Testimony before the Insurance and Real Estate Committee
MARCH 9, 2021

HB 6588 - AN ACT CONCERNING MENTAL HEALTH CARE AND SUBSTANCE ABUSE SERVICES.
Jeffrey Santo, RSS

Senator Lesser, Representative Wood, and distinguished members of the Insurance Committee thank you for reading my testimony today.

My name is Jeffrey Santo. I am a registered voter currently residing in the city of Norwalk. Three years ago, I became a Certified Recovery Support Specialist, which is why I have come before you today. I specifically want to talk about Section 5 of House Bill 6588. This section discusses creating a task force to study any means available to increase health coverage for peer support services provided to individuals in this state. I strongly support the creation of this task force because I believe it is necessary for our future. Not just to fill service gaps in the current mental health and addiction services system but also to bring new ideas and practices to the table that are proven to aid in a person's recovery.

In 2017 the Substance Abuse and Mental Health Services Administration, better known as SAMHSA, created a presentation called, Value of Peers, 2017, which contained the following observation. "Peer support offers a level of acceptance, understanding, and validation not found in many other professional relationships. By sharing their own lived experience and practical guidance, peer support workers help people develop their own goals, create self-empowerment strategies, and take concrete steps towards building fulfilling, self-determined lives for themselves."

The insight provided in the SAMHSA publication was not new information to those of us living in Connecticut. We know the value of peers. The Insurance and Real Estate Committee introduced two bills, HB 6887 in 2017 and HB 5270 in 2019. Both addressed reimbursement for peer services, but both bills failed to pass. Today we still have no reimbursement strategy for peer support services in place. Even though this obstacle exists, DMHAS funded programs are still training these peers for recovery support roles in the workforce.

Over the last decade or so, a few thousand people in our state have been trained, and they have become recognized as peer supporters by the agency through which they received their educations. This is astonishing, considering that the certifying agencies can't even reach an agreement on the term "certified." While attending a conference call over Zoom to discuss peer advocacy and billable peer support in Connecticut, I learned something. According to the Executive Director of the Connecticut Certification Board, who was also in attendance, I am not a certified peer. In fact, according to him, no one who has gone through the Recovery Support Specialist training is actually "certified." His statement is contrary to the information posted on the Department of Mental Health and Addiction Services website, which says:

"*DMHAS is pleased to support Advocacy Unlimited Inc. Recovery Support Specialist Training and Certification process to assist individuals in becoming Certified Recovery Support Specialists in Peer Delivered Services under the new Medicaid Waiver program.*" DMHAS defines me as a certified peer, yet the Connecticut Certification Boards Executive Director tells me I am not. Is he right, and If so, where does he get the authority to make that determination? Does it have something to do with national accreditation vs. state recognition? I honestly don't know, but it is one example of an issue that needs to be ironed out by the task force.

Let's talk about employment. I know by my certification number that Advocacy Unlimited alone has trained over 1,100 of us as Recovery Support Specialists, but only a small percentage of us find work. Jobs we do find that call for the RSS title have requirements and responsibilities well outside our purview. Some of us wonder why there is so much confusion as to our intended role. Many postings do not require the certification that allows the use of the Recovery Support Specialist title. As an advocate for peer supporters, I often reach out to these agencies and explain what an RSS is and what the requirements are to become one.

In one of those correspondences, I discovered something disturbing in the response I received. *"Thank you for reaching out to Clifford Beers. The job title is a requirement of our funder, the Department of Children and Families for the SAFE-Family Recovery program. SAFE-FR is a Statewide network of providers (5 contracted agencies) working in collaboration with DCF on parents/ caretakers with substance abuse concerns."* This means we have two separate state agencies, DCF and DMHAS, using the Recovery Support Specialist title for two different jobs with different job requirements and responsibilities. This leads to confusion about how Recovery Support Specialist should be used on a treatment team. Why is it essential to resolve this confusion? In the future, if a DMHAS service recipient asks for an RSS, we can't guarantee

the level or type of support they will receive. Peer support starts by building trust. How can a client trust us if they can't even be sure we are, in fact, a peer? This is another question that a dedicated task force should be able to answer.

At this time, I would like to share some personal information about how my role as a Certified Recovery Support Specialist has affected my community and the people around me. Since my graduation, I have talked to 23 people who were all dealing with some level of suicidal ideation. I have spoken to dozens more, helping them through episodes of depression, anxiety, PTSD, and feelings of severe isolation. Even though I am not employed in the mental health field, I have become known for these conversations. Members of the local NAMI chapter have given out my phone number on several occasions to people in crisis who needed to reach out and talk to someone. Sometimes it takes hours to comfort a person and return them to a safer place and state of mind.

I believe that I am successful in doing this for two reasons. First, I understand the mechanics that create suicidal thoughts and depression. I know what it does to the mind and body because I live with the effects of them on a fairly regular basis. The second reason is the training that taught me how to turn my experiences into a powerful force to give people hope. SAMHSA didn't exaggerate when it said peers could offer a support level that can not be found anywhere else. Without the task force, there will be an ongoing discussion, and in some cases, arguments, on the validity of current certifications already held by peers around the state. More importantly, it will finally end the debate on what fair reimbursement should look like for these dedicated mental health peer professionals.

In our state, a social worker must complete 15 hours of continuing education every year as a requirement to renew their certification. They must abide by the rules set forth by HIPAA, conform to a code of conduct, and the ethical guidelines put in place by the state and the agencies where they are employed. As a Certified Recovery Support Specialist, I must also abide by the rules set forth by HIPAA, conform to a code of conduct, and any ethical guidelines put in place by the state and the agencies where I may become employed. The difference is that I must accumulate a total of 60 hours of continuing education credits over three years. Five hours a year more than my social worker counterpart. If we are not considered professionals by the greater mental health services community, I would be the first to point out that we certainly conduct ourselves as such.

What I find most exciting about creating this task force is that it might also open the doors for peer-led organizations to implement new services for the community. This could potentially lead to methods that will allow us to create self-sustaining programs running on the revenue generated from the reimbursable peer services we can provide. Peer respites and retreats could be established and run without the need to rely on grants or state funding to operate. We could increase the number of community bridgers, create more holistic healing centers like Toivo, and perhaps even build peer-staffed community clubhouses that are not reliant on DMHAS funding. I invite you to consider what Connecticut's mental health landscape would look like if properly trained and certified peers could achieve these things in the future. Some of you may question if we are capable of turning any of these ideas into a reality. Let me give you one example of what could happen.

After becoming a Recovery Support Specialist, I entered the volunteer role and currently serve as the Executive Director of Recovery Innovations for Pursuing Peer Leadership and Empowerment (RIPPLE). By mid-2020, we had become legally incorporated and recognized by the IRS as a not-for-profit organization. On September 15, 2020, while the Covid-19 pandemic had many people isolated, RIPPLE created the state's first late-night peer support group using the Zoom platform. On paper, the group runs three nights a week from 10:00 PM to midnight, though in reality, some sessions end closer to 2:00 AM. Eventually, our goal is to expand to seven nights a week and offer services from 9:00 PM until 6:00 AM, the hours where many people find themselves struggling and no one around to provide support.

At this time, two peers with lived experience co-host our late night peer support group, I am one, and the other is Desiree Barton, RIPPLE's board secretary and soon-to-be student in the upcoming RSS class. Desiree and I routinely open the zoom room for one-on-one sessions outside of our regularly scheduled support groups. Those who attend our meetings know that we will make ourselves available whenever we are able. They contact us through text message and request some time with us. In December, we logged over 50 hours above and beyond our late-night peer support meetings. We do all of this as volunteers. We draw no income even though we are in demand and perform a service. I should add that on top of these volunteer hours; I also work a full-time job.

If insurance reimbursement for peers can be established, an organization like ours could potentially bill for some of the services we provide. The revenue produced could allow us to hire a full-time staff, increase the numbers of hours we are available, maybe even build that respite we mentioned earlier. In 2017 with HB 6887, we started asking how reimbursement for peer supporters in the mental health services system work? As I sit here four years later, I believe the time to create the task force and finally answer that question is long overdue. Thank you for your time.