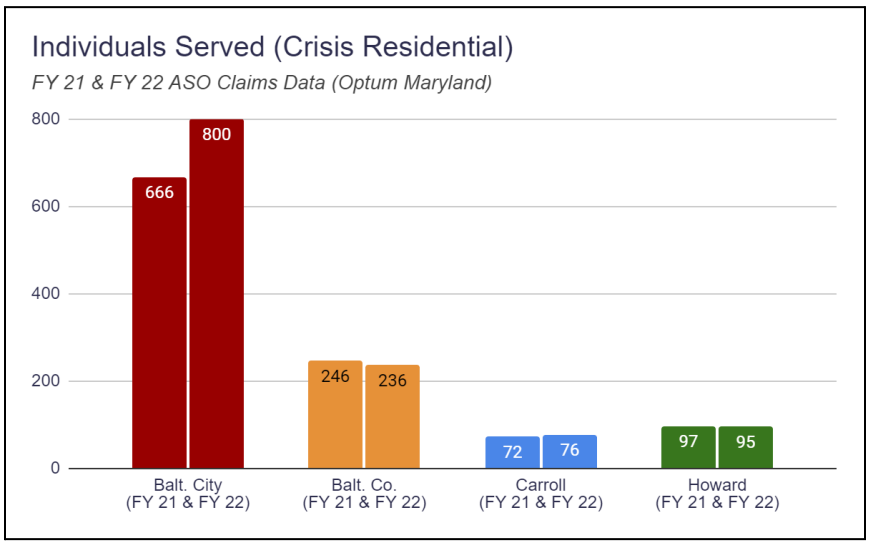
with the demonstrated potential for significant (re)traumatization and deadly harm, no statewide training standards or initiatives currently exist to equip the relevant professionals with adequate, up-to-date knowledge of the legal, ethical, and health implications of each step of the involuntary commitment process. The Central Maryland Crisis Response System is in the process of improving training and data collection regarding involuntary commitments, but much work remains to be done.

In 2014 and 2021, BHA-convened stakeholder workgroups on the topic of involuntary commitment came to agreement that more training on involuntary commitment criteria and processes were needed to address observed misuse and suspected disparate impact. Maryland's Public Behavioral Health System cannot consider itself to be "trauma-informed" without addressing these expressed and observed needs in policy and practice.

Crisis Residential

Why It Matters: *Crisis residential services (also referred to as residential crisis programs) and peer respites both offer diversion from inpatient psychiatric hospitalization. In some cases, these programs can also serve as a stepdown from psychiatric hospitals. Understanding a community's perception and use of crisis residential services, can provide an indication of how well peer respite will be received.*

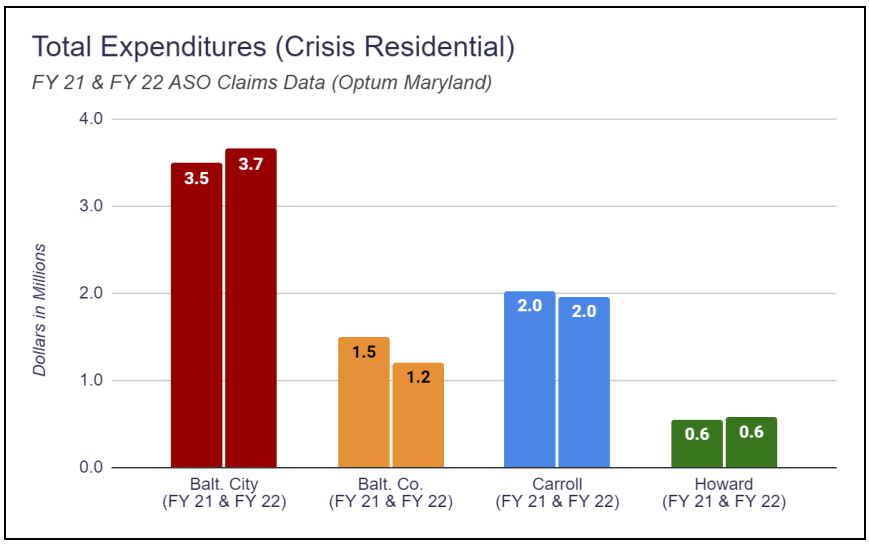
More alike to peer respite than other types of services, crisis residential programs are generally unlocked, serve individuals with a recovery-oriented approach to care, strive to offer a comfortable environment, and operate on the premise that the program model offers more potential for good outcomes than the perceived or actual risks they pose.



Crisis residential programs in the Central Maryland region served approximately 1,200 individuals in FY 2022, and the average cost per individual ranged from $4,600 to $6,100 per stay.[73,74]

[73] Baltimore City, Howard, and Carroll also host substance use crisis beds related to the State Opioid Response (SOR) program; these are not included in the analysis as they function under different parameters.

[74] ASO Optum Claims



For Baltimore City, Baltimore County, and Howard County, crisis residential services provide an average cost savings of 64% to 73% compared to psychiatric inpatient stays.

The facilities designated as crisis residential in Carroll County are located on the grounds of the local state hospital, and are used as step-down programs for individuals discharged from the hospital but 'not ready' or not able to be placed in community settings, resulting in longer lengths of stay and higher costs.

Mobile Crisis

Why It Matters: *Mobile crisis teams work to stabilize a person's mental health crisis in the community, with a goal of diverting people from a more intensive level of care. Mobile crisis teams can be a strong partner and referral source for peer respite programs.*

The GBRICS Partnership's *Environmental Scan of Crisis Hotlines and Mobile Crisis Teams* 2019 report profiled the availability and features of these services across the region. With the exception of BCRI in Baltimore City, all MCT services in place use a co-responder model where law enforcement accompanies the behavioral health team. Particularly relevant to this study are the criteria used to determine dispatch of a mobile crisis team, approximate number of calls responded to on a monthly basis, and approximated rate of interactions resulting in Emergency Petition. Together, these reveal the practical consideration and service flow in each county:

- **Howard County** (Grassroots): MCT is dispatched by the police department. The County may request MCT to solve issues of homelessness, eviction, or other issues. 100-199 calls per month. 19% EP rate. *Note: Grassroots also serves youth and young adults.*
- **Carroll County** (Santé): Consumers can call the crisis line and complete an intake requesting dispatch defining their own crisis, or police dispatch MCT. 50-99 calls per month. 5% EP rate.
- **Baltimore County** (Santé): Hotline determines there is a need for a face-to-face assessment which is more acute than an appointment with the organization's Urgent Care Center. Police refer all behavioral health related calls from 911/patrol to MCT teams if a team is available. 200-299 calls per month. 19% EP rate.

- **Baltimore City** (BCRI): Hotline determines the caller is at least 18 years or older, is suspected of having a DSM V diagnosis, and is exhibiting the following: experiencing a mental health crisis, may be exhibiting behavior that is threatening to self or others but can contract for safety, may be experiencing rapid deterioration of functioning due to psychiatric symptoms. 200-299 calls per month. 65% EP rate.

Baltimore Crisis Response, Inc. (BCRI) served over 2,600 people through mobile crisis team visits in FY 2022, which equates to approximately 7 visits per day. Notably, BCRI operates the additional Mobile Crisis Teams funded through the Central Maryland Regional Crisis System, which respond across the Central Maryland Region. Howard County's MCT served over 1,100 people (3 per day), and Carroll County's MCT served 552 people (1.5 people per day).

Estimating Crisis Episodes and Peer Respite Capacity

The *Crisis Now Calculator* estimates that approximately 200 behavioral health crisis episodes occur monthly for every 100,000 population.[75] This equates to the following estimates for crisis episodes in each county region:

County	Population	Estimated Crisis Episodes *(per Month)*	% Referrals to Peer Respite Needed
Baltimore City	602,000	1,204	2.5%
Baltimore County	828,000	1,656	1.8%
Carroll County	168,000	336	8.9%
Howard County	322,000	644	4.7%
Regional Total	**1,920,000**	**3,840**	**0.8%**

Knowing that it takes approximately 30 referrals a month to keep a 4-bed peer respite at 100% capacity,[76] three of the four county regions (Baltimore City, Baltimore County, and Howard County) could each keep a peer respite filled to capacity by referring fewer than 5% of individuals in crisis.

For a single 4-bed respite able to accept referrals from anywhere in the region, less than 1% of crises in Central Maryland would need to be successfully referred in order to maintain full capacity.

[75] Crisis Now. (2023). Calculate Your Local Crisis Need: The Volume Estimation and Clinical Distribution Guide,

[76] Based on an average of a one week stay per guest, 28-30 referrals per month are needed to keep a 4-bed peer respite at capacity.

Environmental Scan of Peer Services

Environmental Scan of Peer Services

Recovery is not a linear process, and it requires chosen supports to be consistently integrated throughout all aspects of a person's life. The limited but powerful experiences during a few days' hospital stay can increase stress and stigma, and often have little practical influence on precipitating and perpetuating factors that can continue a 'crisis cycle' if left unaddressed upon returning home.

Peer support services, including peer respite, offers opportunities for the individual to work through their crisis in a supportive, non-judgemental manner and learn how to practice recovery and wellness concepts and tools with others who use these skills in their everyday lives.

Maryland's Peer Support Landscape

The number of individuals practicing peer support in a formal or semi-formal role in Central Maryland is vast and uncountable, as it includes community support groups such as 12 step programs, Depression and Bipolar Support Alliance (DBSA) groups, National Alliance on Mental Illness (NAMI) Peer-to-Peer groups, as well as issue-specific peer support groups, such as on grief and loss, chronic pain, cancer, or other illnesses.

Formal, professional, and paid peer support positions within Maryland's behavioral health system have been steadily growing over the last decade. Peer support specialists can be found in community-based programs such as Wellness Recovery Centers (mental health) and Recovery Community Centers (substance use), in recovery-supportive housing programs, in treatment programs such as on Assertive Community Treatment (ACT) teams and Opioid Treatment Programs (OTP), in local Health Departments, on Mobile Crisis Teams (MCT) and in Urgent Care Centers, and in hospital-based in Emergency Departments and inpatient units.

As standalone peer support services were not eligible for reimbursement through Medicaid before 2023, most paid peer support positions have been within the context of special grants, contracts, or projects within provider agencies, or in a state-funded Wellness & Recovery Center or Recovery Community Center.[77] Within the public behavioral health system, BHA's Office of Community Based Access and Support provides oversight of a large portfolio of peer-operated programs and peer services. The number of state-funded peer support positions has rapidly expanded in the last decade, with 140% growth between 2017 and 2022 (193 to 470).[78]

[77]Notably, the U.S. Department of Veterans Affairs (VA) has been an active proponent of peer support, even before a 2014 Executive Action expanded the role of peer specialists in primary care Patient-aligned Care Teams (PACT).
[78]Behavioral Health Administration. (2021). *Maryland's Peer Recovery Specialist Workforce Survey* Presentation

The recent expansion of crisis services has also opened up more opportunities for peer support staff to be integrated into specific service settings, including:

- **Crisis Walk-In / Urgent Care:** In July 2022 the state approved four new peer support positions in new centers, with an expansion goal to reach up to 12 jurisdictions by 2025.
- **Mobile Crisis / Response Teams:** While MCTs across the state use a variety of staffing models, a key component of the Central Maryland Crisis Response System initiative is to establish additional Mobile Response Teams consisting specifically of a peer and clinician.
- **Emergency Departments:** Peer support specialists are stationed in some Emergency Departments across the region, often related to SBIRT (Screening, Brief Intervention and Referral to Treatment) initiatives for substance use recovery.

Statewide & Regional Peer Support Organizations

In 1983, a peer-operated nonprofit organization, On Our Own, Inc., was the first in the United States to receive federal and state funds to open a consumer operated drop-in center in Baltimore City. The center stood as definitive proof of concept that people with lived experience could successfully operate programs "on our own," and subsequently inspired a network of similar peer-led support and advocacy groups to form in other parts of Maryland over the next decade.[79] In 1992, leaders from across this network established a separate nonprofit organization, On Our Own of Maryland, to continue expanding peer-run alternatives as well as advance training, policy, and advocacy initiatives at the statewide and systems levels.

For over 30 years, OOOMD has been a leader and active partner in transforming Maryland's public behavioral health system to become more person-centered, trauma-informed, recovery-oriented, and participant-driven. OOOMD innovates peer-driven solutions to address emerging needs in the behavioral health system and the peer/consumer community through a diverse array of education and advocacy projects including the Anti-Stigma Project, Transitional Age Youth Outreach Project, peer support practices training (ex: Wellness Recovery Action Plan (WRAP), Intentional Peer Support (IPS), conferences and events), and peer representation in system policy, planning, and implementation initiatives. OOOMD is an independent, peer-run nonprofit organization, with a substantial majority (at least 60%) of the Board of Directors and all staff members being people with lived experience of behavioral health challenges.

A more recently developed statewide peer network is the Maryland Peer Advisory Council (MPAC), a peer-run advocacy, outreach and training program for individuals, families, allies, faith-based community members, and supporters who advocate on local, state and national levels to address, and influence social change to include actionable efforts for recovery. Launched in 2012, MPAC grew out of

[79] The name "On Our Own" is an homage to pioneering mental health consumer/survivor/ex-patient activist Judi Chamberlin's book, On Our Own: Patient-Controlled Alternatives to the Mental Health System (McGraw Hill, 1979).

the Baltimore Recovery Corp (2011-2018) initiative, and is sponsored by The Light of Truth Center, a nonprofit organization which offers supportive recovery housing to women. MPAC's Advocacy & Leadership Program offers cohort-based training and mentorship opportunities to educate and equip peer leaders in a variety of roles and settings.

It is also important to acknowledge the history and contributions of many other regional organizations with strong mental health and/or substance use peer support components (ex: NAMI Metro Baltimore, DBSA Greater Baltimore Area Chapter, regional AA/NA associations) as well as the statewide credentialing agency for peer support specialists and other certifications, the Maryland Addiction & Behavioral-Health Professionals Certification Board (MABPCB).

Peer-Operated Wellness & Recovery Organizations (WROs)

This section reviews the independent, nonprofit, peer-operated Wellness & Recovery Organizations (WROs) active in the statewide OOOMD affiliate network, as these organizations are positioned for the greatest capacity for peer respite operations: necessarily peer-operated in structure and governance, and actively providing peer support services in their communities from a brick-and-mortar facility.

As of the date of this report, there are 16 peer-operated Wellness & Recovery Organizations (WROs) active in the statewide OOOMD affiliate network. While each is a unique organization and independent legal entity, they are all grounded in the common values of peer support and seek to align with OOOMD's *Standards of Affiliation*, which were formally launched in 2023. In FY 22, the entire statewide OOOMD-affiliated WRO network served nearly 6,400 unique individuals.

WROs typically operate brick-and-mortar Wellness & Recovery Centers, which offer open access, no-cost peer support and recovery resource navigation assistance services to any community member, regardless of diagnosis or insurance status. The vast majority of individuals finding support through WROs face multiple barriers to recovery, including instability or absence of housing. employment, insurance, family support, and/or connection with health services. In the Central Maryland region, there are five peer-run, OOOMD-affiliated WROs: On Our Own, Inc., On Our Own of Howard County, On Our Own of Carroll County, Hearts & Ears, and Helping Other People through Empowerment (H.O.P.E). (See **Appendix G: Central Maryland Peer-Operated WROs** for more information.)

As discussed in this report, entities seeking to open a peer respite must have substantial administrative capacity and organizational fortitude to sustain a 24/7/365 program model that is not yet widely understood by the traditional behavioral health world, and which requires highly trained, highly supported staff to maintain fidelity and achieve intended outcomes. Reviewing Maryland's current level of financial commitment to supporting standalone peer support organizations provides a baseline for exploring what additional support might be found for peer-operated respite.

Core funding for Wellness & Recovery Centers is provided through annualized contracts with the Local Behavioral Health Authority (LBHA) at the county or regional level, with baseline conditions of award and funding levels established by the Behavioral Health Administration at the state level. The total funding awarded by BHA for Wellness Recovery Centers (mental health dollars) was just under $3.9 million in FY 23, of which 86% went to peer-operated organizations and 14% went to provider organizations with peer-staffed programs. A separate funding stream for Recovery Community Centers (substance use dollars) totalled $3.6 million in FY 23. Some peer-operated WROs hold both WRC (mental health) and RCC (substance use) contracts, and some have been able to secure other public and/or private funding to add or expand services, such as harm reduction, transportation, peer workforce development training programs, etc.

While decades of dedicated state funding has been the key to sustainability for the OOOMD-affiliated WRO network, it has been inadequate with respect to growing organizational capacity. In 1999, the Mental Hygiene Administration (predecessor of the Behavioral Health Administration) established a standard operating budget for peer support centers at just $65,000/year, which barely supported a single full-time staff person, and did not provide for operating essentials like appropriate staff training, adequate liability insurance, or bookkeeping and audit services. In 2006, OOOMD successfully advocated for an increase to this baseline budget to $114,000/year, concurrent with a strategic shift from a "drop-in" model to a "wellness & recovery" focus. This was envisioned to support a staffing structure of one full-time executive director ($15/hr or $31,200/yr), and two part-time assistants. For context, the national average for a social worker salary around that time was just over $50,000/yr.[80]

As of FY 23, the statewide median WRC contract budget is approximately $146,000/year, and the average award for WRCs located in the Central Maryland region is $182,000/year. Anticipated percentage increases (per legislation) could bring that median budget to just under $200,000/year. What this reveals is that most of Maryland's peer-operated organizations are still not suitably financed to be fully staffed (with appropriate pay and benefits) for dynamic programming at least 40 hrs/week.

In order for an existing peer-operated organization such as an OOOMD-affiliated WRO to be prepared to operate a respite as part of a continuum of peer support services, significant investment will need to be made in the following areas:

Staffing: WROs must increasingly compete with large entities like hospital systems and traditional provider agencies when recruiting and retaining qualified peer professionals for staff positions, and so will need to sufficiently match market salary and benefit packages. Even in some government-funded positions, peer workers are relegated to part-time or contractor status and thus prevented from accessing important benefits such as employer-sponsored healthcare. Additionally, significant investment needs to be made in initial and ongoing training specific to crisis support, as discussed further below.

[80] The National Association of Social Workers Center for Workforce Studies (March 2006) Licensed Social Workers in the United States, 2004.

Facilities: In order to truly provide no/low-barrier services, WROs need to be located in areas with high access to community services (e.g. transportation, health services, employment hubs, etc.) and in buildings which support a welcoming, healing, and hopeful environment as well as appropriate space for administrative functions. Just in the Central Maryland region, two WROs have had to move locations in the previous 18 months and another is considering a move due to continuous difficulties with building maintenance needs or landlord relations. While some WROs are located in spaces that can easily support meal preparation, shower and laundry facilities, and extended hours (7 days/week, evenings, weekends), others are operating out of spaces that cannot accommodate such activities.

Organizational Capacity Expansion: Most WRO Executive Directors are actively involved in providing some level of direct service on a day-to-day basis, sacrificing time needed for operational and strategic management functions like resource development (activating Board members, expanding partnerships, growing funding sources) or leading organizational performance and quality improvement efforts. Adding peer respite as an additional program under an existing local peer-operated organization would require a boost in funding to support additional dedicated FTEs to manage administrative, data, and financial responsibilities as well as additional direct service staff.

Peer Workforce Expansion

Maryland, and specifically the Central Maryland region, has the distinction of a long and storied history of promoting and supporting independent peer-operated organizations as well as growing the number of peer support positions in treatment service settings. In this section, we highlight the existing strengths, and opportunities for further developing the professional peer support workforce as will be necessary to successfully launch peer respites.

The broad and diverse range of formal and informal peer support groups across Central Maryland offers a tremendous pool of potential candidates for recruitment into a professional peer support career track. In a peer respite program, the benefits of having certified peer staff include assurance of core competencies, accountability to the code of ethics, expectation of continuing education, and the ability to meet any funder requirements related to credentialing. However, certification takes considerable investment of time, money, and personal effort from trainees and trainers. Currently, peers working in traditional behavioral health settings are generally required to either have their CPRS designation or obtain it within a certain amount of time after hire. In many peer-operated WROs, staff are encouraged but not always required to achieve certification, subject to funding contract requirements.

Training and Certified Peer Recovery Specialist (CPRS) Certification

While there are sets of nationally-recognized core competencies, best practice standards, and ethical guidelines, there is no single, universal, authoritative standard by which peer support professionals are currently credentialed.[81] Instead, certification is determined on a state-by-state basis as is the case with many other professional designations in healthcare.

Since 2013, the State of Maryland has recognized the Certified Peer Recovery Specialist (CPRS) credential administered by the Maryland Addiction & Behavioral-Health Professionals Certification Board (MABPCB). Maryland's CPRS requirements were designed by peers who represented diverse recovery experiences, who hoped to create standards that would uphold the values of peer support, allow for multiple recovery support skill frameworks, and provide appropriate rigor for a professional credential. An additional credential for Registered Peer Supervisor (RPS) seeks to equip supervisors with appropriate understanding of the scope of practice and ethics of the peer specialist role.

[81] Such as SAMHSA's Core Competencies for Peer Workers and the National Association of Peer Supporter's National Practice Guidelines.

Maryland's Certified Peer Recovery Specialist (CPRS) Credential

Peer Identity: Applicants must be at least 18 years of age and self-identify as being in long-term recovery from the effects of a mental health and/or substance use disorder for at least two years.

Residency: Applicants must be a resident of Maryland at least 51% of the time.

Education: Specific education in peer support knowledge, skills, and abilities is achieved through at least 46 continuing education unit (CEU) hours with an MABPCB-approved organizational provider to be accumulated over no more than a 10 year period.

- A high school diploma (or equivalent) with an official transcript is required.
- The majority of educational credits are achieved through completion of a required "Core" curriculum course, which is typically 30+ hours. Core courses orient the individual to the fundamental frameworks and practices of peer support. Multiple curricula (ex: Intentional Peer Support, Wellness Recovery Action Plan, CCAR Recovery Coach Academy) are available.
- Through and in addition to the Core course, a minimum number of hours must be accumulated in each domain area: Advocacy (10 hours), Ethical Responsibility (16 hours), Mentoring and Education (10 hours), Recovery/Wellness (10 hours), General Supervision with Self-Care (5 hours).
- At least 41 CEU hours must be completed in person, with no more than 5 hours of webinar-based or asynchronous training. Up to 12 hours may be in-service education (within an agency by and for its employees, by a paid staff member).

Service Hours and Supervision: The applicant must complete 500 documented paid or volunteer service hours providing peer support in a clinical or community peer recovery setting within a two-year period, with at least 25 of those hours being directly supervised by a Registered Peer Supervisor (RPS).

Application: Candidates must submit a written application, including a personal statement, reference(s), and a $125 application processing fee. MABPCB staff review the application for completeness and vet that all requirements have been met.

Exam: The CPRS examination is administered by the International Certification & Reciprocity Consortium (IC&RC). Exams are conducted via computer based testing at an approved testing site. If not passed, the applicant must wait a minimum of 90 days before retaking the exam and paying a retest fee of $50.

Recertification: Once initial certification is achieved, the CPRS professional must maintain recertification every two years by completing an additional 20 CEU hours (inclusive of a specific 6-hour Ethical Consideration course), complete a recertification application, and pay another application processing fee of $125.

Across the peer community, there is a wide range of experiences with and opinions on Maryland's current training offerings and certification process. A 2021 *Peer Recovery Specialist Workforce Survey* conducted by the Behavioral Health Administration and the University of Maryland Systems Evaluation Center found that the majority of respondents (285) saw "sense of accomplishment" as the greatest benefit from achieving certification, with 20% indicating benefit from being "viewed as a profession," but just under 10% seeing potential gains with respect to better pay or job opportunities. The 2023 *Peers That Count* survey conducted by the Maryland Peer Advisory Council in partnership with the University of Maryland School of Social Work found that only 55% of 465 respondents were certified. Training gaps identified in this survey included "technology, leadership development, and role-specific workshops relevant to particular peer settings (i.e., at hospitals, jails, schools)."[82]

[82] Maryland Peer Advisory Council and University of Maryland School of Social Work. (2023). *Peers That Count: A Call to Action! A Peer-Led Peer Recovery Census to Determine Where We Are, What We Contribute and What We Need.*

Aspects of the peer support training landscape and CPRS certification process with particular relevance to a peer respite workforce include:

- **Training Availability:** MABPCB-approved training providers include government agencies, nonprofit organizations, and private businesses. While the BHA Office of Community Based Access and Support maintains a popular listserv (BH Peer Mentors in Maryland) which circulates training and employment opportunities on a daily basis, there is no centralized database of current, upcoming, or regularly occurring training events with CPRS CEU credits. Instead, there are a diverse number of training providers which offer both nationally established (e.g. WRAP, CCAR) and independent courses on their own schedules.
- **Content Variability:** While multiple tools are used by MABPCB to support consistency (ex: required CEU hours and defined Knowledge, Skills and Abilities for each domain, written exam, Ethics Code of Conduct, Principles and Service Guidelines), individuals earning their CPRS designation may have completed significantly different educational courses and practical experience hours. This diversity in training is a strength as well as a challenge, and means that organizations must be very clear in determining core competencies, required prior experience, and clear expectations for a specific role or program environment.
    - **Mental Health:** It is widely acknowledged by multiple stakeholder groups that there is a lack of regularly available training and service hour opportunities for mental health-focused peer support, in contrast with the more widely available options in the substance use arena.
    - **Crisis-Specific:** Despite the growth of peer positions in crisis services environments, there is not yet an official definition or special designation (an "endorsement" by MABPCB) of any specialized knowledge base and key competencies needed to be successful in these high-intensity environments.
- **Affordability and Accessibility:** The cost of a "Core course" for the CPRS credential can vary greatly, from full scholarship to $1,500+, depending on the format, location, and curriculum. While many entities are able to offer scholarships and subsidies, these can be limited in quantity or have specific eligibility criteria. Peers employed in various settings often do not have sufficient access to funding and time away from work for professional development, especially if travel is involved. For those not already employed in a peer support role, amassing the required 500 service hours can be a daunting task. Volunteer and internship opportunities exist, but may be difficult to find if not enrolled in a workforce development program or be unrealistic for individuals with existing full-time employment.

Peer respite workers must be knowledgeable and skilled in mental health support practices, and so sufficient funding for ongoing training (to maintain CPRS certification and respite-specific skills) must be included in the annual operating budget.

Given the present scarcity of crisis-specific peer support training, additional curricula will need to be made available through development by local peer training organizations or sponsored training from other agencies outside of Maryland.[83] Respites in other states have repeatedly emphasized the usefulness of the Intentional Peer Support (IPS) curriculum as a foundational required training, along with connection skills such as through Emotional CPR (National Empowerment Center), and suicide-specific training such as Alternatives to Suicide (Wildflower Alliance).

Training for peer respite extends beyond didactic learning into soft skills and a high degree of self-regulation. Peer specialists must develop their ability to steadily sit with distress, shared trauma and mental health experiences without exerting power and control or being too casual while working in a homelike environment. Peer respites could potentially offer internship opportunities for individuals completing their certification as a way to supplement staffing during weekend and evening shifts. However, the respite environment is not an entry-level experience, and so the appropriate internship candidate would be an individual who has significant prior experience in peer support.

Recruitment and Supervision

Peer staff in traditional behavioral health services programs receive a high level of exposure to clinically-oriented protocols and cultural environments. For peer supporters who came into the practice through disability rights and Consumer/Survivor/Ex-Patient movements, this prompts some reasonable concerns which have also been voiced in some recent statewide research surveys.

The BHA/UM *Peer Specialist Workforce Survey (2021)* found that while 88% of respondents reported feeling respected and supported by their supervisor, almost as many (83%) felt their supervisor treated them "as a client." The more recent MPAC/UM *Peers That Count* survey (2023) recounted "although some respondents felt well supported, there were numerous others who did not. A lack of support was attributed to lack of clear roles, lack of understanding of the peer role, and systemic barriers including bias and stigma.

For greater support and resourcing, peers felt "a shift was needed to respecting peers for their 'lived experience and lived expertise'" … Peer opinions, perspectives, and skill sets often get overlooked and undervalued… A lack of understanding of the peer role shows up in other ways, including host organizations lacking a clear plan for peer integration, and peers wondering whether administrators at policy-making agencies truly understand peers' needs. Peers did not want to be seen as a quick fix to organizational or sector-wide problems, or simply a way to support a grant or new funding streams."

[83] Prior to and unrelated to this study, On Our Own of Maryland began two separate projects which relate to these training need gaps. The IPS Baltimore Project, funded by BHSB, has offered cohorts of Core and Advanced IPS training with full scholarships to eligible participants since Summer 2022. Through a SAMHSA-funded grant, OOOMD is developing and piloting a specific Peer Support in Crisis Services training pathway of up to 10 modules of relevant existing or to-be-developed training courses; this is expected to launch in Fall 2023.

With respect to creating successful working referral relationships between clinical programs and peer respite, the role of Registered Peer Supervisors (RPS) may be of key influence. This designation is attained through MABPBC (same body providing the CPRS credential), and is available both to peer support professionals as well as those in clinical or administrative roles who directly supervise peer staff. Applicants must have between six months and one year of supervisory experience, complete a six hour "Supervising Peers" training, complete a written application, and pay a $50 application fee. Recertification through a 'refresher' course is required every two years. While six hours of training may be sufficient to learn the scope of practice, code of ethics, and practical functions of a peer support specialist, it is only the beginning of cultivating an understanding of how to protect and lift up the values and qualities of peer support within a traditional behavioral health services organization.

The success of a peer respite relies on the staff team being deeply committed to and skilled in upholding the core values of peer support and recovery: mutuality, reciprocity, transparency, non-hierarchy, non-linear, relationship-focused, person-driven, and choice-based. Peers who have primarily had practicum and/or employment experience in clinical environments may need significant reorientation to the type of peer support practiced in a respite environment. A strategy employed by some peer-operate respites in other states is to offer training and technical assistance services to clinicians who may supervise peers, interdisciplinary teams, and service organizations to strengthen their understanding of peer support, skills to support genuine peer integration, and confidence to recommend independent peer-run programs such as respite.

Medicaid Reimbursement for Peer Support

Across the nation, at least 40 states offer Medicaid reimbursement for peer support services.[84] The trend of expanding reimbursement for peer support services through insurance plans is rapidly picking up speed on a local and national level. Despite the inherent conflict between the medical model of mental illness and the non-clinical nature of peer support, increasing demand for access to peer support is opening opportunities for peer professionals to navigate these different worldviews.

In Maryland, family peer support has been eligible for Medicaid reimbursement in a limited capacity under a 1915(i) Home and Community Based Services waiver program.[85] In 2018, the Maryland Department of Health issued a report on Medicaid reimbursement for peer support with recommendations from a legislatively-mandated working group. Six barriers were identified to transitioning funding currently supporting the CPRS workforce to a Medicaid-funded fee-for-service system. Barriers particularly relevant to a peer respite model include:

- ***Barrier 1:*** The majority of the peer-operated organizations that provide peer support services may not be eligible for or interested in submitting reimbursement claims for services delivered under a traditional Medicaid model.

[84] Kaiser Family Foundation. (2023). "Medicaid Behavioral Services Peer Support Services 2022"

[85] Intensive Behavioral Health Services for Children, Youth and Families, known locally as the Residential Treatment Center (RTC) Waiver.

- ***Barrier 5:*** There is a philosophical dilemma of how "peer support services" are defined and delivered within diverse service settings.
- ***Barrier 6:*** There is a lack of consistent outcomes data that result from the interventions and services delivered by peer recovery specialists.

The primary recommendation was to "support ongoing recovery services and positively impact the total cost of care by pursuing Medicaid reimbursement for defined services (individual and group) provided by CPRS in designated service settings (e.g. hospitals, primary medical care settings, and specialty health services) in addition to maintaining the current infrastructure which supports peer recovery services." Relevant to a peer-operated respite is the recommendation to "explore Medicaid reimbursement for peer support services delivered through standalone peer-operated organizations when a nationally recognized accreditation body provides accreditation of peer support services."

As of 2023, Medicaid reimbursement will be available for peer support services delivered in a narrow set of community-based Substance Use Disorder Programs (OP Level 1, IOP Level 2.1, PHP Level 2.5) and Opioid Treatment Programs (OTP).[86] Reimbursement will be available for up to 24 units of 15-minute individual sessions (6 hours) and 1 group (up to 90 minutes) each day. Similar to concerns expressed by crisis services providers about the rates schedules, increments, and regulations proposed for Mobile Crisis Teams and Crisis Stabilization Centers, implementation may show insufficient alignment between the established rates and real costs.

[86] Medicaid provider types 50 and 32, respectively

Model Respite Programs (Site Visits)

To better understand the peer respite model and philosophy in action, PRS Project Team members and key behavioral health stakeholders from across the CMRCS region visited five peer respites in communities that share similar population density, demographics, and geography to parts of Baltimore City, Baltimore County, Carroll County, and Howard County.

New York City

In April 2023, stakeholders from Baltimore City visited two peer-staffed respites in New York City: Miele's Respite at TSINY in Queens, and Community Access Crisis Respite Center in Lower Manhattan.

In 2012, New York City launched Parachute NYC, a program to support persons experiencing a psychiatric crisis with mobile or in-home services as an alternative to hospitalization. The program was funded through a federal grant from the Centers of Medicaid and Medicare Services to provide services through mobile teams and the development of five so-called hybrid peer respites, staffed by peer supporters, but operated by non-peer-run organizations. These "crisis respites" have been in operation since 2014, started with a $17.6 million three-year grant for four respites from the U.S. Department of Health and Human Services, with the goal of saving the state $50 million in hospital expenses by keeping individuals in crisis or emotional distress out of the emergency departments and psychiatric hospitals, using a federal Medicaid waiver.

Staffing: It's important to note that both organizations are not entirely peer-owned and peer-operated, and were never designed to be. However, onsite respite staff are majority peer supporters, trained by their respective organizations and certified by New York.

TSINY Miele's Respite has 12 total employees: two full-time salaried employees, the Program Director and Assistant Director, as well as nine hourly full-time positions: six Peer Workers, one Peer Supervisor, one Peer Health Navigator, and one Cook/Counselor, who helps guests prepare meals and advises them on nutrition. The program manager is a person with lived experience. At least two people are required to be on each shift, with the day shift 8 a.m. - 4 p.m., evening 4 p.m. - 12 a.m., and night shift, 12 a.m. to 8 a.m.

Community Access has 9 full-time Respite Workers and 1 Senior Respite Worker, with two 12-hour shifts and one overlapping mid-shift which is noon to 8 p.m. They have no part-time employees, but do have a porter subcontracted to work daily for half days. The program manager is the only person on the team who does not identify as a peer support specialist.

Guests and Length of Stay: Both programs are on the larger side of respite capacity, which typically operate with fewer than 6 beds. For both respites, the first phone call begins the process of connecting someone to support and services, and guests completing a stay must wait six months before they can apply to return.

TSINY Miele's Respite can have up to 10 guests at a time. With a greater number of beds, the wait list is one week, and 28 days are both the maximum and average length of stay, as this is what Managed Care Organizations will allow.

Community Access' respite can have up to 7 guests. The typical length of stay is two weeks, which is encouraged for guests to both get the most benefit from their stay and to help ensure access for people on the waitlist, which averages about two weeks long.

Location and Facility: TSINY's Miele's Respite is housed in a single-story building on the campus of a former state psychiatric hospital in Queens. Existing organizational operations on the campus and affordability of the space were driving factors in the selection of this location.

Community Access' respite is located inside of a multi-story townhome in a mixed residential/commercial neighborhood in Lower Manhattan. As typical with NYC townhomes, there are four floors accessible by a central staircase, but no elevator. The first floor holds the kitchen and staff offices, several common areas are located on the second floors, with private bedrooms on the third and fourth levels.

Values and Services: In both programs, staff and guests alike took pride in their dwellings and spoke effusively about the importance of the peer respite on guests' recovery journey. Program directors emphasized the importance of affording guests the same freedoms they would have in their own homes, from group participation to meals.

Funding and Sustainability: Crisis respites in New York City accept Medicaid payments for individuals who have a managed care organization (MCO) managing their benefit, with a long-term goal that any type of Medicaid (MCO-managed or not) will cover peer respite. For individuals that are not covered by Medicaid, city and state funds continue to supplement the operation of the respites.

TSINY's Miele's Respite's annual budget is about $1 million, with a 50/50 split between MCO and state funding.

Community Access' respite has a budget of about $1.5 million, about $700,000 of which comes from Medicaid reimbursement, and the remaining $700,000 funded by grant contracts from the city.

Notably, both respite programs are operated by nonprofit entities with large portfolios of programs and services, as well as extensive fundraising, resource development, and community partnership efforts.

Lessons Learned and Best Practices: The managers of both respites spoke about how they originally disallowed people experiencing homelessness, but quickly realized that was unrealistic. Community Access had originally targeted their outreach to the local hospitals and Emergency Rooms, but ultimately found that outpatient providers were the best referral source. Both respites rely on strong program managers who personally oversee the intake process, and emphasize the importance of hiring staff who are a good fit for the respite, with ongoing training and support.

Supervisors at both respites noted that the extra bureaucratic layer of Medicaid billing (defining and documenting treatment plans, goals, and progress notes for each guest), plus follow-up and record-keeping, took considerable staff time away from programming. One also noted that while a payor-blind waitlist was the goal, financial pressures resulted in allocating beds by funding sources in order to manage incoming revenue against costs. However, an advantage of being licensed under a Crisis Residential program was that the Length of Stay can extend to 28 days without issue.

Communist Access Respite's Program Director noted that the biggest challenge was staffing, and emphasized the need to align staffing with administrative operating requirements in addition to direct services: *"If I could do it over, I wish we had a program administrator. The 'invisible' burden of administrative tasks is a real weight on our productivity. We are saddled with things like preparing petty cash submissions and purchasing submissions which pile up, and would be far easier with a dedicated administrative support person. We also would benefit from having a health navigator to support our guests with commitments offsite during and after their stay, say for up to 90 days."*

Massachusetts

In May 2023, stakeholders from BHSB, Baltimore County, and Carroll County visited two peer respites outside of Boston, MA, operated by Kiva Centers (Kiva). Kiva is a nationally recognized peer-run and trauma-informed organization that operates several programs and offers statewide peer support training, technical assistance, and the Massachusetts Statewide Peer Network.

Kiva operates two peer respites (Juniper and Karaya), with plans to open two more in the near future. They developed an innovative Mobile Respite service, which meets with people seeking support in the community for up to 4 hours if they wish, ensuring that lack of transportation is not a barrier to accessing peer support. Additionally, Kiva operates virtual peer support (phone and Zoom), a satellite center offering peer support for Spanish-speaking individuals and families, a Peer Bridging service (peer support for individuals transitioning out of psychiatric hospitals and back into the community) and peer support certification training.

The respite model has strong support from the state of Massachusetts itself, which currently has four respites. Respites have been so successful in achieving hospital diversion in Massachusetts that a bill is under consideration that would establish and fund a total of 14 respites in the state, one for each county, including two established for the purpose of serving the LBGTQ+ community.[87]

Staffing: Juniper and Karaya are both managed by a single director who is responsible for interviewing all potential guests and making determinations about who can benefit from the respite as well as which one best meets their needs. There is a manager who supervises both houses, with a minimum of one full-time peer support specialist available at each house at all times, working in three shifts on weekdays (8 a.m. to 4 p.m., 4 p.m. to midnight, and midnight to 8 a.m.), with part-time workers covering the weekends and coming in if needed during the week.

Guests and Length of Stay: Both respites are able to serve individuals from across the entire state. The respite program asks individuals to complete a referral form (available on their website), with or without assistance from a supporter or provider. Referral forms are reviewed by the respite within 1 business day, and outreach is made to start the screening process.

Juniper Respite accommodates 4 guests; Karaya accommodates 6 guests. For both houses, guests stay 7-10 days on average, although guests can stay up to three weeks, based on availability.

[87] Sabadosa, L. and Pignatelli, S. (2023), "MA Bill H3602: An Act Establishing Peer-Run Respite Centers Throughout the Commonwealth." The General Court of the Commonwealth of Massachusetts.

The waiting list for both respites may be weeks or months long, depending on availability and demand, and guests must wait at least 30 days after their stay before they can re-apply to stay again. Their Mobile Respite team provides support to individuals on the waiting list.

Location and Facility: Juniper is located in the rural town of Bellingham, Massachusetts (population: 17,000) in a two-story home surrounded by a large yard. The home is leased by Kiva, which has a relationship with a real estate company that purchases and owns the space specifically for use by Kiva Centers for peer respites. The home possesses a welcoming atmosphere, with comfortable living and dining rooms, and a large backyard deck. Each of four private bedrooms is equipped with a television.

Karaya is located in Worcester, Massachusetts (population: 207,000), a more urban environment, and can accommodate six guests in a three-story home which was previously used as a group home. The house has numerous common living spaces for guests to retreat, be creative, read, or connect, as well as private bedrooms for each guest.

Values and Services: Both respites are very affirming of culture, race, gender identity, sexual orientation, and intersectional identities, and collect demographic information on their referral forms. Both houses offer groups on-site as well as various wellness activities (musical instructments, reiki, etc.). Community relationships are important, not just for guests needing services, but for the respite programs, which also prioritize maintaining excellent relationships with neighbors, landlords and local police.

Funding and Sustainability: Kiva has a long history as a peer-run entity in Massachusetts, having started from strong advocacy initiatives. They began operating peer respites in 2020. The state pays for peer respites through mental health block grant funding, with reimbursement invoices and services data submitted on a monthly basis. As a result, access to the respites is not connected to insurance and there are very few restrictions of who can stay at either respite.

Lessons Learned and Best Practices: According to Kiva's Director of Peer Respite Services, most critical to their success is that they exist under a peer-operated organization with other programs, supports, and ways for guests to stay engaged beyond their stay, such as peer training and certification, the Central Massachusetts Recovery Learning Community, technical assistance, the Massachusetts Peer Workforce Coalition, advocacy, plus online and mobile peer support. *"Kiva works because it's not just the experience of the house, but a healing community, with connection to all kinds of other support services. We check in with all of our guests after they leave, with their permission. Although people stay with us for 5-7 days… we still like to do things together as a community. On Saturdays or Sundays, we could go to the Worcester Public Market, and we have tea or we're sharing a meal, showing up for the Pride parade, doing things together, because we do actually believe that it is in collectivity, it is in community that we find healing."*

North Carolina

In June 2023, stakeholders from BHSB, Baltimore City, Carroll County, and local and state advocacy groups visited The Retreat at the Plaza, a peer respite in Charlotte, NC, operated by Promise Resource Network (PRN).

PRN is a nationally recognized peer-run agency that operates 18 peer programs and applies peer support to the areas of social justice, community re-entry, employment, and social determinants. Stakeholders spent time at both the peer recovery center, called The Recovery Hub, and the respite, called The Retreat at the Plaza, to get a sense of what peer respite operation looks like in the context of a multi-faceted peer service delivery system.

Staffing: The Retreat has a full time Respite Director, a full time Team Lead, and two certified peer support specialists available on-site at all times, working in three shifts to cover 24 hours in 8-hour shifts (8 a.m. to 4 p.m, 4 p.m. to 12 a.m., and 12 a.m. to 8 a.m.).

Guests and Length of Stay: Up to three guests can stay at a time, though they are currently expanding to accommodate six, as part of the state's *Olmstead* Plan to support people with disabilities who are leaving institutions.[88] The Retreat operates on a self-referral basis for any adult aged 18 years or older who is experiencing a self-defined crisis. Guests generally stay up to 7 days, or longer if needed. The wait list is short, and immediate exploration, orientation, and stay is often available.

Location and Facility: The Retreat is located in an urban area at a semi-busy intersection, a remodeled nine-bedroom home previously used as a 3-unit vacation rental property. The front of the property faces businesses and condos, and the back of the property faces a quiet residential neighborhood. The back of the property has a parking lot, and the house has a yard, porches, a courtyard, and landscaping with many flowering plants, water features, fire pits, and walkways. The location is accessible to the city and public transportation and is walkable to parks, restaurants, a city library, etc.

The Retreat was renovated for accessibility and features a ramp, larger door openings, a completely ADA accessible bathroom, kitchen counter extensions, and furniture layout that allows for guests that utilize wheelchairs, walkers, canes, or other medical devices.

Guests have their own room with self-determined privacy, as each bedroom is set up similar to a hotel room with an inward facing door lock, mini fridge, white noise machine, lock boxes, and extra linens. Furnishings are akin to a vacation rental property.

[88] North Carolina Department of Health and Human Services (2021), "North Carolina's Olmstead Plan"

Values and Services: Guests at the Retreat can access PRN's full array of supports and resources before, during, and after their stay, including in-person programming at a nearby peer support center (the Recovery Hub), an online community, and a 24/7 peer warm-line. PRN is an independent, entirely peer-operated organization that is federally designated as a Consumer-Operated Services Program (COSP) and Recovery Community Organization (RCO). PRN embraces the values of SAMHSA's 8 Dimensions of Wellness and trauma-informed peer support, and operates as a zero-coercion agency.

Funding and Sustainability: The Retreat is funded by Mecklenburg County tax dollars, allowing accessibility for any person in the community. The full operations of PRN's continuum of services are supported through federal grants, contracts, foundations, training and technical assistance contracts. Intentionally, PRN does not pursue Medicaid funding.

Lessons Learned and Best Practices: PRN's CEO emphasized the importance of carefully selecting the property location to ensure it offers a high-quality environment, both in terms of the physical space and the immediate neighborhood surroundings. The Retreat's space was chosen for its natural light, ample indoor and outdoor space, and potential for ADA accessibility. The respite team then worked to create a visible local presence and ongoing positive relationship with neighbors, such as through partnering and participating in community events like block parties, pop up markets, and cleanup days.

Other lessons learned from PRN management and staff include the importance of recruiting and retaining personnel who are the "right fit" for the respite, and investing in ongoing training, mentoring and consistent support and supervision from leaders who can balance the values and intent of the respite with support and accountability for the team. Gathering quantitative and qualitative data, even if rudimentary, is considered a fundamental part of being able to share the story of the respite's value and impact.

Other East Coast Peer Respites

While not able to make onsite visits to other peer respites, PRS Project Team members were also able to discuss aspects of program design, operating challenges, success stories, and funding strategies with representatives from People USA of New York, which operates 5 respites, and Collaborative Support Programs of New Jersey (CSPNJ), which operates 3 respites. Both organizations utilize Medicaid reimbursement in their funding mix, and were quick to emphasize that this funding stream was not sufficient to cover their operating costs. They emphasized the high degree of continuous internal adaptability and external advocacy required in order to meet authorization, documentation, and billing standards while maintaining integrity to the peer support model. Importantly, these are both large organizations with multi-million dollar annual budgets, a diverse portfolio of programs, and robust internal infrastructure to meet operating demands and challenges.

Feasibility Assessment Recommendations

Feasibility Assessment

Feasibility Factor	Rating
Model: Is the program model sound in principles and practices? Are there examples of successful implementations? Is there evidence to support its efficacy?	**High**
Market: Is there a demonstrable and verified need for the program? Is the size and scope of the need sufficient to support successful implementation? Are there sufficient pathways to connect potential users to the opportunity?	**High**
Metrics: Are there reliable measures by which program operations and impact can be evaluated? Do these measures support results-based accountability?	**High**
Money: Is the cost-to-benefit ratio reasonable and compelling? Are there identified and interested potential funders?	**Medium**
Management: Are there potential operators present in the region? Do they have the capacity to manage the development and implementation of the program? Is there a sufficient workforce with the required knowledge, skills, and abilities?	**Medium-Low**

Based on multifactor analysis through this study, the PRS Project Team concludes that peer respite is demonstrably feasible in Central Maryland. The peer respite model has been successfully replicated in 15 states, many of which have sociopolitical and behavioral health services landscapes similar to Maryland, and there is a demonstrated need and market for crisis-responsive residential services ("Somewhere to Go") in Central Maryland.

The prerequisites for launching peer respite in Central Maryland with fidelity to the model are developing capacity for more complex operations and service arrays at peer-operated Wellness & Recovery Organizations, and enhancing the current peer workforce with more crisis-specific training, experience, and mentorship opportunities (management).

The challenges to operating peer respites in Central Maryland will be securing adequate and sustainable funding (money), navigating regulatory requirements for securing a property (model), and building awareness among potential guests and behavioral health service system networks (market).

Peer respite has the potential to generate notable year-over-year savings through effective diversion of people in crisis from the hospital system. Needs for ongoing investment in capacity building to realize this opportunity are detailed in the recommendations below and in **Appendix B: Business Plan**.

Location and Licensing Considerations

Local zoning and neighborhood restrictions are a significant issue that affects location of peer respite programs. Each county in Central Maryland has a separate zoning or planning commission, each with different zone definitions and stipulations that could potentially apply to a peer respite, depending on the size of the respite and how it is classified, regulated, and licensed.

While peer respites involve an overnight stay, they are neither housing nor treatment programs. The stay is shorter than 30 days, no payment is collected from the guest, no lease agreement is made, and the respite is not designed, intended, or offered to serve as a 'primary residence' for any individual (guest or owner/operator). Staying at the respite and participating in any support activities is completely voluntary, without any eligibility criteria based on diagnosis, medical necessity, or housing status. However, a respite stay is made available only to those individuals experiencing a (broadly defined) behavioral health crisis, and is not open for use by the general public.

A peer respite would therefore not match current regulatory descriptions for a bed and breakfast, retreat center, homeless shelter, hotel, motel, rooming house, boarding house, halfway house, recovery residence, supportive home, group home, or assisted living facility as found in the zoning codes of the Central Maryland counties. Given the highly localized nature of zoning requirements and conditional use permits, active collaboration and advocacy with the relevant oversight agencies in the particular target area for a peer respite program would be necessary to identify or create opportunities for property location and operation. (For more detail on identified barriers, see **Appendix F: Zoning Considerations**.)

It is as of yet undetermined how peer respite may be considered in light of Maryland's existing conceptualization of respite care and behavioral health-related housing program models, which are subject to licensure and accreditation. Not only do these processes demand substantial time and money to maintain, but they are antithetical to peer respite's fundamentally non-clinical model. Peer respites looking at licensure as a pathway to overcome zoning restrictions face a Catch-22: to be licensed typically requires a property ready for inspection, but status as a licensed program may be needed to secure a property.

Respite Services Care Program

Maryland recognizes a Respite Services Care Program designation, which is primarily centered in the experiences of caregivers of an individual receiving services (such as a foster child, elderly person, or individual with developmental or functional disabilities), not the desires of the individual themselves.

The Code of Maryland Regulations (COMAR) defines a Respite Care Services (RPCS) Program as providing "short-term, in home or overnight temporary services to support an individual to remain in the individual's home: (1) Through enhanced support or a temporary alternate living arrangement; or (2) By temporarily freeing the caregiver from the responsibility of caring for the individual."[89] Licensure requires the following:

- Compliance with the requirements and standards of an accreditation organization.[90]
- Attestation of capacity and compliance with applicable regulations and licensing requirements.
- A signed agreement to cooperate with the LBHA of the jurisdiction in which the respite will be located.
- Inspection of the property within 6 months of the licensing application.

Maryland's Administrative Services Organization, Optum Maryland, notes in the *Maryland Public Behavioral Health System Provider Manual* that respite programs are classified as facilities, which "may receive reimbursement for services delivered by individuals who are under the direct supervision of appropriately licensed staff but are not independently licensed themselves."[91]

In the associated *Level of Care Appendix*, respite programs are subject to authorization in full-day increments with a 12-hour minimum, and are not eligible for enrollment with Medicaid. Note is made that "enhanced support services" such as those delivered by Psychiatric Rehabilitation Programs (PRPs), Residential Rehabilitation Programs (RRPs), and Mobile Treatment Services (MTS)[92] will not be authorized in conjunction with respite services.[93] From the perspective of peer respite, there is no inherent conflict with an individual using peer respite and maintaining simultaneous engagement with other clinical services such as PRP, MTS, or ACT.

Optum's *State of Maryland Medical Necessity Criteria* indicates that respite care for adults is provided when "the caregiver, family member, or participant requires another environment on a short-term basis to support the participant in order to prevent escalation to more intensive levels of care… respite is an option when participants who live in congregate settings need a hiatus from the interactions with roommates in order to maintain their living environment."[94]

---

[89] Code of Maryland Regulations. 10.63.03.15 Respite Care Services Program (RPCS).

[90] It is unclear which, if any, accreditation entities would be found appropriate by regulators and peer respite operators. The Commission on Accreditation of Rehabilitation Facilities (CARF) does list "respite program" under its Employment and Community Services category, but has no mention of respite in its 2023 Behavioral Health Program Descriptions document. (CARF International: Programs: Employment and Community Services)

[91] Optum Maryland. Maryland PBHS Provider Manual (2022)

[92] Mobile Treatment Services is assumed inclusive of Assertive Community Treatment (ACT) programs

[93] Optum Maryland. Maryland Public Behavioral Health System (PBHS) Level of Care Appendix (2020)

[94] Optum Maryland. State of Maryland_Medical Necessity Criteria. (2020)

Documentation of the following criteria for admission and continuing stay is required before treatment will be authorized:

- "The participant has a PBHS specialty mental health DSM 5 diagnosis and has emotional and/or behavioral problems which stress the ability of the caregiver to provide for the individual in the home.
- The family or caregiver's ability to participate in normal activities of daily life in the community, including employment, training opportunities, other family obligations, and social connection is compromised as a result of caring for the individual.
- The additional stress on the caregiver of caring for the participant puts the participant at-risk of out-of-home placement, homelessness, or a higher level of care."[95]

Group Home

Some operators in other states have been forced to fit peer respite programs under a Group Home designation in response to the dynamics of local communities, their human services and behavioral health systems, and/or funding sources.

In a housing context, "group home" is defined in the Code of Maryland Regulations (COMAR) in Title 5: Department of Housing and Community Development as a housing facility which provides:

- "Common, shared, or independent living, dining, kitchen, sanitary, and sleeping facilities, or emergency and temporary housing facilities for homeless persons"
- "supportive services or supervisory personnel as may be considered necessary by the sponsor or required by any licensing agency"[96]

In a behavioral health context, it is defined in COMAR Title 10: Maryland Department of Health as "community-based residential program that provides services: (a) For individuals who have been or are under treatment for a mental disorder; (b) When possible, in the individual's community of origin; and (c) In a home-like environment."[97] Requirements include but are not limited to:

- "A group home may admit an individual if the individual: (1) Has a mental disorder; (2) Because of the mental disorder, requires residential services for assistance and support in community living; (3) Has the ability to understand and states, in writing, willingness to comply with the rules and regulations of the group home; and (4) Is able to take appropriate action, under emergency conditions, for self-preservation.[98]

[95] Ibid

[96] Maryland Division of State Documents. COMAR 05.04.09.05 Department Of Housing And Community Development, Special Loan Programs, Group Home Financing Program, Eligible Projects

[97] Maryland Division of State Documents. COMAR 10.21.04.02 Group Home Definitions

[98] Maryland Division of State Documents. COMAR 10.21.04.03 Group Home Admission Standards

- "A group home may not admit an individual if the individual: (1) Has a primary diagnosis of alcoholism, drug addiction, or severe brain damage; or (2) Shows current violent or antisocial behavior."[99]
- "If an individual is a Medicaid recipient or… the cost of care is subsidized through the public mental health system, the individual may be admitted to a group home only if the services are pre authorized by the Administration's administrative services organization (ASO)."[100]
- "Before rendering services to an individual, a provider shall notify the [ASO or CSA of the jurisdiction where the individual resides], as appropriate, and receive preauthorization for services, according to the provisions of COMAR 10.09.70.07."[101]
- Licensing of a group home by the Department requires compliance with "administrative requirements under COMAR 10.21.17, Psychiatric rehabilitation programs under 10.21.21; and Residential rehabilitation programs under 10.21.22,"[102] which include clinical services.

A group home designation does not fit the peer respite program model in numerous ways: it is not permanent, semi-permanent, transitional, temporary, or shelter housing;,it does not require or exclude any particular diagnosis, and it does not offer clinical services.

Halfway Houses and Recovery Residences

A 'halfway house' is defined in Maryland Code as a "clinically managed, low intensity residential treatment service for individuals with substance–related disorders who are capable of self–care but are not ready to return to independent living."[103] Optum Maryland further specifies it as a Low Intensity Residential program which meets criteria for the American Society of Addiction Medicine (ASAM) Level 3.1, including at least 5 hours per week of clinical services.[104]

Since 2016, Maryland has recognized and provided a certification program for Recovery Residences, defined as providing "alcohol-free and illicit drug-free housing to individuals with substance-related disorders or addictive disorders or co-occurring mental health and substance-related disorders or addictive disorders."[105] Recovery Residences generally collect rent, are abstinence-based, and offer drug screening as an element of recovery support.

As peer respite is not a clinical program, not housing, and not limited to substance use-related challenges, certification under Halfway House or Recovery Residence standards would not be applicable or appropriate.

---

[99] Ibid
[100] Ibid
[101] Maryland Division of State Documents. COMAR 10.21.17.03 Community Mental Health Programs — Definitions and Administrative Requirements - Authorization and Payment
[102] Maryland Division of State Documents. COMAR 10.21.04.05 Group Home License Required
[103] Maryland Code Health - General §8–101 Item (m)
[104] Optum Maryland. Maryland PBHS Provider Manual (2022)
[105] Maryland Department of Health, Behavioral Health Administration. Maryland Certification of Recovery Residences.

Recommendations

Based on information gathered from stakeholder interviews, community feedback, landscape analysis, and service utilization review, the PRS Project Team believes the Central Maryland region is primed to add peer respite to its continuum of behavioral health crisis services.

The region is well underway in building out a robust behavioral health crisis system through the GBRICS Partnership initiative. Stakeholders from various perspectives have shared perspectives around safety net adequacy and the importance of person-centered, recovery-oriented care. The provider community demonstrates openness to innovation and collaboration, and there is a strong history of established peer services in the region. However, people in crisis still lack adequate facility-based resources for care as there is no 24-hour non-medical alternative to an emergency room or inpatient hospital stay. Peer respite would fill this gap and could deliver significant cost savings as a hospital diversion option.

The opportunity to finally bring the peer respite model to Maryland is particularly timely and relevant considering the Biden-Harris Administration's May 2023 *Actions to Tackle Nation's Mental Health Crisis* report that sets national priorities to expand access to peer support, enhance crisis response, promote the importance of social connection and expand access to recovery.[106] This is consistent with President Biden's Unity Agenda, released in February 2023, during which he committed to the expansion of peer support, including mental health services, enhancing crisis services, strengthening system capacity and expansion of recovery based treatment.[107]

Vision

The PRS Project Team recommends launching at least five peer respites throughout the region over the next 10 years, through a phased implementation approach based on an initial Pilot Respite in Baltimore City, as further described in this report and in **Appendix B: Business Plan**.

While a ratio of one respite per 250,000 people[108] would be truly transformational for the region and be more likely to produce statistically significant population-level impact for ED diversion, this is beyond what seems realistically feasible to recommend for near-term implementation, given both the capacity development needs in the current continuum of peer-operated programs and the massive investment

[106] The White House. (2023). Fact Sheet: Biden-Harris Administration Announces New Actions to Tackle Nation's Mental Health Crisis.

[107] The White House. (2023). Fact Sheet: In state of the Union, President Biden to Outline Vision to Advance Progress of Unity Agenda in Year Ahead

[108] The Crisis Now Calculator estimates 200 behavioral health crisis situations per month for every 100k population. The suggested ratio of 1 respite : 250k pop would require only 6% of all crisis situations to be successfully referred to the respite to maintain it at full capacity. See Estimating Crisis Episodes & Peer Respite Capacity.

in crisis system expansion currently underway in the Central Maryland region. Thanks to the vision and dedication of peers, providers, and policy makers, the system has and will continue to shift in noticeable ways toward increased community-based crisis response, recovery, and peer support options over the next decade.

As a first-of-its-kind program in Maryland, the Pilot Respite is sure to experience learning curves, and so adequate time must be allowed for development, implementation, and evaluation. Subsequent replication of the model in other areas will become easier with repetition and a growing dataset of positive outcomes. Through an intentionally phased approach, the goal of launching five respites over 10 years is both achievable and a meaningful leap forward for Central Maryland.

Operating Entities

To ensure fidelity to the model, peer respites should be operated by independent, nonprofit peer-operated organizations which have an established mission dedicated to the promotion and provision of alternative, holistic, and/or peer support services, and which have at least 51% Board members with lived experience.

It is strongly recommended that peer respites not be designed as a standalone operation, but rather as a formal partner, subsidiary, or program within an existing peer-operated organization that offers a continuum of peer support services. This leverages existing on-the-ground expertise, peer leadership, and community partnerships to ease immediate integration and accessibility to a ready array of peer support services for guests.

Peer-operated organizations with historically limited resources, staffing, and administrative support will require mentorship and funding for program development and operational expansion. These capacity development needs are not unique to Maryland, but are the result of federal, state, and community entities investing in the growth of traditional clinical and hospital systems without the equivalent investment in independent peer-operated organizations.

Locations

The location of a peer respite is highly dependent on the success of the intended operator to navigate the challenges posed by a lack of clear zoning designation(s) appropriate to the temporary, non-clinical, non-housing nature of peer respite.

Assuming any zoning and licensing barriers are overcome, peer respites will be ideally located in diverse communities throughout the region for maximum accessibility, such as, but not limited to:

- **Baltimore City**: Northeast (Loch Raven, Hamilton, Belair-Parkside), Northwest (Park Heights, Dorchester/Forest Park)

- **Baltimore County:** Southeast (Dundalk/Essex), Southwest (Catonsville, Arbutus), Northwest (Randallstown, Owings Mills), Northeast (Parkville), Central (Anneslie)
- **Carroll County:** North (Westminster)
- **Howard County:** East (Elkridge/Hanover)

These neighborhood locations are based on stakeholder suggestions and appear to meet key standards: available stock of larger residential properties; accessibility to public transit; reasonable levels of safety; and ample nearby health, social, and community services.

The ideal respite location has a high potential to be in one of the example neighborhoods above, but the availability of housing stock at any given time will always be subject to change. Requirements for the building include the following, further detailed in **Appendix B: Business Plan: Property.**

- An adequate layout and space for private bedrooms and common areas (indoor and outdoor) which support a restful and hopeful environment.
- Accessibility for people with a wide range of physical abilities.
- Occupancy and maintenance costs within budget parameters.
- Owner(s) willing to partner with operating entities.
- Local community support.
- Compliance with zoning and neighborhood covenant requirements for its intended purpose.

Phased Implementation Approach

Despite anticipating the demand for peer respite to quickly exceed supply, respites should not set maximizing capacity or rapid replication as top priorities. Maintaining an intentionally small scale of operations is essential to preserving the individualized support and retreat-like environment that directly correlates to respite's effectiveness as an intervention.

Baltimore City Pilot Respite

With consideration of per-capita need, density of peer workforce, available property stock, current zoning allowances, availability of community resources, and demonstrated appetite for innovative approaches to ED and hospital diversion, Baltimore City is recommended as the location for the initial Pilot Respite.

Baltimore City experiences inordinately high inpatient psychiatric utilization and opioid overdose rates compared to the neighboring counties, but also has many examples of successful collaborative projects in the spirit of community-based crisis response (e.g. 911 Diversion Pilot Program, sobering and crisis stabilization services, a non-co-responder MCT model, LBHA-driven initiatives, etc.). Baltimore City is also home to an active philanthropic community and foundations with demonstrated interest in behavioral health, healthcare, and addressing social inequities.

The area has a variety of appropriately zoned and sufficiently large residential homes accessible to public transportation. However, it also boasts a complex web of zoning codes and neighborhood covenants, where houses located next door to each other may be subject to different parameters. See **Appendix B: Business Plan** for more detail.

The PRS Project team estimates that a Planning Phase of 12-18 months will be needed to fully activate resources, partnerships and community support in order to launch the Pilot Respite in Baltimore City, followed by 2-3 years of ongoing operations to establish best practices and generate sufficient impact data prior to replication.

Replication in Central Maryland

Based on needs analysis and positive feedback from behavioral health stakeholders in each of the other three counties, respites may also be successfully installed in Baltimore County, Carroll and Howard Counties, with similar timelines as the Pilot Respite for a planning phase followed by operational launch.

The PRS Project team strongly recommends that all respites in the region be aligned to a common set of standards and deliverables and be encouraged to actively share ideas and resources. This could align with the current approach to Wellness & Recovery Centers in Maryland, which respond to

templated BHA-designed Conditions of Award and have the opportunity to participate in technical assistance, training, and organizational development support through affiliation with or technical assistance from On Our Own of Maryland.

Conditions in other counties could be navigated after the successful launch of a pilot program demonstrates its clear value to the community. Baltimore County and Howard County have identified potential barriers with respect to zoning, and Carroll County appears to have the greatest current flexibility. See **Appendix F: Zoning Considerations** for more detail.

Respite-Adjacent Services

While outside the fundamental requirements, the PRS Project Team also encourages consideration of enhanced respite operations to include a mobile peer respite team and evening/weekend warmline.

Mobile Peer Respite and a Peer Line / Peer-Run Warmline can strengthen engagement with potential guests and facilitate linkages between the respite and the continuum of traditional behavioral health services. Both serve functions for outreach and awareness-building, information and referral, education and pre-screening of potential guests, and pre/post support for individuals utilizing the respite. Additionally, they offer operational benefits in terms of hosting and training volunteers (such as CPRS interns), onboarding new staff, allowing additional hours for part-time positions, and providing reprieve for respite workers who need to temporarily step away from in-person services for personal wellness or particular circumstances.

For more information on these models, see **Peer Respite Model Overview: Integration with Crisis Service Systems:** **Innovation in Peer-Led Crisis Supports** earlier in this report.

Recommendations for Potential Funders

Peer respites enhance community life and can save money in multiple community systems. Engaging a broad array of stakeholders in dialogue during the development and pilot phases can lay the groundwork for exploring opportunities to maximize shared investment and braided funding. The vision for long-term sustainability of peer respite should include ways to reinvest a portion of savings achieved through hospital diversion back into respite programs, such as through contracts for services or grant-based funding.

Funding for respite operations should adopt a firehouse model[109] approach to reliably and proactively covering realtime costs, with annual assessment of utilization to determine future operating budgets.

[109] A "firehouse model" of funding means assuring that the costs of operating a program are covered without utilization as the singular priority. Just as a community would want its fire departments to be funded for needed capacity and not paid on a per-fire basis, peer respite services work best when funding is not contingent on utilization, although utilization is monitored as a key performance indicator.

Funding streams may be blended together based on availability and flexibility of terms and requirements. Potential funding opportunities for peer respites include but are not limited to:

- **State funding** through MDH, 988 Trust Fund, Opioid Restitution Fund, or other state entities
- **Federal funding** through mental health block grants, community development block grants, other federal programs, legislative action, or congressional earmarks
- **Private funding** through foundations, philanthropy networks, and fundraising
- **Institutional funding** through managed care organizations, hospital systems and related entities, and private insurance companies

Smaller peer respites (2-3 beds, smaller buildings) may be able to operate on budgets between $550,000-$650,000 annually, depending on location and local cost of living. However, most larger peer respites (4-6 beds) operate with an annual budget of $1M+ as demonstrated through recent Requests for Proposals in Pennsylvania, Oregon, and others.[110,111]

It is important to consider all potential sources of funding for the start up and ongoing operation of a peer respite while still prioritizing the core values and principles. Funding sources and mechanisms must align with the vision and objective of the model and the gaps that it is filling in the community. For example, if a funding stream will limit access to a subset of the community, this may not aid the community in meeting its objective to establish a no/low barrier option. Similarly, if the intention is for rapid entry and a funder requires authorizations or prior approval for guests, then access during a crisis situation will be impeded and the respite may be unable to demonstrate the impact for which it is intended.

Planning Phase (12-18 Months)

The planning and preparation phases of development will require consistent outreach, education, and relationship-building within and outside of the behavioral health system and focused resource-securing efforts (advisory board, partnerships, funding applications, etc.). Funding for dedicated paid staff will allow for focused and consistent activities, which may not be achievable in a timely manner through volunteer-only efforts. Given the likelihood of needing to braid funding together to meet operating needs, a planning phase of at least 12 months allows time to grow relationships with funders and align with decision-making cycles.

[110] Request for Proposals: Peer-Run Respite as a Community Based Non-Clinical Crisis Support (March 2023) Allegheny County Department of Human Services, State of Pennsylvania
[111] Request For Grant Proposals: For the creation and operation of Peer-Run Respite Programs in Oregon (September 2022) Office of Recovery & Resilience, Behavioral Health, Oregon Health Authority

Pilot Phase (3-5 Years)

Launching a respite requires one-time funding for initial outfitting of the residential building (improvements for accessibility, enhancement of interior and exterior features, furnishings) as well as administrative supplies (furnishings, equipment, promotional materials, etc.). Funding for routine operations is composed of expected categories: personnel, infrastructure, and direct program services. Factors influencing total budget on an ongoing basis include but are not limited to:

- **General economic trends**: inflation, market salary ranges
- **Property needs**: rent increases, regular or emergency maintenance, major systems replacement (if owned)
- **Program services**: enhancements to services array, savings achieved through partnerships, changes to expenses based on programmatic adjustments
- **Revenue fluctuations**: new, modified, or terminated sources of income

Sample First Year and Annual operating budgets are included in **Appendix B: Business Plan**.

Sustainability

For peer respites to truly and fully serve as a non-clinical, peer support-based alternative, they must exist outside of the medicalized fee-for-service structure to which many other programs and services subscribe. There are recent examples from initially non-clinical programs in the Central Maryland region which demonstrate the felt cost to quality and accessibility:

- *"[Due to funding instability,] we had to sign on to accept Medicaid to keep our doors open. In order to be licensed to accept Medicaid, we have to do a clinical assessment, make goal plans for people, keep daily progress notes. It's more documentation and more bureaucracy. About 70% of people that we serve, we can't bill Medicaid for. Or we have to turn down people who are [enrolled with other providers], because those programs are billing for the services that we're actually providing." ~ Provider, Baltimore City*

Considering the significant challenges of implementing fee-for-service or insurance-based funding at any time – and especially when launching a brand-new program for the region – the PRS Project Team recommends that the first cohort of respites be funded on an annualized contract basis for at least the first five years of each site's operations. During this period, the respite may collect robust data on referral pathway, insurance status, Medicaid eligibility indicators, and prior/current treatment service use from prospective and actual guests. This would allow for retrospective analysis to ascertain what types of funding are viable options based on proven utilization and operational demands.

However, concurrent with these concerns, peer advocates on a national level continue to advocate for updates to Medicaid requirements to better support authentic peer services in a variety of settings, including peer respite. By the time an analysis of utilization data from piloted peer respites in Central

Maryland is available, important shifts to relevant regulations that ease friction with the non-clinical model of peer respite may also be coming into place.

Metrics and Key Performance Indicators

Metrics are an essential part of an accountable crisis system and funding partnerships. Knowing who you serve and how well your services are received impacts funding, growth, and sustainability. For stakeholders who do not understand or are not moved by the peer respite philosophy, data revealing the effectiveness of services can turn skeptics into believers.

Informed by existing research around peer respite and crisis residential programs, the PRS Project Team recommends the metrics and key performance indicators established for peer respites in Central Maryland be aligned to the following categories in order to measure quality and effectiveness on personal, programmatic, and systemic levels:

- Operator fidelity to peer respite, peer-operated, and nonprofit management standards
- Guest satisfaction with amenities, services provided, staff interactions, and overall experience
- Points of referral, community connections made, and destination at exit
- Identity demographics and Social Determinants of Health factors
- Estimated Emergency Department and Hospital Diversion[112]
- Individual-level outcome measures of recovery, healing, voice and/or hopefulness

Specific suggested indicators are described in **Appendix D: Data, Outcome, and Fidelity Measures**

Recommendations for Potential Operators

Maryland has significant advantages over many states and communities that are currently pursuing peer respite, most notably the existence of multiple independent, peer-operated organizations working on the statewide and local community levels. However, their limited size and capacity at present will require a significant investment to be prepared for the sustained effort of securing support for and launching a new program model in addition to existing programs and services. Specifically, operating budgets for peer-operated Wellness & Recovery Organizations must support full-time Executive Directors and dedicated administrative staff (fiscal, operations, etc.) with minimal responsibilities for direct program service delivery and primary focus on organizational management and strategic growth.

The organization(s) taking on peer respite development must assure they have strong commitment and sufficient capacity, such as substantive prior experience with:

[112] This can be achieved through questions such as “Were it not for the peer respite, I would have likely gone to the Emergency Department,” with Likert Scale answers ranging from Strongly Disagree to Strongly Agree.

- Recruitment, training, supervision, and retention of qualified staff, contractors, and volunteers
- Providing direct peer support services, ideally with implementation of established evidence-based and best practice programming.
- Operating extended hours programming (i.e. on call/responsive, overnight, 24/7, 365).
- Sustaining active partnerships with other community or clinical services agencies.
- Managing a portfolio of funding grants and contracts, including public monies.

Leadership

Peer respite is predicated on a number of core beliefs essential to peer support and behavioral health recovery outlined in earlier sections of this report. Garnering an adequate level of support for the concept and reality of respite requires dedicated and multi-level efforts. Organizations interested in running a peer respite will need to cultivate leaders in each of these three groups:

Torch Carrier (Director): This individual leads the planning and development process, and is typically the future director of the peer respite. This person needs a strong and well-defined relationship with the operating entity, whether on an employment, consulting, or volunteer basis. The traits of this person, beyond their lived experience, are key to their success: deeply knowledgeable about peer support and the behavioral health system; an asset-based community-builder who desires to complement the local ecosystem, not replace it; organized, patient, resilient, and resourceful; and passionately committed to partnering with people in crisis toward their self-determined recovery. While help should be abundantly available from Advisors and Ambassadors around them, they are the primary public leader.

Advisory Group: This group of stakeholder representatives brings content expertise and connections to guide key operational issues necessary to launch the respite, with thoughtful consideration of the nuisances and complexities of location, cost, leadership, access, provider relationships, neighbor relationships, and funding resources. They also engage in effective advocacy at the community, policy, and funding levels as needed to secure support for the respite before, during, and after launch. This may take the form of a special committee of the Board of Directors of the operating entity, or be structured as an independent group with defined boundaries with respect to decision-making related to the respite. (In cases where a subsidiary organization may be formed, they may become the future Board of Directors.)

Ambassadors: These are external stakeholders allied to the principles and concepts of peer respite, who occupy positions of influence across the behavioral health system: emergency departments and inpatient units, outpatient clinics and programs, mobile crisis teams and site-based crisis programs, consumer/family advocacy groups, health system administrations, law enforcement, government offices, and funding entities. They

provide valuable insights, feedback, and connections to the Advisory Group and Torch Carrier.

Operations

Operating any crisis response service requires strong internal policies and procedures, an understanding and tolerance for risk, and a healthy appetite for creative problem-solving. Running a 24/7/365 peer respite demands an even higher level of infrastructural integrity as the physical and emotional safety of guests who are in a crisis state presents a constant responsibility.

Potential peer respite operators are encouraged to give serious consideration to the following areas:

Demonstrating Safety: Stakeholders expressed concern about how a respite that accommodates people in crisis and operates in an urban environment can ensure safety for guests and staff. While a respite is unlocked for guests, it needs to employ the same necessary security precautions against intruders as any residence. Peer-operated Wellness & Recovery Organizations in Maryland already have a strong track record of successfully supporting a respectful and safety-conscious culture on a daily basis. Managers in successful respites also emphasized the importance of interviews with potential guests to establish an understanding of policies and that the respite is a good mutual fit.

Data and Recordkeeping: Broadly speaking, peer services rely on a minimum of paperwork in favor of active communication, relationship-building, and flexible direct service delivery. However, respites will need to contend with both operational data management (referrals, waitlists, internal communication) as well as utilization and outcome data for demonstrating proof of concept. Organizations may require capacity building in their understanding of how best to collect data while maintaining peer values, and how to use technology most effectively for recordkeeping and analysis.

Residential Facility Operations: Whether leased or owned, respite operators will need to plan for routine, proactive, and responsive maintenance to keep the building in good condition, with a peaceful and healing environment. Urgent and emergency situations may incur significant expense and demand immediate resolution, such as in the case of equipment failure or damages at the respite building. Appropriate measures to maintain a healthy and hygienic environment can be shared between respite guests, staff, and contracted services as needed. In order to maximize access and occupancy, rooms must be quickly cleaned after each guest departs and readied for the next person.

Insurance and Liability: Respite operators may need to educate and advocate with insurance providers to define the proper terms and coverages for a respite program, which is neither a clinical service nor housing. Adequate general liability, property, and personnel-related (e.g. abuse and molestation, crime, worker's compensation, etc.)

policies must be put in place, with required staff training and protocols as needed. In the event that a confluence of zoning and funding restrictions require program licensure, additional considerations in this domain may come into play.

Fiscal Capacity: Organizations operating on narrow margins with respect to cash flow or who frequently experience payment delays from funding sources will need to maintain adequate financial reserves and/or be eligible for a sufficient line of credit in order to ensure such issues do not interrupt or compromise respite operations. Diversification of revenue streams and active fundraising efforts may be helpful.

Workforce and Culture

Providing effective, empowering, and trauma-informed peer support in a crisis context requires specialized training, ongoing professional development, and a strongly supportive organizational culture. The peer respite operator must be committed and immersed into being a trauma-informed organization as a whole. Organizational and program leaders may require training themselves related to the nuances of respite model, trauma-informed supervision, and recovery-friendly workplace policies and practices.

Recruitment and Retention: Respites will be competing for high-performing peer support professionals in an increasingly crowded employment market of other peer agencies, clinical programs, hospital systems, and non-healthcare settings with competitive wages and benefits. (See **Appendix B: Business Plan** for suggested salary ranges.)

As a program which explicitly hires individuals with lived experience of behavioral health challenges, health insurance should be provided to all full-time employees, as is the case for 65% of Maryland nonprofits. Access to a retirement plan can also support retention, and is the growing norm for 59% of nonprofits in the state. Additionally, the respite should provide maximum support for employees to obtain and maintain CPRS (re)certification as well as additional required training.

Training: The ideal workforce for peer respite are individuals who have personally experienced trauma, mental health crisis, and recovery, and who are able to maintain healthy boundaries and self-care while supporting others through intentional and authentic peer support skills and practices on a daily basis. Recommended trainings and training topics for all respite staff include but are not limited to:

- **General:** First Aid, CPR, Universal Precautions, Anti-Oppression/Anti-Racism and Cultural Humility
- **Peer Support:** CPRS Certification, Intentional Peer Support (IPS) Core Competencies, Ethics and Boundaries for Peer Support Specialists, Trauma-Informed Concepts

- **Crisis Issue-Specific:** Emotional CPR, Suicide (Alternatives to Suicide, When the Conversation Turns to Suicide), Extreme States (Hearing Voices Network)
- **Recovery Support:** Wellness Recovery Action Planning (WRAP), Recovery Coaching, Personal Medicine, Dimensions of Wellness

Partnerships

Respites increase their likelihood for success by maintaining active relationships with access points across the continuum of care, including the provision of training by the respite on how other agency staff can accurately describe peer respite, how and when to suggest peer respite within their standard operating procedures, and how best to support an individual to self-refer to the respite.

Organizations considering peer respite are encouraged to assess and strengthen their current relationships with local organizations providing the following services, which would be cultivated as key referral sources for the respite:

- Peer Support Networks (organizations and grassroots/informal groups)
- Community BH Services (OMHC, PRP, IOP, PHP, RRP, ACT)
- Hot/Warm/Helplines
- 988 Call Centers
- Open Access and Urgent Care Clinics
- Mobile Crisis/Response Teams
- Crisis Stabilization, Detox/Sobering, and Crisis Residential centers
- Hospital BH Services (Emergency Departments, Inpatient Psychiatric Units)
- EMTs and first responders
- Local Behavioral Health Authorities and Health Departments
- Crisis Intervention Teams and local Police Departments
- Justice diversion and reentry programs
- Speciality Courts (Mental Health, Drug)

Additionally, the respite will need to build partnerships with community agencies which support individuals who may be experiencing socioeconomic barriers or instability, trauma, or marginalization, all of which can cause or contribute to behavioral health challenges. These organizations may function both as potential referral sources as well as linkages for individuals staying at the respite who may desire their services. The 8 Dimensions of Wellness (emotional, physical, occupational, social, spiritual, intellectual, environmental, and financial) can be a helpful framework for guiding partnership development.[113]

[113] Swarbrick, M.(2006). A wellness approach. Psychiatric Rehabilitation Journal.

Potential Community Partners

- Food pantries and meal delivery services
- Community Action Councils and other basic needs resource providers
- Shelters and transitional housing programs
- Housing Authorities and public housing providers
- Accessible transit providers
- Legal Aid and bonafide credit counseling services
- Adult Literacy and GED programs, colleges and universities
- Workforce development programs and American Job Centers (employment services)
- Military and Veteran supports and services programs
- LGBTQIA+ resources, groups, organized efforts
- Spiritual wellness centers, churches, synagogues, etc
- FQHCs and free/sliding scale medical clinic
- Community service and civic engagement (Rotary, community action or alliance groups)
- Disability rights, protections, and advocacy organizations

Community Support

The stakeholder groups, presentations, conferences, meetings, and surveys deployed throughout the feasibility study have laid a foundation for additional community outreach, engagement and awareness. However, fully embedding peer respite into Central Maryland will require extensive community education beyond what was provided throughout the duration of this project.

Garnering active support for peer respite can begin within the behavioral health community through creating virtual platforms (website, social media) to act as a centralized resource with information and regular updates, producing virtual and in-person educational events, and leveraging existing publications and conferences to reach different stakeholder groups. Further public awareness and support can be achieved through traditional avenues used to introduce new services to a community such as social media, printed materials with broad circulation, participation in public events (e.g. resource fairs, community gatherings), and marketing through television and radio. LBHAs and community groups are experienced and skilled with establishing outreach and marketing strategies. A similar, scaled-down version of a 988 awareness campaign could be adapted to promote peer respite.

Neighborhood relationships are critical for this model to be embraced and valued by the community. Addressing concerns about NIMBYism (Not In My Back Yard) and safety will require level-headed spokespersons who can quickly build consensus with diverse people voicing a variety of concerns. Introduction to and involvement in community requires respite programs to be a “good neighbor,” and the hospitality that is offered inside the peer respite should extend to the community in intentional ways.

Risks

Sustainable Funding: Identifying, pursuing, securing, and sustaining a diverse funding portfolio is an evergreen challenge for all human services and nonprofit operations. Funder hesitancy to invest in an untested program model or relatively unknown organization can be partially alleviated by operating the respite as a partner, subsidiary, or program under an existing organization with a stable reputation and prior successes. Transparent sharing of metrics and outcomes are also necessary to demonstrate the impact on individuals and the system, including demonstrated cost savings which can encourage reinvestment of those dollars into program operations.

Introducing a New Model of Care: Communities who are familiar and comfortable with high reliance on inpatient psychiatric hospitalization will need ongoing education and guidance about how peer respite complements the array of existing services and leads to better experiences and outcomes for both individuals and institutions. The stakeholder engagement work accomplished through this study is essential but only the beginning. Strategies for building awareness and cultivating partnerships are included in **Appendix B: Business Plan.**

Mission Drift: When peer respites must navigate traditional funding structures steeped in a medical model of care, or experience leadership transitions that prompt reassessment of protocols and priorities, the pressure is considerably higher for the operator to mold the program to status quo (clinically-oriented) staffing structures, policies and procedures, and interpersonal approaches. Education and investment from all levels of leadership (including HR, finance, and IT) are critical to lay the groundwork for maintaining fidelity, and supporting ongoing innovation in response to emerging needs and opportunities.

Recommendations for Respite Design

To ensure lasting success and meaningful impact on guests and their recovery, the PRS Project Team recommends the following considerations on key components of peer respite program design.

Location

The same attention to detail given by homeowners to the choice of location, style, and feeling should be given to the decision about which residential property will make a great peer respite.

Neighborhood: Assessing community culture and welcoming attitudes toward diversity and inclusion is a nuanced process that requires input from multiple stakeholders who may experience the community differently, with particular consideration to time of day. Public events, yard signs and flags displayed by residents, law enforcement activity rates, public perception (word of mouth, local newsletters, social media neighborhood groups), and district voting records on social issues may indicate how friendly a neighborhood, town, or city is to people with different worldviews and diverse cultural backgrounds, to behavioral health concepts and services in general, and to a peer respite.

Community Connections: Accessibility and support for people of all abilities and life stages is important. Peer respites located near public transportation allow for easy travel to work or school for those who wish to remain involved in those activities during their stay. Core public services like grocery stores, retail shops, libraries, recreational facilities, healthcare services, etc. should be located within a reasonable radius from the property so guests may engage with community life as desired.

Building: Zoning laws will have considerable impact on the location and size of a peer respite; see **Appendix F: Zoning Considerations** for more detail. In addition to meeting all safety requirements and relevant building codes, the building should ensure all common spaces, and at least one bedroom and bathroom be ADA accessible. Bed capacity will be determined by the size of the chosen home, as each guest should have their own bedroom of adequate square footage. No respite should have more than 6 beds, to maintain an intentionally restorative and homelike setting. Furnishings should match and support the guiding principles of respite, and both interior and exterior maintenance should be easily manageable by the respite staff and operating entity. The exterior of the respite should be beautified consistent with community standards and avoid signage that feels too formal or appears conspicuous amidst a residential area. (See **Appendix B: Business Plan: Property** for more detail.)

Ownership & Occupancy: Careful consideration must be given to how the respite can best maintain appropriate responsibility for its physical location. A rental arrangement with a supportive landlord offers the greatest flexibility to continuously adapt to changing conditions, especially in the early years of operation. While ownership of a building ultimately affords the greatest control and capital improvement funding may be readily available, the significant long-term liability that building ownership places on the organization – especially before funding and neighborhood relationships are sufficiently stabilized – may not be worth the potential benefits gained.

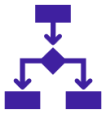
Access

Complexities and competing priorities for access have emerged as a significant topic of conversation throughout this feasibility study. A tension exists between utilizing community-based crisis residential programs to prevent or divert the use of emergency departments and inpatient settings, and the frequent practice in Central Maryland of using these programs instead as a step-down from hospitalization.

Diversion Focus: While many respites around the country work with hospitals to arrange transitional stays to support people coming out of long-term institutionalization, this approach is not recommended for the launch of respites in Central Maryland at this time due to the current use of existing crisis residential programs for this purpose and the urgent need for more initial diversion options, as expressed by stakeholders from community, crisis, and hospital-based settings.[114]

Self-Referral: Most peer-run respites operate on a self-referral basis and use a multi-step communication process with the individual to suss out and eliminate any pressure or coercion. Whether voiced by family members, friends, or clinicians, statements like "you can either go to the hospital or to the respite" sets false expectations for the individual, their supporter, and the respite. An open self-referral process eliminates gatekeeping or positioning others as "knowing what is best" for the individual. The mutual agreement approach begins to model the non-hierarchical nature of recovery, self-determination, supported decision making, and the person in distress as the expert in their own lives. However, community partners, providers and family members can provide important support in raising awareness, fostering connection to the respite, accompanying a person to the respite (if desired), and serving as allies and champions.

[114] While outside the scope of this report, implementing a Peer Bridger program (based on the widely-replicated NYAPRS model) could support individuals being discharged from the hospital.



Pilot Phase Access Priorities: Recognizing the inherent challenges and necessary time for capacity building that comes with launching the first peer respite in the Central Maryland region, it is recommended that the following considerations, priorities, and limitations be put into place during the pilot phase (first 3-5 years) of respite operations, to be revisited every 2 years and adjusted as appropriate:

- Prioritize educating 988 Call Centers, Mobile Crisis/Response Teams, Urgent Care Clinics, and Emergency Department personnel on how to support a person in self-referring to the respite.
- Use a waiting list with priority for individuals who have experienced hospitalization in the previous 12 months, as an indicator of likelihood to experience pressure (internalized or from others) for rehospitalization, or who have utilized the Emergency Department in the previous 6 months, as an indicator of continuing high-intensity distress and likely return to the ED.
- Develop policies for situations where individuals are under guardianship, conditional release, probation, parole, or who are listed on the sex offender registry. These circumstances can compromise the legal standing of the individual or pose significant potential complications that may exceed capacity in the pilot stage.
- Include flexible funding that may be used to support guests' transportation to the respite or small personal needs if unable to be met through other means. This helps eliminate small barriers that may distract or impede guests to focus on their recovery.
- Maintain a maximum stay of 10 days and a post-stay waiting period of 90 days. This seeks to balance maintaining full capacity with remaining accessible, especially as awareness and interest in the respite program grows during the pilot phase.

Service Array

The peer respite should be designed as a safe sanctuary space inside and out, from the furnishings to the activities and opportunities available to guests before, during, and after a respite stay. During a stay at the respite, guests should have options for support which address key facets of recovery and the 8 Dimensions of Wellness. At minimum, the Respite should ensure guests have access to the following services, which may be provided by respite staff or in partnership with other peer support or community organizations:

- **1:1 and Small Group Peer Support:** All guests should have 24/7 access to 1:1 peer support from respite staff (and other guests if mutually desired), and at least one support group opportunity each day, whether onsite at the respite, offered virtually, or at another community location within reasonable distance. It is strongly recommended to offer multiple types of support groups (available locally or virtually) to support a variety of recovery pathways.

- **Nervous System Self-Regulation:** Guests should be offered options for physiologically supportive practices such as healthy food and comfort food, walking, stretching, biking, drumming, tapping, meditation, fidgets, listening to music, etc.
- **Creative Self-Expression:** Guests should have access to journals, art supplies, craft supplies, personal cell phones, computers with internet access and printers, and musical instruments to explore creative self-expression for healing.
- **Bodily Wellness Support:** Guests should have access to bodily wellness support services such as yoga, acupuncture, acupressure, massage, Reiki, tai chi, qi gong, exercise classes, etc. Any practice requiring special skills or licensure should be conducted by a trained and certified practitioner, such as through a partnership with an independent contractor or agency.
- **Wellness Recovery Action Planning (WRAP):** This Evidence-Based Practice was developed by and for peers, and offers a totally personalized, highly flexible framework for designing and self-directing wellness tools, strategies, and supports as well as crisis and post-crisis planning. WRAP is specifically recommended because it can be applied to any behavioral health challenge or distressing situation. While not a prerequisite for Psychiatric Advance Directives (PAD), WRAP is a more robust self-reflection and planning tool that can lay the foundation for a formal PAD document.
- **Community Connections:** Through information and referral facilitation, guests should be able to connect with other community services and resources as desired for their wellness journey, such as those supporting the key dimensions of recovery:
    - *Housing:* If houseless, the respite should actively facilitate connection with shelter, temporary, service-linked and/or permanent housing, at the guest's direction.
    - *Health:* If not connected with somatic or behavioral service providers, guests should be offered assistance with navigating the process of exploring options, connecting with providers, and understanding insurance enrollment and service payment processes.
    - *Purpose:* Guests should be supported in exploring what interests and motivates them, and any desired education, volunteer, employment or vocational options.
    - *Community:* The respite should already have strong connections with the local community, through which guests can be invited to social and recreational events.

A balance of many pathways of well-being should be considered and intentionally offered. Spiritual well-being, financial literacy, physical health, emotional well-being, social connections, and familial relationships are all valid ways that people heal and should be made available internally and externally to the respite guests.

Achieving a full service array will likely require establishing partnerships with community agencies in the area, including Maryland's existing peer-operated Wellness & Recovery Organizations, other peer support networks, and health and wellness services.

Peer respites should be built around a commitment to supporting the community at large. Besides serving people in emotional distress and crisis, this may also mean hosting and participating in neighborhood activities (block parties, holiday celebrations, open houses), and offering resources to solve collective community problems (joining watch groups, local committees and councils, organizing for advocacy on issues of local priority).

Finally, peer respite operators should consider how to engage their alumni after completing their stay at the program. People and purpose are two critical elements of a good quality of life, and when peer respites activate the potential of their past guests, they strengthen their own sustainability through developing the next generation of peer supporters, advocates, and leaders.

Policies and Procedures

While starting a respite, it is not possible to anticipate every situation for which a process, policy or organized procedure is needed. For this reason, policies must be continuously reviewed and updated to consider new needs as they emerge. While not a exhaustive list, some key policies and procedures to consider from inception include:

Language and Culture: The words and phrases that are used and not used at the respite reinforce the programmatic culture and values. Policies around trauma-informed, non-clinical language should be overt to avoid defaulting to phrases such as "intake," "client/consumer/patient," "non-compliant," etc. The policy established should reflect the authenticity of peer support and set the expectations about minimizing hierarchy and demonstrating unconditional high regard, mutuality, and a space without judgment.

Accessibility: Clear delineation of who may and may not benefit from the respite (eligibility criteria) with required screening process steps and necessary data collection should be clearly stated in policy, including provisions for use of waitlists (with or without prioritization).

Trauma and Safety: Policies regarding substance use, self-harm, thoughts of suicide, and other issues that could be related to safety should be well-thought, documented, trained, mentored and become a part of supervision of team members. Any standards regarding calling 988, 911, involving police, medical emergency first responders, transporting people during an emergency, etc., should have written procedures.

Confidentiality and Disclosure: Considerations around a guest's permission to disclose whether they are staying at the respite and to whom, under what circumstances staff may or may not communicate with a loved one, service provider, friend, etc., what information can and cannot be shared, and how information will be documented and communicated between staff team members and the guest should all be established in policy and training.

Guest Experience: Process guides and any written information needed for the guest experience need to be created and regularly updated, such as: welcome packet, check-in / check-out checklists, guest agreement, local resources guide, FAQs, initial and exit reflection surveys, goal or activity planning tools, follow-up communication, etc.

Partnerships and Linkages: Policies and agreements related to how and when guests may be supported in connecting to other community resources or health services should be written and shared with guests, staff, and partners. This may include frameworks for designating some external entities as 'partners,' which might indicate completion of specific training about the respite model, information sharing agreements, or eligibility of respite guests for services (ex: free classes at a local wellness studio, mobile crisis/response team for voluntary support in heightened situations, etc.)

Data Collection and Use: What, when, how, why, and by whom specific data is collected, stored, accessed, and analyzed should be defined in policy and training. Data security and access should be safeguarded in accordance with relevant standards and practices. Quality Assurance and Improvement protocols should be designed to address gaps, needs, and opportunities at the guest and program levels.

Operating Policies & Procedures: Standard HR and specialized policies should address job descriptions, staff training (initial and ongoing), supervision requirements, performance evaluations, incident reporting, confidentiality, use of systems and property, and peer support boundaries and ethics.

Conclusions

Peer respite is more than a program or service to add to a continuum of behavioral health services; peer respite is a noble demonstration of the essential system values of recovery, restoration, equity, and empowerment. The values espoused by the effective operation of a peer respite should impact other peer services, other crisis services, and other stakeholders in the behavioral health continuum.

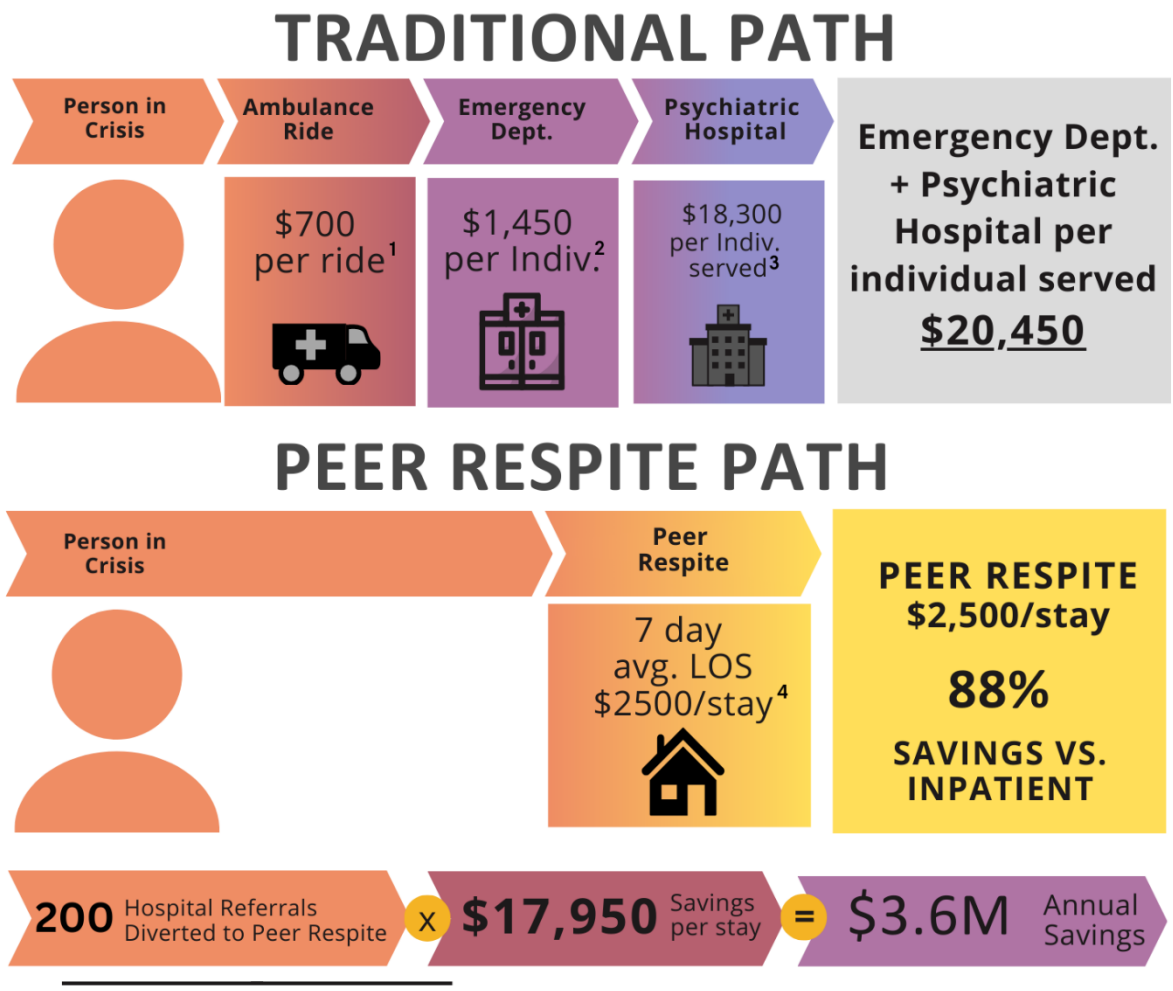
Temptations to compromise on values, function, or staffing to align peer respite with the status quo of the existing system must be met with resolve and fortitude, with a consistent return to the mission and vision of peer respite and its place in the recovery model for behavioral health. Instead of pressuring a peer respite to conform to traditional parameters, existing clinical crisis, residential, and inpatient programs should be encouraged to adopt more of the practices of peer respite: hospitality, shared decision-making, person-centeredness, and healing focus.

Through *in vivo* exposure to the concepts and operations of peer respite, Central Maryland stakeholders have been invited to witness a way of thinking and helping that they can incorporate and implement into their crisis care delivery systems. When peer respite is done well, operators understand that the spirit behind peer respite is more than its walls, its decor, or even its staff: it is a paradigm shift towards re-humanizing behavioral health crisis care, with a vision for hospitality that exceeds any expectations in the current safety net.

The transformative potential of peer respite is perhaps best understood by looking back at the evolution of the first question often asked to a person seeking services, moving from a medical model ("What's wrong with you?"), to a trauma-informed lens ("What happened to you?"), and finally to a healing-centered approach:

What do you want to happen next?

Appendix A: Peer Respite Cost Savings



1 Based on Baltimore County ambulance cost reports. https://www.baltimorecountymd.gov/departments/fire/ems/#:~:text=The%20fees%20are%20%24700%20or,the%20level%20of%20care%20required

2 Associated Expenditured per Individual for Individuals Receiving Receiving Emergency Department Services within the Maryland Public Behavioral Health System FY 2021 and 2022. Based on Optum ASO Claims.

3 Associated Expenditures per Individual for Individuals Receiving Receiving Inpatient Services within the Maryland Public Behavioral Health System FY 2021 and 2022. Based on Optum ASO Claims.

4 Based on cost reporting data from peer respite operated by Promise Resource Network, Charlotte, NC.

Appendix B: Business Plan

Value Proposition

Peer respites provide a low-barrier, community-based, short-term 24/7/365 residential option for individuals experiencing behavioral health crises who are overrepresented in and not well served by hospital-based services. Through peer-delivered, trauma-informed, and explicitly non-coercive approaches, peer respites offer individuals a supportive environment in which to develop skills and practices for healing and personal growth, and foster strong connections with local peer support networks for sustained recovery. Peer respites are a highly cost-effective enhancement to the crisis services continuum, as they are able to prevent and divert unnecessary use of Emergency Departments and inpatient hospitalization, as well as decrease future utilization of high intensity clinical services by activating individuals' capacity for self-management and engagement with community supports.

The Baltimore City Peer Respite Pilot Program (Pilot Respite) will successfully complete at least 150 diversions from unnecessary use of hospital-based services each year by offering 4 respite beds with an 7-day average length of stay and an average annual occupancy rate of at least 75%.

Target Population

Individuals experiencing any level of emotional distress — from subclinical depression and anxiety to "chronic and persistent serious mental illness" — may all qualify for and benefit from peer respite. Fidelity to the model requires no limitations be placed on eligibility with respect to diagnosis, clinical assessment, insurance, or socioeconomic status.

While designed to be open access for any individual self-identified as experiencing a behavioral health crisis, high priority target populations for peer respite include:

- Individuals utilizing the Emergency Department for behavioral health crisis but not qualifying for inpatient services.
- Individuals with repeat utilization of Emergency Departments for behavioral health distress without medical emergency.
- Individuals who have experienced psychiatric hospitalization in the previous 12 months.
- Individuals with behavioral health needs who have experienced poor outcomes or been dissatisfied with hospital-based services in the past.

Individuals matching the target population characteristics will be made aware of the Pilot Respite through targeted direct outreach and referral networks as described in the Activities: Outreach section.

Market Needs/Opportunity Analysis

Analysis of the Central Maryland Regional Crisis System found high rates of behavioral health presentations in Emergency Departments, high costs for inpatient utilization, and low availability of community-based crisis residential beds. Peer respite is an ideal option for individuals experiencing behavioral health crises without severe co-occurring medical needs requiring clinical or nursing care. Launch of the nationwide 988 crisis hotline and enhancements to expand, coordinate, and regionalize Central Maryland's crisis response service system presents multiple opportunities for individuals to be referred to peer respite prior to any interaction with hospital-based services.

Expected Impact

Peer respite can effectively prevent and divert individuals from unnecessary hospital-based services with significant benefit to the individual, the system, and the State. Estimates suggest that a 4-bed peer respite could produce cost savings up to $3.6M per year compared to total costs for ambulance, ED, and inpatient services on a per person per stay basis.

- **Individual:** Experiences a trauma-informed and healing-focused environment, free of coercion, and direct support from other individuals with lived experience of similar behavioral health challenges and specific expertise in self-directed recovery and wellness practices. They become aware of and connected to local peer support networks and recovery support services, which can result in less reliance on clinically-based services, better address of multiple Social Determinants of Health, and increased quality of life. They avoid the negative impacts of high costs, stigma, and collateral consequences that often result from ED use or inpatient hospitalization, especially if experienced on an involuntary basis.

- **Service System:** Gains an alternate placement for individuals who desire or require 24/7 support during a period of behavioral health crisis, but who are not a good fit for traditional options (e.g. crisis residential, inpatient), whether due to not meeting clinical criteria, insurance-based barriers, lack of availability, or individual circumstances (conflicting family or work obligations, fear, disinterest, or resistance).

- **State:** Realizes both immediate and long-term cost savings through use of peer respite as hospital diversion. Not only is the average cost for a peer respite stay approximately 80% less than an inpatient stay, but research has found that many individuals using peer respite services have lower future utilization of emergency and inpatient services.

By recognizing and removing retraumatizing aspects of many traditional crisis response services, focusing on individualized skill-building for personal healing, and facilitating direct connection to local peer support networks, respites can change the trajectory of a person's life from identifying as dependent on the behavioral health system to independence through self-empowerment, community engagement, and sustained recovery.

Assumptions and Contingencies

While outside the clinical care paradigm by design, peer respites can be significantly influenced and impacted by the landscape of behavioral health services in which they are located. Key assumptions and contingencies informing the successful launch and sustainability of peer respites include but are not limited to:

- **Funding Model:** The non-clinical nature of peer respite does not match well with insurance-based billing structures. Grant or contract-based funding may consist of public (federal, state, local) or private (foundation, philanthropy, earned) funds.
- **Workforce:** Peer respite workers require specific and ongoing training, competitive wage and benefit packages, and a strong organizational culture of support.
- **Referral Network:** Peer respites must maintain strong relationships with outpatient, crisis, and inpatient entities to effectively serve as a viable and accessible hospital diversion option.
- **Real Estate Market:** Like other residential programs, peer respites require physical facilities to meet accessibility and environmental standards. Appropriate housing stock at the right level of quality and affordability can be difficult to secure, and is subject to zoning requirements.
- **Community Relationship:** Respites must balance privacy for guests with active community engagement to build support for the program in the face of potential NIMBYism or skepticism.

Structure and Partnerships

The Pilot Respite would be launched as a new program under an existing operating entity which has sufficient capacity to manage and support both programmatic and administrative needs, and which offers complimentary recovery support services.

Operator

To ensure fidelity to the model, the Pilot Respite operator would be a nonprofit, peer-operated entity, i.e. having at least 51% Board members with lived experience, all direct service and programmatic staff having relevant personal lived experience, and with an established mission dedicated to the promotion and provision of alternative, holistic, and/or peer support services.

To guide program development, community outreach, and accountability, the Pilot Respite would maintain an Advisory Group composed of representatives from defined stakeholder groups. This group will have significant responsibilities in the initial years (planning and launch), and shift to a more traditional advisory role in subsequent years. For more detail, see **Appendix C: Advisory Group**.

Partnerships

To support successful launch, contracted technical assistance and training services may be required from entities currently providing peer respite services equivalent in size and scope to the Pilot Respite. The frequency and intensity of consultation will be significant in the initial year (planning and launch), and decrease to an as-needed basis in subsequent years.

The Pilot Respite would need to build and maintain strong relationships with community-based organizations providing peer support, recovery support, bodily wellness, outpatient behavioral health services, crisis response services, and somatic healthcare services within the local area to promote understanding and use of the respite, and connection to other services which guests may select to use in their recovery journey.

Activities

Services

The Pilot Respite offers guests 24/7 onsite access to non-clinical peer support specialists, who can guide and support self-help, personal wellness, and meaning-making skills and strategies to navigate periods of emotional distress and behavioral health crisis.

The Pilot Respite should offer a sufficient range of core services from the first day of operations, with the ability to enhance offerings through partnerships. The following chart suggests what, how, and by whom services may be organized and delivered during the pilot stage (first 3-5 years).

Service Area	Description	Delivery Method
1:1 and Small Group Peer Support	Formal and informal meetings	Onsite with respite staff and guests
Peer Support Groups	WRAP, 12 Steps, Seeking Safety, WHAM, Wellness Tools, Issue-Specific, etc.	- Onsite by respite staff - Virtual access - Offsite at partner organization - Offsite by self-referral
Nervous System Self-Regulation	Healthy food and comfort food, walking, stretching, biking, drumming, tapping, meditation, fidgets, listening to music, etc.	- Onsite self-practice - Onsite with respite staff and guests - Onsite with partner/vendor - Offsite at partner organization

Service Area	Description	Delivery Method
Creative Self-Expression	Journaling, arts & crafts, computers with internet access and printers, musical instruments (as available), etc.	- Onsite self-practice - Onsite with respite staff and guests - Onsite with partner/vendor
Wellness Recovery Action Planning (WRAP)	WRAP books and materials, 1:1 WRAP support, WRAP groups	- Onsite self-practice - Onsite with respite staff or partner/vendor with appropriate credentials - Offsite at partner organization
Bodily Wellness Practices	Yoga, acupuncture/acupressure, massage, Reiki, tai chi, qi gong, etc.	- Onsite with respite staff or partner/vendor with appropriate credentials - Offsite at partner organization - Offsite by self-referral
Community Connections	Resources to support the 8 dimensions of wellness (social, environmental, physical, emotional, spiritual, occupational, intellectual, and financial) and 4 key dimensions of recovery (health, home, purpose, community)	- Onsite self-practice - Onsite with respite staff and guests - Onsite with pPartner/vendor - Offsite at partner organization - Offsite by self-referral

Access

To achieve maximum accessibility and the greatest opportunity for successful diversion from Emergency Departments and hospital-based services, the following parameters for access are recommended:

- Self-referral on a strictly voluntary basis, initiated by the potential guest by phone call or written request.
- Consistent process used by senior respite staff, to include initial interview by telephone or video conference, in person interview, respite tour, and orientation.

- Data elements collected at natural opportunities presented throughout the process; see **Appendix D: Data, Outcomes, and Fidelity Measures** for detail.
- Considerations for respite stay may included (1) ability and agreement to uphold respite expectations for mutuality, wellness and recovery focus, and physical and emotional safety for self, guests, and staff, (2) ability to clearly communicate and to maintain adequate daily self-care, and (3) sufficiently medical stability (ex: not requiring 1:1 nursing or clinical care). Other considerations include situations where Individuals have particular circumstances (ex: under guardianship, on conditional release, subject to sex offender registry notifications).
- Priority consideration given to individuals with recent hospitalization (within the last 12 months) or Emergency Department use (within the last 6 months).

Quality Assurance and Evaluation

The Pilot Respite would maintain compliance with all legal requirements for the scope and nature of its services, programs, operations, and organizational standing. On a regular basis and no less than quarterly, the Pilot Respite would perform internal audits to ensure policy and procedure implementation, evaluate progress on intended outcomes, and identify opportunities for improvement. On an annual basis, the respite would prepare a summary report of key performance indicators and successes, in a format appropriate for sharing with the public.

Implementation Milestones

Timeframe	Objective
Planning Phase (12+ Months) *Listed objectives are suggestions only; activities are highly dependent on resource availability.*	
Q1	Identify and hire Director Identify and invite Advisory Group members Convene Advisory Group Scout locations Identify and pursue operational funding
Q2	Identify and hire Assistant Director Finalize core respite design frameworks (policies, procedures, metrics, etc.) Outreach to community partners Scout locations Identify and pursue operational funding
Q3	Secure community partnerships Secure operational funding Secure location and complete necessary modifications/readiness Finalize marketing plan

Q4	Conduct broad marketing and outreach Hire respite staff Test run operations with volunteer peer support professionals Finalize data collection protocols Hold community engagement event(s) Welcome first guests
Pilot Phase (First 3-5 Years) *Listed objectives are suggestions only; activities are highly dependent on resource availability.*	
Year 1	Maintain at least 50% occupancy on an annual basis Collect utilization and impact data
Year 2	Maintain at least 75% occupancy on an annual basis Collect utilization and impact data
Year 3	Maintain at least 75% occupancy on an annual basis Perform formal fidelity evaluation Analyze Year 1 and 2 data to identify needs, gaps and opportunities Implement operational improvements as needed
Year 4	Maintain at least 80% occupancy on an annual basis Collect utilization and impact data Prepare for replication process
Year 5	Maintain at least 85% occupancy on an annual basis Collect utilization and impact data Begin replication process

Resources

Funding

The Pilot Respite may seek different funding for each distinct phase of implementation: planning, pilot, and replication. Sample Budgets are included below.

Priority funding sources for core operations include public monies already specifically designated toward the creation, sustainment, or enhancement of public mental health or substance use services. When pursuing these opportunities, the Pilot Respite will emphasize how it addresses gaps, alleviates known bottlenecks in the continuum of care, and can achieve cost savings through effective hospital diversion.

Planning phase funding may be sought from entities looking to support innovative, community-led, and JEDI (justice, equity, diversity, inclusion)-responsive initiatives in the healthcare field. As a participant-driven and participant-delivered program, peer respite intrinsically shifts the paradigm of

service delivery and intentionally breaks down the stigma associated with mental illness, addiction, and behavioral health challenges.

One-time funding, such as for necessary property improvements, initial furnishings, or sponsorship of special activities, projects, or events, can provide valuable support and opportunities to build relationships with new funding sources through smaller proposals.

Prior to application for a specific funding initiative, the Pilot Respite will need to secure any necessary partnership agreements and letters of commitment as needed to fulfill required objectives and deliverables.

Staffing

The standard staffing ratio for peer respites is 1:4. However, in consideration of the pilot status and anticipated workforce development needs, the Pilot Respite will implement an enhanced staffing model at launch, to be evaluated and adjusted as necessary based on observed and emergent needs.

Core staff employed at the respite should have direct, personal lived experience of trauma and mental health crisis and recovery, Certified Peer Recovery Specialist (CPRS) status, and substantial experience providing authentic peer support, with a priority for previous work in crisis response settings. There is also an opportunity for peer supporters who have not yet achieved CPRS certification to work at the respite in a supportive capacity and gain experience toward the service hours and supervision requirements for that credential.

The full staffing structure envisioned consists of six full-time positions (Director, Assistant Director, Weekdays: 3 Specialists, 1 Supporter) and four part-time positions (Weekends: 3 Specialists, 1 Supporter), as reflected in the sample budget. This allows for the possibility of weekend shifts being taken on by peer professionals already employed in other full-time roles, such as in a peer-operated Wellness & Recovery Organization or in clinical services. The goal is for the majority of shifts to be filled by full-time workers, who are positioned to receive the greatest level of support (training, benefits) and deliver consistency for guests and operations. However, recruitment challenges may require some shifts to be filled on a rotating basis by per diem staff, drawing on the pool of peer support professionals in Central Maryland.

Salaries of respite employees must be in alignment with local market values and competitive with other peer support positions in clinical settings. According to the 2021 Maryland Nonprofits Salary Survey, the median salary for a community health worker/educator in Maryland is $44,500; this aligns with findings from the 2023 *Peers That Count* survey, which reported 54% of peer respondents making between $30,000-$50,000/year.[115] The MDNP report offers the median salary for a housing manager as $53,000, with Program Director salaries ranging from $47,500-$55,500 annually.

[115] Maryland Peer Advisory Council and University of Maryland School of Social Work. (2023). Peers That Count: A Call to Action! A Peer-Led Peer Recovery Census to Determine Where We Are, What We Contribute and What We Need.

However, the additional responsibilities for program development, partnership-building, funding/contract management, and 24/7 responsiveness required for a successful launch of the first peer respite in Maryland are beyond that of a typical Housing Manager or Program Director. Additionally, hourly wage differentials of 7.5-15% have been estimated to support recruitment for evening, overnight, and weekend shifts. Suggested salary ranges are included below and integrated into the sample budget.

Staff Position & Salary	Credentials	Role and Responsibilities
Program Director *$65-73k/yr* *Full-time, exempt*	CPRS, RPS Management Exp. Supervisory Exp. Residential/Crisis Exp. Bachelor's Degree	Directs respite operations, supervises staff, manages budget, maintains partnerships, ensures deliverables are met, determines guest eligibility. Typically works Monday - Friday, including on call for overnights.
Asst. Program Director *$55-63k/yr* *Full-time, exempt*	CPRS, RPS Team Lead Exp. Residential/Crisis Exp. HSD or GED *Preferred: Associate's degree or higher*	Assists with respite operations, partnerships, guest and alumni relations. Typically works Thursday - Monday, including on call for overnights.
Peer Respite Specialist *$24-27.50/hr (shift diff.)* *Non-exempt* *Full & part-time positions*	CPRS 3+ yrs Peer Support exp. HSD or GED *Preferred: RPS, residential/crisis exp.*	Provides 1:1 and small-group peer support at the respite. Supports guests with linkage to desired recovery supports and community resources.
Peer Supporter *$18-22/hr* *Non-exempt* *Full & part-time positions*	Required Core Training 1+ yrs Peer Support Exp. HSD or GED *Preferred: CPRS in process*	Only eligible for swing/support shifts where CPRS is present. Under supervision, provides 1:1 and small-group peer support at the respite. Supports guests with linkage to desired recovery supports and community resources.

Two full-time leadership positions (Program Director, Assistant Program Director) ensure adequate management coverage for 24/7/365 respite operations and robust community education/engagement efforts to support guest referrals, partnership development, and staff recruitment. Their work schedules should overlap to support effective coordination. The Program Director will have greater administrative responsibility for staff supervision and HR, policies and procedures, budget management, contract deliverables, and program evaluation. The Assistant Program Director will have enhanced responsibilities for marketing and community outreach, partnership development, guest and alumni relations. Both positions are expected to regularly work onsite at the respite, but may also

work from the operating entity office location, in community, or remotely as appropriate. Each position will have on-call responsibilities for overnights during their regular weekly schedule.

Onsite staffing at the respite consists of three 8-hour shifts worked by a Peer Respite Specialist with active CPRS certification. A supplemental swing shift spanning the afternoon and evening hours may be filled by a Peer Supporter, who must complete specific training but is not required to have a CPRS credential. This provides additional support during hours expected to have increased activities, and assists with consistency and knowledge transfer across shifts.

A 2021 Maryland Department of Health analysis of ED use for behavioral health crises found "the vast majority of [EMS/911] calls for BH-crisis occur between 9 am and 2 am (80%) with call frequency peaking between the hours of 2-10 pm. Calls for [mental health-related] crisis transportation begin… to markedly increase at 8am, plateauing around noon and then beginning to taper off starting around 10 pm." [116]

Considering that peer respite might be explored as an option as a result of a 911/EMS call, these timing trends suggest additional staffing at the respite in the afternoons could help support conversations and onsite tours with these potential guests.

Shift	Staff Coverage	Notes
Weekday Early Monday - Friday 8:00 a.m. - 4:00 p.m.	Program Director Respite Peer Specialist	Specialist is onsite at the respite building. Director may work from various locations as needed.
Weekday Swing Monday - Friday 12:00 p.m. - 8:00 p.m.	Respite Peer Supporter	Supporter is onsite at the respite building. Supervised by CPRS staff.
Weekday Evening Monday - Friday 4:00 p.m. - 12:00 a.m.	Respite Peer Specialist *On Call: Program Director*	Specialist is onsite at the respite building.
Weekday Overnight Sunday - Thursday 12:00 a.m. - 8:00 a.m.	Respite Peer Specialist *On Call: Program Director*	Specialist is onsite at the respite building.
Weekend Early Saturday - Sunday 8:00 a.m. - 4:00 p.m.	Assistant Program Director Respite Peer Specialist	Specialist is onsite at the respite building. Assistant Director may work from various locations as needed.

[116] Maryland Department of Health. (2021). Transformation of Outpatient Mental Health Clinics to Crisis Stabilization Centers Grant: Data Analysis

Shift	Staff Coverage	Notes
Weekend Swing Saturday - Sunday 12:00 p.m. - 8:00 p.m.	Respite Peer Supporter	Supporter is onsite at the respite. building. Supervised by CPRS staff.
Weekday Evening Saturday - Sunday 4:00 p.m. - 12:00 a.m.	Respite Peer Specialist *On Call: Asst. Program Director*	Specialist is onsite at the respite building.
Weekday Overnight Friday - Saturday 12:00 a.m. - 8:00 a.m.	Respite Peer Specialist *On Call: Asst. Program Director*	Specialist is onsite at the respite building.

Property

Baltimore City is disproportionately affected by structural inequity, community disinvestment, substance use, and gun violence, making it more challenging to find and maintain a space that all guests and respite workers feel is secure and restful. However, examples of successful peer respites in Charlotte (NC), Worcester (MA), and New York City (NY) demonstrate that with thoughtful site selection and planning, it can be done.

All non-owner occupied properties in Baltimore, City, including short-term rentals, must file a registration statement online, and short-term rentals must pay an annual fee of $200 a year per "dwelling unit."[117] All newly registered units must also be inspected by a state-licensed, Baltimore City-registered Home Inspector, the cost of which is set by the individual inspector, and is typically based on the square footage of the property and borne by the property owner, at the average cost of about $410 for a basic inspection, plus any needed additional costs for specialized inspections such as termite damage, lead paint, sewer scope, or houses with difficult-to-access roofs or crawl spaces.

As supplement to the general considerations shared in **Recommendations for Respite Design: Location**, the following checklists of suggested features are provided to support property selection for the Baltimore City Pilot Respite. Checklist items may be amended by the operating entity in consultation with the Advisory Group.

Neighborhood:

- ☐ Residential neighborhood or mixed use with majority residential
- ☐ Accessible by public transportation

[117] The Mayor and City Council of Baltimore. (2022). Article 13: Housing and Urban Renewal, Subtitle 4-2: Registration of Non-Owner-Occupied Dwellings, Rooming Houses, and Vacant Structures. Baltimore City Department of Legislative Reference.

- ☐ Community amenities (grocery and convenience stores, retail shops, parks or green spaces) within walking distance
- ☐ Within 1 hour drive of hospital(s) accepting psychiatric admissions
- ☐ Acceptable levels of crime and safety per Baltimore Neighborhood Indicators Alliance or similar data-based tool
- ☐ Acceptable levels of diversity per Baltimore Neighborhood Indicators Alliance or similar data-based tool
- ☐ No known recent incidents of significant intolerance or discriminatory practices in the local community (ex: acts of violence, publicized negative incidents, etc.)

Rental Arrangement:

- ☐ Owner is fully informed and supportive of intended purpose
- ☐ Owner is in good standing with the State of Maryland and local DHCD, with no known active complaints, liens, or lawsuits
- ☐ Property has a current and valid rental license and lead paint certificate (as applicable)
- ☐ Lease terms appropriately delineate responsibilities for maintenance and repairs
- ☐ Lease term is a minimum of 1 years (2-3 years preferred) with option to renew, and with acceptable early termination requirements and consequences
- ☐ Rental amount is congruent with the local market and meets budgetary constraints

Building:

- ☐ Structurally sound (foundation, framing)
- ☐ Lead paint certified (as applicable), and free of contaminants (mold, odors, etc.) and pests (termites, rodents, etc.)
- ☐ Compliant with zoning, building code, and safety requirements
- ☐ Adequate capacity heating, cooling, electrical, and plumbing systems in good working order
- ☐ Acceptable quality and low-maintenance interior features: floors, walls, ceilings, stairs, insulation, etc.
- ☐ Acceptable quality and low-maintenance exterior features: walls, siding, windows, roofing, gutters, porches, fences, sidewalks, garages, etc.
- ☐ Accessible or able to be modified to meet ADA standards

Land Plot:

- ☐ Size, shape, and features congruent with community standards
- ☐ Adequate parking (onsite or street) available for guests and staff
- ☐ Adequate area for outdoor group meeting space
- ☐ Visually pleasing and low maintenance landscaping, or ability to modify accordingly

- ☐ Minimal known hazards (trees in poor condition, land drainage issues, uneven walkways, etc.)

Interior Common Areas:

- ☐ Interior layout supportive of intended purposes, consisting of at least a kitchen, living room, and dining room. Additional room(s) or semi-private space suitable for 1:1 meetings or administrative work preferred.
- ☐ Sufficient natural light and ventilation to support wellness
- ☐ Common rooms of adequate size and shape for furniture needed to support the maximum number of people (guests and staff) participating in activities: cooking, eating, socializing, completing paperwork, using computer stations, etc.
- ☐ Kitchen:
    - ☐ Adequate capacity refrigerator/freezer for multi-person use
    - ☐ Adequate storage space for common pantry items and guest-specific items
    - ☐ Dishwasher strongly recommended
- ☐ Laundry: adequate capacity washing machine and dryer rated for large household use
- ☐ Adequate storage space for household items: linens, cleaning supplies, activity supplies, etc.
- ☐ Eligibility for reliable, high-speed internet service

Bedrooms:

- ☐ 1 private bedroom per intended guest.
- ☐ 100 sq ft minimum, sufficient for a double bed, clothing/item storage unit, and mini-fridge
- ☐ At least 1 direct egress (emergency exit) to the outside
- ☐ Directly accessible from a common area (hallway, etc.)
- ☐ At least 2 electrical outlets
- ☐ Adequate heating and cooling
- ☐ Sufficient natural light and ventilation to support wellness
- ☐ Accessible for comfortable use by persons with disabilities, mobility challenges, or of large size

Bathrooms:

- ☐ Minimum 1 full bathroom and 1 half bathroom (Two full bathrooms preferred)
- ☐ At least one full bathroom directly accessible from a common area (hallway, etc.) and having direct egress (emergency exit) to the outside
- ☐ Adequate heating, cooling, and ventilation
- ☐ Accessible for comfortable use by persons with disabilities. mobility challenges, or of large size
- ☐ Shower, with bathtub strongly recommended

Sample Budgets

These budgets assume that the peer respite is operated by an existing organization with sufficient capacity development potential. Accordingly, an indirect rate has been applied to support the necessary administrative costs (ex: accounting and auditing, HR, organizational management, etc.).

Initial Year

This budget assumes a 12-month timeframe during which planning activities must be completed and the respite opened in Q4. Hiring of staff is staggered throughout the year, with full-time Director and Assistant Director beginning in Q1 and Peer Respite Specialists are brought on for training a few weeks prior to the respite program opening. Consultant services are included to guide policy, program, and program development. Rent, utilities, communications, repairs/maintenance, and furnishings are all highly dependent on property selection.

Category: Line Item	Amount	Notes
Staffing		
Salaries	$234,368.00	Staggered hiring over initial year
Fringe (25%)	$53,580.80	FT fringe 25%, PT fringe 10%
Consultants		
Peer Respite Ops SME	$42,000.00	Consulting on best practices
Legal/Regulatory	$14,000.00	Consulting for implementation
Advisory Board Chairs	$6,000.00	5 chairs x $1,200 stipend/ea
Furnishings & Equipment		
Common Areas	$25,000.00	$5,000 per common area x 5 areas (LR, DR, KI, EXT, OVR)
Bedrooms	$10,000.00	$2,500 per bedroom x 4 rooms
Laundry	$2,000.00	Purchase and installation of machines for guest use
Computer Station	$3,500.00	Onsite equipment for staff and guest use
Staff Equipment	$5,500.00	Technology needed for staff use
Operations		
Rent/ Mortgage (Adm/Office)		*Included in indirect costs*
Rent/ Mortgage (Residential/Client)	$21,000.00	$3,500/mo for 6 mo

Utilities	$5,100.00	$850/mo for 6 mo
Communications	$2,400.00	$400/mo for 6 mo
Transportation/Travel (Staff)	$5,895.00	500 mi/mo x 2 staff x 9 mo
Transportation/Travel (Client)	$1,303.57	$25 per guest per stay (for 3 months of operation)
Insurance	$10,000.00	Est. annual cost
Legal		*Included under consultants*
Accounting		*Included in indirect costs*
Audit		*Included in indirect costs*
Office Supplies	$1,500.00	Initial supplies
Food	$7,350.00	Initial pantry supplies + $450/week x 13 weeks
Printing/ Duplication	$10,000.00	Promotional printing: brochures, flyers, cards, etc.
Building Repairs/ Maintenance	$15,000.00	ADA modifications, initial maintenance
Housekeeping	$3,100.00	Initial professional deep cleaning, monthly supplies
Equipment Repairs/ Maintenance	$600.00	Estimated for coverage
Staff Development/ Training	$10,000.00	$1,000 per staff per year
Promotional/ Personnel Advertising	$1,500.00	
Client Activities	$5,607.14	One-time Open House special event Up to $50 per guest per stay for necessary personal items (for 3 months of operation)
TOTAL DIRECT COSTS	**$496,304.51**	
INDIRECT COSTS	$49,630.45	10% for operating entity's indirect costs
TOTAL COSTS	**$545,934.97**	

Annual Operating

This budget assumes a 12 month timeframe and maximum number of staff positions filled on a full-time basis with benefits package. Rent, utilities, communications, repairs/maintenance, and furnishings are all highly dependent on property selection. Food, transportation, "client activities" and some consultant services are highly dependent on occupancy rates and subject to change as the respite establishes best practices and expanded partnerships.

Category: Line Item	Amount	Notes
Staffing		
Salaries (432B)	$430,476.80	10 staff positions: 6 FT, 4 PT
Fringe (25%)	$94,590.08	FT fringe 25%, PT fringe 10%
		FT includes FICA, HI, 403b, WC, SUI
Consultants		
Bodily Wellness Provider)	$11,700.00	Conducting activities requiring particular certification or skills
Peer Respite Ops SME	$8,400.00	Consulting on best practices
Landscaping Maintenance	$1,650.00	Lawn service, annual maintenance
Operations		
Rent/ Mortgage (Adm/Office)		*Included in indirect costs*
Rent/ Mortgage (Residential/Client)	$42,000.00	$3,500/mo
Utilities	$10,200.00	$850/mo (gas, electric, water)
Communications	$4,800.00	$400/mo
Transportation/Travel (Staff)	$3,000.00	$250/mo (~400 mi/mo)
Transportation/Travel (Client)	$10,428.57	Up to $50 per guest per stay
Insurance	$10,000.00	Est. annual cost
Legal		*Included in indirect costs*
Accounting		*Included in indirect costs*
Audit		*Included in indirect costs*
Office Supplies	$1,200.00	$100/mo
Food	$23,400.00	$450/week
Printing/ Duplication	$3,000.00	Promotional printing

Building Repairs/ Maintenance	$1,200.00	Estimated for coverage
Housekeeping	$1,200.00	$100/mo x 12 months
Equipment Repairs/ Maintenance	$600.00	Estimated for coverage
Staff Development/ Training	$10,000.00	$1,000 per staff per year
Promotional/ Personnel Advertising	$500.00	
Client Activities	$10,428.57	Up to $50 per guest per stay for necessary personal items
TOTAL DIRECT COSTS	**$678,774.02**	
INDIRECT COSTS	$67,877.40	10% for operating entity
TOTAL COSTS	**$746,651.43**	

Appendix C: Advisory Group

Effective peer respite development requires a committed and diverse group of stakeholders equipped with passion and knowledge to secure resources, build lasting community relationships, and navigate challenges. As described in **Recommendations for Potential Operators: Leadership,** this can include Ambassadors who assist with general promotion of respite, individual stakeholders serving in a formal guidance capacity as Advisors, and a "Torch Carrier" as the primary leader of respite development and future operations.

A formal Advisory Group is a critical first step in identifying allies, customizing program design, and advocating for funding and any necessary policy changes for a successful launch.

Stakeholder Representation

This group serves as credible messengers to the community and potential funders and therefore must be committed to the values of the model while building their content expertise. Members should be carefully selected to balance skills, perspectives, resources, and political and social connections. Key role in an Advisory Group of 7-10 persons include:

- **Peer Leaders:** The majority of advisory group members should consist of peer leaders that have been directly impacted by trauma, mental health crisis, involuntary treatment, crisis services, etc., and share their wisdom of lived experience and navigating system involvement. These Advisory Group members are Experts by Experience and are critical to center planning and decisions in human experience, balancing the focus on administrative, political or systems lenses.
- **Community Champions:** Community leaders with experience in the political and social landscape can leverage relationships and partnerships to ensure that the planning process considers community resources, unmet needs, and critical leaders to engage.
- **Healthcare Partners:** Representatives from crisis, hospital and/or behavioral health services can serve as a bridge to their respective sectors as well as share potential concerns that traditional providers may express. The members selected should have a worldview beyond their own organization and an understanding of systems-levels challenges and opportunities.
- **Gatekeepers:** These are the Advisory Group members that may not be directly involved in service provision, however have access to decision makers in policy, social, or political positions and can provide validation, awareness, and access for this effort.
- **Potential Funders:** Representatives from state or county agencies, foundations, or philanthropy communities can inform the group about critical issues that influence funding decisions, and can aid in messaging and access.

- **Researchers:** Social science and public health researchers can add valuable perspective by advising on best practices for establishing metrics to measure and demonstrate outcomes.
- **Skeptics:** A skeptic is someone who remains open to the concept of respite, but is cautious and able to raise and help resolve valid concerns. Having at least one skeptic on the Advisory Group can be helpful for the group to think through any risks, challenges, or considerations needed to turn other skeptics into champions.

Scope and Responsibilities

The Advisory Group may function as an independent decision-making authority or may be subordinate to the staff or Board of Directors of an operating entity. It can be convened a brief, discreet group with specific objectives prior to launch, or designed to continue in a leadership capacity during full operation. Key responsibilities of the Advisory Group include but are not limited to:

- **Content Expertise:** Share and build content expertise about the peer respite model and how it can integrate, enhance, and help expand the continuum of behavioral health services.
- **Plan Development:** Organize meeting agenda and logistics, including recordkeeping and communication. Conduct research and advising on location, policy, strategic/implementation planning and operationalization factors.
- **Advocacy & Credible Messaging:** Actively cultivate relationships and resources for social/political support and funding. Serve as an ambassador/credible messenger for the respite model to the community

Strong leadership of the Advisory Group process is critical. Discussion and decision-making protocols may involve appointment of officers (Co-Chairs, Chair/Vice Chair, Committee Leads) or be more flexible, to be determined by the group and guided by peer support values. Clear expectations must also be defined around:

- Minimum and maximum number of group members, and composition requirements (e.g. percentage of people with lived experience, specific stakeholder roles)
- Candidate vetting, acceptance, and termination
- Time commitment and length of service
- Frequency, timing, and venue of meeting (virtual, local) and accessibility considerations
- Recordkeeping and distribution of meeting minutes and other communications
- Compensation or reimbursement (if any)
- Scope of purpose, process, and decision-making authority in areas such as:
    - Mission, values, brand identity, marketing materials
    - Operating policies, hiring, site location
    - Direct advocacy or fundraising activities
    - Group governance and address of substantial disagreement

- Defined leadership roles (ex: Co-Chairs, Chair/Vice Chair, Secretary, Committee Chairs), with the Torch Carrier occupying a leadership position
- Defined committees as needed for specific aspects of planning and development (ex: Operations and Policy, Resource Development and Funding, Property Selection, Partnership Development, Marketing and Outreach, etc.)

Recruitment and Facilitation

Identification and recruitment of potential Advisory Group members should align with the capacity and knowledge needs (and gaps) of the convening entity. It is important to intentionally model the values of hospitality and the importance of shared decision-making from the beginning. Invitations can be tailored and personal to each candidate, but with consistent content explaining the Advisory Group's role and the work to be done together.

Consultation from an external content expert can support the Advisory Group to organize, plan, strategize and brainstorm options and potential solutions. Offering training, onsite visits, and shadow days to nearby respites in operation (similar to the site visits sponsored through the feasibility study), are also highly valuable orientation experiences for Advisory Group members.

Depending on the terms of any funding secured for the planning phase of peer respite development, it may be beneficial to define specific committees with leadership roles within the Advisory Committee and provide a stipend to Committee Chairs in recognition of expected effort, especially if dedicated paid staff positions are not established.

Appendix D: Data, Outcome, and Fidelity Measures

Reliable and relevant data collection is necessary to assess fidelity to the peer respite model (including operator entity standards), to identify opportunities for continuous improvement, and to demonstrate accomplishment of intended outcomes on the individual, programmatic, and systems levels. However, the benefits and drawbacks of data collection methodologies, tools, measures, and frameworks must be carefully considered to ensure they are not overly clinical in nature and intentionally communicate the non-hierarchical and self-directed values of peer support.

Goals, policies, and procedures about data collection and analysis should be thoroughly discussed by the Advisory Group during the planning phase of respite program development, including a plan for performance management through regular review and discussion with stakeholders. Training for respite staff must communicate both the why and how of data collection protocols. Confidentiality and data security must be maintained, with informed consent procedures in place to allow for de-identified data to be analyzed and/or shared for reporting, research, or promotional purposes.

Data Collection

Respites should strive to collect data during the course of guest-directed, relationship-building interactions which are integrated into the respite stay experience as reflection and self-advocacy opportunities. Wherever possible while maintaining alignment with respite values, data points to be collected should be matched to local, national, or research-based definitions to support comparative analysis. Potential areas of data collection helpful to evaluate equity, effectiveness, and opportunities to improve respite program may include:

- **Demographics:** Age, gender, sexual orientation, race, ethnicity, culture, familial status, residency (neighborhood, zip code, county).
- **Social Determinants of Health (SDOH):** Housing status, income level, insurance status, employment status.
- **Systems Engagement:** Prior interactions with the behavioral health, human services, or justice system, particularly level of engagement and services used within the prior 12 months and recent use of crisis services, Emergency Department use, or hospitalization (number of stays, number of hours/days, voluntary/involuntary status).
- **Crisis Features:** Guest-identified factors or features of the current crisis situation, such as: related to SDOH, related to trauma, particular experiences (ex: panic attacks, insomnia, thoughts of suicide, hearing voices, etc.)

- **Personal Wellness:** Change in feelings of distress, hopefulness, and empowerment before, during, and after respite stay. Quality and quantity of knowledge and skills gained in self-help techniques or practices.
- **Satisfaction with Respite Services:** Physical environment, interactions with guests and staff, type and quality of services offered/received, interest in returning, likelihood of recommendation to others
- **Connection with Recovery Supports:** Quantity and quality of connections or reconnections with desired recovery supports, including community engagement, social relationships, and health/human services.

Data collection should always occur on a voluntary and trauma-informed basis, with guests able to review any records kept about their experience and contribute additional comments or corrections. Techniques might include respite staff asking open-ended questions to guests while capturing discrete information in standard forms; using everyday language, simple likert scales, and checklists; offering guests the opportunity to complete surveys in paper, digital, or interactive formats, and reviewing any documentation with the guest to ensure it is an accurate reflection of their experience. Recommended data collection methods for peer respite include but are not limited to:

- **Referral Questionnaire:** Conducted during the self-referral and screening process. Potential guests may be given the option of completing a questionnaire survey directly or working with respite staff to address needed areas of information through interactive conversation. Aims to collect demographic, SDOH, systems engagement, and crisis features data, with the option to complete specific questions or sections at check-in (subject to respite operating policies).
- **Check-In Reflection Survey:** Conducted onsite at the respite, at check-in or within 24 hours of guest arrival at the mutual agreement of the guest and staff. Collects any needed information not obtained during the referral process, with additional questions about current state of personal wellness and self-identified needs, desired supports, and/or goals. May be completed independently by guests or through peer support interactions with respite staff.
- **Comment Box:** Located onsite at the respite and accessible online, allows potential, current, and past guests to anonymously share insights or suggestions in real time.
- **Check-Out Reflection Survey:** Conducted onsite at the respite prior to check out. Asks guests to rate their level of satisfaction with respite services and make recommendations for improvement. Collects information on current state of personal wellness and new knowledge, skills, or connections gained through the respite stay. Importantly, confirms self-reported diversion from intensive crisis or hospital-based services.

- **Alumni Reflection Survey:** Conducted by phone or electronically at 3, 6, 9, and 12 months after the respite stay. Collects information on changes in SDOH, systems engagement, maintained use of or connection to self-help and peer/recovery supports initiated through the respite stay, and any use of crisis or hospital-based services.

- **Guest Experience Summary:** An internal report summarizing key metrics necessary to assess effective diversion and costs savings achieved through the respite program, such as: initial status (location/status of guest at time of referral, crisis features, insurance type), time on waitlist, total length of stay, exit status (destination/status), change in personal wellness/recovery outcomes, subsequent use of ED/hospital (from alumni survey).

Personal Recovery Outcomes

Reliable measures of recovery continue to evolve as systems become more attuned to the myriad factors which can support or hinder the recovery process. For a peer-informed review of multiple tools, see Measuring the Promise: A Compendium of Recovery Measures Volume II (2005) published by the Human Services Resource Institute. Potential frameworks from which individual-level impact recovery outcome indicator questions may be integrated into the data collection methods discussed above include but are not limited to:

- Mental Health Recovery Measure (MHRM)
- Recovery Assessment Scale (RAS)
- Stages of Recovery Instrument (STORI)
- Recovery Markers Questionnaire (RMQ)
- Adult Hope Scale (AHS)
- Outcome Questionnaire (OQ-45.2)

Operator and Program Fidelity

Regularly assessing fidelity to operator standards and the peer respite program model support active performance management and continuous quality improvement. Suggested frameworks for evaluation of operating standards include but are not limited to:

- SAMHSA's Consumer-Operated Services Evidence-Based Practices (EBP) Kit Fidelity Assessment Common Ingredients Tool (FACIT).
- Human Services Research Institute's Toolkit for Evaluating Peer Respites
- On Our Own of Maryland's Peer-Run Wellness & Recovery Organization Standards of Affiliation Handbook
- Maryland Nonprofits Standards for Excellence

Appendix E: Communications and Outreach

Language and Approach

Language, information, and visuals need to be tailored to effectively reach the intended audience. All communication should avoid using systems language, jargon, and clinical or medical language to convey the different approach and represent the values of a peer respite. First-person language ("I" or "we") and recovery-oriented language ("hope," "safety," "connection," and "healing") demonstrate the personal, mutual, trust-based nature of a peer respite program.

Systems-Based Language	Values-Based Language
A peer respite is designed for people experiencing mental health crises.	If you have ever needed a safe space to connect and heal when experiencing a crisis, peer respite may be for you.
A peer respite is not intended for people who cannot independently complete ADLs.	The peer respite space is intentionally designed to support personal decision-making and autonomy. People who need daily support for basic self-care may not benefit from this approach.
We work with people with mental illness to create a safe place when they are in crisis.	This is a safe space when our neighbors and family members have experienced trauma and need a place to heal. I am a survivor of [experience], and desperately needed a place to go where I felt safe and heard and supported. Now, I get to be a part of creating that experience for others.
Intake, Status Update, Discharge	Check In/Orientation, Wellness Connection, Check Out

Communication Modalities

Peer respites should use the same modalities as other nonprofits and service providers to communicate their mission, scope, services, and goals, including but not limited to:

- **Brand Identity:** Have an appropriate program name, inspiring mission statement, well-designed logo, memorable tagline/motto, defined values, and professional-caliber style guide (signature colors, document templates, etc.).

- **Digital:** Actively maintain a website with relevant information for potential guests, referral sources, stakeholders, and the general public. This may include FAQs, self-referral process walkthroughs, pictures, annual reports, press releases, white papers or research findings, etc. Care should be taken to preserve the anonymity of guests, and consideration should be given to whether the respite address is public by default. Given the effort needed to maintain social media campaigns, operator entities may evaluate if the respite can be sufficiently promoted through existing organizational channels, or requires a standalone account.
- **Print:** Materials for public distribution (e.g. brochures, info cards, posters) should be designed with potential guests in mind, and be widely distributed across targeted referral sources and community partners.
- **Videos:** Promotional videos about the respite program as well as recordings of relevant presentations (from conferences, community events, etc.) can reach individuals through social media sharing who may not otherwise encounter print materials.
- **PR and Presentations:** Program staff and operating entities should look for opportunities to raise awareness about the respite through general public awareness strategies (news, radio, television, podcasts, advertisements) as well as community events (health fairs, town halls) and professional conferences and events (behavioral health, human services, etc.).

Stakeholder Communications

Especially during the Planning Phase, peer respites should plan to circulate regular updates to inform stakeholders of progress towards goals and calls to action for support to advocacy to help overcome barriers to launch. This might be accomplished through an email listserv, webinars, or in-person events. The goal is to maintain excitement for the vision of peer respite, to celebrate successful completion of milestones, and to continually broaden the network of supporters who may be willing to contribute time, skills, resources, and connections to ensure a successful launch and sustainability.

Communications with stakeholders should seek to demonstrate the multifaceted value of the respite, featuring both personal accounts from guests and staff about the impact of respite on their lives and wellbeing (with permission and by mutual agreement), as well as performance metrics like number of guests served, diversion from high-intensity, high-cost services, increase in personal recovery outcomes, decreased use of crisis/emergency services post-stay, and estimated cost savings achieved.

Community Engagement

When communicating with neighbors and the general public, it is important to balance giving information with the privacy of future guests. The language used should be intentional, designed to convey hope while dispelling myths and reducing stigma.

Open House: Prior to the respite opening and on an annual basis, a community-wide Open House is a great way to introduce allies, stakeholders, neighbors, funders, family members, providers, and potential guests to the respite space. The event should be a day of celebration and exploration: offering tours, answering questions, and providing basic information about the respite along with music and fun activities that promote community connection.

Community Wellness Events: Hosting events for the neighborhood themed around hope, connection, and healing (ex: drum circle, yoga class, arts and crafts group, beautification/trash pick-up day, gardening club) can strengthen integration with and support from the neighborhood.

Civic Participation: Getting involved in the community association or similar advisory or advocacy groups demonstrates the respite's commitment to being a full partner in the development and responsible stewardship of the community. Patronizing local businesses builds trust and opens doors for collaboration.

Appendix F: Zoning Considerations

Each county in Central Maryland – Baltimore City, Baltimore County, Howard County and Carroll County – has a separate zoning or planning commission, each with different zone definitions and stipulations that could potentially be brought to bear on a peer respite. Most require some form of licensing for rental housing units, typically involving inspection and registration fee(s).

No current zoning designation in the Central Maryland region has been found to adequately or accurately describe the non-treatment, not-housing model of peer respite. The following considerations have been identified for each county in the Central Maryland region.

Baltimore City

Zoning in Baltimore City is managed through the Baltimore City Department of Housing and Community Development (DHCD) and includes 43 different classifications, with residential districts designated from least to most dense by numerical code. Additionally, some neighborhoods are restricted by covenants that prohibit or permit specific property uses.

Baltimore City recently adopted new regulations governing short-term residential rental units such as those offered through vacation rental services like Airbnb or VBRO. They include restrictions that the property must be the permanent residence or an additional dwelling unit of an individual (non-business) owner, that the rental agreement must be facilitated in whole or in part by a "hosting platform," and that fee(s) must be exchanged from guest to owner.[118]

Peer respites offering more than 3 beds could potentially fall under the definition of a "Rooming House" as set forth in § 202.2 of the Baltimore City Building, Fire, and Related Codes. However, "rooming house" is defined in the Code as a building that "contains more than 2 rooming units occupied or designed or intended to be occupied by individuals who, even though they might share common areas and facilities, do not form a single housekeeping unit and do not provide compensation under a single lease for occupancy of the rooming house,"[119] implying that the use of individual leases and compensation exchanged for occupancy is expected.

Baltimore County

Zoning In Baltimore County is managed by the Department of Permits, Approvals, and Inspections.

[118] The Mayor and City Council of Baltimore. (2019). Baltimore City Code Article 15 Licensing And Regulation: Subtitle 48. Short-Term Residential Rentals.Department of Legislative Reference

[119] The Mayor and City Council of Baltimore. (2021). Baltimore City Building, Fire, and Related Codes of Baltimore City (2020 Edition): Section 202.General Definitions: 2.14: Rooming house. Baltimore City of Department of Legislative Reference.

According to the Department's *New Tenant Notification* form provided in their online guide for rental property registration, "rooming and boarding houses are not permitted in Baltimore County and therefore, no more than two unrelated adults are permitted to live in a dwelling unit."[120]

However, Baltimore County Zoning Regulations do include procedures for requesting a permit for Boarding or Rooming Houses in certain Density Residential Zones (D.R.10.5 and D.R.16), which require "conspicuous posting" of the notice for application for 15 days and for "any interested person may file a formal request for a public hearing before the Zoning Commissioner" within that posting period. Even if no request is submitted, the Director may "at his or her discretion, require a public hearing whereat the applicant shall be required to satisfy the burden of proof required for such use to be granted."[121]

The definition of "Boarding or rooming home" in the Code[122] includes:

- "A building: 1. Which is the domicile of the owner and in which rooms with or without meals are provided, for compensation, to three or more individuals who are 18 years old or older and not related by blood, marriage or adoption to the owner; or 2.Which is not the owner's domicile and which is occupied in its entirety, for compensation, by three or more individuals who are 18 years old or older and not related to each other by blood, marriage or adoption."
- "For purposes of this definition only, "owner" means an individual who: 1.Has more than a 50 percent legal or equitable interest in the property; and 2.Shares in more than 50 percent of the profits or losses derived from the compensation paid under Paragraph A of this definition."
- "If an individual who is 18 years old or older and who is not related to the owner by blood, marriage or adoption resides for more than 30 days during any 12-month period in a building in which compensation is received from any person, the building shall be considered the domicile of the individual for compensation for purposes of this definition and shall be counted as an individual in the domicile."

Howard County

Howard County zoning regulations are set forth by the Howard County Planning Commission.

Short-term rentals for less than 30 days are considered transient housing, and prohibited in residential buildings. Options include classification as a hotel, motel, or Bed & Breakfast.[123]

---

[120] Baltimore County Department of Permits, Approvals and Inspections: Rental Registration. New Tenant Notification Form.
[121] Baltimore County Government. Baltimore County Zoning Regulations: Article 4 - Special Regulations, SEction 408B - Boarding- or Rooming Houses in D.R.Zones.
[122] Baltimore County, Maryland - Zoning Regulations. Article 1: General Provisions, Section 101: Definitions: Boarding- or Rooming House.
[123] Confirmed via phone call with Howard County Department of Inspections, Licenses and Permits

Bed & Breakfast Inns are permitted by conditional use only, and must be located in a "dwelling which is a historic structure… managed and operated by the owner(s) of the dwelling and the dwelling must be the principal residence of the owner(s)."[124]

Carroll County

Carroll County zoning code is administered by the Office of Zoning Administration, and divides Residence Districts into four categories based on minimum lot size.

The licensing of rental housing has been established within the City of Westminster, managed through the City's Department of Housing Services. Their definition of rental unit includes "A dwelling, dwelling unit or portion thereof… if it is occupied by any person other than the property owner in exchange for any compensation or monetary remuneration."[125]

Carroll County also has zoning designations for Bed & Breakfasts, which must be owner-occupied and provide daily meals to paying guests, and Retreat Facilities, which are limited to "professional, educational, or religious conclaves, meetings, conferences, or seminars" and being "located on a property of not less than five acres." [126]

[124] Zoning Regulations of Howard County, Maryland: Section 131.0: Conditional Uses, N8: Bed and Breakfast Inns.
[125] City of Westminster, Department of Housing Services. Rental Housing License Program Frequently Asked Questions (FAQ)
[126]Carroll County, MD Code of Ordinances, Title XV: Land Use, Chapter 158: Zoning Regulations, 158.002: Definitions.

Appendix G: Central Maryland Peer-Operated WRO Organizations

This Appendix only lists peer-operated nonprofit Wellness & Recovery Organizations which meet the following criteria: an established physical location in Central Maryland region; provide open-access, in-person peer support services; have an explicit majority of persons with lived experience on their Board of Directors; and have a mission statement directly addressing the provision or promotion of peer support. There are many other groups and programs with peer support components operating in the Central Maryland region which do not meet all of the above-mentioned criteria.

Baltimore City

Hearts & Ears, Inc.
heartsandears.org
611 Park Ave, Suite A
Baltimore, MD 21201

Helping Other People Through Empowerment, Inc.
hopebaltimore.com
2828 Loch Raven Rd
Baltimore, MD 21218
**HOPE also operates Safe Haven, a 20 bed non-traditional residential facility for individuals who have a history of chronic and persistent homelessness and mental illness as defined by HUD.*

On Our Own, Inc.
onourownbaltimore.org
1900 E Northern Parkway, Suite 309
Baltimore, MD 21239

- **Charles Village Center:** 2225 N Charles St, 3rd Floor, Baltimore, MD 21218
- **Northern Parkway Center:** 1900 E Northern Parkway, Suite 309, Baltimore, MD 21239

Baltimore County

On Our Own, Inc.
onourownbaltimore.org

- **Catonsville Center:** 7 Bloomsbury Ave, Catonsville, MD 21228
- **Dundalk Center & One Voice Dundalk:** 299 Willow Spring Rd, Dundalk, MD 21222
- **Towson Center:** Gibson Building, Sheppard Pratt, 6501 N Charles St, Towson, MD 21285

Carroll County

On Our Own of Carroll County, Inc.
onourownofcarrollcounty.org

265 E Main St, Suite C
P.O. Box 1174
Westminster, MD 21158

Howard County

On Our Own of Howard County, Inc.
ooohci.org
6440 Dobbin Rd, Suite B
Columbia, MD 21045