From: [redacted]
Sent: Tuesday, September 14, 2021 3:19 PM
To: Lynda Stewart <Lynda.Stewart@dmh.ms.gov>
Subject: State Plan FY22-23 Public Comments

Page 13: Crisis Coordinator - This person must be able to make decisions independently and not be limited to only the direction of DMH. Will they be hiring peer supporters to work on their team?

Page 13: Real-Time Bed Registry - Will there be a Real-Time Registry of community-based services that can be accessed during a crisis to prevent someone needing a bed? Wait times to see a MH provider, including a peer supporter, at a CMHC?
Many crises do not require the Beds-n-Meds approach.

This does not fully address the gap of service in the crisis response continuum and keep people in the community.

Our system needs Peer-Run Respites for people to practice self-care in their own community for a safe recovery-oriented environment to prevent the need for CSU's or hospitalization.

According to SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, "essential crisis system elements include peer respite programs... For mental health crisis response, we can see the impact of comprehensive approaches in lives saved from suicide and people cared for effectively and more efficiently via mobile crisis visits or brief respite stays that might cost $300 per day versus inpatient rates of $1,000 per day. This approach better connects the individual to his or her community while minimizing disruption in the person's community connections."

Page 13: 988
Nationwide best practices includes Peer-Run Respites as a core resource for people who use 988.

Page 14: CPSS's at CSU's "often take the lead on engagement and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis"
This is only successful if non-peer staff at CSU's are committed to the value of peer support as crisis responders. There are numerous reports that CPSS's are not given full latitude to do do their jobs as they were trained, but instead are coerced or made to adopt medical-model practices that are pervasive in Mississippi's CSU's. They are not allowed to "take the lead in engagement."
A successful integration of peer support in CSU's will require:
1) Proper training of non-peer staff in the peer supporters' roles
2) A demonstrated commitment by non-peer staff to embrace recovery-oriented care.
3) A safe and efficient way for Peer Supporters to report work-place issues that hinder their work or cause them to feel abused, discriminated against, and/or coerced by non-peer

staff. And a demonstrated commitment that DMH will promptly respond to such reports and protect the CPSS from retaliation.

Page 15: Diversion Coordination to be evidence-based must include peer respite services to ensure a person can remain safely in their community.

Page 15: Technical Assistance/Evidenced-Based Training includes how the system must remove its over-reliance on law enforcement as mental health crisis responders.
According to SAHMHA's Executive Order 13929, Safe Policing for Safe Communities, "It is time for LE to return to policing and for mental health professionals to assume the role of crisis response. The most appropriate role for LE in a behavioral health crisis is limited or none (unless there are imminent safety concerns). It is time to redirect our reliance on LE as mental health crisis responders and create the momentum to develop crisis services systems based in behavioral health principles.
Peer Support and [Peer-Run Respites] are extremely effective in crisis response services and reduce reliance on law enforcement to appropriately engage individuals experiencing behavioral crises."

Many of Mississippi's Mobile Crisis Teams do not respond to crises. They call the police and allow law enforcement officers to decide if the Mobile Crisis Team should respond. We have sheriffs and police chiefs alike who have expressed their concern about DMH providers using their jails as waiting rooms for crisis beds. This is a violation of a person's civil rights, and it guarantees a traumatizing experience that will prolong their mental health crisis and cause them to be reluctant to ask for help in the future.
This practice INCREASES the incidence of suicide and mental health crises, which is the opposite of DMH's stated goals.

As stated in the FY22-23 Plan itself on Page 74, "Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices."
Yet, I have not seen offers for such training except to peer supporters. Who teaches this and how often?
How many have taken advantage of this training that employ peer supporters? As mentioned before, the buy-in by all practitioners is essential to prevent abuse and hostile work environments for peer support specialists.

Page 18: Once again, SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, "essential crisis system elements include peer respite programs."

Page 60: Between FY15 and FY20, there were an estimated 1,000 people trained to be peer support specialists. DMH currently employs 271. Where are the 700+ people who have been trained? Have we done follow up to see if they are currently using that training in a non-DMH capacity? How many never had a job offer? How many worked at DMH and chose to go elsewhere? How many are the only CPSS at their agency in violation of Best-Practices?

I feel like DMH has a responsibility to follow up and track what happens to the people they have trained over the years knowing the limited number of positions available to them for employment.

Page 90: Services for persons with co-occurring M/SUDs are extremely limited in most areas and nonexistent in others, even knowing that almost all people with SUD have a co-occurring mental health condition as well.
People are still forced to only have one condition addressed at a time, or lie about one condition in order to receive services for the other.
If an SUD program accepts a person with a co-occurring mental health condition, their care is usually limited to medication maintenance.

Page 99: Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? DMH answered YES. I am requesting a list of the trauma-informed organizations that have been developed by peers with lived experience in trauma.