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ORIGINAL ARTICLE

Peer Respites: A Qualitative Assessment of Consumer Experience

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Abstract
This qualitative study explored the experiences of persons staying at two peer respites through interviews with 27 respite guests near the end of their stay and at 2–6 months following their stay. Trained peer interviewers conducted baseline and follow-up interviews. Peer respites can be beneficial spaces within the mental health system for guests to temporarily escape stressful situations while building relationships with other persons with mental illness, though some respondents were uncomfortable receiving services from peers, and several guests did not want to leave after their stay. Ongoing training of peers and orientations for respite guests can help ensure optimal respite experiences.

Keywords Qualitative · Peer-respite · Mental health services

Introduction

The current emphasis on recovery-oriented mental health service models (Davidson et al. 2006) has motivated consumers and service providers to support care that promotes consumer choice, community participation, and overall wellness (Whitley and Drake 2010). Peer-support services are an important component of the recovery-oriented service philosophy (Chinman et al. 2017). Peer-support services are based on the notion that individuals who have personal experience with the mental health service system offer a unique perspective on mental health, can promote hope surrounding the possibility of recovery, consumer strengths, and consumer choice (Chinman et al. 2006). Peer-support services typically include consumer advocacy, outreach and engagement, and overall support to consumers of mental health services (Davidson et al. 2006). Peer providers utilize a range of theoretical orientations and typically receive some form of training in mental health service delivery from their organizations, though content of such trainings can vary (SAMHSA 2016).

In recent years, the scope of peer-support services has expanded to include the staffing of peer respites. These respites were developed to provide a voluntary, short-term, residential alternative to support individuals experiencing or at risk of a psychiatric crisis (Ostrow and Croft 2015). These programs aim to provide a safe and homelike environment, and are usually located in a house in a residential neighborhood. A defining feature of peer respites is that they are operated by staff members who have personal experience with the mental health system and are typically trained using Intentional Peer Support (IPS) (Mead 2009). Similar to other peer-based services, such as recovery centers (Whitley and Siantz 2012), peer respites facilitate supportive relationships between guests, and help guests create connections within the community outside of the respite. Respites also typically provide optional skill building and wellness groups, and can serve as conduits to

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community-based self-help resources, such as the Wellness Recovery Action Plan (Copeland 2002).

A recent literature review examining the effectiveness of peer-support services reported that peer-based services can lead to improvements in psychosocial and recovery outcomes among consumers of these services (Chinman et al. 2014). However, a smaller body of literature has examined the benefits of peer respites specifically. One randomized controlled trial compared the effectiveness of a peer respite to a locked inpatient psychiatric facility among a sample of uninsured adults who were civilly committed for severe psychiatric problems (Greenfield et al. 2008). Using interviewer-rated and self-reported measures of psychopathology, this study reported that persons who were assigned to a peer respite experienced improvements in mental health functioning and treatment satisfaction, compared to individuals assigned to the locked inpatient facility. Another study used propensity score matching to compare a cohort of persons who used respite services to those who did not. Using county derived service use data, the study reported that respite stays were associated with decreased use of emergency services and inpatient psychiatric stays such as crisis support services, crisis residential services, short-and long term psychiatric inpatient hospitalization, compared to persons with similar demographic and clinical characteristics, and service use histories who did not stay at a respite (Croft and Isvan 2015). However, no studies that we know of have captured the experiences of respite guests using a qualitative approach.

A qualitative approach is germain to the mission and philosophy of peer respites, which emphasize self-directed goal setting and a general desire to understand guests' perception of services (Ostrow and Croft 2015). An in-depth examination of these experiences can help mental health systems gain better understanding of the specific elements of peer respites that are especially helpful to guests, along with the needs and experiences of persons who have experienced a respite stay.

The present study is a qualitative assessment of the implementation of two newly funded peer respites in Los Angeles County. This study was designed in close collaboration with the peer providers who staff the respites and aims to (1) understand why and how people came to the respites, and (2) explore experiences persons who have stayed at peer respites.

Methods

Study Setting

The present study was conducted at two peer respites designed to support to people with mental health and co-occurring substance abuse concerns. These programs were funded as part of an initiative to deliver mental health service innovations using money from California's Mental Health Services Act (MHSA), which places a 1% tax on incomes > $1 million to create new funding streams for community mental health services. Both programs aimed to support guests in cultivating supportive relationships with other guests through community meals and meetings. The programs also aimed to support the development of life skills, such as conflict resolution, communication skills, budgeting, shopping, and cooking. Guests of both programs have the opportunity to create individualized wellness and recovery plans that are centered on the Eight Dimensions of Wellness and Wellness Recovery Action Planning (Copeland 2002). The respites were designed to serves adults (18 years and older) who were in psychiatric distress, not a danger to others, with one or more co-occurring disorders related to physical health or substance abuse, and could perform basic daily living skills independently. Individuals who met the legal criteria for involuntary acute psychiatric hospitalization were considered to be inappropriate for the respites. Thus, these programs did not serve persons in the midst of a severe crisis nor did they serve as hospital diversions. Further, both respites were intended to serve people who had an identified source of housing prior to their respite stay, though some guests' housing arrangements changed during their respite stay.

The two programs differed in terms of capacity and regulations. Program A had capacity for nine guests who can stay from 3 to 29 days. Each guest had his or her own room and shared a bathroom with one other guest. Guests of Program B were permitted to stay for up to 2 weeks, and typically had between five and eight people staying at a time. Program B rotated availability based on gender by exclusively serving women for 2 weeks, and men for the next two.

Peer Interviewers

Given the consumer-driven philosophy of the peer respite programs, the participating organizations and study team determined that it would be more appropriate and effective for peer-interviewers to conduct all study interviews (Croft et al. 2016). This approach was not only commensurate with the programs' philosophies surrounding authoritative roles, but also preserved the peer-based environment. Three persons with recent experience working as a Peer Advocate, a Peer Specialist, and/or a Health Navigator were recruited and hired by the study team.

Prior to data collection, the interviewers participated in 7 h of in-person training led by the study team and peer-respite staff, which occurred over the course of 2 days. During the sessions, interviewers learned about the peer respites, reviewed the study's learning goals, were presented

information about research ethics, and practiced interviewing techniques. Each interviewer participated in at least three mock interviews and received feedback from both the evaluation team and the peer providers to strengthen their skills. Interviewers also completed human subject's protection training, as required by the study team's Institutional Review Board. Interviewers also received four booster training sessions that occurred at 2 month intervals throughout the study period to review the interview protocols and receive feedback on interview recordings and general advice. Peer-interviewers were also given a manual of hard copies of all training materials, including protocols for emergencies. Interviewers were paid for their participation in training sessions and for their work.

Data Collection

Qualitative data for this study were gathered from respite guests at two time points. Baseline interviews were conducted with respite guests shortly before their respite stay ended. These interviews occurred at the respite and focused on questions related to how the individual found the respite, their expectations regarding benefits of staying at the respite, and other questions related to their perceptions, experiences, and satisfaction. The present study used a convenience sampling approach for study recruitment. Individuals who came to stay at the respites between the months of January–July of 2015 were invited to participate through a flyer that was given to them at check in during the beginning of their stay, and were asked if the study team could contact them with more information. Interested guests provided the respite staff with their contact information, after which they were contacted by the study team. Individuals were eligible to participate if they were a guest at one of the two respites and were at least 18 years old. Individuals were excluded from the interviews if they were incapable of giving informed consent. Potential participants' capacity to give informed consent was evaluated by peer interviewers using skills learned in IRB training. Study participants were given a $10 gift card following participation in a baseline interview.

Follow-up interviews were conducted in community locations 2–6 months after the respite stay ended. To increase participation in follow up interviews, the study team maintained contact with each participant through monthly phone calls between baseline and follow-up. Study participants were given $5 gift cards after each monthly follow up phone call. The follow-up interviews were focused on the impact of their respite stay on their own mental health, interpersonal relationships, and their experiences in general. Study participants were compensated $25 after completing the followup interview.

Qualitative baseline and followup interviews lasted approximately 30–60 min. Interviews were audio recorded and professionally transcribed. The University of California, San Diego Human Research Protections Program approved all study protocols.

Data Analysis

This study used case study analysis, which prioritizes depth over breadth, to understand differences in participant experiences of peer respites. Specifically, we analyzed each transcript with attention to the benefits and challenges of staying at a peer respite, changes in the lives of respite guests following their stay, and their reflections on whether the peer nature of the respites was beneficial. This involved initially coding peer interview transcripts using a technique known as open coding, which is an inductive process in which meaningful segments of text are identified with a descriptive code. Examples of codes include: "respite community," "challenges," and "respite expectations." Using coded material, respite guest experiences along with illustrative quotes were then entered into a case summary matrix (Miles and Huberman 1994). We then conducted both within and across case analyses using constant comparative methods (Strauss and Corbin 1994) to consider the perspectives of guests from each respite. We elected to use this approach as a way to explore any differences between guest experiences "within" each of the two respites, although we found no significant differences in guest experience between each respite. We also searched the data for negative cases, or anomalies within each theme to ensure that our analysis was on track (Padgett 1998).

Finally, peer interviewers were presented the findings to help clarify and confirm that the study team appropriately interpreted the data. As part of this meeting, interviewers participated in a discussion with the evaluation team to glean their impressions of the interview process and to note the themes and findings that stood out for them. The purpose of this meeting was to help clarify and confirm that the evaluation team correctly interpreted the information they heard during their interviews, and to better understand the context of some direct quotes. Interviewers confirmed that or understanding of the results was accurate. Thus, findings were not changed as a result of these conversations.

Results

In total, 25 individuals were interviewed for a baseline interview. Of these 45 individuals, 27 participated in a follow-up interview and were included in the present study. We elected to include only individuals with data at both time points because we were interested in guest perspectives on how useful the services were looking back on their respite stay. The exact number of individuals who declined an interview

with the study team is not known to us, since all individuals who came to stay at the respite during the study's timeframe were theoretically given a flyer and invited to participate. However, each month at Program A, a maximum of nine guests can stay per month. At Program B, a maximum of 16 guests can stay per month. Therefore, during the study's 7 months of data collection we can estimate that a maximum of 184 individuals could have been eligible to participate.

The present study includes data from interviews with 27 respite guests, which yielded a total of 54 transcripts. Previous qualitative studies have found that information becomes repetitive and little new information is gained after analyses of data collected from 20 to 30 participants, (Strauss and Corbin 1998; Miles and Huberman 1994) and some authors have suggested that saturation can be achieved with as few as 12 respondents (Patton 2002; Guest et al. 2006). According to these standards, interviews with 15–20 guest key informants is adequate to achieve saturation.

Respondents who completed both baseline and followup interviews were majority women (n = 16), and Black (n = 15), with average age of 48 (range = 20–56) (see Table 1). Eighteen respondents completed only the baseline interview (and were not included in the present study). These individuals were majority male (n = 10), Black (n = 8), and had an average age 49 (range 20–59). While we are unable to report the exact extent to which our study sample differs from the demographics of guests at these respites, an annual report prepared for the Department of Mental Health that was compiled for evaluation purposes in the same year as the present study's data collection which indicates that our study has a greater number of Black participants, compared to the respites' guest population (61 vs. 30% at Program A, and 50 vs. 32% at Program B). The study sample from Program B also had a greater number of Latino participants, compared to Program B's guest population (28 vs. 17%). The annual report also indicates that the respondents included in the present study are similar to the overall guest populations of both respites in terms of age.

Analysis of pre and post guest interviews revealed about 20 codes related to utilization of peer respite services. These codes were then organized into three broader themes that were salient across both respite settings—the first of which was captured through an in vivo quote: (1) "A normal person wouldn't understand me;" (2) Benefits of shared living; and (3) Life after the respite. Each theme is described below.

A Normal Person Wouldn't Understand Me

For many participants, being in an environment with other persons who have mental illness and peer-staff normalized the experience of having a mental illness. Several participants reported that they didn't know that so many other people were also experiencing mental illness, and one commented: "I never knew that everyone had mental health issues similar to mine." Participants described how knowing and interacting with others who were living with mental illness in the respite de-stigmatized the experience and made them feel less lonely. As one participant commented:

> They said 'I feel you.' By them feeling me, took away my shame. Took away my guilt. Took away my embarrassment and my pride because then I said, 'Oh I ain't by myself.' Sometimes when you feel isolated and you feel like you're the only one going through something like this.

Respondents also lauded respite staff for both normalizing mental illness and for providing inspiration:

> A normal person wouldn't understand me. Like a person that had symptoms like me or has suffered any type of mental illness like me, they know. And it's good because I am schizophrenic but I know, watching the next person who works here and is a peer, I know I can do it. With faith and hope, I can do anything. Absolutely it makes a difference to me.

Table 1 Demographic characteristics of study participants

Variable	Full sample (n = 27)		Program A (n = 13)		Program B (n = 14)	
	n	%	n	%	n	%
%Female	16	60	7	53	9	64
Race						
Black	15	55	8	61	7	50
Native American	1	3.1	1	7.6	0	
White	6	22	2	15	4	28
Missing	3	11	1	7.6	2	14
Multiracial or "other"	2	7.4	1	7.6	1	7.1
Hispanic	6	22	2	15	4	28
Age[a]	48.25	range 20–68	48*	range 20–68	48.5	range 35–56

[a]Mean age is reported

Guests from both programs came to stay at a peer respite for a temporary escape from a range of highly stressful situations which included lack of stable housing, custody disputes related to their children, recent car accidents, eviction, and ongoing issues with past trauma including suicide attempts and abusive relationships. According to one guest:

> When I got here I had such a burning anxiety, ball of anxiety in my stomach that it was like a big bomb that had the fuse that was ready to go off, a cannonball with the fuse lit. That's what my stomach felt like, and when I got here the staff here has diffused that bomb with their talking to me...

That the respite was staffed by individuals in recovery from mental illness was also reviewed favorably, and several respondents articulated that the peer staff instilled a sense of hope for what one could eventually achieve in the realm of personal relationships, employment, and general recovery. According to one respite guest:

> If we all have the same condition of being bipolar or depression-Or Schizophrenia or all three, which I have-I find that it feels really good to see them working and participating-And sharing what they can share about their experiences. And it makes me feel good. Like, I'm not so far down the scale that I can't get back up myself…Maybe I can go get a job.

Participants described how the staff's lived experience also increased the feeling of safety:

> They know what to look for. They know, they understand. There's not just staff that are psych techs or something. You know, they get it. They're here to help you.

Nevertheless, a notable minority of guests (i.e. "negative cases") questioned the credibility of peer staff and were skeptical that people who also had mental illness could be trusted to oversee the respite. As one guest vividly remarked, a peer respite was:

> Like having a zoo run by the monkeys. The people were not professional, they all have their own mental health problems, and there's no person of responsibility or authority in charge of overseeing them.

Some participants were also concerned that peer staff lacked training required to handle crisis situations or psychiatric emergencies and argued that "People that are specialists can do more." Some participants also expressed the concern that, because they have mental illness, the staff were at risk for a psychiatric crisis themselves:

> I was just uncomfortable. I was like "I wonder if they are going to go off." If they are going to go off, they going to go off on me. How sick are you? Are you in crisis right now? Like, I'm in crisis, because if you're in crisis right now and I'm in crisis together that ain't going to work.

Still, the overall response from participants was that having respites run by peers would help avert crisis and facilitate guests' recovery.

Benefits of Shared Living

The communal environment of the peer-respites provided opportunities to develop and utilize interpersonal and coping skills. As one guest commented: *Here you live in close quarters with people you don't know, so you get used to speaking to people you don't know*. According to another participant, a benefit of the respite was:

> Learning how to live with people that you don't agree with and getting through it without running away or cussing or stuff like that.

Although conflict was at times unavoidable during a respite stay, the combination of group living and team-building activities provided opportunities to utilize the interpersonal skills gained through structured self-help groups. According to one respite guest:

> My mouth muscles. I'm in control of that. That's one of the biggest things I learned and that's what I really came here for. And I learned how to cope when people talk to me a certain way. I'm not going to beat them up or try to kill them like I used to, it's just, it's amazing what this place did for me in 10, 8 days. Yeah, that girl that was sitting here, I ain't her.

Both programs were situated in house-like buildings, and several participants commented on role of the built environment in creating a culture of camaraderie and mutual support. The physical living spaces included several bedrooms inhabited individually or by two persons, plus common areas in the kitchen, living room, and outdoor space on the respite property. According to one guest:

> I like the downstairs, it's kind of a big open area and everyone sits around-Because you're not allowed to go sit in a corner somewhere by yourself because that's not what we need. That's not why we're here.

Guests of Program B were expected to plan, shop for, and then prepare meals together using a budget provided by the respite. The respite space was designed accordingly.

> I love that kitchen. It's an appropriate working kitchen. Especially for big groups, and it works perfectly. You go from this counter, to the stove, to the sink, to the dishwasher, and then to the area where you serve it.

> People go out, pick up the plates, and the big dining room table where everybody can sit around.

Despite the comraderie that accompanied communal living, a minority of respondents (i.e. negative cases) described moments of frustration that resulted from living in close quarters, and one respondent referred to the communal nature of the respite as "a whole bag of problems." In program B, these moments of conflict were frequently related to the expectation that they would shop for and prepare meals together:

> You can't please everybody…This is what was frustrating, it's the food because everybody wants to make it their way. We only have a $32 budget…

However, there were still others who described the process of achieving consensus as learning experience.

Life After Respite

While most guests agreed that their stay at the respite was beneficial, several guests noted that they would have preferred a longer stay. As one participant explained,

> It's like a baby. We have to crawl all over again. I feel that really can't be done in 30 days. It takes time. Like me, 30 days, it's fine, but I feel more, a little, maybe two months, maybe 60 days. Maybe, since this place is limited with the rooms, maybe 60 days can help people.

Some also described apprehension towards the end of their stay, and others did not want to leave at all.

> It's still a fear there, right now saying I'm anxious and I'm scared because I know I've got to move. This is a temporary.

Also of note, following the respite stay several participants were still facing homelessness or other difficult personal situations, and some expressed feeling that their service needs had not yet been met. This resulted in at least some participants expectation that they would likely return:

> Like I said to you earlier, I hate today…tomorrow is my last day, but I'm going to come back again, in about another two months.

Nevertheless, many guests reported experiencing positive life changes following their respite stays that were most likely to be expressed during their follow-up interview as they reflected on their time at the respite. Several guests were adamant that their respite stays had contributed to improved abilities to cope with their psychiatric symptoms. According to one guest: "I gave [my symptoms] a name. I call it the Idiot. When it starts talking. I call it the Idiot." In general, study participants noted that the encouragement from staff and from other respite guests was something that they carried with them through their follow up interviews which were several months following their stays. According to one guest:

> I'm more in focus than I used to be. They gave me some good tips while I was in there...One day there was an activity. She puts down a piece of paper in front of me, and it said, "5-year goal." I'm like, how are you giving this to me, 5-year goal? I don't even know what my goal is for tomorrow She says, "Turn the page over," and it says, "Day 1."

Discussion

This study found that peer respites have the potential to create a beneficial space within the mental health service system that can allow guests to temporarily escape stressful situations while building relationships with other persons who are also living with mental illness, and avoid the authoritative nature of the traditional mental health system. From this analysis we have three main points of discussion.

First, our study identified a tension between the participants' enjoyment of a peer respite and a contradictory questioning of the limited structure of respite programing and peer provider credibility. Most participants in this study appreciated the lived experience of the respite staff and often found the respite staff to be good role models for recovery. However, some found the lack of structure and authority at respites to be problematic and believed that the lack of a professional who is actually in charge jeopardized the recovery of others at the respite. Previous studies have described lack of structure to the peer role as a challenge to implementing peer providers in community mental health settings (Gates and Akabas 2007; Mancini 2017). That participants in the present study found the lack of structure and authority to be worrisome could speak to the need to clarify and add structure to the roles of peer providers delivering care in community mental health settings. This finding could also indicate a need to create and clarify ground rules at the beginning of a given groups' respite stay, as has been done by consumers of previous peer-based services previously (Whitley and Siantz 2012). Service providers who connect consumers with peer respites should also be clear on what respires are, so that potential respite guests know what to expect, and whether a respite would be a therapeutic place for them.

That study participants regarded peer providers both as recovery exemplars and as lacking in credibility are also consistent with prior literature (Austin et al. 2014). One explanation for why guests were troubled that the staff lacked formal training could be the result of internalized

stigma of mental illness. Internalized stigma, also called *self* or *felt* stigma, is a process whereby individuals affected by mental illness endorse stereotypes about mental illness, anticipate social rejection, and believe that they are devalued members of society (Livingston and Boyd 2010). The skepticism about respite staff also having mental illness could be the embodiment of the negative stereotypes that persons with mental illness are not trustworthy or are not able to maintain employment. Peer respites in the future might consider offering group interventions that address self-stigma at the individual level. For example, ending self-stigma (Lucksted et al. 2011) is a structured group intervention to help people with SMI reduce internalized stigma, and could be an appropriate and effective anti-self-stigma intervention to delivery in a peer respite. Alternately, there could be genuine cases where the peer staff are not trained appropriately, or an individual peer hire is not an appropriate fit for the organization, which could be unrelated to having a mental illness.

Our second point of discussion relates to the perceived changes in the lives of respite guests following their stay. Whereas several participants found the experience to be extremely beneficial for the development of coping skills and for getting connected with social services, others reported that they did not benefit from staying at a respite. This could suggest a need to clarify and communicate the intent of the respites and the types of goals that can be accomplished during a time limited stay. Although previous research has evaluated how a respite affects use of hospital based services among participants (Croft and Isvan 2015), additional research is needed to understand their potential for improving additional consumer-level outcomes. Potential domains to explore could be related to changes in empowerment and quality of life. This also leads to a larger question regarding the mental health service community's expectation regarding the benefits of peer respites, and how researchers will know when a desirable outcome has been achieved. An additional consideration is whether and to what extent respite guest outcomes should improve in the long term, given the brief nature of a respite stay; and whether peer respites are beneficial in their own rights, or should be considered as part of a larger continuum of services.

A final point of discussion pertains to the usefulness of peer interviewers for a collection of these data. The need for and the utility of peer interviewers in mental health research have both been documented in the literature (Croft et al. 2016). The present study found that peer interviewers were an effective means for collecting data at two different time points with this study population. Further, transcripts demonstrated several moments where peer interviewers related with the study participants by normalizing mental health and social services needs. There were several instances throughout the interviews where the interviewers applauded the participants for achieving their recovery goals, and other moments when they probed gently to make sure that the study participant was not in crisis or suicidal. It is possible that the shared experience of recovery from mental illness increased the comfort of study participants, and helped ensure the high level of participation. It is also likely that the peer interviewers elicited more candid interviews and higher levels of disclosure from participants, relative to non-peer interviewers.

There were also challenges to using this approach. Conducting semi-structured interviews was a new experience for the peer interviewers, and despite having received training, the lack of previous experience in conducting qualitative interviews may have impacted the data quality. For example, during data analysis, it became clear that the interviewers did not probe as consistently as a more experienced qualitative interviewer might have. The interviewers were also reluctant to deviate from qualitative questionnaire to follow relevant, but off script topics that emerged during conversations. The authors want to be clear that this relates to the peer interviewers' novice interviewing skills, and not their mental health status. Regardless, we found the benefits to outweigh the downside to using peer interviewers. Future studies should also include peer interviewers to build rapport with study participants, and to ensure that that the right questions are being asked.

Limitations and Strengths

These findings should be taken in light of some limitations. First, participation in the study was voluntary and so was based on a self-selected sample of participants. Thus, this sample's responses are not necessarily indicative of the full range of views on this topic. Since we employed a convenience sampling approach, we are not able to generalize these results to other respite guests in this service setting, or elsewhere. As our study only considers the views of respite guests, future research should also include the perspectives of the respite staff. Further, from these data we are not able to comment on the efficacy and effectiveness services at these respites. Future studies should evaluate outcomes as well as process to assess overall influence of such centers.

This study also had a number of strengths. We employed many strategies to ensure the rigour of this qualitative study which included use of peer interviewers, co-coding by independent reviewers, sharing findings with peer interviewers throughout the course of analysis, and prolonged engagement with study participants. Further, this study was designed in collaboration with the respite staff, which is an approach that is commensurate with the respites' consumer driven philosophy.

Conclusion

This study contributes to a limited but growing body of literature on peer respites from a respite guest perspective, and highlights the benefits and challenges to implementing and utilizing these programs. Peer respites have the potential to be spaces of learning, growth, and community for their guests. However, additional work is needed to identify specific outcomes that can be targeted by these services. As we move towards a more recovery oriented mental health system, these efforts are necessary to help consumers of peer based services thrive.

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Compliance with Ethical Standards

Conflict of interest The authors declare they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with and the 1964 Helsinki declaration its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants in the study.

Research Involving Human Participants The Institutional Review Board of University of California, San Diego, Human Research Protection Program, and the Office of Statewide Health Planning and Development approved this study.

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