‘Not Everything is Going to Work for Everybody’: How Peers’ Understanding of Self-Determination Shapes Their Conceptualizations of Peer Respite Centers

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A thesis

submitted in partial fulfillment of the

requirements for the degree of

Master of Social Work

University of Washington

2022

Committee:

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Program Authorized to Offer Degree:

Social Work

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Abstract

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This qualitative study explores how Washington State peer advocates’ self-described purposes of peer respite centers influence their specific articulations of the model and associated organizing efforts. A critical inquiry was conducted with leading peer advocates (N=4) through two in-depth interviews with each participant. Mad Studies and critical feminist theory informed thematic analysis of subsequent data. Findings showed participants’ universal focus on the value of self-determination in describing the purpose of peer respite centers. Although they shared a commitment to autonomy and choices for peer respite guests, participants’ detailed conceptualizations of the model varied according to how they sought to maximize these values at peer respite centers. The range of participant perspectives on clinical involvement and permitted substance use at the centers indicate potentially irreconcilable differences in peer respite center definitions that parallel historical divisions in U.S. peer movements. The study has implications for future iterations of peer respite centers and their degree of peer control in Washington and beyond.

Acknowledgements

I extend my deepest gratitude to Ryan Petros, without whom this project would have remained a lawless flurry of ideas rolling around my brain. Ryan's unwavering guidance and passion for person-centered research proved invaluable over the last year and a half. He spent countless hours walking me through the "messiness" of qualitative research, responding to the storm of emails I delivered to his inbox every Monday morning, and perhaps most importantly, bringing me back down to earth when I dreamt up project goals fit for a doctoral dissertation! I also could not have undertaken this journey without the support of Ian Johnson. As a student in Ian's social work course during the fall of 2020, I felt energized after a class meeting in which his chosen readings integrated disability justice and the psychiatric survivor movement. I emailed Ian with the beginnings of a thesis project, he sent back an exuberant "love, love, love this idea," and the rest is history.

My utmost appreciation goes to the four peer-participants who trusted me with their personal stories, peer wisdom, and insightful opinions on peer respite; I feel honored to have landed in such a vibrant community of changemakers, dreamers, and advocates. Very special thanks also goes to my Purple House family (Erica, Seth, Steven, Christian, and all the furry beings we steward) for lifting up my passion for this project every step of the way. I would be remiss not to also extend my gratitude to Erin Bernardy, for the bond that we formed over many Sundays spent feverishly writing at local cafes, determining what the heck is the difference between a background and a literature review, and supporting each other through to the end. Lastly, I honor my Mad predecessors and comrades in disability justice whose collective care and organizing for a world beyond pathologization, coercion, and force paves the way for this work.

Introduction

When the average American finds themselves in the throes of a mental health crisis, their options for immediate, overnight mental health support are generally limited to a visit to the nearest emergency room and subsequent psychiatric unit. These hospital environments treat people in crisis using clinical interventions which sometimes include disempowering practices of seclusion, restraint, and involuntary detainment (Cohen, 1994; Pistrang & Wood, 2004; Frueh et al., 2005). Individuals looking for humane, community-centered, and voluntary support in non-medical settings may be hard pressed to find them, but that could soon change with the growing numbers of peer respite centers opening their doors across the United States (National Empowerment Center, 2022). A peer respite center is typically a large home or apartment staffed by 'peers' who offer voluntary, non-clinical support to a handful of 'guests' who seek a short-term space to take a break, reflect, and gain tools to cope during moments of crisis (Davidow, 2018). In this context, peers are individuals with "personal experience of trauma, extreme states, and/or psychiatric labels" (Live and Learn, Inc., 2018). Peer respite centers value mutuality, empowerment, the autonomy of every guest, and reframing crisis as a learning opportunity (Live and Learn, Inc., 2018; Davidow, 2018). Research shows that guests report feelings of heightened connection and acceptance, and are less likely to use emergency psychiatric inpatient services after staying at peer respite centers (Croft et al., 2020; Croft & Isvan, 2015).

As they increase in prevalence, peer respite centers are being designed and interpreted by more and more individuals, community groups, and government agencies, resulting in a variety of conceptualizations for the centers' operational realities. The first peer respite center in the U.S. was fully peer-run, but varying organizational structures for respites have since developed (National Empowerment Center, 2017; Ostrow & Croft, 2015). Additionally, peer respite centers

are under-researched, adding to the nebulous nature of the model and its resulting iterations (Ostrow & Croft, 2015). Washington State is not immune to the tension between different stakeholders' visions for peer respite centers. The Washington legislature recently passed House Bill 1394 (2019), which enables the Department of Health to fund and credential peer respite centers. Years leading up to the passage of H.B. 1394 were fraught with controversy as local peers appear to have organized for a fully peer-run respite center while lawmakers tied the centers to Medicaid funding and subsequently, administration by clinical organizations (Washington State Legislature, 2019; Washington Healthcare Authority [WHA], 2020). This study attempts to understand what Washington peer advocates consider to be the purpose of a peer respite center, and how those purposes influence their specific conceptualizations and organizing processes for the centers.

Background and Significance

Landscape of Peer Respite Centers in the United States

History

Peer respite centers emerge from a storied history of grassroots organizing by former psychiatric inmates who rejected psychiatric methods of "treating" those who society deems "mad" or "mentally ill." Although users and survivors of psychiatric settings have organized against restrictive, invasive, and infantilizing mental health treatments for centuries, the latter half of the 20th century witnessed growth of the Mental Patients/Psychiatric Inmates Liberation Movement and Mad Pride in North America (Starkman, 1981). The movements were led by self-identified consumers, psychiatric survivors, and ex-patients (c/s/x) who critiqued–or sought to abolish–the field of psychiatry and associated interventions such as involuntary confinement, drugging, restraint, and seclusion of people labeled mentally ill (Ben-Moshe, 2020). C/s/x agitators were spurred on by a period of deinstitutionalization, feminist consciousness-raising groups, the gay liberation movement, and anti-war protests, all of which challenged the idea that doctors, scientists, and the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) always knew right from wrong (Starkman, 1981).

After their initial formation, the c/s/x movement formed anti-hierarchical, autonomous groups that prioritized consensus decision-making. Most notably, they launched experimental mutual aid-based programs offering supportive crisis alternatives to psychiatry (Starkman, 1981). In 1997, one such experiment resulted in the first peer respite center–Stepping Stone, in Claremont, New Hampshire–offering short-term, voluntary overnight support in a home environment to people in crisis. Stepping Stone was an entirely peer-run house with two bedrooms for people to stay in for up to five days. The purpose of the respite was to support

guests to avoid institutionalization and move from “crisis to wellness” through peer support (National Empowerment Center, 2017). As more c/s/x alternatives like Stepping Stone cropped up, so did funding opportunities and attention from mental health professionals. Thus, in the 1980s, the c/s/x movement splintered into factions: those who were willing to collaborate with mental health professionals and try to reform the existing system, versus those who dug in their heels against involuntary treatment and committed to maintaining the autonomous, abolitionist roots of the movement (Ben-Moshe, 2020; Starkman, 1981). This divergence became evident in the terms c/s/x movement members used to describe themselves (e.g., “consumers” of mental health services vs. “survivors”/ “ex-patients” of an oppressive system) (Ben-Moshe, 2020, p. 102). The different historical strands of the early c/s/x movement are still evident today in varying types of peer respite centers and their perceived legitimacy within the modern movement.

Defining Peer Respite Centers

Since the first peer respite center opened its doors in 1997, thirty-two more have followed suit across 14 U.S. states in the two decades since (Pelot & Ostrow, 2021). Tallying the scope of peer respite centers across the nation necessitates clarity around their characteristics. In recent years, the iterative process of defining peer respite centers yielded two different sets of widely-used criteria outlining key elements of respite organization, structure, and programming. First, Live & Learn, Inc.–a research and consulting agency centering people with lived experience of psychiatric systems–organized a consensus panel of leading peer support advocates, trainers, researchers and administrators to develop, with c/s/x movement principles in mind, a specific set of structural criteria for peer respite centers. The resulting definition offers a short summary of respite center program elements:

> A peer respite is a voluntary, short-term, overnight program that provides community-based, non-clinical crisis support to help people find new understanding and ways to move forward. It operates 24 hours per day in a homelike environment. Peer respites are staffed and operated by people with psychiatric histories or who have experienced trauma and/or extreme states (Live & Learn, Inc.).

Live and Learn also includes specific criteria focused on management and administrative features of peer respite centers: All staff and program/house manager positions require lived experience of extreme states and/or the behavioral health system. Additionally, the respite must either be operated by a peer-run organization (meaning the majority of people in leadership positions have lived experience of extreme states/and or the mental health system) or has an Advisory Board in which 51% or more of the members have lived experience (Live & Learn, Inc.; Ostrow & Hayes, 2015).

A second standard definition of peer respite centers emerged in 2014 when peer organizers came together at a Mind Freedom Conference to create a Peer Respite Charter (Mind Freedom International [MFI], 2014; Davidow, 2018). As described in a recent foundational text *Peer Respite Handbook*, the Charter was created based on the group's discussions, surveys, and input from leadership of existing peer respite centers (Davidow, 2018). The Mind Freedom group's criteria is broader than that of Live and Learn because it focuses on programmatic and philosophical elements of peer respite centers and omits specific requirements for the organizational structure of a respite center. The Charter outlines 19 specific programmatic characteristics of all peer respite centers, summarized below:

- All paid respite staff and direct leadership have lived experience of "life-interrupting emotional distress and other significant life challenges and are willing to share some of that experience with others as a part of their work"
- Philosophical underpinnings of the respite include crisis as a learning opportunity, self-determination, mutuality, awareness and interruption of trauma due to systemic oppression
- Openness to various ways of making meaning of one's experiences and healing
- Minimal documentation of people staying at the respite
- Staff training and development
- Use of open, non-clinical language rather than psychiatric diagnosis
- Supporting any connections people staying at the respite want to maintain
- Freedom of movement to and from the respite
- No required schedule of activities; allowing people to structure their time as they see fit
- Avoiding use of force such as calling police or crisis services without consent; requiring a review process if it is ever used
- Avoiding house rules that create power imbalances between staff and people staying at the respite (Davidow, 2018).

Contrary to the singular Live and Learn definition, the Mind Freedom Charter expands on their initial set of criteria by delineating three subcategories of respites and their different elements: *peer-run* respite centers, *hybrid* peer respite centers, and *peer-integrated* respite centers. These categories parallel other commonly used groupings of peer services marked by varying degrees of peer control. For example, social welfare scholar Phyllis Solomon categorizes all peer-delivered services into those that are peer-run/peer-operated, peer partnerships (partially

operated by non-peer organizations), and peer employees (peers hired as staff members in traditional clinical organizations) (Solomon, 2004). Similarly, in the Charter, "peer-run" respite centers meet all of the general criteria in addition to functioning "independently or as part of a larger *non-clinical* organization," existing in a homelike, non-clinical environment, having organizational structures with majority lived-experience members, being open to guests regardless of whether they use other types of mental health services, and having no clinical involvement or clinical eligibility assessments (Davidow, 2018). Given the original peer respite center model adhered to these five criteria, it follows that the majority (84%) of peer respite centers in the U.S. today are classified as peer-run entities (Pelot & Ostrow, 2021).

In contrast, "hybrid" peer respite centers meet the Charter's aforementioned criteria for all peer respite centers, but do not adhere to every criterion for fully peer-run respites. For example, hybrid respites must ensure staff and direct leadership have lived experience, but they may be operated by a clinical agency and clinical services may be offered alongside peer support (Davidow, 2017). Only 12% of currently operating peer respite centers could be classified as a hybrid model as they are part of traditional mental health agencies or administered by non-peer governmental institutions (Pelot & Ostrow, 2021). Lastly, "peer-integrated" respite centers also meet each of the Charter's criteria for all peer respite centers, with one important exception: They do not require all direct leadership or staff members to have lived experience. Importantly, the Charter notes that peer-integrated respite centers are not "technically" peer respites because they are not fully staffed by peers, yet they meet all other criteria (Davidow, 2018).

Comparing Peer Respite Center Definitions

Juxtaposing two foundational sets of criteria used to define and categorize peer respite centers reveals both converging and contentious elements of peer respite conceptualizations in

the literature. Both Live and Learn and the Mind Freedom Charter's definitions ground all peer respite centers in values of autonomy and respect for the multitude of pathways people take to make meaning or find healing from their experiences. The definitions also maintain that all (or most, in the case of "peer-integrated" respite centers) staff members and direct leadership must be peers. However, the Live and Learn criteria for *all* peer respite centers only aligns with the Charter's sub-set of criteria for *peer-run* respite centers. This mismatch indicates that some leading peer respite scholars and practitioners–many of whom contributed to the Live and Learn definition–would not classify the Charter's other subcategories (hybrid peer respites and peer-integrated respites) as legitimate peer respite centers. Indeed, national survey-based research on peer respite centers excludes peer-integrated centers by tying their eligibility criteria to those with all peer staff and direct leadership (Pelot & Ostrow, 2021).

The primary areas in which the two definitions differ include the degree of peer control over the center, the structure housing the respite, and the degree of clinical involvement in respite activities and administration. Live and Learn's definition is the narrower of the two, in that its criteria binds all peer respite centers to peer-run administrative or advisory bodies, a home-like environment, and 100% peer staff and leadership; the Charter leaves these elements open to interpretation, and accounts for resulting variation by creating sub-categorizations of respite centers. Although divergence between the two sets of criteria are notable, there is evidence of conversation between them: The Mind Freedom Charter acknowledges the blurriness of the peer-integrated respite center model by mentioning its drift away from the "technical" definition of a peer respite center as 100% peer staffed (Davidow, 2017). The acknowledgement shows how the Charter recognizes a wide variety of respite center models while accounting for the origins of the model as peer-run. Comparing the two definitions reveals which characteristics of

peer respite centers are prioritized and legitimized as the model evolves over time. Variations in the criteria also reflect a flexible interpretation of the peer respite center model (within some parameters) in the national peer respite stakeholder community; the effects of these varied interpretations are felt locally as Washington State prepares to join the peer respite movement.

Landscape of Peer Respite Centers in Washington State

Peer respite centers have yet to open in the state of Washington, but recent legislation and peer organizing indicate change is on the horizon. Washington began training and employing Certified Peer Counselors in 2005, and over 3600 peers are now certified in the state (HCA, 2020). In 2019, peer support services for both mental health and substance use became reimbursable under Washington State Medicaid (HCA, 2020). During that same year and in large part due to grassroots peer organizing, Washington State House Bill (H.B.) 1394 allocated funding for up to four Medicaid-funded peer respite centers (Washington Department of Commerce, 2019). In the years preceding and following the passage of H.B. 1394, peer-led organizing groups advocated for local and state governments to fund respites that specifically adhere to a fully peer-run, non-clinical model. Ultimately, legislative outcomes and funding implications indicate that the peer organizers' vision for peer-run peer respite centers will not materialize in Washington State.

King County Peer-Run Respite Center

Peers in Washington state organized and lobbied for peer-run respite centers for at least the last eight years, an effort that propelled respites onto local and state officials' agendas. In 2016, MindFreedom Seattle–a local affiliate group of an international psychiatric survivor organization–launched a petition addressed to Washington legislators requesting funding to open a peer-run respite center in King County (Seattle MindFreedom, 2016). The group also gathered

peers and testified at county and state-level meetings on the benefits of peer respites (MindFreedom International, 2019). Then in 2019, a group of Seattle-area peer advocates followed the lead of MindFreedom Seattle by forming the Community Peer Respite Planning Council (CPRPC). The Council campaigned for the allocation of funding toward fully peer-run respite centers in King County's 2019-20 biennial budget; they organized a website, monthly newsletter, Twitter page, and a petition as part of their campaign, which garnered over 700 signatures in just one week (CPRPC, 2018). Ultimately, CPRPC's efforts were successful, and the King County budget included a one-time, $2 million allocation for peer-run respite centers (King County, 2018). At just the moment this funding became available in 2019, however, new state-wide legislation on peer respite centers was introduced in the Washington House of Representatives. Anticipating forthcoming regulations from the state, King County administrators withheld a Request for Proposals for the local peer respite center, stalling peer organizers' efforts as they awaited news from Olympia (CPRPC, 2019).

Washington House Bill 1394

The original version of H.B. 1394 was introduced in January 2019 and sub-titled "community facilities needed to ensure a continuum of care for behavioral health patients" (Washington State Legislature, 2019). This first version made no mention of peer respite centers but did direct the Department of Health (DOH) to establish licensure and certification for peer-run "mental health drop-in centers" (2019). The drop-in centers would provide "voluntary, short-term, noncrisis services that focus on recovery and wellness" under the following requirements:

- Operated by licensed and certified agencies that meet requirements to be established by the DOH

- Formally partnered with the local crisis system (e.g., Designated Crisis Responders and inpatient psychiatric facilities)
- Staffing requirements ensure the service is peer-run
- Limits use to individuals 18 years and older who do not meet eligibility criteria for involuntary hospitalization but are in “psychiatric distress”
- Limits use to seven days per month for each individual (Washington State Legislature, 2019).

This version of the bill passed the House and reached the Senate as S.B. 5431. During public testimony, legislators who sponsored the bill testified that the drop-in centers are “based on a model in New York for fully voluntary peer-run respite up to seven days”; this quote indicates that peer drop-in centers and peer respite centers were initially conceptualized by state leaders as the same service, despite respite centers offering 24/7 (rather than strictly daytime) support. A second version of the Senate bill modified the definition of a drop-in center to be a “twenty-four-hour peer-run program to serve individuals referred from emergency rooms, hospitals, or designated crisis responders,” further revealing the service designation mix-up and possibility of involuntary drop-in center/respite use (Washington State Legislature, 2019). In the final amended version of S.B. 5431, the Senate Ways and Means Committee renamed the peer drop-in centers as “mental health peer respite centers”, removed an added requirement that service users be referred from crisis responders, and specified that *community behavioral health agencies* must operate the respites (Washington State Legislature, 2019). With these adjustments intact, Governor Inslee signed the final version of H.B. 1394 into law on May 9, 2019 (Washington State Legislature, 2019). Major bill modifications and confusion around service

model elements during this legislative process reflects national ambiguity around definitions of peer respite centers.

Funding and Licensing Washington Respites

At the same time that H.B. 1394 became law, its partner bill H.B. 1102 allocated $5,000,000 to fund at least four Medicaid-reimbursable peer respite centers as part of the 2019-2021 Behavioral Health Capacity Grants (Washington Department of Commerce; Washington State Legislature, 2019). Soon after, state officials solicited peer input to review a draft of the Washington Administrative Code (WAC) detailing licensing regulations for peer respite centers (Washington State Department of Health, 2019; CPRPC, 2019). Tension in the workgroup emerged around Medicaid regulations because the Washington State Medicaid plan requires assessments and diagnosis of service users by mental health professionals (Washington Health Care Authority (WHA), 2004). The opposing visions were summarized in the public notice for the WAC:

> The national model for peer respite services differs in several ways from the model that was arrived at by the workshop participants and reflected in the current rule proposal. The model in this proposed rule, as directed by the legislation, allows for Medicaid reimbursement which has additional requirements that would not otherwise be imposed. The department and many partners and participants desire to work towards a future legal and payment structure in the state of Washington that will allow this national model to take shape as a state licensed service. At this juncture, the workgroup participants were agreeable to allow this new service type to follow Medicaid model (Washington Department of Health, 2019).

The statement implies that differences of opinion between workgroup participants and state leaders were resolved, but it remains unclear whether peer participants were genuinely satisfied with the WAC outcomes and Medicaid funding source.

Ultimately, the finalized peer respite WAC included four important additions to the bill's original description of peer respite centers: Respites must be overseen by a Licensed Behavioral Health Agency, have Memorandum of Understandings with local crisis system providers "to ensure timely response to and assessment of individuals who need a higher level of care," be peer-run, and include supervision by a peer who is also a mental health professional (WAC § 246-341-0725, 2020). The WAC's licensing requirement indicates that only agencies delivering clinical outpatient services will be eligible to implement a peer respite center program (WAC § 246-341-0718, 2021); this all but ensures that resulting centers will *not* be peer-run, according to the Mind Freedom Charter's requirement that they "function independently or as part of a larger non-clinical organization" (Davidow, 2018). Additionally, requiring supervision by a mental health professional–even if they also have lived experience–means that a clinical approach will drive peer service delivery (WAC § 246-341-0515, 2021). These additional requirements may have widened the gap between the peer-run model that local organizers had advocated for, versus the clinically-involved, hybrid models funded by the state.

Outcomes

All evidence points to a future in which Washington's state-funded peer respite centers–barring any changes to the WAC or State Medicaid plan–adhere to hybrid peer respite models with clinical service involvement and affiliation. Indeed, in late 2020 the Department of Commerce awarded peer respite center funding to three agencies, two of which offer clinical services alongside peer support (WHA, 2020; Passages Spokane; Lucid Living; Colville Tribe).

Although all three agencies were projected to open respite centers in Spring 2021, none came to fruition, perhaps due to the impact of the Covid-19 pandemic (WHA, 2020). Most recently, the new 2021-23 budget cycle allocated $970,000 to peer respite centers; utilizing a portion of these funds, in late 2021 the Health Care Authority posted a 'Peer Respite Start-Up' Request for Applicants (RFA) with the intention of awarding one agency $226,000 to open a peer respite center (Washington Department of Commerce, 2022; WHA, 2021). Which agency, if any, has since been chosen for the RFA remains to be seen. At the local level, King County officials re-started their own peer respite center process following the WAC release by distributing a Request for Proposals (RFP) for the creation of a two-million dollar Seattle-area Peer Respite Pilot Program (King County Department of Community and Human Services [DCHS], 2020). However, peer organizing groups' hopes for a King County respite were dashed when the local RFP and associated $2 million in funds expired in late 2020 before they could be allocated (King County DCHS, 2020).

Research Focus

A review of the literature shows the range of national peer respite center model conceptualizations according to their organizational structure and degree of peer control; the story of peer respite center legislation and grassroots organizing in Washington State illustrates the complexity of this definitional range. Washington peers in organizing groups gathered, lobbied, and campaigned for peer-run, non-clinical respite centers but in the end, funding and licensure requirements created hybrid peer respite centers overseen by clinical agencies. In order to understand the degree to which peer-organizers were satisfied with this outcome, the ways in which they define and articulate the need for peer respite centers must be understood. Thus, this study explores two questions: How do Washington State peer advocates' described purposes of a

peer respite center shape their conceptualizations of the centers? How do participants' identified purposes influence organizing and advocacy for peer respite centers?

Methods

Institutional Review Board

On April 29, 2021 the University of Washington Human Subjects Division reviewed this study and approved its qualification as human subjects research with exempt status. No other approvals were needed for the purposes of this research.

Methodology

The study utilized an interpretive descriptive methodology with thematic analysis of qualitative data to understand and describe salient themes from eight in-depth interviews. Interpretive-descriptive qualitative research generally involves open-ended research questions, systematic analysis of all data, organizing data into categories, and creating a coherent story, all while maintaining a critical awareness of the researcher's interests, expectations, and frameworks (Elliott & Timulak, 2021). To implement the interpretive-descriptive approach, this study utilizes thematic analysis: a method for identifying and examining "the underlying ideas, assumptions, and conceptualizations–and ideologies–that are theorized as shaping or informing the semantic content of the data" (Braun & Clarke, 2006, p. 84). Thematic analysis yields a rich and complex interpretation of the data because it encourages the researcher to consider the sociocultural and structural conditions that impact an individual's story (Braun & Clarke, 2006). The methods chosen to guide this study–particularly their encouragement of critical self-reflection and integration of both personal and political experience–are aligned with the researcher's theoretical frameworks in critical feminist research and Mad studies.

Positionality

As a researcher trained in feminist studies, I engaged in holistic reflexivity throughout this study. Reflexivity in feminist research challenges the idea that science yields objective truths

by ensuring the researcher both explores and acknowledges their unique individual and structural-level standpoints (Hesse-Bibber & Piatelli, 2012). Although I hold a multitude of life experiences, my identity as a psychiatric survivor is what drives my passion for peer respite centers and all alternatives to involuntary or coercive mental health care. I claim the term "psychiatric survivor" because I live with the effects of coercion, restraint, and institutionalization imposed by the psychiatric system and by those entrusted to "treat" me during moments of distress. When engaging in reflexivity, qualitative researchers often invoke the idea of having partial "insider" status with the participants they engage with (Berger, 2015). Openly yet sensitively disclosing my identity as a psychiatric survivor during recruitment immediately revealed my partial insider status during this study, as all participants also had a history of involvement with the mental health system and used similar self-descriptors of lived experience. This shared experience helped build more of a personal connection and rapport during interviews, which likely yielded richer data as a result.

My negative experiences in psychiatric environments also informs my personal alignment with the fully peer-run, non-clinical respite center model. Owing to my personal vision for non-carceral care, I intentionally recruited participants for this study who explicitly endorsed a definition of peer respite centers as *peer-run* entities. Additionally, I designed the study to center the perspectives of peers or people with lived experience, rather than mental health professionals and institutional leaders; this decision stemmed from both my personal experience of psychiatric oppression and from feminist standpoint theory, which posits that marginalized groups offer a fuller understanding of the world because they have had to closely learn the dominant narrative (in addition to their own) in order to survive (Henwood & Pidgeon, 1995). I also conceptualize peer respite centers through the lens of Mad Studies, an emerging discipline based on a powerful

reclamation of the term “Madness” as expansive emotional, spiritual, and neuro-diversity. Mad Studies builds on the c/s/x and Mad Pride movements of the late 1900s by “rejecting clinical labels that pathologize and degrade; challenging the reductionistic assumptions and effects of the medical model; [and] locating psychiatry and its human subjects within wider historical, institutional and cultural contexts” (LeFrançois et al., 2013, p. 10). I utilize these key tenets in both my research framework and political stance as a Mad scholar.

Although my survivorhood brought me closer to participants, other identities distanced me from them. Occupying the formal researcher role felt incongruent to the informal connection built with participants over our shared peer identity, in part because of my Mad-informed rebuke of “power-over” relationships. However, my age at the time of the research was significantly younger than research participants, which may have helped offset the power wielded by my position as a researcher since participants were my elders in the peer movement. I was also an outsider in that I was not a guest or staff member at a peer respite center nor was I involved in organizing and advocating for respites in Washington State or elsewhere. At the beginning of the interviews, participants noted my newness by asking about the history of my involvement with peer work and recent move to Seattle. The differences between researcher and participant can be helpful in that the participant is empowered to be an expert while the researcher is an unknowing newcomer (Berger, 2015). However, a major challenge is the development of a research question that participants perceive to be relevant and important to participants; I adapted my interview guide and presented preliminary findings to participants in an attempt to ensure alignment of my research focus to areas of importance in the peer community.

Sample & Inclusion Criteria

This study involved two interviews with each participant (N=4) for a total of eight interviews. Participants were Washington State peers who are or were involved in local peer respite center advocacy and organizing. The sample size was kept small in part due to the interconnected nature of the Washington peer community, and due to limitations of time as well as the narrow, specific scope of the study. Eligible participants were those who identified as peers (or use similar self-descriptors denoting lived experience of trauma, extreme states, and/or psychiatric labels) and agreed to the inclusion criteria outlined below:

1. Self-identify as a peer legislative advocate and/or peer community organizer
2. Advocated for peer-run respite centers in Washington State in the last five years
3. Agrees with the definition of peer-run respite centers established by the Western Mass Recovery Learning Center (now the Wildflower Alliance) and detailed in their affiliated book, *Peer Respite Handbook*:
    a. Functions independently or as part of a larger non-clinical organization.
    b. Exists in a house, apartment or other homelike space, and not in a medical building or other structure that is simultaneously being used for clinical or other purposes that would represent a potential conflict with the mission of the respite.
    c. The design of the organizational Board of Directors and any other advisory boards includes a commitment to having a majority of appointees who have personal experience with psychiatric diagnosis, trauma, addictions, homelessness, and other significant life challenges.
    d. There is no requirement that someone be receiving any other particular services (at a particular agency, through a department of Mental Health, etc.) in order to access the respite.

e. There is no formal clinical involvement, including no clinical assessments required in order to access the respite (Davidow, 2017).

Recruitment

Eligible participants were located and recruited through purposive sampling. This method involves selecting a sample that the researcher predicts will “yield the most comprehensive understanding” of the subject (Rubin & Babbie, 2017, p. 446). The researcher’s prediction for where to find a sample stemmed from prior knowledge of various Facebook groups by and for the Washington peer community. A recruitment graphic summarizing the eligibility criteria and identifying the researcher as a fellow peer were posted in four Facebook groups. The posts were re-shared by a key informant–a leading peer advocate not otherwise involved in the study–which helped reach wider audiences. Ultimately, two of four study participants were identified through self-selection by their posting a comment indicating interest on the researcher’s Facebook post. The other two participants were identified through snowball sampling, or “the process of accumulation as each located subject suggests other subjects” (Rubin & Babbie, 2017, p. 356). All interested participants were screened for eligibility using a brief survey to confirm alignment with each criterion. If they were eligible, participants were sent an electronic consent form reviewing study procedures, anticipated risks, benefits, and confidentiality.

Data Collection

A semi-structured interview guide was developed prior to data collection and adapted over the course of the study according to preliminary data and for clarification purposes. As shown in the Appendix, interview questions were designed to obtain data related to participants’ history of involvement in Washington’s peer community and peer respite organizing; satisfaction with outcomes of organizing for peer respite centers; and conceptualizations of peer respite

centers (purpose, key program elements, core values, leadership/management, funding). During the second round of interviews with each participant, the researcher reviewed a summary of the four participants' peer respite center conceptualizations as heard in the first interview. This ensured accuracy of researcher interpretations, allowed each participant to clarify their definition, and put participants' conceptualizations in conversation with one another while maintaining confidentiality. All interviews were conducted and recorded virtually using Zoom. Following completion of the interview, the Zoom-generated audio file was uploaded to transcription platform Otter.ai and reviewed by the researcher for accuracy. Descriptive memos were also written following completion of each interview and subsequently shared with the researcher's thesis committee for review.

Data Analysis

Following a review of each interview, transcripts were uploaded to qualitative data analysis software NVivo to code and generate themes. During the preliminary analysis process, the researcher drew concept maps for emerging themes such as diverging conceptualizations, clinical involvement, respite purpose, and organizing methods. These maps ultimately became the framework for grouping codes in NVivo. Throughout the process, the researcher and thesis committee members took steps to increase the credibility and trustworthiness of the study. This was particularly important given the researcher's identity as a psychiatric survivor with biases toward a specific model for peer respite centers. Methods used to enhance rigor and improve trustworthiness of findings included:

- Weekly or biweekly consultation with thesis committee members throughout data collection and analyses for perspectival triangulation

- Midpoint member checks during the second round of interviews to ensure resonance of preliminary findings and researcher interpretations
- Researcher wrote analytical, descriptive, and self-reflective memos throughout data collection and analysis to maintain a record of the process; memos were shared and discussed with committee members
- Consultation with a key informant to provide context for the Washington peer community and peer respite center organizing
- Two interviews conducted with each participant to allow opportunities to clarify or amend earlier points

Taken together, these efforts generated a documented audit trail of the process of collecting, organizing, and analyzing data, all while acknowledging and accounting for the researcher's own standpoint and its possible influence on the construction of themes and presentation of findings.

Findings

Participants uniformly described peer respite centers as a place for guests to explore their feelings, gain perspective, and decide for themselves how to best move forward. They articulated a shared commitment to person-centered services, but described a range of visions for how to maximize guests' self-determination at peer respite centers. Participants applied self-determination according to their unique understandings of it, thereby revealing a spectrum of ideas on the degree of clinical involvement and permitted substance use at peer respite centers.

Theme 1: Peer Respite Centers Provide a 'Respite from the Storm'

Participants articulated the need for peer respite centers to offer a "temporary haven" and "respite from the storm" of life that brings guests to its doors. One participant described the experiences that may bring individuals to the peer respite center for such a reprieve:

> [The purpose of a peer respite center is] to provide that parenthetical place for people to regroup, who may be dealing with a–there is no one definition because each individual is different–but it's whatever is building in their lives that they need to step away from to gain perspective, it is the place for that. …. If I keep thinking I'm hearing the neighbors talk about me, and I just need to get away from the neighbors because I don't want to hear them talk about me anymore–because if I do hear one more thing, I don't know what will happen–this may be the place for them.

During guests' respite stay, participants emphasized the unique healing power of peer support:

> I see a peer run respite center being much more of a home like environment, where it's comfortable and conducive to the kitchen table wisdom that we can share with each other. A place where people can feel safe and not judged, and not have somebody from the medical profession be telling them, "you're sick, you'll be sick forever and this is how it'll be." They told my family that I would likely be institutionalized for the rest of my

> life. And so, you know, to hear wisdom from someone who's been down the road is very, very different than hearing it from someone who's been in school for a long, long time.

Participants also understood peer respite centers as a unique support service that prevents and diverts individuals away from psychiatric hospitalizations, emergency room visits, police encounters, and incarceration, all of which are described as compounding existing trauma:

> This is the way that you know people can get better, and not even be that unwell in the first place, if we can do it right. Which is why I think peer respite is such a key component to the overall system of care when it comes to peers. There has to be an option like that, because your only option is to get arrested, go to the hospital. Say you are, you know, there's this big thing that happens when all of a sudden you're like I'm a drug addict, or I have a mental health problem, right? But if you can just take good care of yourself and find some space to do that, none of those labels might have to happen.

By drawing on their lived experience and imagining the kind of environment people in crisis would want, participants relayed a description of peer respite centers as distinctive spaces to pause and access non-judgmental support.

Theme 2: Peer Respite Centers Maximize Guests' Self-Determination

Participants emphasized the importance of creating peer respite centers that allow guests the autonomy to cope, process, and learn in the way that works best for them. Indeed, one participant described respite centers as fundamentally "built on the idea that humans are capable" to make their own decisions. Others linked the core value of self-determination at peer respites back to the voluntary, reciprocal nature of peer services:

> So we have to stop thinking about peer services in the context of our own experience and think about what is peer services in general. …. Peer services says that you have the

> autonomy, the ability to experience and to learn yourself, what works for you. And if you want to ask how other people do it and hear ideas and choose to do it, you can choose to do it. This is a very safe place to be.

Participants also described how peer staff could support respite center guests' empowerment:

> We have to value what people say they want. I think people in their darkest moments know exactly what they want. They say, "I don't know" because they don't know what the menu looks like. But if you were to really say, "what would, you know, what do you, what do you really want?" They can tell you, they want to be with their kids, they want to, you know, they want to paint, they want to work on cars, they want to get a degree in business, they can tell you, they can always tell you, if you're willing to let them have those dreams. When all most conversations are about right now is, "can you quit using?" or "can you, you know, can you balance your medication?" Can we, you know, and we know it's all about trauma. So I think the trauma-informed platform has to be where we start.

Although all drew on the value of self-determination to explain their perspectives, participants generated a range of ideas on permitted substance use and degree of clinical involvement at peer respite centers.

Substance Use at Peer Respite Centers

Participants described degrees of permitted substance use at peer respite centers according to how they applied the concept that guests are free to make their own choices. Their responses generated two primary standpoints: guests' self-determination is prioritized by allowing them to (1) access a calm environment that offers respite from substance use, or (2) use substances to the degree they need or want during their stay.

Sober Peer Respite Centers: Prioritizing a Calm Space. Some participants envisioned peer respite centers that offer a reprieve from substance use, intoxication, and associated environmental stressors. They listed sobriety and detoxification as a requirement for guests to stay at the center. Participants advocated for sober peer respite centers by describing how the environment would become unsafe and chaotic for guests seeking tranquility if substances were allowed:

> One of my first hospitalizations had a long ward. And on one end was the folks with mental health issues and the other end were folks with addiction issues. And I was a person, you know, when I, when I break, I go inside, I go internal. And any stimulus just freaks me out. If the lights are too bright, or it's too loud, or anything, and I'll tell you what, the people on the other end of the ward and dealing with addiction issues, they were out of control, they were just loud and playful. And so I would not want to create an environment where somebody really in need of help feels like they can't get it, feels like it's not the right environment for them.

These participants also anticipated that active drug use at the peer respite center home would present an added burden to staff as they try to create spaces for rest. One participant predicted, "There's going to be problems, drug paraphernalia, sharing with other people at the house, and, you know, all that kind of thing. So it can be really messy." Those who advocated for sobriety at peer respite centers prioritized the centers' purpose as a calm, controlled setting to recuperate, even if it meant erecting barriers to entry.

Substance Use Permitted at Peer Respite Centers: Meeting Guests' Self-Identified Needs. Other participants described peer respite centers that accept guests who use substances alongside a present experience of heightened emotional states, as long as their primary goal is to

access the peer-to-peer environment, rest, and/or plan their next steps. One participant highlighted how peer respite centers should shift away from a focus on the substance use itself and instead focus on the individuals' strengths and hope for the future:

> I think people who, drugs and alcohol aren't really the problem, maybe they're using some wine for their harm reduction at night, will not go to a sober living retreat center. Right? Because that wine is the only thing keeping them sane. .... Whether or not the alcohol will be allowed on the premises, I don't think that should be the focus, I think the focus should be, "Is that person using the time to rest and to make a plan of some sort to leave?" So I think, coming in the door, the conversation should be about how it's great that they're there but where are they going?

Requiring abstinence of guests, according to these participants, would be an unreasonable ask of individuals in need of peer support. Instead of imposing sobriety, peer respite centers could meet each guest where they are in that moment, as one participant described:

> A person who is experiencing serious mental health, serious addiction, has been living on the streets for 20 years, is just trying to survive. This idea that they stop using while homeless, completely, right, and no drugs, start taking your meds, start going to appointments, find a phone, I guess. You know like, it's impossible. …. Under a peer model, you could come in and say that, you know, "I have co-occurring" right. And, "I need to work with folks who could help me deal with my mental health in that regard. And over here on the addiction side, I've been using meth to address it, I still drink, I smoke pot, it's not a problem for me." …. What happens over time is that people can stair step up as they get better.

These participants also explained how requiring strict eligibility criteria and an abstinence-only framework would negate self-determination at the peer respite:

> Sober houses are not [safe] unless you happen to be in AA and abstinent, you know? …. AA, though peer-led, is directive in nature, and is not the, is not a peer, true peer role by any means whatsoever. If it was around addiction, abstinence approach is also judgmental. It means that you are now telling them what to do, how to live their life.

As long as guests are seeking the supportive, strengths-based nature of a peer respite environment, these participants welcome those using substances. They emphasize peer respite centers as low-barrier spaces that honor multiple pathways to recovery.

Clinical Involvement at Peer Respite Centers

Figure 1

Spectrum of Participant Perspectives on Desired Degree of Clinical Service Delivery and Affiliation at Peer Respite Centers in Washington State

Participant perspectives on the degree of clinical service involvement and affiliation at peer respite centers ranged from a fully peer-run model with zero clinical involvement to full-time clinicians offering services on-site, as shown in Figure 1. Some participants' views land in the middle of this spectrum in that they allowed for partial clinical involvement contingent on respite guests' desires. Participant descriptions of clinical involvement were marked by two major applications of self-determination: freedom of guests to access a safe place away from

potentially harmful clinical services, and freedom of guests to access a variety of service options during their stay.

No Clinical Involvement: Respite from Traditional Treatment. Some participants invoked self-determination to justify exclusion of all clinical services or affiliations at peer respite centers. For these participants, the mere presence of clinical services implies that respite guests should use them, which removes their ability to choose which kind of support is best for them. One participant described how a peer respite center with clinicians on staff would eliminate guests' sense of safety and choice:

> You're treated by clinicians, who are going to observe you in this state of duress. Yeah, you're in duress. That's why you're there, right? You're trying to walk through it. They're now handling your meds, telling you what to do. And they have the power to call in a DCR [Designated Crisis Responder] and take you away. Do you feel safe? Do you feel like you can walk through this immense duress in this place, in this space, knowing that? No. So do you go there? Probably once. Just once. It takes just once or twice for somebody to get snagged up by Ricky's Law or a DCR. To learn what not to say.

Participants who exclude clinical staff, oversight, and treatment at peer respite centers associate these services with coercion, force, and erasure of one's self-determination. The presence of professionals adds "additional chaos" and "extraneous stressors" to the house, as one participant described. Another participant clarified that guests at their envisioned peer respite would still have autonomy to access clinical services, as long as they are delivered off-site and via unaffiliated service providers:

> [Respite guests] are more than welcome to use medications and to use clinical treatments and supports. We will support them in getting to those facilities. But the space that we're

> thinking about is even a respite from requiring that or having that available or in their face. The moment you introduce clinical services into an operation, there is a co-opting that goes on.

To underscore their concern about co-optation of peer authority at peer respite centers, participants reflected on a parallel process in their advocacy and organizing efforts. Participants campaigned for non-clinical peer respite centers on workgroups and committees convened by the state, but legislation ultimately tied respites to Medicaid funding requiring clinical diagnoses and oversight. They predicted peer support would be co-opted and mission drift would occur in state-funded peer respite centers, as they experienced an equivalent process in government settings:

> My experience, particularly with the Health Care Authority and DBHR [Department of Behavioral Health and Recovery] is they listen to you because they have to. They might pull a group because they need to, but they really don't have any intention of doing anything you want to do, they're going to do what they want to do, or they're gonna do what their folks internally think is great. And so what you end up having, again, is non-subject matter experts making their best decisions based on their ideas of people living with behavioral health, which of course, are ingrained with stigma.

Participants described peer respite centers that provide a refuge from clinical support to prevent harm to guests and a shift in power away from peer support.

Clinical Involvement: A Menu of Support Options. On the other hand, some participants turned to self-determination to explain their inclusion of clinical services for guests at peer respite centers. They imagine a peer respite like a “highway rest stop” that offers all types of support–including clinical services–to attend to guests’ different needs, as long as services are

entirely voluntary. To exclude clinical services from the menu of available supports, from their perspective, would indicate the peer respite center is making a decision *for* guests by limiting services to peer support. One participant described their rationale:

> I think that all of it [both peer and clinical services] should be there, we should just stop having to decide whether one's good or bad. There was nothing wrong with the medical model until it took over and didn't allow people to have any self-reliance. Until it said, "Oh, you must take these pills. That's the only way to get better." Not, "If you want pills, here we are." Right? I guess the relationship between the two should be open doors. They should support one another. What [those who think respite centers should be non-clinical] don't understand is how hard they've become, that they're reducing the choices for people by saying peer services, "This is how we do them." Really? That's how you do peer services between you and another peer. That is not how that peer wants to do it between that peer. And there's no flexibility for that.

Another participant emphasized the need to be flexible in accommodating different guests' needs, even those who want clinical services:

> When there is a strict rule [of non-clinical involvement], I'm coming from the perspective of there are times when that rule still needs to be challenged. Because we're different. And, you know, not everything is going to work for everybody.

Although these participants advocated for clinical involvement at peer respite centers, some thought clinical services should only be delivered on a case-by-case basis via part-time staff while others envisioned full-time therapists or doctors working alongside peer support staff at the center. Additionally, participants were divided on whether a clinical organization (e.g., an outpatient psychiatric program) should be permitted to administer and govern a peer respite

center or not. Nuances aside, participants who desired some degree of clinical services at peer respite centers sought to magnify the self-determination of each guest such that there is something available to meet each individual's needs.

Discussion

This study explored how Washington State peer advocates' articulated purposes of a peer respite center shape their organizing process and understanding of the peer respite center concept. Findings show that peers consistently center autonomy and choices for guests in their conceptualizations of peer respite centers, but the core value of self-determination manifests differently according to how they detail specific program elements. All described peer respite centers as a safe place to pause and utilize peer support amidst heightened emotional states, yet diverging purposes emerged from a spectrum of perspectives on clinical involvement and permitted substance use at the centers. The organizing process of peers who envisioned non-clinical peer respite centers was particularly fraught as legislative outcomes did not align with the respite model they advocated for.

Results of this study indicate that although the local peer community is supportive of the general idea of peer respite centers with an emphasis on guest autonomy, significant and potentially incompatible variation exists between their detailed visions for how to operate a peer respite center that best promotes said autonomy. Tension between participant conceptualizations indicate that some peers will be satisfied with and promote use of Washington's future state-funded peer respite centers while others will consider the respites' requisite clinical involvement as antithetical to their purpose as a safe haven for people in crisis. Findings also reveal a notable shift away from the peer-run, non-clinical model of peer respite centers, and the potential impetus to rebrand hybrid peer respite centers for clarification of key peer respite center program elements.

Common Ground in Peer Respite Center Conceptualizations

Participants gave near identical general descriptions of the peer respite center concept as

a safe, non-judgemental place to regroup and draw on the power of peer support; they also rationalized peer respite centers as a unique support service intended to prevent and divert individuals away from interactions with law enforcement, hospital-based, and psychiatric systems. These uniform responses represent the parts of the original peer respite center model that appear to have migrated fully intact from the first respite on the East Coast to Washington State. Indeed, participant responses align with the first respite's intent to decrease use of psychiatric hospitalization and offer a comfortable space for processing experiences (National Empowerment Center, 2017). Current literature defining peer respite centers from Live and Learn and the Mind Freedom Charter also echo respites as places to gain new perspective in a distinctively open, non-hospital setting, just as participants described. Participant overlap in general ideas for what a peer respite is and why it is needed shows an area of common ground amongst the local peer community as they make sense of peer respite centers and formulate a vision to bring to decision-making tables in Washington State.

Another major overlap in participant peer respite center conceptualizations was the prioritization of "self-determination," or guests' freedom to make their own decisions regarding support needs and pathways to healing. Like their general descriptions, participants' vision of a person-centered approach embedded in all aspects of peer respite centers is echoed in relevant literature: The Mind Freedom Charter definition lists required respite characteristics such as freedom of movement, use of non-diagnostic language, and most notably, "openness to various ways of making meaning of one's experiences and healing" (Davidow, 2018). Similarly, the Live and Learn definition explicitly describes peer respite centers as voluntary services, indicating symmetry with values of autonomy and choice.

Although they shared a vision for self-determination at peer respite centers, participants

differently translated this core value into practice according to their perspective on the degree of clinical involvement and permitted substance use at the centers. These diverging applications of self-determination led to contrasting purposes: Some thought respites should offer a space away from the potential of harm caused by clinical services, while others prioritized offering the full array of services to guests; some envisioned respites as a refuge away from all substance use and intoxication, while others wanted them to be a low-barrier support service tailored to guests' self-identified needs regardless of substance use involvement. The range of opposing perspectives evidenced in this finding is potentially influenced by diverging philosophies for addiction support as well as a long-held ideological divide within the mental health peer support movement.

Ideological Influences on Diverging Perspectives

Permitted Substance Use: Abstinence and Harm Reduction

Participants' conflicting beliefs about whether guests should be allowed to use substances at peer respite centers align with two ends of the spectrum of approaches to substance use peer support: abstinence and harm reduction. Most participants brought up substance use guidelines unprompted during interviews, as questions were not focused on this intersection; participant attention to substance use indicated a trend in the peer community toward the integration of mental health and substance use peer support services, as the two have historically been siloed in the continuum of care. Participant perspectives align with the range of existing peer respite center guidelines on substance use, although evidence shows that the majority of centers find middle ground between an abstinence and harm reduction approach (Davidow, 2017; Live & Learn Inc., 2019).

Some participants described peer respite centers with the requirement of total sobriety

and detoxification in order to use its services, as well as a ban on substances at the house. This perspective echoes that of an abstinence approach to substance use treatment, which removes all drugs and alcohol from a person's environment and encourages them to quit using entirely. While the abstinence approach and its prescriptive nature may seem contradictory to established core values of peer support (e.g. choice, flexibility, person-centered), it is often utilized in well-established self-help peer support services such as Alcoholics Anonymous (AA) and Oxford Houses/peer-staffed sober living homes (Oxford House, 2019). These abstinence-driven support services and their apparent differences to c/s/x-led peer support values reflect an entirely different strand of the peer movement focused on substance use recovery rather than psychological well-being. The history of the substance use peer recovery movement is beyond the scope of this document given peer respite centers' emergence as a mental health-focused model, but its existence offers a possible rationale for why some participants infused sobriety into their conceptualizations of respite centers. Additionally, it bears repeating that participants advocated for abstinence at peer respites in an effort to ensure they are *more* aligned with a person-centered approach; they aimed to respect the needs of those guests who may be triggered or overwhelmed around people who are intoxicated and/or in the presence of substances.

On the other end of the spectrum, some participants advocated for an approach to substances at peer respite centers that may have stemmed from or intermingled with the concept of harm reduction. These individuals articulated peer respite centers that are open to people who actively use substances as long as they are seeking the benefits of a peer environment. Participants rationalized this flexibility by describing how individuals may "stair step up" to lessening harmful impacts of substance use on their life as they reap the benefits of peer support. This idea is echoed in harm reduction's goal of "reducing negative consequences associated with

drug use" rather than eliminating usage entirely, unless a person so desires (National Harm Reduction Coalition [NHRC], 2020). Perhaps the most compelling evidence for participants drawing on harm reduction to describe peer respites is its conceptual overlap with self-determination: Harm reduction interventions are "non-judgemental" and "non-coercive" just as peer respite centers build choice and voluntariness into the fabric of their design (NHRC, 2020). Additionally, similar to the centrality of lived expertise at peer respite centers (and peer-run services in general), harm reduction ensures the input of people who use drugs in program design and delivery (NHRC, 2020). Although participants clearly tied peer support values to harm reduction in their descriptions, peer respite centers that allow for open-use risk shifting into supervised use spaces (e.g. guests' primary reason for using the respite is to use substances more safely) unless guidelines are developed around where substances are allowed to be consumed and whether open intoxication is permitted.

Literature on substance use at peer respite centers is sparse, likely due to the model's focus on support for challenging emotions or extreme states rather than substance use *per se*. However, the fundamental text *Peer Respite Handbook* offers a summary of substance use policies reflective of the range of perspectives offered by participants: Some currently operating peer respite centers have a zero-tolerance policy for substance use (on and off-site), while others ask that guests avoid open intoxication or having substances at the house, "less to judge what someone chooses to do on their own time, and more to ask them to be respectful of the impact on their environment" (Davidow, 2018, p. 158). Centers that adopt the latter policy seek to maximize self-determination for a wide range of guests by balancing the need to 1) avoid imposition on guest autonomy via required (off-site) abstinence, while 2) creating a calm, respectful environment inclusive of guests seeking sobriety. A 2018 survey of 31 peer respite

centers in the United States echoed this balanced approach, in that all centers had substance use policies, and none allowed substances on the premises of the house (Live & Learn, Inc., 2019). The majority of centers give guests two strikes for open intoxication, a request that they stay out of common areas, and/or a request that they remove substances from the premises before asking them to leave (2019). By striving for abstinence on the premises while respecting guests' choice to use substances off-site, current policies at peer respite centers integrate elements of participants' diverging harm reduction and abstinence approaches without fully adhering to either one.

Degrees of Clinical Involvement: Consumer Partners and Survivor Separatists

Just as participants' perspectives on substance use have diverging ideological underpinnings, so too do their desired degrees of clinical involvement at peer respite centers. Tension between visions for a respite center with and without the integration of clinical services or affiliations parallels historical splintering of the c/s/x movement into "consumer" and "survivor" camps. Some participants advocated for varying degrees of clinical involvement (ranging from part-time to full-time and onsite clinical services) at peer respite centers by arguing that offering guests the full range of mental health support services–both peer and clinical–maximizes self-determination by offering them choices. From their perspective, excluding the provision of clinical services at peer respite centers would mean imposing on an individual's unique, self-directed path to emotional wellbeing. As described in the work of disability justice scholar Liat Ben-Moshe (2020), this standpoint steeped in choice and options echoes the 1980s push from people accessing mental health services to be called "consumers" rather than the belittling label of "patients." Certain groups of peers adopted this term based on the idea that being viewed as a resource-laden and informed purchaser of mental health services

would redistribute power to service users/peers rather than clinicians. Ben-Moshe describes how these groups sought to reform the current mental health system, for example by creating more humane methods of involuntary commitment, which led to a divide between consumers and psychiatric survivors/ex-patients, the latter of which sought to abolish involuntary treatment entirely. Similarly, in 1977 antipsychiatry movement leader Judi Chamberlin (2012, p. 99) described the consumer approach to creating alternatives to institutionalization as a “partnership” model by which peer-delivered services are overseen by clinical organizations and work side-by-side with professionals. Now over four decades since Chamberlin’s original summary of the consumer movement strategy, some participants articulated a partnership model between peers and clinicians in their conceptualizations of peer respite centers as spaces offering both peer support and professional services.

Meanwhile, participants who steadfastly excluded clinical involvement in their visions for a peer respite center reflected the philosophy of the psychiatric survivor movement and its nonconformist design of alternatives to psychiatry. These participants strove to create a respite center with the purpose of providing refuge *from* clinical services in response to experiences of harm in those settings, while still supporting guests to use clinical services off-site if they so choose. Historically, peers who experienced harms that some participants articulated (e.g., coercion, force, medicalization of distress) called themselves “psychiatric survivors” or “ex-patients" to describe their interactions with an abusive, paternalistic system. They formed a branch of the peer movement aimed at abolishing psychiatry while building–as Chamberlin described them–“separatist” alternatives such as the original peer respite center which was run by and for peers with no involvement of psychiatric system professionals who could re-create controlling environments (Ben-Moshe, 2020; Chamberlin, 2012, p. 99). Participants who

advocated for non-clinical involvement aligned with the separatist approach of survivor movements when they described how guests' fears due to the threat of force would counteract the core value of self-determination if clinicians and doctors were to work alongside peers. Just as psychiatric survivors pushed for full peer control to avoid the power dynamic of a clinical environment, participants predicted that the implicit power of licensed mental health clinicians at a respite would result in a process of co-optation as the power to institutionalize, diagnose, and medicate overcomes the value of peers' lived experience. Indeed, participants experienced this process first hand when voicing their perspectives on peer respite-focused governmental workgroups: They felt unheard and tokenized for their lived experience in spaces where an imbalanced power dynamic replicated clinical environments, a concern with demonstrable evidence (see Fletcher et al., 2020). It follows that outcomes of the workgroups did not reflect these peer participants' desire for non-clinical respite centers.

Evidently, participant decisions to involve or exclude clinical services from their peer respite center designs are modern-day displays of longstanding peer movement tensions. On the one hand, participants who excluded clinical services–and their psychiatric survivor predecessors–warn about the impact of systemic psychiatric oppression in a way that their pro-clinical/consumer counterparts do not. The field of psychiatry wields the power and influence of Western medicine, which means its diagnosis and treatment methods for what is called mental illness are considered effective and necessary by wide swaths of the populace; thus, individuals labeled as mentally ill are denied their freedom and bodily autonomy per involuntary commitment and treatment laws across the country. With a critical analysis of psychiatric hegemony in mind, a peer respite center where embedded clinical services (and their medicalized approach to emotional distress/extreme states) maintain equal power to peer support

is nearly inconceivable. Participants who conceptualized peer respite centers as such a partnership between peers and clinicians did so on the basis of maximizing choices for services; however, the main critique from survivors and ex-patients is that consumers falsely assume that guests have the freedom of choice in the first place, without consideration of the external ideological forces (e.g., clinical services are considered more legitimate and scientific than peer support) and physical forces (e.g., involuntary detainment, forced drugging) that push individuals unwillingly into clinical services.

On the other hand, those who want clinical services at peer respite centers are mobilizing core peer values of flexibility and respect for differences to a degree that survivors/non-clinical respite advocates could be accused of sidestepping for anti-psychiatry political motives. An excerpt in the *Peer Respite Handbook* attends to the need for continual centering of peer support's non-judgemental, person-centered values, regardless of personal bias toward or against clinical services: "Any peer respite that attempts to get in the way of someone seeking the support of a psychiatrist, a therapist, or any other clinically oriented worker has lost sight of their own most important principles and values" (Davidow, 2017, p. 214). Indeed, all study participants agreed that guests should be supported in accessing any kind of service they desire, but tensions focused specifically on whether those services could be affiliated with and delivered at the peer respite itself.

Implications

The findings of this study offer important insights into how members of the Washington State peer community understand the concept of a peer respite center, with implications for local respite design and model evolution. The study uncovered common ground amongst peers, as they all advocated for peer respite centers offering refuge from an individual's stressors in order

to prevent use of services that could compound harm; participants also universally focused on how to build peer respite centers with the core value of self-determination in mind. These commonalities cannot be mistaken for uniform understanding of the concept, however, as their descriptions of respite center substance use and clinical involvement revealed a range of conflicting perspectives. Although the study's eligibility criteria required that participants agree with the definition of a *peer-run* model for peer respite centers (with full peer control and no clinical involvement), some participants still advocated for on-site clinical services and affiliation akin to the hybrid peer respite model articulated in the literature. The presence of these participant perspectives, as well as recent Washington State legislation funding hybrid peer respite centers (and some peers' unsuccessful efforts to change it), indicates an important shift away from the original peer-run respite service developed by grassroots survivor movement organizers in the late 1990s.

Findings from this study offer evidence for two different explanations within the peer community regarding the shift toward hybrid peer respite centers. From one perspective, the inclusion of clinical services in peer respite design may denote an increasing commitment to accommodate the broadest range of individuals' recovery needs, even those who seek clinical services alongside peer support. In this view, the peer respite experience is progressively being tailored to the unique needs of each guest. From a Mad Studies perspective, the shift is evidence of the sheer power of the medical model to morph the design of a peer respite center in its favor over time, even if the centers initially formed as an alternative to the very system that now has potential to envelop them. Mad scholar Jijian Voronka asserts that when peer services are delivered in clinical environments, peers' "inclusion does little to disrupt structural violence," and in fact encourages "compliance and cooperation with dominant conceptual models of mental

illness" in those they support (Voronka, 2017, p. 335-337). This perspective understands clinical services and peer-run respite centers as mutually exclusive entities, the former being part of a system of psychiatric oppression and the latter being an alternative space of refuge from that system.

Ultimately, findings indicate that Washington State's state-funded peer respite centers will meet the needs of some, but not all individuals seeking its services. Only peers whose conceptualizations of peer respite centers include partnership and affiliation with clinical services will likely support these future, hybrid-model respites; others will hardly consider Washington's centers peer respites at all, as they understand clinical services and values of self-determination or safety to be contradictory. Not enough information on state-funded respites' guidelines on substance use currently exists to determine the degree to which they will align with abstinence or harm reduction approaches articulated by participants; however, eligibility criteria will likely be determined by Medicaid regulations, indicating these respites may require abstinence and detoxification of guests prior to entry.

Underlying tensions between varying peer respite center conceptualizations may be best addressed by further clarification of the peer respite center model to account for irreconcilable differences; relevant literature shows an existing categorization of peer respite centers into models according to peer control (peer-run, hybrid, and peer-integrated), but findings show that local peers use the umbrella term of "peer respite centers" to describe a range of service models. Thus, generating new terminology for hybrid peer respite centers (e.g., "crisis diversion homes") that dissociate them from the original peer respite center model has the potential to clarify important aspects of their service delivery model such as the involvement of clinical services. In that case, the peer respite center concept could more clearly link to its survivor movement roots

and peer-led, non-clinical services. Splitting hybrid respites into a new support service would also strengthen peer efforts to organize and advocate for appropriate funding and legislative design of their desired model of peer service delivery. Peers and lawmakers or healthcare officials could more effectively communicate if proposed service models were mutually understood.

In the end, not every kind of peer respite center "will work for everyone," as one participant so poignantly stated. However, this knowledge will likely not stop the peer community from trying to build support services that collectively *do* work for everyone while diversifying options for person-centered crisis response. Indeed, peer support principles of flexibility and respect for many pathways compel peers to expand community access to support services, rather than limiting them according to one's personal needs and lived experiences. Regardless of the type of peer respite center being supported, we–the peer community–must call on our radical movement history to sustain vigilant attention to the power imbalance between clinical services and peer support in the centers' designs; when carefully implemented, safeguards against the co-optation of peer support, autonomy, and leadership have potential to develop peer respite centers fully reflective of their liberatory roots.

Study Limitations

Limitations of this research are two-fold. First, the pool of peers in Washington State who recently advocated and organized for peer respite centers is small given the newness of the concept and lack of existing centers in the state. The perspectives of participants–while variable and diverse in and of themselves–may not be an exhaustive representation of views currently held by the local peer community. Secondly, only the primary researcher conducted coding of interview transcripts via qualitative data analysis software. The potential impacts of solitary coding on study validity was offset by regular consultation and interview excerpt review with the study's advisor.

Future Research

This study's findings yield three recommendations for further research. First, future studies on peer respite centers should expand their samples to include peer organizers and advocates from multiple states, as well as legislators and health officials with relevant experience. Expanding the pool of participants will capture a more exhaustive range of perspectives on peer respite center organizing, funding, and implementation both within and outside of the peer community. Second, a comparative research study on guest satisfaction at peer respite centers with varying degrees of clinical involvement and/or allowed substance use could facilitate an understanding of which kinds of services best meet guests desired support needs while maintaining self-determination. Lastly, further exploration of peers' perceptions of safety as they relate to clinical services is warranted in order to increase public understanding of survivor and consumer experiences, and create future respite environments that are responsive to fears around loss of autonomy.

Conclusion

This qualitative study found that peer-participants understand the purpose of peer respite centers as spaces to rest and process experiences of distress or crisis in an environment that prioritizes each individual's self-determination. Participants' unique applications of guest autonomy resulted in a range of conceptualizations for two peer respite center service elements: degree of clinical involvement and permitted substance use. Longstanding divisions in national peer movements and ideologies may be reflected in tensions between participant conceptualizations of peer respite centers. Recommendations include new, clarifying terminology for "hybrid" peer respite centers with clinical involvement, ongoing responsiveness to clinician-peer power dynamics, and future studies on guest satisfaction at differing types of peer respites. By highlighting key areas of unity and tension in peer respite center conceptualizations amongst peers, this research yields important insights for future peer-led organizing and advocacy in Washington State and across the nation.

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Appendix

Initial Interview Guide

Project Title: *Peer Respite Centers in Washington State*

Researcher:
Olivia Jacobs, MSW Student, University of Washington School of Social Work

Intros/Consent Review

- Thank you for making time to participate!
- Logistics:
  - Interview is voluntary
  - Feel free to skip any questions that you prefer not to answer
  - Will be recorded, transcribed, reviewed by the research team -- identifying information removed
  - Reports or publications resulting from the research will not include identifying information about you -- will only include quotes from the interview that will not reveal your identity
  - Will take about 60 mins, let me know if you need a break
  - Overview of questions:
    - *History of involvement with peer community*
    - *Your vision of a peer run respite*
    - *Organizing story/process*
    - *Organizing outcomes*
  - Any questions for me?
- OK to begin recording?

Part 1: History of Involvement

- How and when did you first connect with other peers in Washington State?

- What led to your commitment to peer-run mental health services as opposed to those that are only peer-staffed or managed by non-peers?

Part 2: Peer Run Respite Visions

- Describe your ideal peer-run respite center in Washington State.
  - Funding, management, eligibility
  - Differences from traditional mental health services
  - Central values

- This study defines peer-run respite centers according to guidelines established by the Western Mass Recovery Learning Center (now the Wildflower Alliance) and detailed in their book "Peer Respite Handbook":
  - Functions independently or as part of a larger non-clinical organization.
  - Exists in a house, apartment or other homelike space, and not in a medical building or other structure that is simultaneously being used for clinical or other purposes that would represent a potential conflict with the mission of the respite.
  - The design of the organizational Board of Directors and any other advisory boards includes a commitment to having a majority of appointees who have personal experience with psychiatric diagnosis, trauma, addictions, homelessness, and other significant life challenges.
  - There is no requirement that someone be receiving any other particular services (at a particular agency, through a department of Mental Health, etc.) in order to access the respite.
  - There is no formal clinical involvement, including no clinical assessments required in order to access the respite.

- Is there anything in this definition that doesn't fit with your definition of peer-run respite centers?

Part 2: Organizing Story

- Tell me about your organizing experience.
  - *[who, what, why/how come, when, where]*
  - Overall goal(s)?
  - When and where?
  - Your role?
  - With who? Connections with fellow peers?
  - Target audience of organizing?
  - Methods of organizing?
    - Any legislative testimony? Impact on final bill?
  - *I noticed there were a few different social media pages focused on advocating for peer respite centers in Washington, for example the "Community Peer Respite - King County" (Facebook page created by the Community Peer Respite Planning Council) and MindFreedom Seattle (created a Change.org petition for peer-run respites in 2016)*
    - To what extent were you involved in online organizing?
    - What role did these online pages and petitions play in the organizing and advocacy process?

Part 3: Organizing Outcomes [30 minutes]

- What were the outcomes of the organizing and advocacy efforts for a peer-run respite center?
  - Feelings about outcomes?
  - Impact of feelings on future organizing?
  - Values stated earlier in line with outcomes?

Closing [5 minutes]
- Did I miss anything?
- Next steps:
  - Identify and analyze common themes via transcript in peer respite center organizing and advocacy processes
  - Invitation to review my preliminary findings and offer any clarifications
- Look out for an email from me in the coming months!
- Any questions about this process?
- Thank you!