KEEP THE PROMISE COALITION
Advocacy and action for Connecticut's mental health

May 2nd, 2023

Commissioner Nancy Navarretta
Department of Mental Health and Addiction Services
410 Capitol Ave,
Hartford, CT 06134

CC: Julienne Girard, Donna LoCurto

Dear Commissioner Navarretta,

We are writing as advocates for the introduction of peer-run respite programs in Connecticut, and nationwide. We were excited to see that DMHAS recently released a Request for Proposals for peer respite. This follows two March 2022 DMHAS town hall meetings which demonstrated clear enthusiasm amongst the Connecticut recovery community for the introduction of peer respites in our state. While we appreciate steps taken by the Department to achieve this, we are deeply concerned by the Request For Proposals (RFP) dated April 10th titled Evidence Based Practice Peer Respite Program.

Our coalition has spent significant time and energy researching the most effective models of peer respite. We are concerned that the requirements outlined in this RFP conflict with the core components and values of peer respites nation-wide, as well as the suggestions raised by the peer advocacy community, including the participants of the 2022 peer respite town hall meetings.

A number of advocates, including those from Keep The Promise Coalition, have submitted questions through the RFP's formal Q&A process regarding these areas of concern. The intent of this letter is to provide further explanation of those concerns.

**Regarding the Provider Organization:**

We are concerned that the RFP only minimally requires the responding provider organization to have experience with the provision of peer support services. As currently written, a clinical organization with only a small number of peer supporters and 501(c)(3) status over the past two years would qualify. Organizations lacking extensive experience of providing peer services are notoriously challenged by implementing peer-to-peer supports in ways that are consistent with the integrity of those supports. Therefore, **the RFP should make explicit requirements that the responding provider organization have much more extensive experience with peer support, including the following:**

- A minimum of 5 years of demonstrated experience employing people in both direct peer support and peer leadership roles;
- Evidence of incorporation of relevant values into organizational practice;


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- Demonstrated practice of seeking input from individuals receiving supports and other community stakeholders, and incorporating that input into practice; and
- A strong preference for a peer-led organization as defined by a majority of Board Members and employees (including those in key leadership roles) identifying as having a personal history with psychiatric diagnosis and/or substance use.

Furthermore, the RFP only requires that the program's advisory group consists of 51% individuals with lived experience. Given longstanding power imbalances between people with psychiatric history and clinical providers, we are concerned how requiring only a simple majority of people with lived experience, and not explicitly requiring that members of that group be peer supporters, might affect the integrity of the peer services offered at the respite. We recommend that **the advisory group consist entirely of people with lived experience, including a majority peer supporters,** who are familiar with the services offered by respite staff. This is common amongst existing peer respites, and is designed to prevent mission drift and maintain the integrity of services.

**Regarding the Respite Environment:**

We are also concerned that the predetermined site at Southeast Mental Health Authority is located on a clinical campus, and is therefore not suitable for a peer respite. Data from respites in our neighboring states, such as Afiya in Massachusetts, makes clear that many respite guests have prior experience with hospitalization, and that many do not favorably reflect on time spent in clinical settings. **Part of the appeal of peer respite is the non-clinical feel of the services and environment**. In contrast to clinical settings, peer respites are located in home-like environments, and many are located within residentially-zoned neighborhoods. This provides a greater sense of integration with community, and helps differentiate the respite from inpatient services. **This is not achievable on a state clinical campus.**

The trust gained through providing privacy is another core component of many respites' success. In Afiya's 2021 report, guests reported the sense of privacy as an essential feature contributing to the peer respite's positive impact. While we are aware of the addendum issued on April 24th, 2023, which would provide two private as well as two shared bedrooms, we are concerned by the fact that this RFP would still not provide all respite guests with the dignity of private bedrooms during their stay. **This approach is not trauma informed.** Placing two guests in a single room detracts from the home-like feel of a respite, and violates the sanctuary of each guests' privacy and sense of safety. Many guests who are not afforded a private room will experience serious distress sharing a room with a stranger— this is especially true for people who are survivors of domestic or sexual violence, and gender minorities. This is not conducive to the purpose of recovery. For this reason, most respites provide guests with rooms on a 1:1 basis. Iris Place, a peer respite in Wisconsin states on their website that guests can expect *"[their] own private, locking bedroom"* If the goal of this RFP is to host up to 6 guests at a time, **the provider organization should be allowed to choose a more suitable location which can accommodate this, while maintaining each guest's privacy.**



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The chosen location also only has space for one common area, which would be shared between 8 people, guests and staff. Given that the RFP has also required the respite to host regular monthly alumni meetings, we are concerned how this single space could be effectively used simultaneously by all respite guests and staff for private conversations, group events, and other respite activities. **A greater number of common areas is required to effectively manage respite activities.**

**Regarding the Target Population:**

The stated target population of this RFP is individuals who are in *"distress and/or in urgent or emergent mental health/substance use crisis."* However, we are concerned that this RFP would exclude many individuals who are most likely to benefit from peer respite.

Specifically, we are concerned that it excludes individuals as they are directly discharged from inpatient or emergency settings, for the reason that *"it is assumed that the crisis which precipitated the admission would be resolved by the time of discharge from an inpatient setting/emergency room."* **This assumption is broad, sweeping and incorrect.** Research has consistently shown an enduring high suicide risk following an individual's discharge from inpatient and emergency settings. If anything, these findings indicate the need for more support post-discharge, not less. Peer respites are well positioned to provide this support to individuals emerging from these settings who experience ongoing crisis and suicide risk. Furthermore, according to Afiya's 2021 report, the majority (63%) of respite guests reported prior hospitalization. **Disqualifying those who are emerging from a hospital setting from respite eligibility is contrary to the purpose of a peer respite, and <u>will leave these individuals at risk during the critical post-hospital discharge period.</u>**

Additionally, we are concerned that the RFP states that people may be excluded from respite *"due to legal issues that prohibit him/her to be in proximity to a daycare, school, etc."* **This provision will exclude many who can benefit from the respite's services.** The respite's stated target population is disproportionately more likely to have prior justice involvement, and many of the issues that might lead to their exclusion can be solved by **moving the respite outside of the proximity of daycares, schools, etc., rather than placing it at the predetermined site.**

**Regarding Referrals and Clinical Requirements:**

The nature of the referral system remains unclear. We hope that DMHAS will not require the respite to take referrals from clinicians, police departments, etc. The success of peer respites is built on the fact that they remain a **<u>voluntary service.</u>** Referrals made by clinicians, police officers, or others may intentionally or unintentionally come across as coercive, and individuals who feel peer respite does not suit them may feel pressured to go along. Utilizing a formal referral system may erode the voluntary nature of peer respite services, and thus work counter to the basis of the program's efficacy. Instead, **we recommend that the role of police, clinicians, and others be that of messengers,** who will inform individuals of the peer respite option and support them in accessing it independently, rather than making formal referrals.



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Furthermore, we support the right of each individual to choose whether to bring their medications into the respite. However, we would appreciate clarification concerning the requirements in this RFP surrounding medications, such as those used for treatment of Substance Use Disorder, or mental health conditions. Specifically, **if DMHAS were to require the handling of medication by respite staff, we are concerned how legal requirements surrounding the provision or distribution of medication might affect the non-clinical nature of the peer respite.** Respites in other states provide guests with locked storage boxes for the safekeeping of medication and valuables. This approach avoids clinical legal requirements related to the distribution of medications. Given the context of coercive histories and power imbalances of prescriber-client relationships, **we support voluntary self-administration**.

**Services and Staffing:**

We are also concerned that this RFP is overly prescriptive about which program components and support services should be provided. While many of the services mentioned should be offered, **it is critical that respite guests have the agency to voluntarily choose which interventions and approaches they believe will work best in accordance with their goals.** It should be up to guests, and the peer supporters who work with them, to determine which programs and services to offer at the respite in a manner which is responsive to community needs. Many respites offer services in this manner. Guests at Rose Houses, an often-cited respite model in New York for example, *"have access to a full, customizable menu of services"*.

The RFP also calls for staff who are *"Connecticut certified/trained peer specialists."* Staff at many peer respites utilize skills learned from Intentional Peer Support (IPS) training. This is an intensive training program which many respites utilize in place of State certification programs which may not be relevant to respite work. Furthermore, although rigorous for substance use related peer support, the Recovery Coach training from Connecticut Community for Addiction Recovery (CCAR) does not substantially address mental health, and thus peers trained by CCAR would require additional training. **We recommend prioritizing IPS training for respite staff.**

In summary, the model outlined in this RFP makes specific requirements that are inconsistent with successful peer respite models, and should not be considered a peer respite without significant revisions. **We hope that DMHAS will consider putting forward a less prescriptive RFP which allows peer respite staff and clients the ability and flexibility to independently set goals and shape their respite stay in a useful, contextually, and culturally appropriate manner.**

Thank you for your consideration,

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