Addendum 2

State of Connecticut Department of Mental Health and Addiction Services

RFP# DMHAS-EBP-Peer Respite Program-2023

The State of Connecticut Department of Mental Health and Addiction Services is issuing Addendum 2 to the **Evidence Based Practice Peer Respite Program Request for Proposals.**

Addendum 2 contains changes to the following sections:

A. **Procurement Schedule - A change has been made to Legal Notice Section I. General Information, B. Instruction 4. Procurement Schedule** (page 4 of the original RFP) is hereby deleted and replaced with the following:

4. Procurement Schedule. See below. Dates after the due date for proposals ("Proposals Due") are non-binding target dates only (*). The Agency may amend the schedule as needed. Any change to non-target dates will be made by means of an amendment to this RFP and will be posted on the State Contracting Portal and, if available, the Agency's RFP Web Page.

RFP Released	4/10/2023
Letter of Intent Due	5/01/23 by 3:00 pm
Tour of Program site – (self-tour)	5/04/23 at 10:00 am to 11:30 am
RFP/Bidder's Conference Date	5/04/23 at 2:00 pm
Deadline for Questions	5/11/23 by 3:00 pm
Answers Released	5/18/23 by 3:00 pm
Proposals Due (New Date)	**6/15/23 by 3:00 pm**
(*) Proposer Selection	TBD
(*) Start of Contract Negotiations	TBD
(*) Start of Contract	8/1/2023

B. **Contract Awards - A change has been made to Legal Notice Section I. General Information, B.5. Contract Awards** (page 5 of the original RFP) is hereby deleted and replaced with the following:

5. Contract Awards. The award of any contract pursuant to this RFP is dependent upon the availability of funding to the Agency. The Agency anticipates the following:

- **Funding Available: $650,000.00 annually**
- Number of Awards :1 at the discretion of DMHAS
- Contract Cost: TBD by DMHAS
- Contract Term: 3-year term. DMHAS has the right to extend this Contract based on funding availability
- Funding Source: Federal; Safer Communities Mental Health Block Grant/ State Funding

C. **Electronic Proposal Due Date and Time – A change has been made to the Legal Notice Section I. General Information B. Instruction 11. Electronic Proposal Due Date and Time** (page 6 of the original RFP) is hereby deleted and replaced with the following:

11. Electronic Proposal Due Date and Time. The Official Contact is the **only authorized recipient** of proposals submitted in response to this RFP. Proposals must be **received** by the Official Contact on or before the due date and time:

- **Due Date: June 15, 2023**
- **Time: 3:00 PM EST**

Proposals received after the due date and time will be ineligible and will not be evaluated. The Agency will send an official letter alerting late respondents of ineligibility.

An acceptable submission must include the following:

a. One (1) conforming electronic copy of the original proposal.

b. The proposal must be complete, properly formatted and outlined, and ready for evaluation by the Screening Committee.

c. The electronic copy of the proposal must be emailed to the Official Agency Contact for this procurement. The subject line of the email must read: **DMHAS-EBP-Peer Respite Program-2023.** Required forms and appendices may be scanned and submitted as PDFs at the end of the main proposal document. Please ensure the entire email submission is less than 25MB as this reflects The Agency's server limitations. Respondents should work to ensure there are not additional IT limitations from the provider side.

D. **Budget and Budget Narrative - A change has been made to Legal Notice Section II. Purpose of RFP and Scope of Services C. Scope of Services Description 8. Budget and Budget Narrative** (page 12 of the original RFP) is hereby deleted and replaced with the following:

8. Budget and Budget Narrative

a. The program will be funded at $650,000 annually.

b. Proposals must contain an itemized annual budget on the budget form delineated in Section VI. Appendix, E. Budget and Budget Narrative, of this RFP. All startup cost must be reflected on a separate budget.

c. Budget narratives must be provided, explaining all costs contained in the budgets (Annual Budget and Startup Cost Budget). All start-up costs must be listed separately and clearly detailed in the start up cost budget narrative.

d. All other funding, including agency financial support must be identified.

   i. Complete a price schedule, budget, or cost proposal in its entirety that will enable the effective delivery of the proposed project or services.

   ii. Describe all direct and indirect costs associated with the service or project.

iii. Describe any key cost variables for the service or project such as volume, frequency, duration or length.

iv. Narrative and justification: Present a detailed, line-item cost narrative that explains the basis and rationale for the costs proposed.

v. Describe how your costs are reasonable, given the nature of your proposed project or service.

vi. Describe any key budgeting decisions you faced, assumptions, or calculation approaches used to develop the cost proposal.

E. **Cover Sheet - A change has been made Legal Notice Section VI. Appendix D. Cover Sheet** (Page 33 of the RFP) is hereby deleted and replaced with the following:

D. COVER SHEET

DMHAS-EBP-Peer Respite Program-2023
Department of Mental Health and Addiction Services
Due Date: 6/15/2023 3:00 PM EST

Primary Business Name | FEIN # & DUNS#

Business Address | Telephone Number

Town, State | Zip Code

Contact Person: (*Individual other than Authorized Official who can provide additional information about the proposal or who has immediate responsibility for the proposal*)

Name | Title

Street Address | Town, State, Zip Code

Telephone Number | Facsimile Number | E-mail Address

Authorized Official: (*Individual empowered to enter into and amend contractual instruments in the name and on behalf of the Contractor*)

Name | Title

Street Address | Town, State, Zip Code

Telephone Number | Facsimile Number | E-mail Address

Signature

Total Amount of Proposal: _____

F. **Equal Employment Opportunity – A change has been made Legal Notice Section VI. Appendix G. Equal Employment Opportunity** (Page 39 of the Legal Notice) is hereby deleted and replaced with the following:

Please see link below for the EEO form or contact your Official Contact person for the form
Home (eeocdata.org)

G. **Proposal Checklist - A change has been made Legal Notice Section VI. Appendix I. Proposal Checklist** (Page 42 of the RFP) is hereby deleted and replaced with the following:
This is a tool for agencies to customize to make response process easier for respondents. It should be customized for each RFP. Agencies may determine to remove it if it causes confusion.

To assist respondents in managing proposal planning and document collation processes, this document summarizes key dates and proposal requirements for this RFP. Please note that this document does not supersede what is stated in the RFP. Please refer to the Proposal Submission Overview, Required Proposal Submission Outline, and Mandatory Provisions (Sections II, III, and IV of this RFP) for more comprehensive details. It is the responsibility of each respondent to ensure that all required documents, forms, and attachments, are submitted in a timely manner.

Key Dates

Procurement Timetable The Agency reserves the right to modify these dates at its sole discretion.		
Item	Action	Date
1	RFP Release	4/10/2023
2	Letter of Intent Due	5/1/2023 by 3:00 pm
3	Tour of Program Site	5/4/2023 from 10:00 am
4	RFP/Bidder's Conference Date	5/4/2023 at 2:00 pm
5	Deadline for Questions	5/11/2023 by 3:00 pm
6	Answers Released	5/18/2023 by 3:00 pm
7	Proposals Due	6/15/2023 by 3:00 pm
8	(*) Proposer Selection	TBD
9	(*) Start of Contract Negotiations	TBD
10	(*) Start of Contract	8/1/2023

Proposal Content Checklist

☐ **Cover Sheet** including required information:
☐ **Table of Contents**
☐ **Executive Summary**: high-level summary of proposal and cost
☐ **Main proposal and with relevant attachments**. *Proposers should use their discretion to determine whether certain required information is sufficiently captured in the body of their proposal or requires additional attachments for clarification*.
Additional attachments may include (bullets below are examples only):
- Organizational Expectations
- Services Expectations/Scope of Services
- Staffing Expectations

- Data and Technology Expectations
- Culturally Competence
- Work plan
- Financial Expectations
- Budget and Budget Narrative (Include startup cost)

Registration with State Contracting Portal (if not already registered):

☐ Register at: https://portal.ct.gov/DAS/CTSource/Registration
☐ Submit Campaign Contribution Certification (OPM Ethics Form 1): https://portal.ct.gov/OPM/Fin-PSA/Forms/Ethics-Forms
☐ **Valid Unique Entity Identifier (UEI)** obtained through www.sam.gov
☐ **Acknowledgement of Contract Compliance – Notification to Bidders**
☐ **Equal Employment Opportunity**
☐ **IRS Determination Letter** (for nonprofit proposers)
☐ **Two years of most recent annual audited financial statements; OR any financial statements prepared by a Certified Public Accountant** for proposers whose organizations have been incorporated for less than three years.
☐ **Proposed budget**, including budget narrative and cost schedules for planned subcontractors if applicable.
☐ **Conflict of Interest Disclosure Statement**
☐ **Statement of Assurances**
☐ **Declaration of Confidential Information**
☐ **Organizational Chart**
☐ **Resume of Key Personnel**

Formatting Checklist

☐ Is the proposal formatted to fit 8 ½ x 11 (letter-sized) paper?
☐ Is the main body of the proposal within the 15-page limit?
☐ Is the proposal in 12-point, Times New Roman font?
☐ Does the proposal format follow normal (1 inch) margins and 1 ½ line spacing?
☐ Does the proposer's name appear in the header of each page?
☐ Does the proposal include page numbers in the footer?
☐ Are confidential labels applied to sensitive information (if applicable)?

H. Questions and Answers

Below please find DMHAS official responses to the following questions received prior, during and after the Bidder's Conference:

In the event of an inconsistency between information provided in the RFP and information in these answers, **the information in these answers shall control.**

Questions related to location of the Program

1. **Question: Why is there a pre-determined site in what appears to be a clinical complex? Peer respites should not be in medical buildings nor associated with medical/clinical complexes. Doing so will reduce any sense of being in a 'homelike' environment and will reduce the ability**

of the program to reach folks who are already alienated from these systems and perhaps may most need to access peer respite supports.

Answer: The Uncas on the Thames Campus is not a medical or clinical complex. It houses multiple entities and has many free-standing houses on the campus. The identified site provides a home-like environment.

2. **Question: Why are there shared bedrooms? This is not the norm within peer respites and is among the many harmful elements of clinical environments. Not only will it cause harm to people who have trauma histories and whose distress will be exacerbated by sleeping around strangers, but it immediately makes the space less accessible to trans and non-binary people who have typically experienced extensive discrimination and marginalization in conventional clinical environments.**

   Answer: The use of available bedrooms will be determined in collaboration with those seeking a respite stay.

3. **Question: The space you have chosen appears to have only one common area for 8 people (two people working and six people staying at the respite). How do you anticipate this working while also creating space for private conversations, optional activities, watching TV, having visitors, etc.?**

   Answer: There are several areas in the setting that allow for private conversation as well as outdoor space.

4. **Question: Under the RFP, will it be considered responsive for the applicant to propose locating the respite in a home-like setting and/or in a facility integrated within a residential community, rather than the identified location at Southeast Mental Health Authority?**

   Answer: No; the location of the site is 401 West Thames Street, Norwich, CT

5. **Question: Under the RFP, will it be considered responsive for the applicant to propose locating the respite in a facility providing for bedrooms which are entirely single-occupant and may be locked by the occupant?**

   Answer: No; the identified site has two single occupancy bedrooms and two double occupancy bedrooms to accommodate a maximum of six individuals.

6. **Question: Under the RFP, will it be considered responsive for the applicant to propose accommodating a maximum of less than 6 guests at any given time?**

   Answer: Yes; we expect an overall average of 90% utilization for the year, so that allows for times when less than six people will be in the program.

7. **<u>Question:</u> Under the RFP, will it be considered responsive for the applicant to propose locating the respite in a building offering more than one common area, to provide for multiple and flexible uses and to accommodate functions involving visitors?**

   <u>Answer:</u> The 401 West Thames Street location has more than one common area.

8. **<u>Question:</u> Under the RFP, will it be considered responsive for the applicant to propose locating the respite in a facility which may legally be sited outside of proximity to daycare, schools, etc., so as not to limit respite services to only those clients who are not excluded by any applicable law?**

   <u>Answer:</u> No; the location will be on the 401 West Thames Street campus.

9. **<u>Question:</u> It is extremely unusual and generally seen as harmful to have a peer respite based on a medical/clinical campus of any kind, and will likely deter many people from using it and impact the efficacy of the house. Is there any option to move the space to a community location?**

   <u>Answer:</u> We are not planning to locate the peer respite at another location.

10. **<u>Question:</u> Peer respites generally avoid having shared rooms as it is not trauma-informed for anyone and reduces accessibility for a number of people including gender minorities. If the space on the clinical campus must be used, will you reconsider how many people can stay at a given time? (Most peer respites have fewer than 6 people staying at a time.)**

    <u>Answer:</u> The capacity will remain six (6).

11. **<u>Question:</u> How do you intend to ensure accessibility to trans and other gender diverse people? At the Bidder's conference you said gender minorities, domestic violence survivors, etc. will be prioritized for single bedrooms. However, this prioritization system is likely to break down in several ways. Will people be required to move to shared bedrooms mid-stay if a trans person wants to enter? (This is likely to be extremely disruptive and not trauma-informed for people being asked to move.) Will you force anyone who doesn't fit the prioritized groups to share bedrooms and leave singles vacant? (Given the vast majority of individuals with psychiatric histories are abuse survivors, won't most people fit a prioritization category?)**

    <u>Answer:</u> The details of the prioritization process will need to be worked out during the implementation process.

12. **<u>Question:</u> Can you clarify the modifications and how many accessible bedrooms and bathrooms there will end up being?**

    <u>Answer:</u> There will be one ADA accessible single-occupancy bedroom and one ADA accessible full bathroom (both on the first floor of the peer respite).

13. **<u>Question</u>: The location of the proposed peer respite is concerning because of the uncontrollable influence the clinical culture will have on the operations of the peer respite. Can the RFP increase by $75,000 to enable the organization to pay occupancy costs and the peer respite be re-located to the community?**

    <u>Answer</u>: No; the location of the peer respite will be at the 401 West Thames Street campus.

14. **<u>Question</u>: The shared rooms pose a risk to the emotional security of people within the space. It is not trauma informed, gender affirming, or culturally responsive to have co-sleeping spaces among strangers. Can you reduce the total occupancy of the peer respite to allow for single rooms, or increase the budget to allow for modification to either subdivide the rooms or add an addition to the house for more rooms?**

    <u>Answer</u>: The identified site has two single occupant bedrooms and two double occupant bedrooms to accommodate for a maximum of six individuals. Some individuals may choose to have an individual bedroom while others may choose to share a bedroom. The use of space should be determined by the preference of those seeking a respite stay.

15. **<u>Question</u>: Can you please identify the property owner and the contact information for a previous tenant who would offer a reference?**

    <u>Answer</u>: The Connecticut Department of Administrative Services (DAS) is the property owner.

16. **<u>Question</u>: If you will not reduce the number of people staying – and given you are already intending to do construction – will you consider adding enough bedrooms so that there are six total bedrooms during renovations?**

    <u>Answer:</u> The cost and time to construct two additional bedrooms has not been allocated for this project.

17. **<u>Question:</u> The house (Cottage 7) already has four bedrooms upstairs. What exactly are the renovations planned to make the house accessible, and how would there not still be 4 bedrooms upstairs (i.e., more than 4 bedrooms total if one or more bedrooms are added downstairs… Note: Peer Respites do not need an 'office,' but should**

also have a small room where work can be done by either people working or staying at the respite)

Answer: Renovations are described in Addendum 1. The selected vendor can set up the house in a way that meets the needs of the program.

18. **Question: Peer respites generally avoid having any shared rooms as it is not trauma-informed for anyone and reduces accessibility for a number of people including gender minorities and victims of domestic violence. Prioritizing people who might most need the privacy does not change the fact that almost everyone will benefit from privacy, and having strangers sleep together when in crisis is not consistent with peer-to-peer or trauma-informed values. Will you reconsider reducing how many people can stay at a given time to match the number of bedrooms available? (Most peer respites have fewer than 6 people staying at a time.)**

    Answer: At this time, the expected capacity is six, but we know there will be fewer individuals than that at times. Overall, we would expect 90% utilization for the year. We are open to collaborating on changes that are needed by the program over time.

Questions related to Organizational Requirements

19. **Question: Why is there no preference for peer-run organizations? Clinical organizations are notoriously challenged by implementing peer-to-peer supports in ways that are consistent with the integrity of those supports. Why doesn't the RFP at least establish a substantial requirement for experience with peer support? The way it's currently written, a clinical organization with minimal numbers of peer supporters over the last year or two would qualify.**

    Answer: The RFP is intended to provide the opportunity for a variety of qualified bidders, based upon the minimum qualifications, to apply.

20. **Question: Why did you not prioritize peer-run organizations or at least designated SUBSTANTIAL experience with peer support (at least 5+ years developing not only peer support but also peer leadership roles, etc.)? Will groups who are peer-run or have that substantial experience be prioritized?**

    Answer: All proposals will be reviewed in the same manner based upon the evaluation criteria.

21. **Question: Who will the grantee report to?**

    Answer: The grantee will be considered an affiliate organization of the Southeastern Mental Health Authority.

22. **Question: If you are going to keep everything the same, would you consider calling this a clinical crisis respite with peer support integrated? That appears to be what you have, and it will cause national problems and risk to the model if you call this as a peer respite.**

    Answer: We do not anticipate changing the name.

23. **Question: Peer-run organizations were not prioritized in the RFP. Will you consider prioritizing peer-run organizations or those with established peer recovery programming that is staffed and supervised by peers?**

    Answer: All proposals will be reviewed in the same manner based upon the evaluation criteria.

24. **Question: During the bidder's conference, it was mentioned that the organization who secures the peer respite contract will report Southeast Mental Health Authority – acting as the contract monitor. Is that accurate? Will the organization be required to report in DDAP? Will the organization be required to collect diagnoses and store Protected Health Information?**

    Answer: The organization will be an affiliate organization of the Southeastern Mental Health Authority. The organization will be required to report in DDAP.

25. **Question: Why did you not prioritize peer-run organizations? No peer respite operating under a clinical organization will be considered a full peer respite. (It will be a hybrid.) Additionally, peer respites operating under clinical organizations almost invariably face greater struggles in maintaining fidelity to the model. Will you consider changing this? (Note: In the Bidder's Conference you failed to differentiate between prioritization and exclusion criteria. Prioritization simply means extra points awarded when evaluating responses. It does not rule out other organizations applying.)**

    Answer: See question #20

26. **Question: Why did you not prioritize organizations (peer-run or not) that have substantial experience with peer support (rather than any amount of peer support as is currently stated in the RFP)? Substantial experience with peer support would mean a minimum of 5 years developing and sustaining not only direct peer support roles, but also leadership peer support roles.**

    Answer: See question #20

27. **Question:** **Co-optation is one of the greatest dangers to our work. Funding a program that is called 'peer respite' but fails to meet many of the basic criteria of peer respite not only harms the local community, but also harms the national peer respite movement. If you will not change any of the qualities or requirements of this program to make it meet fidelity for a peer respite, will you consider changing the name? What you appear to be creating is a clinical crisis respite program that integrates peer support, not a peer respite.**

    Answer: See question #22.

28. **Question:** **You titled this RFP 'Evidence-Based Peer-Run Respite.' However, its design runs contrary to any evidence base for peer respite. Why did you choose this name?**

    Answer: We included information and findings from publications in the field.

29. **Question:** **Co-optation is one of the greatest dangers to our work and is damaging and demoralizing for peer support communities. If you won't consider re-naming the program, will you consider withdrawing the RFP so that it can be rebuilt in collaboration with the local peer support community?**

    Answer: We did include persons with lived experience in the development of this RFP.

Questions related to Referrals

30. **Questions:** **Why would you rule out participation from people who are in hospital and/or an Emergency Room? Hospitals do not work for everyone and taking someone from a hospital who is either not being helped or who won't be able to be released from an involuntary stay without a place like a peer respite to go makes absolutely sense. It makes even more sense to support someone to go to a peer respite from an Emergency Room rather than having them go from the ER to a hospital bed. The ER in particular should in fact be a key spot where people are informed about peer respite as an option.**

    Answer: Hospitals and emergency departments can inform individuals about peer respite as an option. Individuals leaving a hospital or emergency room can self-refer to the peer respite.

31. **Question:** **Will you be requiring the peer respite to take people from the police, clinicians, etc? What is the point of referrals from these groups? Why isn't their role to simply tell someone about this option and support them to access it? What are you expecting this to look like and why do you believe it won't reduce the voluntary nature of things**

if a clinician or police officer is telling someone this is where they should go?

Answer: The peer respite is a voluntary program. Clinicians, police and others are encouraged to inform people about this option and support them to access it if that's what the person in need would like.

32. **Question: Why is the peer required to keep "open beds" (not language that is relevant to a peer respite) logged on a statewide system? Will this not encourage clinicians and others to feel they have the power to force, coerce, or "strongly encourage" someone to go there? Will this not set peer respite employees up to be at odds with clinicians and others who access that system and feel the 'open bed' should go to whoever they are trying to get into it? What is the benefit of this? How does it help set peer respite it apart from the clinical system?**

    Answer: This is a public facing website that allows for individuals in the community to see, in real time, the availability of programs and services. It will enable individuals in crisis/distress to see when beds are available at the peer respite.

33. **Question: Under the RFP, will it be considered responsive for the applicant to propose admission to respite of clients being discharged from inpatient and emergency settings who choose to go to respite?**

    Answer: We encourage widespread education about the peer respite program. Someone being discharged from inpatient or emergency settings are welcome to refer themselves to the peer respite.

34. **Question: Under the RFP, will it be considered responsive for the applicant to propose admission to respite of clients being discharged from Connecticut's existing crisis respites?**

    Answer: Individuals can self-refer to the peer respite.

35. **Question: Under the RFP, will it be considered responsive for the applicant to propose only taking self-referrals, in place of referrals from clinicians, police, etc.?**

    Answer: The Peer Respite Program is a voluntary program and we support clinicians, police and others educating individuals about the peer respite and supporting them, if needed, in the referral/admission process.

36. **Question: Can you clarify the exclusion of people who are in psych facilities or in ERs? It's clear that it's untrue that they will have necessarily been helped effectively. Many peer respites will take people from psych facilities who need the support and are being harmed or not helped by the hospital (especially if they can't be released without a place to go), and the ER piece is even more**

confusing because if this is to help with hospital diversion then it would make a lot of sense for people to be able to go to peer respite instead of a hospital bed... Can you explain?

Answer: Individuals can self-refer to the Peer Respite Program from anywhere. Ideally, individuals would access the peer respite before going to the hospital or emergency department if they feel that is the best option for them.

37. **Question: By listing the "beds" available on the state database DMHAS will create confusion. The "beds" are primarily for detox and other addiction service specific housing options. There has been no marketing, provider training, or community education on the concept of "peer respite" despite the extensive mobilization and funding of 988, as a comparison point. Will the RFP budget be increased to support an administrative assistant who would handle calls from the 1000s of CT providers and community members calling for open detox beds?**

    Answer: The annual budget has been increased to $650,000/year. (Addendum 2)

38. **Question: At the bidder's conference – when asked why people are ruled out for consideration if on an inpatient unit or at an Emergency Room – the only reply was that anyone could self-refer once they leave a space. This did not answer the question. If someone is stuck at an Emergency Room and being considered for inpatient hospitalization, will they be able to instead be considered for the peer respite as an alternative? If not, why not?**

    Answer: Yes they can go to the peer respite.

39. **Question: If the plan is to prohibit people going directly from an ER to the peer respite, does that mean peer respite teams will be prohibited from doing outreach to Emergency Rooms?**

    Answer: During the implementation process, we can educate ER staff about the peer respite so they can educate individuals that present there about its availability.

40. **Question: Peer respites were – by design – created to serve as hospital diversion. How does that align with setting any limits at all on people in Emergency Rooms accessing peer respite?**

    Answer: Diversion happens before an individual presents at an emergency room or inpatient program. Once in the ER, staff there can educate individuals on different options, including peer respite.

41. **Question: The RFP is very vague on expectations regarding what it refers to as "cultural competence." At no point does it mention other languages. Does DMHAS have expectations that the bidder will be accessible to people who speak no or minimal English (e.g., a commitment to hiring folks who are Spanish speaking, etc., materials available in other languages, etc.)?**

    Answer: The peer respite program needs to be accessible to people who speak other languages, including use of interpreters when needed and materials in other languages.

42. **Question: Will the respite be allowed to accept guests who are unhoused?**

    Answer: Yes

43. **Question: What is the reason for the peer respite being required to list "beds" on a state database? This appears harmful and likely to increase the likelihood of clinical interference.**

    Answer: See question #32.

44. **Question: Do you anticipate that the peer respite will ever be required to take someone that DMHAS, the police, or any other party feels should be at the peer respite or will the peer respite team always retain the decision-making power?**

    Answer: This is a voluntary program. Admissions will be between the person in need and the peer respite program.

45. **Question: You define "voluntary" as "no court ordered commitments." That is a very limited definition of "voluntary." Will the program also be supported in not taking people who are being coerced/pushed/given no other option than peer respite by providers and similar?**

    Answer: The peer respite program is a voluntary program, meaning the person utilizing services is the decision maker regarding participation.

Questions related to Staffing

46. **Question: It appears you are requiring two people on shift for all three shifts per day. How did you come to the decision that there should be three shifts? How did you come to the decision that there should be two people on every shift?**

    Answer: The rationale for two staff is to ensure that there is adequate staffing for the safety and support of those individuals staying at the peer respite

program. If one staff member is on a break or supporting one of the individuals, there is a second staff person available for others. Three, eight-hour shifts are commonplace in most work environments. Applicants could propose a different shift model if it covers 24 hours/day, 7 days/week.

47. **Question: Why did you decide on awake overnights? If there are two people on overnight, can they take turns sleeping? Are you aware that in peer respites where people stay up all night it sometimes also encourages people staying at the respite to maintain a disrupted sleep schedule which can be a substantial contributor to their distress?**

    Answer: We are requiring the staff to be awake on overnights to ensure that there is someone available to support and respond to the needs of the individuals staying at the peer respite 24 hours a day.

48. **Question: Are you aware that Intentional Peer Support is in and of itself an intensive training program that many peer respites use *instead* of state certified peer specialist programs that often lack substantial relevant to peer respite work? Are you open to a response that uses IPS as its main training rather than the state certification?**

    Answer: No; the requirement for this RFP is completion of a state certification/training peer specialist program.

49. **Question: This is confusing: "The proposer organization should include a plan for staff supervision from a supervisor/manager from the proposer organization as well as a plan for ongoing training of Connecticut Certified/Trained Peer Specialists." Are you intending to have a program set up that has no leadership that is internal to the peer respite itself? Are you suggesting that the peer respite be made up all of people doing direct support with no internal leadership and then perhaps supervised by clinicians? Who would be on-call for the peer respite? How would you protect against the negative influence of clinicians? It's very unclear what this means.**

    Answer: There should be a supervisor of the program who has lived experience and is a trained/certified peer.

50. **Question: Under the RFP, will it be considered responsive for the applicant to propose employment of peer service providers who have not less than five years of experience offering peer services?**

    Answer: Applicants can propose to employ peer service providers with that requirement.

51. **Question: Under the RFP, will it be considered responsive for the applicant to propose supervision of respite staff by peer support specialist?**

    Answer: Yes.

52. **Question: Under the RFP, will it be considered responsive for the applicant to propose employment of peer service providers who have received Intentional Peer Support (IPS) training?**

    Answer: Yes, but not to the exclusion of being a CT trained/certified peer support specialist.

53. **Question: Are any non-peer certified staff permitted to be employed by the program? including the supervisor?**

    Answer: No; the two staff on each shift and the supervisor of the program need to be peer certified/trained staff with lived experience.

54. **Question: Many peer respites use Intentional Peer Support, and it is typically recognized as a better fit for peer respite. (It was developed by Shery Mead who also developed the first peer respite, Stepping Stones, in NH.) Will you consider that in lieu of CPS?**

    Answer: IPS training cannot be substituted for CPS. We support the addition of IPS training for the peer respite staff.

55. **Question: Do you anticipate a leadership structure that is internal to the peer respite? The RFP seems to suggest the supervisor will be internal to the organization but external to the peer respite? Will supervisors be required to have psychiatric histories or similar?**

    Answer: The supervisor should be an employee of the selected vendor, be a certified/trained peer, have lived experience, and may be part of or separate from the peer support staff. The amount of effort (% FTE) for this position is determined by the applicant in the proposed staffing pattern.

56. **Question: Why was the decision made to have 2 people on each shift? Is there any flexibility in that? It's highly unusual to have two employees working particularly overnight, and it does not appear the budget will sustain that while also allowing for sustainable pay rates and an internal peer respite leadership structure that is properly compensated.**

    Answer: The rationale for two staff is to ensure the safety of everyone at the peer respite and adequate support for all individuals at all times. This is the required staffing pattern.

57. **Question: To be clear, the stated staffing supervisor or program coordinator must also qualify as a peer?**

    Answer: The supervisor should be an employee of the selected vendor, be a certified/trained peer and have lived experience.

58. **Question: Do per-diem staff have to be certified peer support specialists as well?**

    Answer: Yes

59. **Question: Are you requiring peer respite to have leadership with psychiatric histories?**

    Answer: The supervisor should be an employee of the selected vendor, be a certified/trained peer, and have lived experience.

60. **Question: Please clarify, earlier you reported that all staff at the program must be peers, but then you stated supervisors don't need to be peers?**

    Answer: All 2:2:2 direct care staff providing support to the peer respite, and the supervisor, must be certified/trained in peer support and have lived experience.

61. **Question: Is there a training initiative to push the peer certification to ensure there are enough applicants to fill the positions for the required ratios for 24/7 supervision?**

    Answer: There are ample training opportunities provided through Advocacy Unlimited and Hartford Healthcare for Peer Support Certification as well as through CCAR for peer support training. There are also many graduates of these training programs.

62. **Question: Can supervisory staff be included with the 2:2:2 structure?**

    Answer: Supervisory staff can be included in the 2:2:2 structure.

63. **Question: Will per diem staff be expected to be Certified Peer Specialists?**

    Answer: Yes

64. **Question: Does the 2/2/2 include the program supervisor?**

    Answer: That is not required, but allowable.

65. **Question: Staffing Expectations, section c: states: "c. The proposer organization should include a plan for staff supervision from a supervisor/manager from the proposer organization..." Does this mean the supervisor will be an existing supervisor that will be expected to take on this responsibility outside of the Peer Respite funding?**

    Answer: The supervisor does not need to be an existing supervisor with the

organization.

66. **Question: What are the staffing requirements, if any?**

    Answer: Please refer to the "Staffing" section of the RFP.

67. **Question: Are supervisors of the peer respite required to be a certified peer specialist and have direct lived experience with psychiatric histories? If not, why not?**

    Answer: Yes, supervisors should be certified/trained peer specialists and also have lived experience.

68. **Question: Many peer respites use Intentional Peer Support, and it is typically recognized as a better fit for peer respite and superior to any Peer Specialist certification for this type of work. (It was developed by Shery Mead who also developed the first peer respite, Stepping Stones, in NH.) Will you consider that in lieu of CPS? If not, why not?**

    Answer: See question #48

69. **Question: If you plan to continue to require the Certified Peer Specialist training, will there be any grace period? (For example, can an otherwise highly qualified candidate become certified in their first year of employment rather than needing to be certified at the point of hire?)**

    Answer: No; we are requiring staff who work in the program to already have their peer certification/training.

70. **Question: Do you anticipate a leadership structure that is internal to the peer respite? The RFP seems to suggest the supervisor will be internal to the organization but external to the peer respite (". The proposer organization should include a plan for staff supervision from a supervisor/manager from the proposer organization as well as a plan for ongoing training of Connecticut Certified/Trained Peer Specialists.")?**

    Answer: See question #55.

71. **Question: Will supervisors for the peer respite be explicitly required (according to the job description) to have psychiatric histories or similar?**

    Answer: The peer respite supervisor should be a certified/trained peer with lived experience.

72. **Question: Do you understand that if you do not specifically require internal peer respite leadership with psychiatric histories by design (in**

the job description) that it will not meet the most basic definition of a peer respite?

Answer: This is specifically required.

73. **Question: Peer respites need to have an on-call protocol. Typically, that requires not only one but more than one person in a leadership role so that they can share the responsibility. Do you have any expectations regarding a plan for an on-call protocol?**

    Answer: We don't have specific requirements regarding the on-call protocol.

74. **Question: Why was the decision made to have 2 people on each shift? Is there any flexibility in that? It's highly unusual to have two employees working particularly overnight in a peer respite. It can be damaging to the philosophy and approach. Additionally, it does not appear the budget will sustain 24/7 double coverage while also allowing for sustainable payrates and an internal peer respite leadership structure that is properly compensated.**

    Answer: See question #56.

Questions related to the Budget

75. **Question: How did you come to the figure of 500k? If there is to be double coverage 24/7, paying two people at $15 p/h (which is slightly BELOW the average peer support wage and substantially below a rate that will retain highly skilled peer supporters) plus an Assistant Director who works entirely in the schedule at $25 p/h and a Director at $29 p/h who is entirely out of the schedule (bear in mind there needs to be an on-call system and it can't fall only on a single person week after week and so they need to be compensated for that) and then adding in estimated fringe and indirect percentages, that adds up to $474,903. This is without factoring in per diem coverage, mileage, phones, food, supplies, TV, ongoing training, etc. How is 500k sufficient to cover 24/7 double coverage with a leadership structure?**

    Answer: We increased the budget to $650,000 per year. (Addendum 2)

76. **Question: Please disclose the rent agreement, with proposed monthly amount, which will be expected for this cottage.**

    Answer: DMHAS is in conversation with DAS about that and any rent due will be added to the $650,000/year budget. Applicants do not need to include rent in their submitted budgets as part of this RFP process.

77. **Question: Our tour identified some concerning physical plant issues and/or items that should be addressed for occupancy. Please disclose**

how DMHAS will partner with the awardee to resolve and facilitate landlord-tenant issues.

Answer: This will be discussed during the negotiation meeting with the selected vendor.

78. **Question: Who will be responsible for property management, costs, and maintenance, landscaping, furniture, appliances, etc.?**

    Answer: Property management, maintenance and landscaping will be provided by the State of Connecticut or its vendor. There are some furnishings and appliances in the identified site. Any additional furnishings, appliances, or items for the house itself would be the responsibility of the selected vendor.

79. **Question: Will any occupancy costs be included in the lease - utilities, maintenance, etc.?**

    Answer: Utilities will be included in the lease. Maintenance will be provided by the DAS property management vendor.

80. **Question: Will the funding be indexed to inflation?**

    Answer: That is not being committed at this time but can be an ongoing discussion between the selected vendor and DMHAS.

81. **Question: How was the total budget listed in the RFP determined?**

    Answer: The budget was determined based upon research conducted of other peer respite program budgets. It has been increased to $650,000/year. (Addendum 2)

82. **Question: What do you think a starting salary should look like?**

    Answer: Not enough information is provided for us to answer this question. We don't know which position is being referred to.

83. **Question: How will the clients eat? Will grants provide the food for them as other respites?**

    Answer: Yes, food should be included in your budget proposals.

84. **Question: Do you realize that the budget you proposed are incentivizing organizations to pay staff minimum wage, and further marginalized disenfranchised folks?**

    Answer: The annual budget has been increased to $650,000/year. (Addendum 2)

85. **Question: What will the lease amount be for the site?**

Answer: The lease amount has not yet been determined. Discussion of the lease would be part of the negotiation meeting with the selected vendor and is not to be included in the $650,000 annual budget. DMHAS will provide additional funding to cover the cost of the lease.

86. Question: Will funding be indexed to match the DAS lease increments (15% increase every 5 years)?

Answer: We cannot commit to that at this time, but it can be an ongoing discussion between the selected vendor and DMHAS.

87. Question: Will utilities be included in the lease amount?

Answer: Yes.

88. Question: Will the program be expected to provide food for 3 meals/day for 6 individuals?

Answer: Yes, meals should be provided for the individuals residing at the peer respite.

89. Question: Will the site be move-in ready? If not, is the PNP required to provide the renovations? If yes, will there be startup funds?

Answer: The site will be move-in ready. Applicants can submit a separate start-up budget for year one.

90. Question: Will there be startup funds for furniture and technology?

Answer: Yes, furniture and technology can be part of the start-up budget.

91. Question: Current 2/2/2 staffed programs are funded between $6-800,000; program most closely aligned with the 500,000 cap are 2/1/1 staffing and 1/1/1 weekend and even that runs in the red; How was this budget determined? Is the budget negotiable?

Answer: The budget has been increased to $650,000/year. (Addendum 2)

92. Question: Is food, lawn care, fuel, etc. included?

Answer: Landscaping and property management/maintenance is provided by DAS' property management contractor. Utilities will be part of the lease. Food should be included in your proposed annual budget.

93. Question: Will there be additional dollars available in the second year if there is a gap?

Answer: The annual budget has been increased to $650,000 per year.

94. **Question: Will DMHAS cover the cost of PSA and other advertising?**

Answer: DMHAS maintains a website and is active on social media, which will include information about the peer respite. If additional advertising is needed, the selected vendor and DMHAS will discuss the process for doing that.

95. **Question: Does the program cover the cost of making the place available 365 days out of the year, regardless if a bed is being utilized? Or is reimbursement only for when a bed is being utilized?**

Answer: The cost of the program for the whole year will be covered and there will be an expected utilization rate of at least 90%.

96. **Question: Should the proposal include the cost of food, toiletries, etc.? Or do the recipients have SNAP cards they can use?**

Answer: The budget should include the provision of three meals a day for up to six people. Use of resident SNAP cards can be used according to a policy and procedure developed by the agency in collaboration with SMHA/DMHAS.

97. **Question: Are there insurance requirements (health, property, business)?**

Answer: Yes, these insurances are required.

98. **Question: During the bidder's conference, it was mentioned that these are federal dollars. How were these dollars secured? Can you please provide the public document that earmarks these dollars toward the peer respite, and additional budget narrative and project description?**

Answer: Federal funding for this program is from the Bipartisan Safer Communities Act of 2022 as well as some state funding. These federal dollars come to CT and DMHAS through the SAMHSA Block Grant. A project description and budget narrative was not required or submitted to garner these federal dollars.

99. **Question: The total operating budget of $500,000 annually is concerning because it would incentivize a wage & salary disparity. Based on this budget, basic living wage standards would not be met, or would disparage Certified Peer Specialists, with specialized and advanced training (see 2023 Living Wage Calculation for Connecticut, distributed by Dr. Amy K. Glasmeier and the Massachusetts Institute of Technology https://livingwage.mit.edu/states/09). This is with consideration for other operating costs. Would you be willing to increase the allowable annual budget by $250,000?**

Answer: The annual budget has been increased to $650,000/year. (Addendum 2)

100. <u>Question</u>: Can you please list all of the utilities and responsibilities would be held by the property owner, and what would be the responsibility of the bidder?

<u>Answer</u>: DMHAS will pay for the oil. Electricity will be included in the lease and paid for by DMHAS in addition to the $650,000/year. Water/sewer is covered by the property owner.

101. <u>Question</u>: The organization and facilitation of alumni groups puts an additional responsibility on staff that deviates from the role of CPS and will require administrative support. Will the RFP be increased by $75,000 to support an additional FTE?

<u>Answer</u>: The annual budget has been increased to $650,000/year. (Addendum 2)

102. <u>Question</u>: The RFP requires outside consultation for measuring outcomes, which will place an additional fiscal burden on the contracted organization. Will the allowable budget be increased to pay the service fees?

<u>Answer</u>: DMHAS will pay for the evaluation of the program. Other outside consultation for measuring outcomes is not required.

103. <u>Question</u>: Will additional dollars be made available after year one if there is a gap in the budget that was unavoidable given the annual funding limitations in the RFP?

<u>Answer</u>: The annual budget has been increased to $650,000/year. (Addendum 2)

104. <u>Question</u>: Who will be pay for facilities updates, larger appliance replacement, replacing used furnishings, and landscaping?

<u>Answer</u>: Konover Commercial Corporation is currently the DAS contractor for management of the property. They are responsible for the repairs and maintenance of the infrastructure, including the mechanical systems of the building and any exterior site work or repairs, including basic landscaping and snow removal. Regarding furniture, appliances, and any item not physically bolted or anchored to the building, Konover is not responsible for these; the tenant will be responsible. For all janitorial work and cosmetic updates the selected vendor will be responsible.

105. <u>Question:</u> During the Bidder's Conference, a DMHAS employee stated that they felt that sustainable wages could be paid on a 500k budget with 24/7 double coverage, food line, supplies, etc. Can you please define what you consider to be a sustainable pay rate? (The $15

average peer support pay in CT is not a sustainable pay rate, particularly for such a specialized, high peer support skill role.)

Answer: The budget has been increased to $650K/year. (Addendum 2)

106. **Question: During the Bidder's Conference, a DMHAS employee said that who is responsible for utilities and similar will be determined in negotiations with the successful bidder. However, this seems to significantly limit a bidder's potential to evaluate how realistic the total budget will be. Will you please reconsider and provide more detail about what – in addition to any rent payments – will be above and beyond the 500k? (Mileage, food, utilities, cell phones, laptops, supplies, maintenance of the facility, snow/landscaping, IT support, etc.)**

Answer: Mileage, food, cell phones, laptops, supplies, maintenance of the inside of the facility, and IT support should be included in the $650K/year budget. Utilities will be built into the lease, on top of the $650K/year budget. DMHAS will pay for oil.

107. **Question: There appears to be a substantial amount of training required to be provided to peer respite team members by the host organization. There is no room in the budget to pay for trainings. How will trainings be funded?**

Answer: The budget for the program has been increased to $650,000/year. (Addendum 2)

108. **Question: Are there separate start-up funds available to furnish the home, stock up on supplies, etc.?**

Answer: Yes, a start-up budget for year one is allowable.

109. **Question: Are utilities included?**

Answer: Utilities will be included in the lease amount.

Questions related to Program Activities

110. **Question: The RFP seems very proscriptive. What is the reason for requiring Wellness Recovery Action Planning (WRAP)? What is the reason for including Motivational Interviewing? What is the reason for deciding ahead of time what supports and interventions should be offered given that this is likely to reduce the peer-to-peer nature and relevant of these supports?**

Answer: WRAP and MI are suggested interventions that should be available to individuals at the peer respite and not requirements that everyone must utilize.

111. **Question: Particularly in a space with only one common area, why are you including a requirement to hold groups in the peer respite? Is that a misunderstanding of what's written? Typically, peer respites should be flexible and not hold routine groups and allow for people staying/working there to determine what works for them in the moment.**

Answer: Group work is one of the suggested interventions if it benefits the individuals in the respite. It is not required.

112. **Question: Why are you mandating a monthly alumni group? Is that expected to meet at the house? In the only common area? How is mandating specific activities at this level consistent with supporting a peer-run approach?**

Answer: The alumni group being offered once a month is to support individuals who have left the peer respite and are looking for a mechanism to keep connected to the individuals that supported them during their stay. The alumni group is not a requirement for individuals to attend and can be held at any location (in-person or virtual).

113. **Question: Are you expecting EVERY person to create a WRAP when they stay there? The way the section on 'components' is written it comes across as quite prescriptive and infringing on creativity and the voluntary nature of this work. Why is it so prescriptive?**

Answer: The use of a WRAP is a recommendation and should be used based upon the needs of each individual. It is not a requirement.

114. **Question: What do you mean by 'a mechanism for previous individuals to call?' Are you essentially expecting the peer respite to also run a peer support line out of the peer respite without any additional funding or support and in spite of having six people they're trying to support? How do you envision this working without draining the people working there and shortchanging the people staying there?**

Answer: If this component becomes too burdensome, the selected vendor and SMHA/DMHAS can discuss modifications.

115. **Question: Under the RFP, will it be considered responsive for the applicant to propose allowing respite clients to freely leave and return to the respite to attend to errands, work, school, etc.?**

Answer: Yes, this is a voluntary program. Participants are welcome to come and go as they please.

116. **Question: Under the RFP, will it be considered responsive for the applicant to propose that clients of the respite be permitted to**

securely maintain possession of their medications and to self-administer?

Answer: Applicants should develop their proposal on this topic based on different types of medications (e.g., controlled substances vs. other types of medications).

117. Question: Under the RFP, will it be considered responsive for the applicant to propose a flexible menu of services to be offered by the respite, subject to the choice of individual clients?

Answer: Yes; we would expect a flexible menu of services tailored to the choice of the individual.

118. Question: Under the RFP, will it be considered responsive for the applicant to propose a menu of services which does not include motivational interviewing?

Answer: Yes; we would expect a flexible menu of services tailored to the choice of the individual.

119. Question: Under the RFP, will it be considered responsive for the applicant to propose a flexible schedule for clients admitted to the respite, without restricting them to particular services?

Answer: We would expect a flexible menu of services tailored to the choice of the individual.

120. Question: Are you envisioning self-help groups that meet regularly at particular times? WRAP classes? Etc? (Peer Respite don't typically have a rigid schedule and its typically best to maintain ongoing flexibility based on who is there and what's actually needed)

Answer: We are not specifying any particular schedule and we would expect a flexible menu of services tailored to the choice of the individuals at the peer respite.

121. Question: Can you please expand on the 5-7 stay time?

Answer: It is anticipated that the average length of stay will be 5-7 days. However, based upon the specific needs of the individual, some stays may be shorter than 5 days and/or longer than 7 days.

122. Question: With the 5–7-day timeline to move folks along - current environments are unable to move folks along this quickly. How do you think this program will differ?

Answer: We look forward to your proposals around that and how you would ensure that individuals receive the supports they need once they leave the

respite.

123. Question: RFP states 5–7-day transition for individuals in crisis; current environments cannot move individuals along this quickly with current systems in place. How will this program differ?

Answer: We look forward to your proposals around transitioning individuals back to their communities.

124. Question: What support will this program receive from Mobile Outreach?

Answer: If necessary, mobile outreach can offer support if needed.

125. Question: Is Advisory Group separate from Alumni group?

Answer: Yes

126. Question: Monthly Alumni group will be held where?

Answer: That can be determined by the selected vendor.

127. Question: As a peer respite, there is minimal documentation and intake does not include the recording a person's history. This is essential for maintaining fidelity. What are your mandatory documentation requirements for the program?

Answer: We expect there will be an intake interview documented and ongoing documentation. DMHAS DDaP entry will be required. Additional specifics can be discussed with DMHAS during contract negotiation and implementation.

128. Question: The average length of stay at a peer respite varies; however, by definition, a peer respite is a short-term program. What are the expectations for a resident who may stay beyond the stated "5 to 7 days" listed in the RFP? Is there a maximum length of stay? Will there be an expectation that forced discharging occurs?

Answer: It is anticipated that the average length of stay will be 5-7 days. However, based upon the specific needs of the individual, some stays may be shorter than 5 days and/or longer than 7. We have not indicated a maximum length of stay. Every effort should be made to plan a safe discharge.

129. Question: Requiring onsite meetings deviates from DMHAS' commitment to community inclusion, while the peer oriented approach would encourage community-based meetings. Will you remove this criteria and shift towards a requirement that round-trip transportation to community- based recovery friendly meetings is available at least once a day?

Answer: We would expect a flexible menu of services tailored to the choice of the individuals at the peer respite. Community-based meetings are an option and can be used.

130. **Question: Is there an expectation that mobile crisis will be called if someone states that they are, "thinking about killing themselves" or other discussion related to suicidal ideations? Are the peer respite staff required to be mandated reporters?**

Answer: The use of mobile crisis and any reporting needs to be determined on a case-by-case basis.

131. **Question: Are you envisioning self-help groups that meet regularly at particular times? WRAP classes? Etc? (Peer Respites don't typically have a rigid schedule and its typically best to maintain ongoing flexibility based on who is there and what's actually needed) And does WRAP specifically need to be included, or do you primarily mean some sort of access to wellness planning?**

Answer: WRAP should be an option. Adding other wellness planning is good too.

132. **Question: At the Bidder's conference, you referenced that "some could stay longer than 7 days." Do you anticipate at any point intervening in and requiring the peer respite to keep someone for longer or will they always retain decision making power where that is concerned? (Note. Peer respites that are forced or otherwise keep people for substantially longer will experience mission drift and may no longer be a peer respite in practice.)**

Answer: We anticipate that the length of stay for each individual will be responsive to their needs.

133. **Question: Requiring a monthly alumni group is an unusual requirement. Will that be required to meet at the house, or will it be able to meet elsewhere? (It is likely to be very disruptive in a house of this nature to hold groups of people not currently staying there in the space, especially given the small nature of many rooms and limited shared community space in this particular house.)**

Answer: The alumni group does not need to be held at the peer respite program.

134. **Question: The RFP states that the successful bidder will be expected to work with an "outside, independent evaluator" to help measure outcomes. That can be quite expensive. Who will be paying for it, or is it expected to come out of the 500k budget? How often will the**

program be expected to do this? Annually? Bi-annually? Every 6 months?

Answer: DMHAS will be paying for the independent evaluation. It is not to be included in the $650K/year budget that RFP respondents are submitting. DMHAS, the evaluator and the peer respite program will collaborate on the development of the evaluation protocol.

135. **Question: Files and data collection are usually kept to a minimum at peer respites, at least in part because keeping data on individuals is a substantial power imbalance and many people have been harmed by files that follow them around. What data are you expecting the peer respite to collect and maintain on individuals?**

Answer: See question #127

136. **Question: The initial contact is described as a fairly intensive "intake" style process ("Connecticut Certified/Trained Peer Specialists will conduct initial interviews in order to gather information from the individual around self-identified needs, develop a person-centered recovery plan, and assist individual in developing individualized goals.") Do you mean that this will happen upon entry to the peer respite or at some point prior to entry in preparation for future potential entry? Will everyone be required to have a "treatment plan" and "individualized goals?" This sounds unusually structured and runs counter to the values of a peer respite.**

Answer: To answer the first question, that would be upon entry. Traditional treatment plans are not required. The peer respite staff and the individuals there would collaborate on what is needed and how the peer respite can be helpful.

137. **Question: This sounds like language from a hospital or similar clinical setting: "Connecticut Certified/Trained Peer Specialists will partner with individuals to determine discharge options as well as barriers to ongoing recovery." While it would be typical to talk with someone about what they plan to do when they leave the respite, it would not typically be seen as a "discharge." Can you clarify what you are anticipating will be the process for someone leaving the respite? Are they free to go at any time?**

Answer: Individuals at the respite are free to leave at any time.

138. **Question: The RFP implies that the house might need to run an alumni peer support line. With six people staying at a time, this may not be sustainable. What minimum requirements do you have for this? If it is taking too much away from the house, is this negotiable? (E.g., Could they instead be encouraged to call a peer support line?)**

Answer: There are no minimum requirements for the alumni group and supporting peers who have left the program that may want to stay in touch. We look forward to collaborating on these pieces.

139. Question: The RFP implies a 'bridging' component ("Connecticut Certified/Trained Peer Specialists for support/assistance as needed, following discharge"). With 6 people staying at a time, it may not be sustainable to also be routinely supporting people who've left the peer respite. Some peer respites have a Community Bridger whose job it is to work with people on the wait list or after they've left. Will funds potentially be made available to create this role?

Answer: The budget for the peer respite program has been increased. It would be acceptable to include such a position in your budget.

140. Question: The RFP states that the Peer Respite will need to "develop additional operational guidelines in collaboration with SMHA" including criteria for entering the respite, and so on. What are the qualifications of the SMHA that make them equipped to guide or even have a say in peer respite criteria and guidelines? Is SMHA peer-led in some way? In general, it is a set up for additional challenges and losing fidelity to subject a peer respite program to "collaboration" with a clinical authority.

Answer: DMHAS routinely collaborates across disciplines.

141. Question: The RFP indicates that the "collaboration" with SMHA will include collaborating around use of "mobile crisis." Afiya Peer Respite has existed for over a decade and has never had to call for an intervention from a clinical crisis service. Had this happened as initiated by us and particularly if against someone's will, it would have damaged our credibility with the community. What are your expectations about a policy of this nature?

Answer: SMHA operates the adult mobile crisis service for southeastern CT. It is available, if needed, at the peer respite program.

142. Question: What are your expectations around use of force in general by the peer respite? Do you have any expectations for internal investigation any time force is used?

Answer: We do not expect use of force in the peer respite program.

143. Question: Why is there no expectation for anti-racism or anti-oppression training for team members working at the peer respite?

Answer: It is fine to include that kind of training for team members.

Questions related to other Operational Processes

144. Question: Why are you only requiring 51% majority for the peer respite advisory group? Given the historical power imbalances between clinicians and folks with psychiatric histories, doesn't this run the strong potential to still ultimately favor people in clinical roles? Why have you limited the size of this group? Isn't it unusual for an RFP of this nature for the funder to be so explicit and limiting about so many details?

Answer: The requirement is for at least 51% of the advisory committee to be comprised of individuals with lived experience. That does not prohibit the advisory committee from being comprised of more than 51% of individuals with lived experience. A larger size group is also an option.

145. Question: Did you take input from the peer support community in developing this peer respite? It seems to run counter in many ways to what I understand peer supporters in CT have requested and I wonder if there's space for more work there. (The not at a peer respite piece was in reference to "it's normal to have 2 people on all shifts… "It's not normal for a peer respite…just a comment)

Answer: Yes, we received input from the peer support community and two individuals with lived experience were part of the workgroup that developed this RFP.

146. Question: Does DMHAS have a marketing strategy to ensure that the peer-respite is made available statewide?

Answer: We look forward to working with the selected vendor to develop such a strategy.

147. Question: How will we get access to the recording of this session?

Answer: The recording will not be provided. All questions asked during the Bidder's Conference will be officially answered here in this document.

148. Question: Will the PowerPoint presented today be sent out?

Answer: Yes.

149. Question: There is a risk being taken by the State of Connecticut in establishing a peer-respite. The risk will fall on the backs of those who are already working in the peer recovery community. If this fails, it will be blamed on the "peers", and there is no indication that this RFP was developed with the inclusion of peers. How were people with direct lived experience, and working in peer recovery roles, included in the development of this RFP?

Answer: We received input from the peer support community and two individuals with lived experience were part of the workgroup that developed this RFP.

150. Question: Can you please provide a list of the authors of this RFP, including names and titles, department or organization, and sections of authorship?

Answer: Due to the State of Connecticut's contracting guidelines, this information is not available during the active procurement process.

151. Question: Much of the RFP grossly deviates from the basic and defined standards of a peer respite. Have you seen this document: Peer Respite Toolkit published by the Human Services Research Institute (https://www.hsri.org/publication/peer-respite-toolkit)?

Answer: Yes

152. Question: The peer recovery community work at a disadvantage. This is inherent to the classification of "marginalized" and "vulnerable" as having a psychiatric history. The RFP is not a peer respite because it is not within fidelity to the already defined and agreed upon standards of a peer respite. Given that the peer respite model was developed by the peer recovery community and was intended to be operated as a peer-run program, would you change the RFP title to something that more appropriately reflect a crisis diversion program if the RFP were to be awarded to an organization that is not a peer-run organization?

Answer: We do not anticipate changing the name.

153. Question: The house requires significant renovations, and what is the timeline for contracting and renovations?

Answer: The contract start date is anticipated to be August 1st, 2023. It is expected the lease will be in place and renovations completed by November 1st, 2023.

154. Question: Who is responsible for handling disputes between the tenant (successful bidding organization) and the property owner?

Answer: The tenant would work with DAS regarding the building.

155. Question: Who will be responsible for evaluating RFP responses? Will there be any people from the peer support community who will sit on review committees? (Many states including non-employees on RFP

review committees, particularly for programs that serve marginalized communities as this one does.)

Answer: There will be individuals from the peer support community on the review committee.

156. Question: Peer respite is meant to be a support offered by and for people with psychiatric histories and/or having faced similar life-interrupting struggles. In this case, DMHAS appears to have largely ignored the input of the peer support community in Connecticut and done many things that run contrary to their stated wishes and experience. Additionally, DMHAS appears to have ignored the 67-page document created by the individuals who developed and oversee Afiya peer respite in Massachusetts during a consult in 2017. Why did DMHAS make the choice to dismiss all of this input, particularly given the peer-to-peer nature of the program?

Answer: We did incorporate a lot of feedback from the peer support community.

157. Question: Why are only 51% of the advisory group required to have psychiatric histories or similar? If this peer respite ends up under a clinical umbrella, it will be especially important that they have a very strong advisory group with a strong majority who identify as having psychiatric histories, etc.

Answer: See question #144.

158. Question: How were people with direct lived experience, and working in peer recovery roles, included in the development of this RFP?

Answer: Two (2)

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