Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER)

Report to
the Mississippi Legislature

Planning for the Delivery of Mental Health Services in Mississippi: A Policy Analysis

Although the mental health environment in the United States has dramatically changed from an institution-based system to a community-based system in recent years, Mississippi's mental health system has not reflected the shift in service delivery methods. Due to implications of the U. S. Supreme Court's 1999 *Olmstead* decision, which supports the drive toward integrating people with disabilities into the least restrictive settings, the state will be forced to move toward providing more community-based care in the near future. Also, the state's Board of Mental Health and Department of Mental Health will face other critical issues that will continue to impact their roles in providing and regulating mental health services in Mississippi.

According to PEER's analysis of the current state mental health planning effort, strategic planning does not appear to be at the core of the Board of Mental Health's management strategy, nor could it be without key changes in orientation and available information. There is little evidence that the planning process properly focuses the board on data needed to identify and prioritize critical issues and policy challenges. Rather, the board's focus is on administrative details and issues of program implementation.

While the board's minutes properly reflect a concern with the stability and health of current programs, there is less evidence of visionary, future-focused concerns. The board has not aggressively sought plans for reallocation of resources to meet emerging needs in addition to efforts to seek additional funding to meet those needs. While the current process may ensure that the Department of Mental Health will reach the community it intends to serve in the ways that have been established and are traditional, it does not question the composition or mode of service for possible needed change.

Also, it appears that the board has authorized programs that could be marginal to its mission while allowing the development of community-oriented programs to fall behind. This seems to evidence the possibility that the board currently has no identifiable process for deciding whether current or proposed programs and services fall within its mission, allowing the department to be pushed in directions that fragment its mission and increase competition for critical resources.

June 26, 2008

PEER: The Mississippi Legislature's Oversight Agency

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A joint committee, the PEER Committee is composed of seven members of the House of Representatives appointed by the Speaker and seven members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms with one Senator and one Representative appointed from each of the U. S. Congressional Districts. Committee officers are elected by the membership with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of four Representatives and four Senators voting in the affirmative.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues that may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

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The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

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June 26, 2008

Honorable Haley Barbour, Governor
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On June 26, 2008, the PEER Committee authorized release of the report entitled **Planning for the Delivery of Mental Health Services in Mississippi: A Policy Analysis.**

Senator Sidney Albritton, Chair

This report does not recommend increased funding or additional staff.

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Planning for the Delivery of Mental Health Services in Mississippi: A Policy Analysis

Executive Summary

Historically, Mississippi has made a major financial commitment to mental health that has primarily been focused on funding institution-based services, ranking high regionally and nationally in mental health expenditures. Although the mental health environment in the United States has dramatically changed from an institution-based system to a community-based system in recent years, Mississippi's mental health system has not reflected the shift in service delivery methods.

Due to implications of the U. S. Supreme Court's 1999 *Olmstead* decision, which supports the drive toward integrating people with disabilities into the least restrictive settings, the state will be forced to move toward providing more community-based care in the near future. Also, the state's Board of Mental Health and Department of Mental Health will face critical issues that will continue to impact their roles in providing and regulating mental health services in Mississippi.

Based on PEER's analysis of the current state mental health planning effort, strategic planning does not appear to be at the core of the Board of Mental Health's management strategy, nor could it be without key changes in orientation and available information. There is little evidence that the planning process properly focuses the board on data needed to identify and prioritize critical issues and policy challenges. Rather, according to PEER's analysis of three years of the board's meeting minutes, the board's focus is on administrative details and issues of program implementation.

While the board's minutes properly reflect a concern with the stability and health of current programs, there is less evidence of visionary, future-focused concerns. The board has not aggressively sought plans for reallocation of resources to meet emerging needs in addition to efforts to seek additional funding to meet those needs. While the current process may ensure that the Department of Mental Health will reach the community it intends to serve in the ways that have been established and are traditional, it

does not question the composition or mode of service for possible needed change.

Also, it appears that the board has authorized programs that could be marginal to its mission while allowing the development of community-oriented programs to fall behind. This seems to evidence the possibility that the board currently has no identifiable process for deciding whether current or proposed programs and services fall within its mission, allowing the department to be pushed in directions that fragment its mission and increase competition for critical resources.

Recommendations

The Legislature's commitment to the mental health needs of the citizens of Mississippi is evident by the financial support the Department of Mental Health has historically received. The commitment of the board members, DMH officials and staff, CMHC officials and staff, and advisory council members to providing mental health services to the citizens of Mississippi have been evident throughout this review.

PEER believes that through strategic planning the resources of the state and the knowledge and commitment of mental health officials and staff could be enhanced to better serve the mental health needs of the state's citizens. To this end, PEER offers the following recommendations.

1. The Board of Mental Health should implement a strategic planning process to address the current and future mental health needs of the state. The strategic planning process should incorporate clear missions and goals for the state's mental health system and contain clear performance measures to evaluate the effectiveness of the strategic plan in meeting the mental health needs of the citizens of the state.

2. The Board of Mental Health should conduct a self-assessment, taking into consideration performing:

    ▪ an evaluation of the management information currently received by the board and how such management information could be improved to facilitate the board's planning and oversight capacities; and,

    ▪ a review of the current board requirements under MISS. CODE ANN. § 41-4-7 (1972) for the purpose of identifying current duties that

hinder the board's ability to address broader departmental issues (such as strategic planning) and those that could be satisfactorily handled by the Department of Mental Health's administrative staff. The board should submit proposed revisions to the law to the appropriate committees for consideration during the 2009 legislative session.

3. The Legislature should amend MISS. CODE ANN. Section 41-4-3 (1972) to establish a nonvoting advisory position on the Board of Mental Health for a designee of the Mississippi Association of Community Mental Health Centers.

4. The Board of Mental Health should consider developing a patient tracking and management information system, in conjunction with the fifteen regional community mental health centers, to track patients within the state mental health system and to yield usable performance information for managing the Department of Mental Health and for providing mental health services throughout the state.

5. In order to ensure clear observation and measurement of progress toward the agency's and individual bureaus' goals, the Board of Mental Health should develop a comprehensive set of program-specific quantitative performance measures and goals as part of its strategic planning effort. As a model, the board should consider the National Outcome Measures required by the Substance Abuse and Mental Health Services Administration as a part of its grant accountability process.

6. The Board of Mental Health should develop a well-defined agency-wide mission statement that provides guidance for the agency in its decisionmaking process. Further, the Board of Mental Health should develop a complete vision statement that provides a realistic benchmark for the agency's long-term success.

    Following is an example of what a well-defined mission statement for the department might be:

    Our mission as the state's lead agency in charge of regulating and providing mental health services to the people of Mississippi is five-fold:

- *To provide a comprehensive system of care to people affected by mental illness, mental retardation/developmental disabilities, alcohol and drug abuse, and Alzheimer's Disease and other dementia in both community and institutional settings;*

- *To regulate mental health services within the state of Mississippi;*

- *To educate the people of Mississippi about mental health issues within the state and to reduce the stigma associated with mental health issues;*

- *To continually explore new means in which to better improve the lives of those affected by mental health issues; and,*

- *To maximize the benefit of the taxpayer's dollars by meeting the state's mental health needs in the most efficient and effective means possible.*

Following is an example of what a well-defined vision statement for the department might be:

> *The Mississippi Department of Mental Health will provide its clients the opportunity for a better tomorrow by providing the highest quality of life possible via a community-based system of care, where feasible. Our system will be a person-centered environment that is built on the strengths of individuals and their families while meeting their needs for special services and supports.*

Planning for the Delivery of Mental Health Services in Mississippi: A Policy Analysis

Introduction

Authority

PEER conducted this review pursuant to the authority granted by MISS. CODE ANN. Section 5-3-51 et seq. (1972).

Purpose and Scope

Problem

The PEER Committee received complaints from citizens alleging inefficient use of resources by the Department of Mental Health. In addition to concerns about the prudency of specific expenditures, the complainants were concerned about whether the department makes the best use of resources to meet the state's mental health needs.

Purpose

To address these citizens' concerns, rather than conducting a targeted expenditure review, the PEER Committee opted for a broader and potentially more beneficial policy analysis. The purpose of this policy analysis was to determine whether the Board of Mental Health and the Department of Mental Health are positioning the state to make the most efficient use of resources through a well-designed and executed planning process that considers the full range of the state's needs in delivering mental health services.

PEER sought to analyze the Department of Mental Health's planning process and how the resulting plan is used by the Board of Mental Health for general decisionmaking and for establishing priorities, allocating resources, and setting the direction for development of the department's program and service structure.

Scope

While PEER's policy analysis offers recommendations for constructive change, the reader should not infer that either the Board of Mental Health or the Department of Mental Health has acted improperly or contrary to law in their approach to planning and management. The Department of Mental Health and its programs have prospered under the current system, but PEER suggests that opportunities for greater economy and efficiency, as well as achieving a more balanced service continuum, are possible. This policy analysis does not provide the blueprint for changing resource allocation, but suggests ways to improve the state's mental health strategic planning efforts in order that such a blueprint could be produced.

Method and Information Sources

PEER interviewed members of the Board of Mental Health and staff of the Department of Mental Health and obtained financial, programmatic, and operational information related to the department's planning process. PEER also sought information concerning the department's goals and objectives, performance measures, and management information system. In addition, PEER obtained information concerning the department's relationship with the state's community mental health centers.

To develop criteria for the analysis, PEER reviewed not only the literature regarding strategic planning as a management tool, but information on national trends in mental health service delivery and resource allocation. PEER relied extensively on information from the following studies in this policy analysis:

- The *FY 2005 State Mental Health Revenue and Expenditures Study* (also known as the SMHA State Profiles System), produced by the National Association of State Mental Health Program Directors Research Institute, Inc. (NASMHPD). This study contains compilations of state-reported data on revenues and expenditures received and controlled by each individual state mental health agency (SMHA), referred to in this report as "SMHA-controlled expenditures." Data is included for all services provided by the SMHA's mental health programs, as well as community mental health systems, but excludes mental retardation/developmental disabilities (MR/DD)

and alcohol or drug abuse programs. Fund sources include all state general funds received by the SMHA, federal mental health block grants, and local funds required to match state dollars. Capital improvement revenues and expenditures are not included.

- *The State of the States in Developmental Disabilities 2008* (SSDD 2008), a research project administered by David Braddock, Ph.D.; Richard Hemp; and Mary C. Rizzolo, Ph.D., in conjunction with the Department of Psychiatry and the Coleman Institute for Cognitive Disabilities at the University of Colorado. This project includes twenty-nine years of data regarding revenue, expenditures, and trends related to developmental disabilities in the fifty states and the District of Columbia.

Background: How Mississippi Delivers Mental Health Services

Mississippi's publicly funded mental health system addresses both mental illness and mental retardation (i.e., developmental disability).

Mississippi's publicly funded mental health system provides services to address issues related to both mental illness and mental retardation. According to the National Institutes of Health, *mental illness* is "a health condition that changes a person's thinking, feelings, or behavior (or all three) and that causes the person distress and difficulty in functioning" and *mental retardation* is "a condition in which a person has an IQ that is below average and that affects an individual's learning, behavior, and development. This condition is present from birth." Another frequently used term for mental retardation is *developmental disability*.

Mental health issues affect the lives of thousands of Mississippians. During 2006, the Department of Mental Health reported that approximately 92,000 persons with mental illness or emotional disturbance sought treatment in the public mental health system. Based on incidence rates developed by the U. S. Centers for Disease Control and Prevention, an estimated 35,000 to 45,000 Mississippians could be classified as mentally retarded or developmentally disabled.

Statutory Authority for Planning and Delivery of Mental Health Services

The State's Responsibility for Providing Mental Health Services

Regarding the delivery of mental health services, MISS. CODE ANN. Section 41-4-1 (1972) declares that the purpose of Title 41, Chapter 4, which creates the Department of Mental Health, is:

> *. . . to coordinate, develop, improve, plan for, and provide all services for the mentally ill, emotionally disturbed, alcoholic, drug dependent, and mentally retarded persons of this state; to promote, safeguard and protect human dignity, social well-being and general welfare of these persons under the cohesive control of one (1) coordinating and responsible agency so that mental health and mental retardation services and facilities may be uniformly provided more efficiently and economically to any resident of the State of*

Mississippi; and further to seek means for the prevention of these disabilities.

In furtherance of these goals, the remainder of Chapter 4 of the CODE establishes the Board of Mental Health, the Department of Mental Health, and mental health advisory councils.

Board of Mental Health

MISS. CODE ANN. Section 41-4-3 (1972) establishes the Board of Mental Health, whose membership consists of nine individuals appointed by the Governor, one from each congressional district and four members from the state at-large.[1] Of the four at-large members, one must be a licensed medical doctor who is a psychiatrist, one must be a licensed clinical psychologist, one must be a licensed medical doctor, and one must be a social worker with experience in the mental health field.

Department of Mental Health

MISS. CODE ANN. Section 41-4-5 (1972) establishes the Department of Mental Health. Under the authority of the board, the department is organized into seven bureaus, four of which deal directly with facilities and service delivery:

- The *Bureau of Mental Health* oversees the state psychiatric facilities, which include public inpatient services for individuals with mental illness and/or alcohol/drug abuse services and the state crisis centers, as well as the Central Mississippi Residential Center and the Specialized Treatment Facility (for youth with emotional disturbances whose behavior requires specialized treatment).

- The *Bureau of Community Mental Health Services* has the primary responsibility for the development and implementation of community-based services to meet the needs of adults with serious mental illness and children with serious emotional disturbance, as well as to assist with the care and treatment of persons with Alzheimer's Disease and other dementia.

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[1] The Attorney General has opined that the language referring to the appointment of board members by congressional districts "as presently constituted" would here mean the districts in force and effect in 1974 when the legislation was adopted (see *Opinion to Shows*, January 18, 1994). Consequently, the recent change in apportionment of Mississippi's congressional districts did not affect the number of district appointees (five) to the Board of Mental Health or the boundaries of their districts.

- The *Bureau of Alcohol and Drug Abuse* is responsible for the administration of state and federal funds utilized in the prevention, treatment and rehabilitation of persons with alcohol and/or drug abuse problems, including state three-percent alcohol tax funds.

- The *Bureau of Mental Retardation* is responsible for planning, development, and supervision of services for individuals in the state with mental retardation/developmental disabilities.

The *Bureau of Administration*, the *Bureau of Interdisciplinary Programs*, and the *Bureau of Workforce Planning and Development* operate as support bureaus.

See Exhibit 1, page 7, for an organizational chart for the Department of Mental Health.

Facilities Providing Services for Mental Illness

The DMH operates six inpatient facilities that provide psychiatric and alcohol/drug abuse services. Exhibit 2, pages 8 and 9, shows the locations of Mississippi's state inpatient facilities for mental illness. According to the DMH, one of these facilities, the Mississippi State Hospital at Whitfield, is the largest public psychiatric facility in the United States, with 1,118 resident clients in FY 2007.

The Mississippi State Hospital at Whitfield is the largest public psychiatric facility in the U. S.

These facilities provide a wide array of services for persons experiencing problems with mental illness and chemical dependency. Long-term inpatient psychiatric services are offered at Mississippi State Hospital, Central Mississippi Residential Center, and East Mississippi State Hospital. Short-term inpatient psychiatric services and alcohol/drug abuse treatment services are offered at Mississippi State Hospital, East Mississippi State Hospital, North Mississippi State Hospital, and South Mississippi State Hospital. With the exception of the Specialized Treatment Facility, each inpatient facility also offers community services such as group homes, case management, and rehabilitation programs. The Specialized Treatment Facility is designed for youth with mental illness who have been assigned to the facility through the judicial system.

Facilities Providing Services for Treatment of Mental Retardation/Developmental Disabilities

The DMH operates six facilities that provide services for individuals with mental retardation and developmental disabilities. Exhibit 2, pages 8 and 9, shows the locations

Exhibit 1

Organizational Chart: Department of Mental Health

SOURCE: 1) Organizational Chart for the Mississippi Department of Mental Health
2) The Department of Mental Health's Website at http://www.dmh.state.ms.us/

Exhibit 2

State Facilities for Delivery of Services:
Mental Illness &
Mental Retardation/Developmental Disabilities

DeSoto
Benton
Alcorn
Marshall
Tippah
Tishomingo
Tunica
Tate
Prentiss
Union
Panola
Lafayette **E**
6 Itawamba
Coahoma
Quitman
Pontotoc
Lee
Yalobusha
Calhoun
Chickasaw
Monroe
Tallahatchie
Bolivar
Grenada
Webster
Clay
Sunflower
Leflore
Montgomery
Lowndes
Carroll
Washington
Humphreys
Choctaw
Oktibbeha
Holmes
Attala
Winston
Noxubee
Sharkey
Leake
Neshoba
Kemper
Yazoo
Issaquena
Scott
Newton **4**
Lauderdale **5**
Madison
Warren
Rankin
C 3
Smith
Jasper
Clarke
Claiborne
Copiah
Simpson
B
Jefferson
F
Covington
Jones **D**
Wayne
Adams
Franklin
Lincoln
Lawrence
Jeff Davis
Lamar
Wilkinson
Amite
Pike
Marion
2 Forrest
Perry
Greene
Walthall
George
Stone
Pearl River
Harrison
Jackson
Hancock
1 A

N

0 10 20 30
Miles

Exhibit 2 (continued)

State Facilities for Delivery of Service: Mental Illness

IDENTIFIER	NAME	CITY
1	Specialized Treatment Center for Emotionally Disturbed Youth	Gulfport
2	South Mississippi State Hospital	Purvis
3	Mississippi State Hospital	Whitfield
4	Central Mississippi Residential Center	Newton
5	East Mississippi State Hospital	Meridian
6	North Mississippi State Hospital	Tupelo

State Facilities for Delivery of Services: Mental Retardation/Developmental Disabilities

IDENTIFIER	NAME	CITY
A	South Mississippi Regional Center	Long Beach
B	Boswell Regional Center	Magee
C	Hudspeth Regional Center	Whitfield
D	Ellisville State School	Ellisville
E	North Mississippi Regional Center	Oxford
F	Juvenille Rehabilitation Center	Brookhaven

of Mississippi's state facilities providing services for mental retardation and developmental disabilities.

Except for the Juvenile Rehabilitation Center, each of these facilities provides long-term inpatient care and community services through residential and day programs. The Juvenile Rehabilitation Center provides services for mentally retarded adolescent offenders committed by youth or chancery court.

Mental Health Advisory Councils

MISS. CODE ANN. Section 41-4-9 (1972) authorizes and directs the Board of Mental Health to create advisory councils to assist the board and department in the "performance and discharge of their duties."

Advisory councils provide an avenue for clients, family members, and service providers to communicate and work together in identifying and planning services.

Advisory councils provide an avenue for clients, family members, and service providers to communicate with each other and work together in identifying and planning services for individuals in their service area. Advisory councils also assist the DMH and their respective bureau or division directors in developing a state plan for services for individuals (see page 37).

According to the Board of Mental Health and staff of the Department of Mental Health, the following mental health advisory councils are currently active:

- the Bureau of Mental Retardation State Plan Advisory Council (eight members, meets quarterly);

- the Mississippi Alcohol and Drug Abuse Advisory Council (twenty-five to thirty members, meets quarterly);

- the Mississippi Alzheimer's Disease and Other Dementia Planning Council (fourteen members, meets semi-annually); and,

- the Mississippi State Mental Health Planning and Advisory Council (thirty-eight members, meets quarterly).

Currently, one member of the Board of Mental Health also serves on the Mississippi State Mental Health Planning and Advisory Council.

The federal Community Mental Health Centers Act of 1963 authorized the expenditure of funds for the support of community-based and -governed mental health services through community mental health centers.

Although known by different names, community mental health centers (CMHCs) in other southeastern states operate either independently with state oversight, are entirely state operated, or are contracted to third parties. CMHCs in Alabama, Arkansas, North Carolina, and Tennessee operate independently, with the state regulating the facilities. In Tennessee, CMHCs are the "single point of entry" into the mental health system, and the CMHCs maintain responsibility for the patient throughout the course of treatment. In Louisiana, four out of ten CMHCs operate independently, with the remaining six CMHCs being state-owned and -operated. In South Carolina, CMHCs are state-owned and -operated and serve as the state's primary community-based outpatient treatment facilities. In Georgia and Florida, private entities are contracted to operate the CMHCs, with each state monitoring the operation of and services provided by the CMHCs.

In every southeastern state, with the exception of Tennessee, CMHCs are funded at least in part by state funds. CMHCs in Tennessee receive only grants. Other fund sources include Medicaid, fee for service, local support (county or regional), and grants.

Mississippi's CMHCs are autonomous public bodies governed by regional commissions. They are independent from, yet regulated by, the Department of Mental Health.

Mississippi passed legislation in 1966 to authorize the creation of such locally governed community mental health centers. (See Chapter 477, *Laws of 1966.*) In Mississippi, these centers are autonomous public bodies governed by regional commissions that include representatives from each county in that service area and who are appointed by their respective boards of supervisors. As entities that are independent from, yet regulated by, the Board of Mental Health and Department of Mental Health, the community mental health centers play a large role in delivering mental health services to the citizens of Mississippi.

In Mississippi, in order to be certified as a community mental health center, a facility must satisfy the department's requirements for minimum standards.

The centers receive grants from the Department of Mental Health, other public and private grants, local millage, and fees for services (e. g., Medicaid, sliding fee scale, and private insurance). DMH monitors the centers' funds that flow through the department and monitors centers' compliance with minimum standards that the CODE requires the department to set.

Under MISS. CODE ANN. §41-4-7 (f) (1972), the Department of Mental Health establishes minimum standards for the community mental health centers. In order to be certified as a community mental health center, a facility must satisfy the department's requirements for the Minimum Standards for Community Mental Health/Mental Retardation Services.

In order to be a department-approved mental health/mental retardation center, community mental health centers (and other community mental health services providers operated by entities other than the department) must provide the following services across the four spectrums:[2]

- outpatient therapy;

- case management;

- psychiatric/physician services;

- emergency services;

- psychosocial rehabilitation;

- inpatient referral;

- support for family education services;

- support for consumer education services;

- pre-evaluation screening for civil commitment (required only for centers operated by regional commissions established under MISS. CODE ANN. Section 41-19-31 et seq. [1972]);

- intake/functional assessment;

- primary residential treatment (adults);

- DUI assessment;

- outreach/aftercare; and,

- prevention services.

The Minimum Required Levels of Services for community mental health centers states that all community mental health centers must provide case management services for

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[2] The four spectrums are adult mental health services, children and youth mental health services, alcohol and drug abuse services, and mental retardation/developmental disabilities services. The bulleted list of services is a generalized list that is inclusive of all minimum service levels; not all of these services are required for each spectrum of service.

clients with mental retardation/developmental disabilities. If not, the CMHC must have a written agreement with another provider (such as a DMH regional center) for case management services.

Failure to provide minimum levels of service would result in the department's decertification of the facility that fails to comply. If a facility is found to be in violation or deficient, a Certificate of Operation will not be issued. However, if the facility files a Plan of Correction, which states how it will address the deficiencies (which must be corrected within a timeline issued by DMH), a certification process continues in the form of a follow-up visit and ultimately (assuming deficiencies have been corrected), a recertification visit.

Exhibit 3, pages 14 and 15, shows the locations of the community mental health centers, the names of the regions, and which counties lie within each region. Each of the fifteen CMHCs has satellite offices located within its service area.

Mississippi's Financial Commitment to Delivery of Mental Health Services

Revenues and Expenditures

For FY 2007, Medicaid reimbursements for services rendered to clients at MR/DD and mental illness facilities constituted DMH's largest source of funds (approximately $243 million) and state general funds were the second largest source (approximately $236 million). Funds from all sources totaled $587 million. Exhibit 4, page 16, shows a breakdown of the sources of funds. According to the Mississippi Association of Community Mental Health Centers, the fifteen CMHCs collected $190 million in revenue from all sources during FY 2007.

For FY 2007, Medicaid reimbursements for services rendered to clients constituted DMH's largest source of funds and state general funds were the second largest source.

The Department of Mental Health's FY 2007 expenditures totaled approximately $584 million. Salaries, Wages, and Fringe Benefits constituted the largest single category of expenditures (approximately $347 million) and Subsidies, Loans, and Grants was the second largest category of expenditures (approximately $136 million). Exhibit 5, page 17, shows the distribution of expenditures. Community mental health centers received approximately $29 million from DMH in FY 2007 through subsidies, loans, and grants. (See Exhibit 6, page 18, for a breakdown of categories of all DMH subsidies, loans, and grants.) (See page 25 describing Mississippi's financial commitment to mental health.)

Exhibit 3

Community Mental Health Centers:
Main Office and Service Area

DeSoto
Benton
Alcorn
④
Marshall
Tippah
Tishomingo
Tate
Prentiss
Tunica
Union
Lafayette
②
Panola
Lee
Coahoma
Pontotoc
③
Itawamba
①
Quitman
Yalobusha
Calhoun
Chickasaw
Monroe
Tallahatchie
Grenada
Bolivar
Webster
Clay
Sunflower
Leflore
Carroll
Montgomery
Choctaw
Oktibbeha
Lowndes
⑥
⑦
Washington
Humphreys
Holmes
Attala
Winston
Noxubee
Sharkey
⑤
Yazoo
Leake
Neshoba
Kemper
Issaquena
Madison
Scott
Newton
Lauderdale
Warren
Rankin
⑩
⑮
Hinds
⑧
⑨
Smith
Jasper
Clarke
Claiborne
Copiah
Simpson
Jefferson
Jones
Wayne
Covington
Adams
Jeff Davis
Franklin
Lincoln
Lawrence
⑪
Marion
Lamar
Forrest
Perry
Greene
⑫
Amite
Pike
Wilkinson
Walthall
George
Stone
Pearl River
Jackson
Harrison
⑬
Hancock
⑭

N

0 10 20 30
Miles

Numbered circle indicates region number and location of central office.

Sources: MS Dept. of Mental Health; Standing Joint Legislative
Committee on Redistricting and Reapportionment

Exhibit 3 (continued)

REGION	NAME	LOCATION
1	Region One Mental Health Center	Clarksdale
2	Communicare	Oxford
3	Region III Mental Health Center	Tupelo
4	Timber Hills Mental Health Services	Corinth
5	Delta Community Mental Health Services	Greenville
6	Life Help	Greenwood
7	Community Counseling Services	Starkville
8	Region 8 Mental Health Services	Brandon
9	Hinds Behavioral Health Services	Jackson
10	Weems Community Mental Health Center	Meridian
11	Southwest Mississippi Mental Health	McComb
12	Pine Belt Mental Healthcare Resources	Hattiesburg
13	Gulf Coast Mental Health Center	Gulfport
14	Singing River Services	Gautier
15	Warren-Yazoo Mental Health Service	Vicksburg

Exhibit 4: DMH FY 2007 Source of Funds*

General Funds
$236 million (40%)

Other Funds
$89 million (15%)

Healthcare Expendable
Trust Funds
$19 million (3%)

Medicaid
$243 million (42%)

$587 million total FY 2007 funds
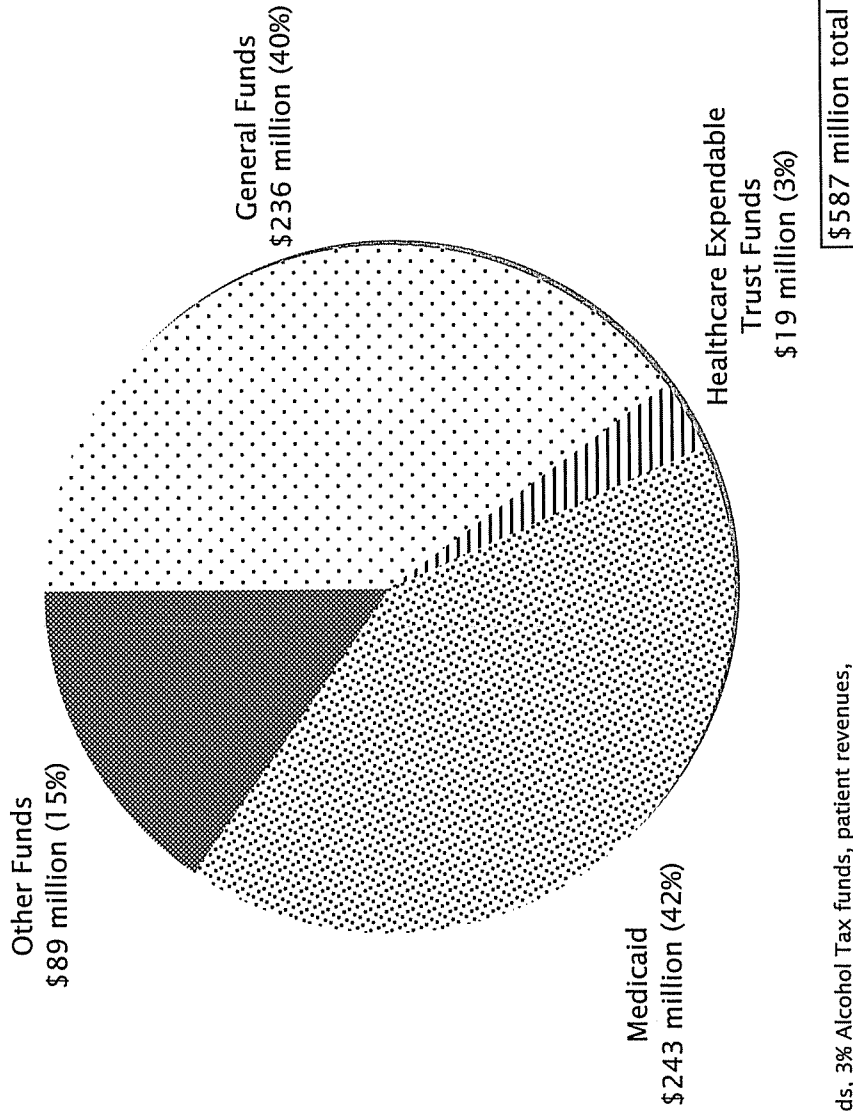
Other funds include Federal funds, 3% Alcohol Tax funds, patient revenues,
Medicare, and Drug Court Assessment Funds.
*Amounts are rounded to the nearest million.
SOURCE: PEER analysis of DMH financial information.

Exhibit 5: DMH FY 2007 Expenditures[*]

Salaries, Wages, and
Fringes
$347 million (60%)
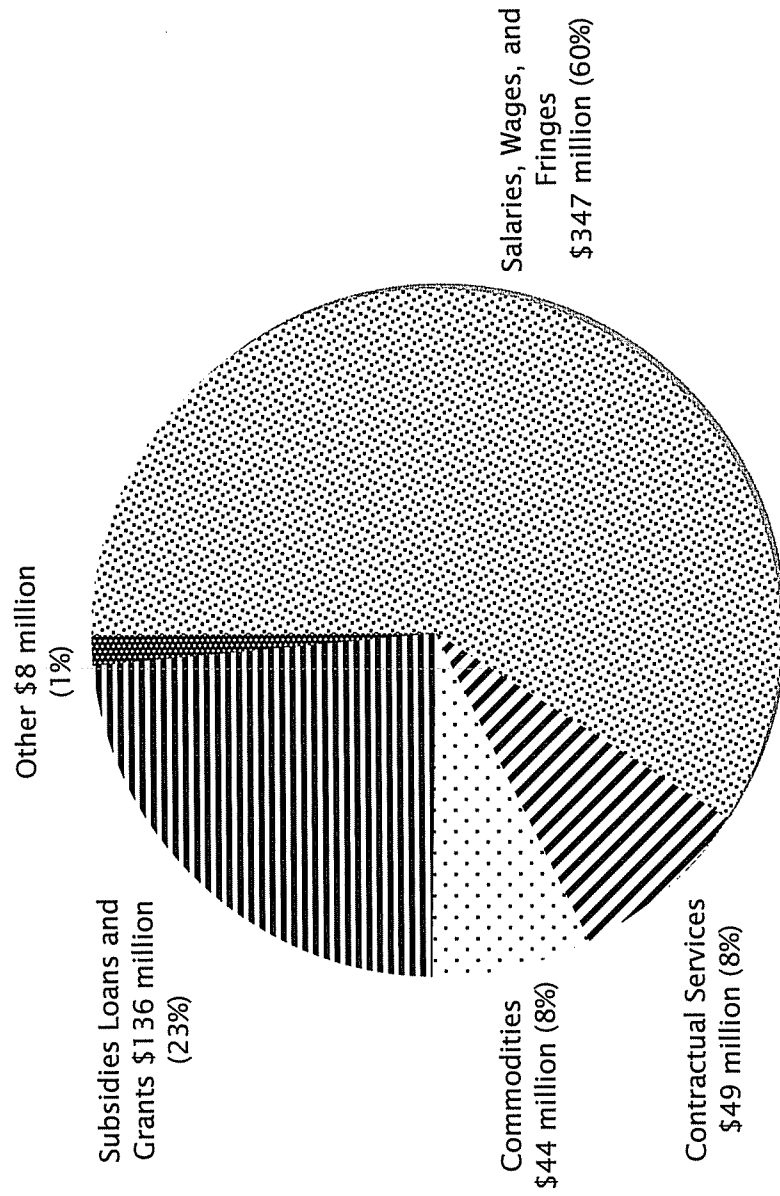
$584 million total FY 2007

Other $8 million
(1%)

Subsidies Loans and
Grants $136 million
(23%)

Commodities
$44 million (8%)

Contractual Services
$49 million (8%)

Other expenditures include travel, equipment, and vehicles.
*Amounts are rounded to the nearest million.
SOURCE: PEER analysis of DMH Final Consolidated Financial Summaries for FY 2007.

Exhibit 6: DMH FY 2007 Subsidies, Loans, and Grants*†

Medicaid Match
$68 million (50%)

Other $18 million
(13%)

Medicaid Bed Tax
$9 million (6%)

Mental Retardation
Programs $5 million
(4%)

Alcohol and Drug
Programs
$19 million (14%)

Mental Health Programs
$17 million (13%)

$136 million total FY 2007 subsidies, loans, and grants
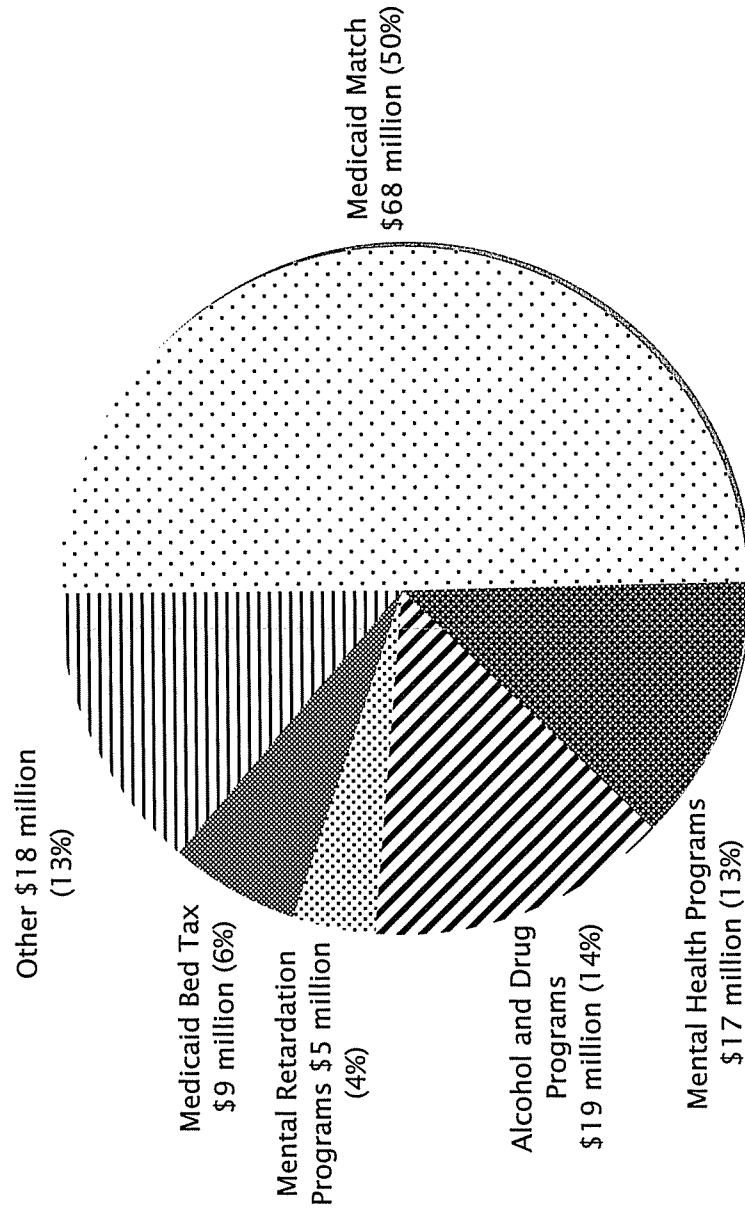
*Amounts are rounded to the nearest million.
† Funds are distributed to governmental and non-governmental entities through the
  Subsidies, Loans, and Grants category.
Other includes Katrina-related services, children's services, miscellaneous items.
SOURCE: PEER analysis of DMH expenditure information.

Changes in National Trends in Mental Health Service Delivery and Mississippi's Response

Although the mental health environment in the United States has dramatically changed from an institution-based system to a community-based system in recent years, Mississippi's mental health system has not reflected the shift in service delivery methods. Due to implications of the Supreme Court's 1999 *Olmstead* decision, the state will be forced to move toward providing more community-based care in the near future.

The Shift in National Trends for Delivery of Mental Health Services

Shifts in Mental Health Policy from the Nineteenth Century to the Present: From Asylum to Community

The mental health policy environment in the United States has dramatically changed from an institution-based system to a community-based system.

In an article written for the Substance Abuse and Mental Health Services Administration's *Mental Health, United States, 2000* report, Gerald N. Grob, Ph.D., of Rutgers University traces the complex, and at times seemingly contradictory, history of mental health policy in twentieth-century America from its roots in the asylums of the mid-nineteenth century to the more contemporary emphasis on community-oriented policy. As we reach the close of the first decade of the twenty-first century, we would do well to reflect on the major changes that have marked the twentieth century to see where Mississippi stands in its evolution of mental health policy. To summarize what Dr. Grob has presented as the history of mental health policy in twentieth-century America, PEER notes several milestones that should serve as a backdrop to viewing Mississippi's mental health policies.

The dominant thrust in national mental health policy has moved away from housing clients in large state institutions and toward treating individuals in a community setting.

From the mid-nineteenth century until after World War II, state mental hospitals were generally seen as "the symbol of an enlightened and progressive nation that no longer ignored or mistreated its insane citizens." In the years between 1890 and 1950, both public policy and scientific shifts led to an extraordinary growth in the proportion of persons with long-term mental health needs being treated in state mental hospitals rather than in local almshouses.

After World War II, public policy began to shift again to a more reasoned emphasis on community-based care and treatment, leading to a widely held perception that mental hospitals were the vestiges of an earlier time needing

replacement with an improved service structure. Although the reasons are complex, the dominant thrust in national mental health policy in the twentieth century moved away from housing clients in large state institutions and toward treating individuals in a community setting.

This "new psychiatric revolution" reached a peak in the 1960s with creation of the community mental health center movement and the availability of federal funding for building a community-based system of services. Culminating with passage of the Community Mental Health Centers Act of 1963, public mental health policy nationwide has trended toward diminishing the role of public mental hospitals and toward an increased reliance on outpatient and community services, although this system never reached the heights for service originally envisioned in support of the broad concept of deinstitutionalization. The community programs grew but their focus was on new populations that had little significant access to the mental health system and were not people in need of long-term care.

In order to create an environment conducive to developing local support, governance of the community mental health centers was placed in the hands of local boards. While this has had advantages in defining local service structures, the arrangement contributes to fragmentation in the planning processes needed to achieve efficient deinstitutionalization and "rightsizing" of state-level institutional care. As a result, the ongoing relationship between community and institutional care during the last forty years has been marked more by evolution than by revolution, as the post-war assertion that mental hospitals were losing their social and medical legitimacy reached primacy.

Factors such as the growth of entitlement programs, judicial decisions such as *Olmstead*, and the relative scarcity of state financial support for community programs have produced a critical need for strategic planning at the state level.

Since that time, changes in federal policies have kept federal, state, and local roles in flux as service and funding priorities have shifted along a broad continuum, with the focus of expanded needs for funding and policy direction appearing to shift significantly back to the state and local level during the 1980s. Other factors such as the growth of entitlement programs during the 1990s due to funding incentives, judicial decisions such as *Olmstead* (which supports the drive toward integrating people with disabilities into least restrictive settings; see page 31 for additional information), and the relative scarcity of state financial support for community programs have produced a critical need for strategic planning at the state level. In order for states to optimize resources and focus on service needs of the population for both institutional and non-institutional care, they must forge rational policy out of a confusing and often contradictory competition for resources. State and community needs must merge in a

rational approach to change involving a wide range of stakeholders.

Data Regarding National Trends in Service Delivery Methods/Facilities

On a nationwide basis, data reflects the states' policy shift from institution-based service delivery to community-based service delivery for mental illness services and MR/DD services.

In FY 2005, the nationwide percentage of expenditures for community-based mental illness services as a percentage of total expenditures for mental illness services totaled 70%.

As a percentage of total expenditures for services related to mental illness, the SMHA State Profiles System notes that the nationwide percentage of expenditures for community-based services first exceeded the percentage of expenditures for institution-based services in 1993 by a ratio of 49% to 48%, respectively. Since 1993, this trend has continued and in FY 2005, the nationwide percentage of expenditures for community-based services as a percentage of total expenditures for mental illness services totaled 70% compared to 27% for institution-based services. The remaining three percent was for SMHA support services. (See Exhibit 7, page 22.)

In FY 2006, the states' fiscal effort for community-based MR/DD services was approximately four times that for institution-based MR/DD services.

For MR/DD services nationwide, in 1989, the states' fiscal effort for community-based services exceeded the states' fiscal effort for institution-based services by $1.59 per $1,000 of personal income to $1.51 per $1,000 of personal income, respectively. Since then, the states' fiscal effort for community-based services has continued to increase while the fiscal effort for institution-based services has declined. By FY 2006, the states' fiscal effort for community-based services was approximately four times that for institution-based services. (See Exhibit 8, page 23.)

Nationwide, the number of beds devoted to residential treatment for mental illness declined by 86% from 1970 to 2002. From FY 1997 to FY 2005, nationwide expenditures on community-based delivery of services for mental illness increased 112%.

Regarding delivery of services for mental illness, the number of beds for residential treatment fell 86% from 1970 to 2002, from 413,066 to 57,263. Likewise, from 1969 to 2002, the number of individuals in state mental illness institutions nationwide declined 86%, from 369,969 to 52,612. From 1970 to 2006, eighty-seven state psychiatric hospitals closed nationwide.

As would be expected, the drop in the number of clients receiving residential treatment for mental illness has been

Exhibit 7: Institutional vs. Community SMHA-Controlled Mental Illness Expenditures for the United States and Mississippi*

Legend:
- US Institution
- US Community
- MS Institution
- MS Community
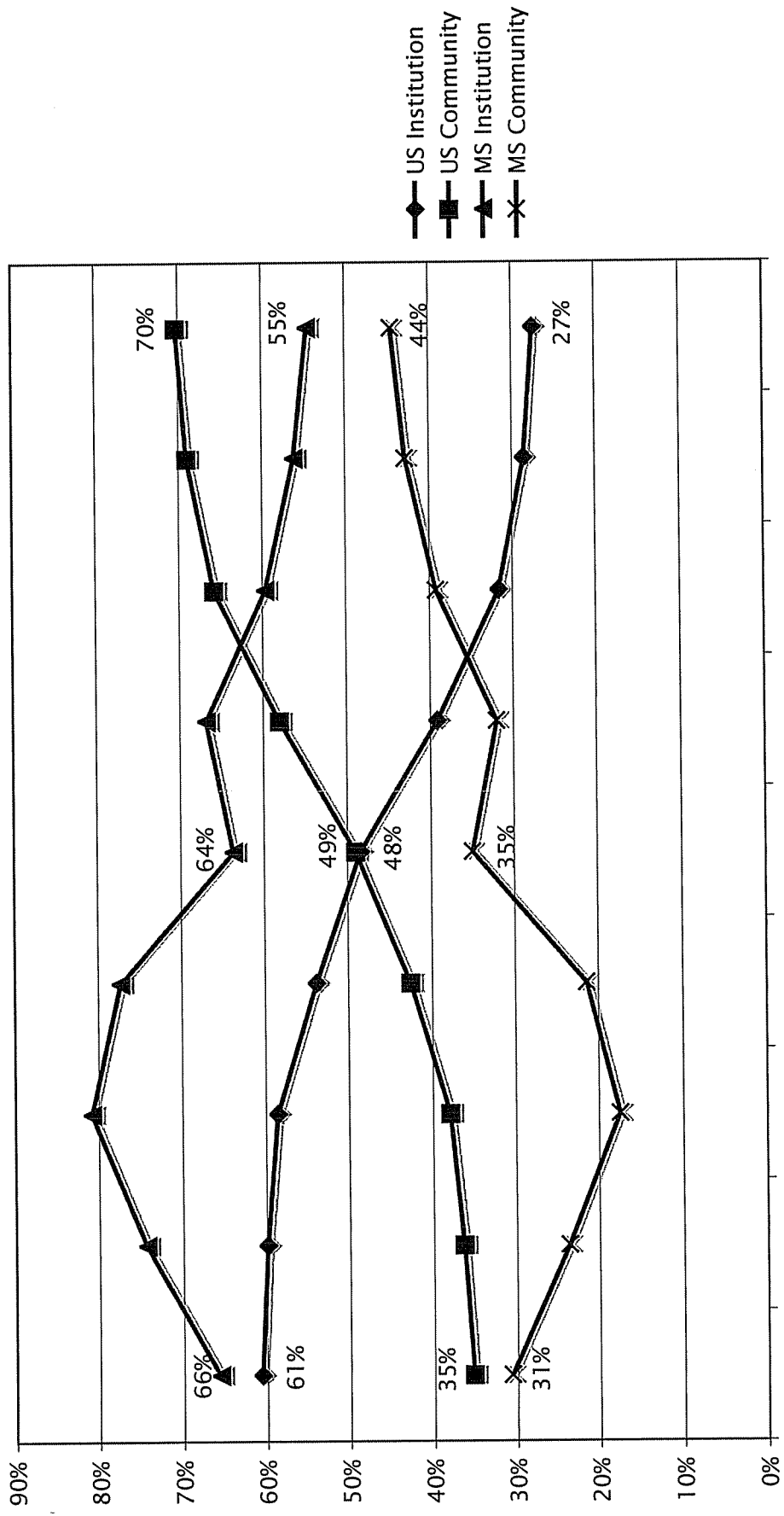
NOTE: In FY 1993, nationwide expenditures for mental illness services in a community setting surpassed expenditures for mental illness services in an institutional setting 49% to 48%, respectively. In FY 2005, Mississippi expenditures for mental illness services in an institutional setting totaled 55% compared to 44% expenditures for mental illness services in a community setting.

*SMHA=State Mental Health Agency

SOURCE: National Association of State Mental Health Program Directors Research Institute, Inc.

Exhibit 8: Institutional vs. Community MR/DD Fiscal Effort for the United States and Mississippi*
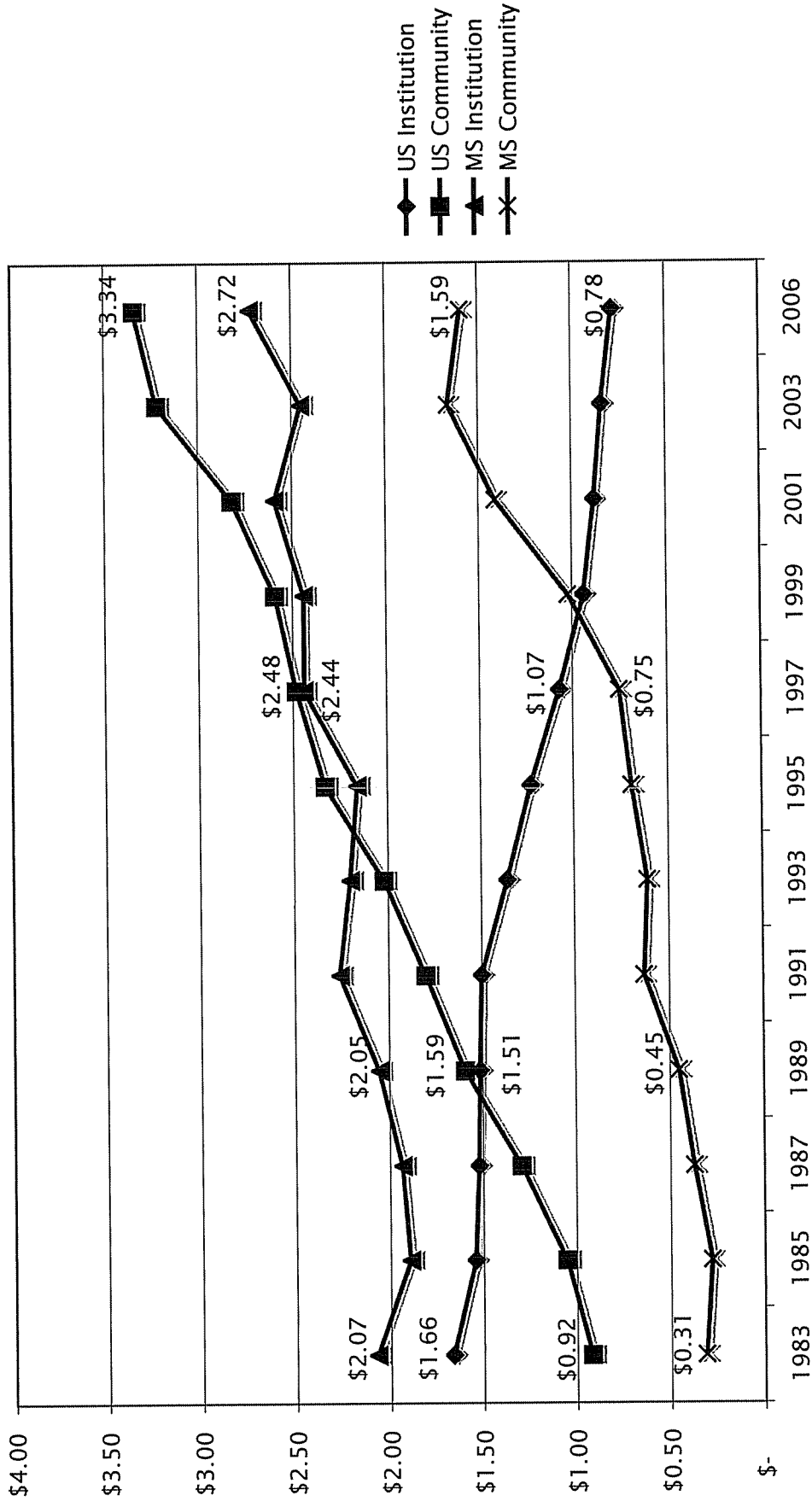
Note: In FY 1989, nationwide fiscal effort for community services surpassed fiscal effort on institutional services $1.59 to $1.51, respectively. In FY 2006, Mississippi's fiscal effort for MR/DD institutional services exceeded the fiscal effort for community services $2.72 to $1.59, respectively.

*Fiscal effort represents a state's commitment of resources to MR/DD services given the competing interests present in every state.

SOURCE: The State of the States in Developmental Disabilities 2008 report.

accompanied by a shift in funding from institution-based to community-based programs:

- In FY 1983, 61% of SMHA-controlled expenditures nationwide were for state psychiatric hospital inpatient care and 35% were for community-based services for mental illness. By FY 1993, nationwide expenditures for inpatient services and community-based services for mental illness were almost equal, with hospital inpatient care accounting for 48% of total mental health expenditures and community-based services accounting for 49% of expenditures.

- In FY 2005, inpatient care expenditures had fallen to 27% of total SMHA-controlled expenditures for mental illness services nationwide and community-based services had increased to 70% of total SMHA controlled expenditures for mental illness. The remaining 3% of expenditures were for administration, prevention, research, and training.

- From FY 1997 to FY 2005, nationwide expenditures for SMHA-controlled community-based services for mental illness increased 112% and SMHA-controlled expenditures for institution-based services for mental illness increased 23%.

Nationwide, the number of individuals in state institutions for the mentally retarded/developmentally disabled declined by 80% from 1967 to 2006. In FY 2006, eighty-one percent of MR/DD expenditures nationwide were devoted to community-based delivery of services.

Regarding delivery of services for mental retardation/developmental disabilities, from 1967 to 2006, the number of individuals in state institutions nationwide declined from approximately 195,000 to approximately 38,000. As the number of institutional residents declined, states began closing MR/DD facilities.   By May 2007, nine states and the District of Columbia had completely closed their public MR/DD institutions. From 1970 through January 2008, 137 state MR/DD institutions closed and three more were scheduled for closure by the end of 2010.

States' MR/DD service delivery expenditures have reflected the trend in expenditures for delivery of mental illness services. According to SSDD 2008, in 1982, 67% of MR/DD expenditures nationwide were devoted to institutional care and 33% were devoted to community-based services. In FY 2006, only 19% of MR/DD expenditures nationwide were devoted to institutional care while 81% were devoted to community-based services. In that same fiscal year,

fourteen states spent at least 90% of their MR/DD
expenditures on community-based services.

Mississippi's Financial Commitment to Mental Health Service Delivery

Historically, Mississippi has made a major commitment to funding mental health service delivery, ranking high regionally and nationally in mental health expenditures.

In recent years, Mississippi has devoted significant resources to the public mental health system. From FY 2003 to FY 2007, the DMH's annual revenue increased by $128 million, a 28% increase, and during this period the DMH's expenditures totaled $2.5 billion.[3] (See Exhibit 9, page 27.) For example:

- In FY 2005, Mississippi ranked second in the southeastern United States and nineteenth in the nation in annual per capita expenditures for services to the mentally ill. Mississippi's FY 2005 per capita annual expenditure of $105.68 for SMHA-controlled expenditures means that for every citizen in the state, Mississippi spent that amount on all services (institutional, community, and administration) related to mental illness.

- In FY 2005, Mississippi ranked nineteenth nationally in expenditures for delivery of services to the mentally ill. While Mississippi spent $105.68 per capita annually, the District of Columbia ranked first, at $404.40 per capita annually, and New Mexico ranked fifty-first, at $24.23 per capita annually.[4] Nationwide, the average per capita expenditure was $99.54.

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[3]PEER obtained information in this section regarding historical data, trends, and comparisons of Mississippi to national and regional efforts for mental illness services from the FY 2005 SMHA Profile Systems report. Also, PEER obtained information in this chapter regarding historical data, trends, and comparisons of Mississippi to national and regional efforts for MRDD services from *The State of the States in Developmental Disabilities 2008* (SSDD 2008) report. See pages 2 and 3 for more information regarding these reports. Southeastern state comparisons with Mississippi included the states of Alabama, Arkansas, Florida, Georgia, Louisiana, North Carolina, South Carolina, and Tennessee.

[4] The FY 2005 SMHA State Profiles Systems report noted that the District of Columbia's SMHA-controlled expenditures include funds for mental health services in jails or prisons and that New

- In FY 2006, Mississippi's fiscal effort for MR/DD services was thirteen percent higher than the average (excluding Mississippi) for the southeastern United States and in FY 2006 ranked twenty-seventh in the nation in total fiscal effort for MR/DD services.[5] Mississippi's MR/DD fiscal effort of $4.31 per $1,000 was the fifth highest of the nine southeastern states reviewed. Louisiana reported the highest fiscal effort, $6.61 per $1,000, and Georgia reported the lowest fiscal effort, $1.96 per $1,000.

- In FY 2006, Mississippi's total MR/DD fiscal effort ranked 27th in the nation. In FY 1977, Mississippi's total MR/DD fiscal effort had ranked 44th in the nation.

How Mississippi Ranks in Expenditures for Institution-Based Service Delivery

Mississippi has focused primarily on funding institution-based delivery of services for mental illness and mental retardation.

In FY 2005, Mississippi ranked second nationally in annual spending per capita for institutional care for mental illness. In FY 2006, Mississippi's fiscal effort for MR/DD services in an institutional setting was the highest in the nation.

The SMHA State Profiles System report defined *inpatient services* for mental illness as SMHA-funded and -operated facilities that provide primarily inpatient care to mentally ill persons and may provide a range of treatment and rehabilitative services. *Community-based services* for mental illness include services, programs, and activities provided in community settings, including CMHCs, outpatient clinics, consumer-run programs, partial care organizations, partial hospitalization programs, and services provided by state hospitals off the grounds of state hospitals. The SSDD 2008 report defines *institutional* settings for MR/DD services as public and private facilities housing sixteen or more persons and community services as facilities housing less than sixteen persons.

Mississippi has focused primarily on funding institution-based services for both mental illness and mental retardation. For example, regarding the state's expenditures for mental illness services:

Mexico's SMHA-controlled expenditures do not include Medicaid revenues for community programs or children's mental health expenditures.

[5] The SSDD 2008 calculated each state's *fiscal effort* defined as a state's expenditures for MR/DD services per $1,000 of total state personal income. A state's fiscal effort represents a state's commitment of resources to MR/DD services given the competing interests present in every state.

Exhibit 9: DMH Revenues and Expenditures FY 2003 - FY 2007*

Legend:
- Revenues
- Expenditures

FY 2003: $460 / $460
FY 2004: $477 / $472
FY 2005: $510 / $504
FY 2006: $522 / $519
FY 2007: $588 / $584
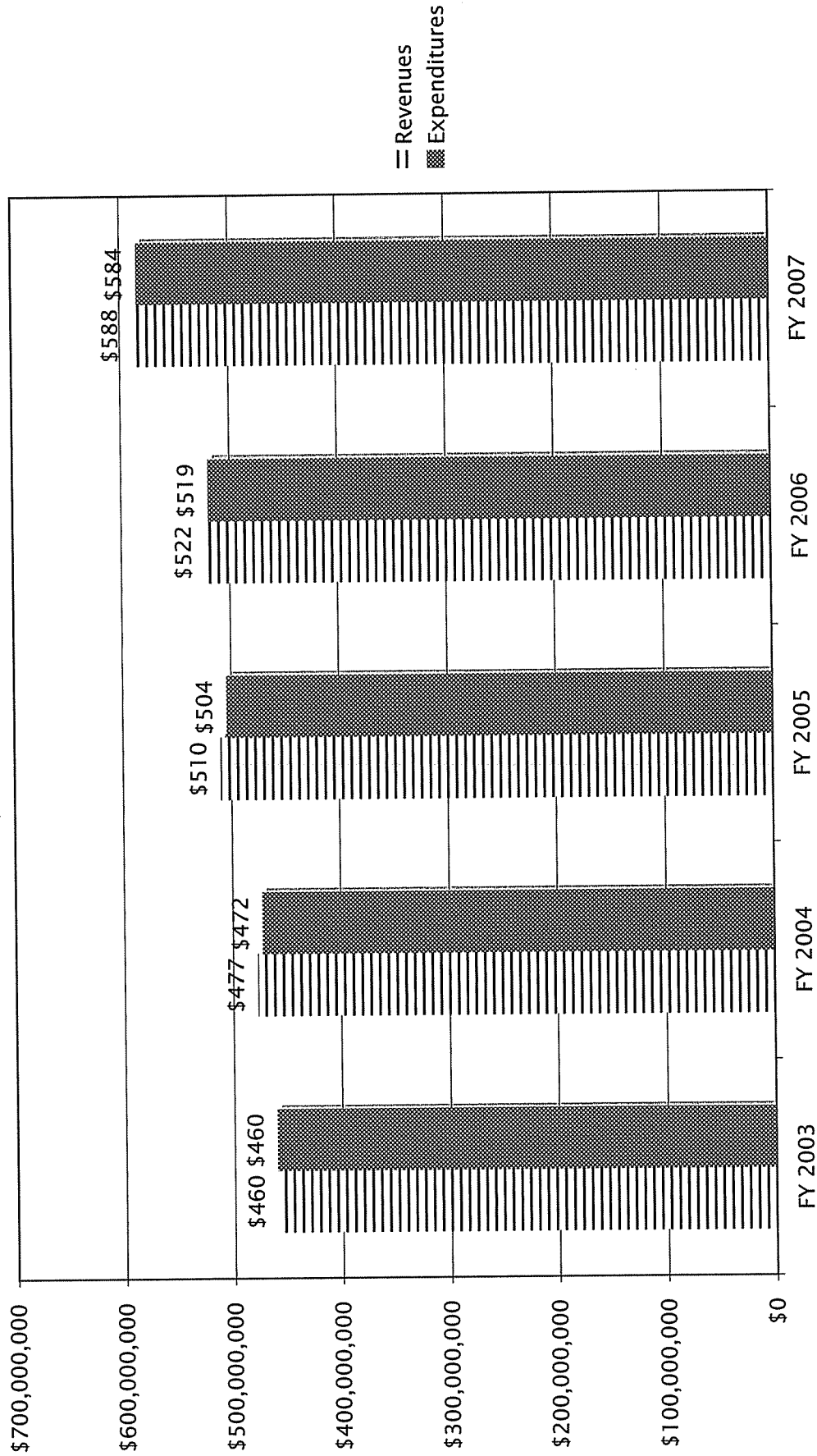
$2.56 billion total revenues from FY 2003 - FY 2007
$2.54 billion total expenditures from FY 2003 - FY 2007

*Amounts rounded to the nearest million.
SOURCE: PEER analysis of DMH information.

- In FY 2005, Mississippi's expenditures for institution-based mental illness services were 152% higher than the southeastern average (excluding Mississippi). In FY 2005, Mississippi ranked second nationally in spending per capita annually for institution-based care.

- Mississippi expended $57.82 per capita annually in FY 2005 for inpatient services compared to the $22.99 regional average, or 152% higher than the regional average (excluding Mississippi).

- Of the $105.68 per capita annual amount that Mississippi spent in FY 2005 for delivery of services for mental illness (see page 25), $57.82 was devoted to institutional care, which ranks Mississippi second nationally in spending per capita annually for institutional care.

Regarding the state's expenditures for mental retardation/developmentally disabled services:

- In FY 2006, Mississippi's fiscal effort for delivering services for mental retardation/developmentally disabled was the highest in the nation and more than double the average fiscal effort of other southeastern states (excluding Mississippi) for institution-based MR/DD services.

- Mississippi's MR/DD fiscal effort for institutional settings was $2.72 per $1,000 of total state personal income, which was 157% percent higher than the southeastern states' average (excluding Mississippi) of $1.06 per $1,000 of total state personal income.

- In FY 2006, Mississippi's fiscal effort for MR/DD services in an institutional setting was the highest in the nation.

While the Department of Mental Health has increased expenditures for community-based service delivery in recent years, the state continues to focus on institution-based service delivery.

Mental Illness: Comparison of Mississippi's Expenditures for Community-Based and Institution-Based Services

Although Mississippi's expenditures for community-based services for mental illness have increased, the rate of increase has been much slower than the nationwide rate of increase. In FY 1983, 31% of Mississippi's expenditures were for community-based care. By FY 2005, community-based services had increased to 44%, but this increase is a

much smaller rate of increase than the national average. From FY 1983 to FY 2005, the nationwide average for expenditures for community-based services for mental illness had increased from 35% to 70%. In FY 2005, Mississippi had yet to follow the national trend set fifteen years ago of devoting the majority of its mental illness expenditures to community-based services.

Although Mississippi's percentage of expenditures for community-based mental illness services increased more from FY 1997 to FY 2005 than did the nationwide average percentage, the state's percentage of expenditures for institution-based mental illness services also increased more during the same period than did the nationwide average percentage.

As noted on page 24, according to the SMHA Profiles System, from FY 1997 to FY 2005, nationwide expenditures on SMHA-controlled community-based expenditures for mental illness increased 112%. During the same period, in Mississippi, SMHA-controlled community-based expenditures for mental illness increased 178%. Also during this same period, SMHA-controlled institution-based expenditures for mental illness nationwide increased 18%, but in Mississippi, SMHA-controlled institution-based expenditures for mental illness increased 64%. Thus, although Mississippi's percentage of expenditures for community-based mental illness services increased more during the same period than did the nationwide average percentage, Mississippi's percentage of expenditures for institution-based mental illness services also increased more during the same period than did the nationwide average percentage.

Mental Retardation: Comparison of Mississippi's Expenditures for Community-Based and Institution-Based Services

Mississippi was the only state in FY 2006 to devote more MR/DD expenditures to institutional services than community-based services.

As noted previously, nationwide, care for persons with MR/DD has also shifted from an institution-based system to a community-based system. However, as with the system of service delivery for mental illness, Mississippi has not followed this nationwide trend and remains primarily an institution-based system, as evidenced by the following:

- In FY 2004, Mississippi reported 1,363 residents in MR/DD institutions and in FY 2006, reported 1,377 residents in MR/DD institutions. Over this same period, the number of residents nationwide decreased from 41,214 to 38,299, a 7% decrease. Although Mississippi has less than one percent of the total population of the United States, over three percent of MR/DD institutional residents, 1,377 out of 38,299, resided in Mississippi institutions in FY 2006.

- Although Mississippi increased spending on MR/DD community services by 134% from FY 1996 through FY 2006, Mississippi was the only state in FY 2006 to devote more MR/DD expenditures to

institutional services than community-based services. According to the SSDD 2008, although by FY 2006, the percent of Mississippi's expenditures devoted to community-based services for MR/DD had reached 37%, on average, 81% of MR/DD expenditures nationwide are devoted to community-based services.

- According to the SSDD 2008 report, from FY 2004 to FY 2006, Mississippi's fiscal effort for MR/DD services in a community setting declined 5%, while fiscal effort for MR/DD services in an institutional setting increased 14%. In contrast, during this same period, nationwide fiscal effort for MR/DD services in a community setting increased 2% and fiscal effort for MR/DD services in an institutional setting declined 5%.

- In FY 2006, Mississippi had 47.1 residents per 100,000 of the general population residing in MR/DD institutions, which was the highest rate in the United States. Nationwide, the rate in FY 2006 was 12.9 residents per 100,000 of the general population.

Recent Opening of New Inpatient Facilities

In contrast to national trends, Mississippi has opened four new inpatient mental health treatment facilities since the mid-1990s.

Mississippi has opened several inpatient mental health facilities aimed at fulfilling different roles and has added nearly 200 psychiatric beds since 1997.

According to statistics from the National Association of State Mental Health Program Directors Research Institute, from 1970 to 2006, the number of state psychiatric hospitals declined nationwide from 315 to 228. Since 2004, four states have closed state psychiatric hospitals and seven states planned to close state hospitals during 2007 and 2008. (The study did not note whether these clients were referred to community-based care or other institutions.) However, since the mid-1990s, Mississippi has opened several inpatient mental health facilities aimed at fulfilling different roles and has added nearly 200 psychiatric beds since 1997, as described below.

- The State of Mississippi acquired the former Clarke College in Newton in May 1997 for use of the Department of Mental Health. The facility was renamed the Central Mississippi Residential Center (CMRC). After six years of construction and renovation to buildings and grounds, CMRC was licensed by DMH for 48 beds and 33 beds opened in December 2003. CMRC serves as a transitional living psychiatric residential facility. Residing

clients are long-term psychiatric clients. CMRC also operates a sixteen-bed crisis intervention center, supervised living for sixteen beds, and Footprints, an adult day service. Footprints is licensed to serve twenty-five individuals daily from neighboring counties that have been diagnosed with Alzheimer's or other related dementia. CMRC also has six beds in an assisted living program and plans to begin accepting residents after July 1, 2008.

- Mississippi also opened two fifty-bed acute care regional inpatient psychiatric facilities within the last ten years. North Mississippi State Hospital opened in April 1999 and operates crisis centers in Batesville and Corinth. South Mississippi State Hospital opened in June 2000 and operates a crisis center in Laurel.

- Opening in September 2004, the Specialized Treatment Facility is a forty-eight-bed facility located in Gulfport for adolescent offenders ages thirteen to twenty-one who are diagnosed with a mental disorder.

Implications of the U. S. Supreme Court's *Olmstead* Decision

The Mississippi Access to Care (MAC) plan is Mississippi's formal response to the Olmstead decision, but the MAC plan's mandates have not been integrated into the state's four mental health plans.

The U. S. Supreme Court's 1999 Olmstead decision notes that states are obligated to develop and implement plans to move toward a system of community-based care for persons with mental disabilities.

Because of the *Olmstead* decision, persons with mental disabilities who believe that their needs have not been met (or persons acting on their behalf) could seek relief through the courts.

In 1999, the U. S. Supreme Court's decision in *Olmstead v. L. C.,* 527 U. S. 581, 119 S. Ct. 2176, 144 L. Ed. 2d 540 (1999), addressed care for people with disabilities. Known as the *Olmstead* decision, the court found that states are required to provide individuals with mental disabilities community-based services if the person's treatment professionals deem such care appropriate, the person does not object to community-based care, and community services can reasonably be provided by the state given that state's available resources in conjunction with the needs of other individuals with disabilities. Thus the states are under obligation to develop and implement plans to move institutionalized persons to community-based care whenever possible. Although the decision sets no deadline for implementation of such plans, persons with mental disabilities who believe that their needs have not been met

(or persons acting on their behalf) could seek relief through the courts.

Implementation of the nine-year MAC Plan was scheduled to begin in FY 2003, but mandates of the MAC plan have not yet been integrated into the state's four mental health plans.

During the 2001 Regular Session, the Mississippi Legislature passed House Bill 929, which provided for the development of a comprehensive plan to address the needs, service options, and service settings for persons with disabilities. This act charged the departments of Mental Health, Rehabilitation Services, Human Services, Education, and Health, and the Governor's Office, Division of Medicaid, with the development of the comprehensive plan. The Division of Medicaid was named as the lead agency. The goal of the plan was to have community-based services available by June 30, 2011, for all persons for whom such services were appropriate and who desired such services.

The goal of the MAC Plan was to have community-based services available by June 30, 2011, for all persons for whom such services were appropriate and who desired such services.

Implementation of the nine-year Mississippi Access to Care Plan (MAC Plan) was scheduled to begin in FY 2003. (See Appendix A, page 63, regarding the requirements of the MAC plan.) However, as of the date of this report, according to the Bureau Director for the department's Bureau of Mental Retardation, implementation of the MAC Plan is only partially into year one (the Home and Community Based Services - MR/DD Waiver Program for mentally retarded/developmentally disabled clients), with implementation of most of the MAC Plan remaining at year zero. According to this Bureau Director, mandates of the MAC plan have not been integrated into the state's four mental health plans because the MAC Plan has never been funded. The Bureau Director stated that the Department of Mental Health has requested funding for the first year of the MAC Plan every year since FY 2003 but has not yet received funding devoted to the MAC plan.

Regarding the role of the MAC plan in transitioning from institution-based to community-based services for mental retardation/developmental disabilities, the Bureau Director for the Bureau of Mental Retardation stated that the MAC Plan places more emphasis on community group homes. Regarding mental illness, he stated the MAC Plan focuses on increasing service activities and medication access to patients in a community-based (or outpatient-based) mental health setting.

According to the Bureau Director, since Medicaid service recipients should have choice of providers by federal rule, the MAC Plan writers decided that a single source of services (such as the community mental health centers)

should not be stipulated. Instead, the plan uses the term "community-based services" to include community mental health centers along with other community-based organizations such as Catholic Charities. Also, the Bureau Director stated some of the community mental health centers have traditionally not provided some of the minimum services such as MR/DD services and alcohol and drug services, but instead must contract with a DMH regional center to satisfy this requirement (see page 12). For example, Region IX (i. e., Hinds Behavioral Health Services) offers MR/DD case management services via the Hudspeth Regional Center and residential alcohol treatment via a contract with another entity.

Over the nine years (FY 2003 to FY 2011) of the plan's scheduled implementation, the MAC Plan was scheduled to cost a total of $447 million in state funds (including the MAC Oversight Committee, Department of Mental Health, the Division of Medicaid, Department of Rehabilitation Services, Department of Human Services, Department of Health, Development Disability Council, Mississippi Development Authority, and the Department of Education). Additional federal Medicaid matching funds would be needed to fund the MAC Plan as well. Since the financial cost of the MAC Plan was calculated in 2001, the MAC Plan's financial cost would now need to be adjusted for inflation and environmental changes. DMH has not developed any estimates of cost savings that might be derived from moving institutional residents to lower-cost community-based services.

Future Issues Facing Mississippi's Mental Health Decisionmakers

In both the short- and long-term future, the Department of Mental Health will face critical issues that will continue to impact the role of the department in being able to provide for and regulate mental health services in the state.

In the future, the needs of the population, both those currently being served by the Department of Mental Health and in the state as a whole, will continue to be greater than the resources available to meet those needs. When the department expends resources to address one type of need, other needs may go unaddressed. Because of limited resources, the Department of Mental Health should reprioritize needs based on the best possible return on client care to utilize each dollar of funding most effectively. The state must also continue to deal with the implications of the *Olmstead* decision to provide client care in the least restrictive setting that is reasonably possible. These are questions that the board and the department will most likely have to address:

- What role will the current state facilities play in serving the state's mental health needs?

- How can the department best continue to transition from an institution-focused system of care to a community-focused system of care?

- What resources are currently in place or available to DMH, what resources need to be added to the system, and what resources should be reallocated and applied elsewhere?

- What role, if any, will the regional community mental health center system already in place play in the future of mental health service delivery in the state?

The above questions raise the need for a comprehensive strategic planning effort by the Department of Mental Health.

Because of limited resources, the Department of Mental Health should reprioritize needs based on the best possible return on client care to utilize each dollar of funding most effectively.

Like all other state agencies, organizations, and families, the Department of Mental Health will continue to face an environment with limited available resources in which to accomplish its mission, goals, and objectives. However, limited funding should serve as a strong indicator to continually tweak the system and to plan to maximize each available dollar. Developing a comprehensive strategic plan for best managing the department's resources to serve the state's mental health needs will be critical to the department's future success and for the people of Mississippi in need of the mental health services the Department of Mental Health is statutorily tasked to provide.

Planning for the Future of Mississippi's Mental Health System

The state's current planning process for mental health focuses on short-term operational issues rather than long-term strategic planning designed to balance the state's future needs with available resources. As a result, the Department of Mental Health has not fully considered alternative service delivery methods to meet the mental health needs of the state.

Although the Department of Mental Health has recently begun to increase emphasis on community-based services, the implications of the Supreme Court's *Olmstead* decision may force the state to move rapidly to provide more community-based services in the near future. The backdrop to this is the concept that needs of the public often exceed available resources and that while needs tend to change over time, service structures tend to be more static.

The planning environment for mental health services in Mississippi is complex, involving a full range of mental illness and mental retardation needs requiring both institutional and community settings. As stated earlier, a primary goal for this report is to assess whether, given this complex environment, the Department of Mental Health positions itself to make the most efficient use of current and future resources through a well-designed and executed strategic planning process.

The Department's Current Planning Process

Although the department's current planning process involves chiefly departmental administrators and advisory councils, state law gives responsibility for planning and policymaking to the Board of Mental Health and Department of Mental Health.

Roles and Responsibilities in Mental Health Planning

The MISSISSIPPI CODE gives responsibility for the state's mental health planning and policymaking to the Board of Mental Health and Department of Mental Health. The CODE directs the board to create advisory councils to assist the board and department in the "performance and discharge of their duties."

As described on page 4 of this report, Title 41, Chapter 4 of the MISSISSIPPI CODE provides that the state will "coordinate, develop, improve, plan for, and provide" mental health services for the citizens of Mississippi and

establishes the Board of Mental Health and Department of Mental Health. Of the powers and duties of the board and the department that are enumerated in the MISSISSIPPI CODE, Section 41-4-7 (1972) lists the board's and the department's powers and duties regarding planning and policymaking, including "developing state plans for controlling and treating mental and emotional illness, alcoholism, drug misuse, and developmental disabilities."

Advisory councils assist the department and the respective bureau or division directors in planning services for individuals within their respective service specialties.

Also, as noted on page 10, MISS. CODE ANN. Section 41-4-9 (1972) authorizes and directs the board to create advisory councils to assist the board and department in the "performance and discharge of their duties." The advisory councils (see listing on page 10) assist the department and the respective bureau or division directors in planning services for individuals within their respective service specialties.

Description of the Current Mental Health Planning Process and Content of the Plans

What is currently held out as the State Mental Health Plan actually consists of four separate, independent plans targeted at distinct mental health specialties or portions of the population needing mental health services. These plans are primarily the result of an iterative process between the advisory councils and the department's administrators.

At present, the department's administrative staff, Executive Director, and the four mental health advisory councils create four state plans:

- the *State Plan for Services and Supports for Persons with Mental Retardation/Developmental Disabilities*;

- the *Mississippi State Plan for Community Mental Health Services*;

- the *Alcohol and Drug Abuse State Plan*; and,

- the *Mississippi Department of Mental Health State Plan for Alzheimer's Disease and Other Dementia*.

These are basically operational plans for each of the four major service delivery bureaus and pertain only to one fiscal year. Although these four state plans have been collectively called the State Mental Health Plan for Mississippi, the plans are actually four autonomous plans with separate goals and objectives. Appendix B, page 70, summarizes the content of the most recent plans.

As noted on page 10, membership on the advisory councils ranges from eight members to thirty-eight members. The

advisory councils (also known as planning and advisory councils) provide an avenue for clients, family members, and service providers to identify and plan services for individuals in their service specialty. The councils assist the department's staff and the respective bureau or division directors in developing the state plan for services for their area of interest.

In developing state plans, DMH bureau directors, division directors, and other selected staff utilize a process whereby they primarily make revisions to prior year state plans.

In developing state plans, DMH bureau directors, division directors, and other selected staff utilize a process whereby they primarily make revisions to prior year state plans. The proposed plan is then forwarded to the appropriate advisory council, which, in conjunction with DMH officials of the advisory council's service specialty, finalizes a proposed state plan. During an iterative process between the advisory council and the department's administrative staff, a final proposed state plan is developed. The department's Executive Director, Planning Director, and two of its bureau directors present the final draft of the state plan to the Board of Mental Health, which has the opportunity to read and make revisions to the plan. The substantive work of developing goals and objectives for each service specialty is performed by the advisory councils and the department's administrative staff without significant prior input from the Board of Mental Health. (See page 47 regarding goals and objectives.)

The substantive work of developing goals and objectives for each service specialty is performed by the advisory councils and the department's administrative staff without significant prior input from the Board of Mental Health.

The department's administrative staff and advisory council chairs gather and present information to the board regarding trends and changes in the external environment from sources such as SAMHSA, the U. S. Census Bureau, and organizations specializing in fields of mental health. However, based on PEER's review of three years of the board's meeting minutes, the board does not take the next step and use this information in setting goals and objectives for the agency.

Although the law charges the board with the duty of setting state plans, the method of doing so is left to the board. As noted previously, under the current method, the Department of Mental Health has prospered from a budgetary point of view and numerous facilities located statewide offer mental health services to citizens of the state.

MISS. CODE ANN. Section 27-103-129 (1972) requires that annual budget requests to the Legislature include a five-year strategic plan with the following:

- a comprehensive mission statement;

- performance effectiveness objectives for each program of the agency for each of the five years covered by the plan;

- a description of significant external factors which may affect the projected levels of performance;

- a description of the agency's internal management system utilized to evaluate its performance achievements in relationship to the targeted performance levels; and,

- an evaluation by the agency of the agency's performance achievements in relationship to the targeted performance levels for the two preceding fiscal years for which accounting records have been finalized.

While the five-year plans required by CODE Section 27-103-129 may contain elements of strategic planning when considering the facility level, from an overall perspective, they are not integrated into the department's state planning efforts.

The department prepares five-year strategic plans for each of its fifteen budget units, the majority of which consist of the department's institutional facilities. However, the department's staff stated that they do not use these statutorily required "five-year strategic plans" as part of their state planning efforts. Instead, DMH staff stated they are merely created by the local facilities to satisfy statutory budget submission requirements. Also, while these five-year plans may contain elements of strategic planning when considering the facility level, from an overall perspective, they are not integrated into the department's state planning efforts. Instead, the fifteen plans would be intermediary plans describing the role of each of the fifteen individual budget units as part of budget submission requirements.

Although the Bureau of Community Services and the Bureau of Alcohol and Drug Abuse submit plans annually for federal review, there is no requirement that the department submit plans for federal scrutiny. Historically, the federal government has not required strategic planning as a part of the grant acquisition process.

Recently, SAMHSA has begun implementing a strategy to require states to identify five-year National Outcome Measures. Originally, state plans were sent to SAMHSA as part of an annual request for funding, but no strategic plan was required. SAMHSA now also requires those who are to receive funds to implement strategies for achieving goals in pre-specified domains (e.g., reduced morbidity, access/capacity, use of evidence-based practices). However, this requirement applies only to facilities that receive funding through SAMHSA.

The Department of Mental Health's current planning process focuses on short-term operational issues rather than long-term strategic planning designed to identify and plan for the future mental health needs of the state.

Strategic Planning versus Operational Planning

Strategic planning balances priorities across a full range of responsibilities and considers any need for change over an extended period. Operational planning is short-term and primarily focuses on efficiency and effectiveness in accomplishing tasks.

The planning efforts of public and private sector decisionmakers may be described as existing on some point of a continuum, with one end of the continuum being strategic planning and the other as operational planning.

Strategic planning pays careful attention to changes in the external environment (e. g., funding trends or political and regulatory changes), horizon issues in relevant fields of service and support, and changes in the needs and service expectations of customers, policy-makers and other stakeholders across a full range of organizational responsibility. This comprehensive effort is focused into a vision of the future that drives the planning process toward making decisions that require the weighing and balancing of priorities across the full range of responsibility and plotting the needed courses for change over time.

Operational planning, while important to the success of an organization, is short-term in focus, typically conducted on an annual basis, and with the primary goal of being efficient and effective in addressing a present need with known resources in a targeted area of responsibility.

Strategic planning requires the reassessment of existing programs for viability to help ensure that all programs and services are adjusted over time to meet changing needs.

As one might expect, over-reliance on operational planning by a governing body may lead to a "status quo" mentality whereby planning and funding decisions revolve around existing views of need and service structures. While a useful tool, an operational plan becomes a liability in longer range planning where a primary goal is to identify shifts in need that could ultimately lead to significant shifts in agency direction or resources. Under a "status quo" approach, funding for new programs and directions generally requires new revenue sources, since existing funding may be tied to existing programs that have not been thoroughly evaluated for relevancy and efficiency.

Strategic planning, on the other hand, provides a better method for identifying and altering the course of an

extremely complex environment such as mental health, since it does require the reassessment of existing programs for viability to help ensure that all programs and services are adjusted over time to meet the changing mental health needs of the state.

Criteria for Comparison

As criteria for comparison, PEER used elements of a comprehensive strategic planning model generally recognized as having both public and private sector utility.

For those unfamiliar with the purpose and form of strategic planning, Appendix C, page 73, provides a handbook on the basic steps in the strategic planning process.

Generally, strategic planning should define a set of priorities that allows for the plan to be adjusted according to changing needs and resources. The plan should be flexible and responsive enough to be adapted to unexpected crises, new opportunities, or changes in available resources. The plan should outline a clear process to reach the agency's goals, not just contain goals with no means proposed to achieve them. Goals included in the plan should be not only achievable but also measurable and time-sensitive. The plan should be reviewed and updated yearly, but should cover five years at a minimum, with ten years being desirable. Ideally, it would have short-term, mid-range, and long-term outlooks with corresponding goals for each.

The ultimate goal for an agency's strategic planning process would be a plan for the rational allocation of available resources and a clearly defined system for monitoring agency progress.

An agency's planning process should be a key element in keeping management in touch with the agency's overall strengths, weaknesses, opportunities and threats, not only at the program level, but also with regard to its position regarding its overall responsibilities. Keeping these strategic elements in mind, agency officials would have the basis for developing a set of priorities across the universe of agency responsibility. By thinking and planning strategically, decisionmakers would be in a position to establish program goals that, while measurable and time sensitive, would be flexible enough to adapt to the unforeseen. The ultimate goal for an agency's strategic planning process would be a plan for the rational allocation of available resources and a clearly defined system for monitoring agency progress.

Many models of strategic planning have been proposed. Nearly all strategic plans include some form of the following elements:

- the mission and vision of the entity;

- the entity's values (i. e., the principles, standards, or beliefs that the entity considers important and that represent it);

- a formal method of analyzing and monitoring the entity's internal and external environment;

- description of core competencies (i. e., organizational skills, processes, or systems that are vital to achieving the entity's mission);

- strategic goals and objectives for the entity;

- strategies with defined action/task plans for achieving the stated goals and objectives; and,

- critical success factors and performance indicators with which to measure achievement toward goals and objectives.

The impetus for strategic planning is that needs of the public often exceed available resources and tend to change over time, whereas service structures tend to be more static. Regardless of the particular strategic planning model selected, a well-designed strategic plan provides an ongoing process that allows management to ensure efficient allocation of resources to a verifiably effective program structure that is optimally responsive to an ever-changing service environment.

Weaknesses in the State's Mental Health Planning Process

The current planning process does not yield a future-oriented, comprehensive document that reflects the basic elements of a strategic plan. The board serves chiefly a reactive role in planning and the department has no common method across facilities and programs for collecting data to use as a basis for analysis.

No Future-Oriented, Comprehensive Document Containing Critical Elements of a Strategic Plan

The current mental health planning process does not produce a future-oriented, comprehensive document that reflects the basic elements of a strategic plan.

With the above-described general principles of strategic planning in mind, PEER assessed the current planning effort for the state's mental health system to determine whether it yields the potential advantages of a well-executed strategic planning model. By taking this approach, PEER was not looking for strict adherence to a particular model, but to whether the department, through its planning process, has achieved a future-oriented,

comprehensive strategic plan for ensuring efficient, effective mental health services for the state.

Although in its statement of philosophy the Department of Mental Health commits to developing and maintaining a comprehensive mental health system, PEER found a fragmented planning effort that results in four separate, independent state plans.

MISS. CODE ANN. Section 41-4-7 (b) (1972) states that the Board of Mental Health has the power and duty "to set up state *plans*" (emphasis added) to address each of the department's areas of service delivery. Currently, as described on page 36, the department's bureaus produce four separate, independent plans. Separate operational plans may be needed to secure outside funding, but nothing in state law precludes the department from producing a single strategic plan that could establish direction for the department for future action.

Separate operational plans may be needed to secure outside funding, but nothing in state law precludes the department from producing a single strategic plan that could establish direction for the department for future action.

Also, as described on page 38, the department annually prepares fifteen five-year strategic plans (one for each budget unit) for the Legislative Budget Office to satisfy requirements of CODE Section 27-103-129 (1972). While these plans may contain elements of strategic planning at the facility level, from an overall perspective, they are not integrated into any department-wide planning effort.

The strategic planning process for the department should be comprehensive and agency-wide. At present, formulation of the four state plans occurs through a process that might best be described as "silo" management--i. e., keeping business units separate with their own budgets and hierarchies. Each advisory council produces its own state plan (see list of advisory groups on page 10) while focusing on its service delivery specialty. Although this process is reasonable insofar as the advisory council members and staff members are advocates for or have some expertise in their particular service specialty and are advocating the programs and expenditures they believe would best serve their particular service area, the process does not yield a single state plan designed to meet the mental health needs of the state. Efficient and effective resource allocations are hindered if decisions for allocations are not based on an understanding of the *entire* mental health environment.

PEER found no evidence of an overall vision statement for the department or evidence of a department-wide effort to implement strategies supporting the department's philosophy statement.

While PEER finds both the department's mission statement and philosophy to be a generally sound basis for comprehensive planning, the department has not clearly tied those statements to an overall planning effort.

As a rule, strategic planning begins with a clear statement of mission that defines the core purpose for the agency's existence, the problems or needs it has been given the responsibility to address, and a basic description of the how the department proposes to meet those needs. Based on a clearly defined mission, the agency then proposes a vision statement for the department. A vision statement describes what the organization will look like after it has successfully implemented its strategies and reached its full potential.

In assessing the department's clarity of mission and vision, PEER found that the department has published a statement of its mission on the agency's website. The mission statement reads as follows:

> *Supporting a better tomorrow by making a difference in the lives of Mississippians with mental illness, substance abuse problems and intellectual/developmental disabilities one person at a time.*

In addition, the board has also developed what it refers to in two of its state plans as the "Philosophy of the Department of Mental Health," which commits to developing and maintaining a comprehensive, statewide system of prevention and service options for adults and children with mental illness, or emotional disturbance, substance abuse problems, and/or mental retardation/developmental disabilities.

While PEER finds both the department's mission statement and philosophy to be a generally sound basis for comprehensive planning, the department has not clearly tied those statements to an overall planning effort.

Two of the state's four state plans, the one for the Division of Alzheimer's Disease and Other Dementia and one for the Bureau of Alcohol and Drug Abuse, include the statement of the department's philosophy. The state plan for mental retardation/developmental disabilities for FY 2008 contains statements of mission and vision for that particular bureau, but do not reference the more general departmental mission statement. However, PEER found no evidence of an overall vision statement for the department or evidence of a department-wide effort to implement

strategies supporting the philosophy statement found in the two bureaus' plans.

Only one of the department's four state plans--the plan for the Bureau of Mental Retardation--clearly defines organizational values to guide decisionmaking and the provision of service and client care. PEER found no such statement of values for the department as a whole.

By defining organizational values, the Department of Mental Health would provide itself and its employees with defined principles that in turn could guide the agency and its employees in achieving its mission.

Organizational values define the culture of each organization. These values are an organization's essential, lasting values that should not be compromised or short-changed for expediency, financial reasons, or for other values that have been identified as important but would not be considered "essential" to providing service and client care.

The Department of Mental Health does not have defined organizational values and culture for the agency as a whole. The FY 2008 state plan for mental retardation/developmental disabilities was the only one of the state plans to define organizational values for its particular bureau within the department. In general, the bureau's value statements were well written. For example, one such value statement reads as follows:

> *Persons with mental retardation /developmental disabilities should have access to life experiences and living conditions as they choose that are appropriate to meet their individual physical, emotional, spiritual, and cognitive needs.*

The Department of Mental Health should develop overarching values to guide the culture, management, and operations of the agency as a whole.

By defining organizational values, the Department of Mental Health would provide itself and its employees with defined principles that in turn could guide the agency and its employees in achieving its mission.

The department's planning documents do not contain evidence that the department has conducted comprehensive, agency-wide internal analysis or thorough analysis of external factors to identify strengths, weaknesses, opportunities, and threats that are both within and beyond the agency's control.

For an organization to reach its optimal potential in providing efficient, effective service to the public, it must

understand both the internal and external factors that potentially affect the decisionmaking process and how the organization can best achieve its mission. For an organization to be successful in developing a comprehensive strategic plan, the analysis of internal and external factors may involve research and analysis in as many as nine areas of concern:

- stakeholder relationships and alliances;

- environmental issues (external and internal);

- need for services;

- service types to be offered;

- service delivery structure;

- improvement of organization systems and processes;

- human resource/management;

- agency governance; and,

- financial/feasibility/cost benefit issues.

(See Appendix C, page 73, for a handbook on strategic planning.)

For an organization to reach its optimal potential in providing efficient, effective service to the public, it must understand both the internal and external factors that potentially affect the decisionmaking process and how the organization can best achieve its mission.

Monitoring an organization's internal structure helps to identify the strengths and weaknesses inside the control of the organization. Strengths and weaknesses focus on the present organization and can be discovered by monitoring an organization's resources (inputs), present strategy (process), and performance (outputs).

Monitoring an organization's external environment helps to identify the opportunities for and threats against the organization that are outside the control of the organization. Opportunities and threats tend to pertain to the future rather than the present and can be discovered by monitoring a variety of political, economic, social, technological, educational, and physical environmental forces and trends. Attention to opportunities and threats, along with a stakeholder analysis, could be used to identify an organization's key success factors, which increases an organization's chances of success in relating to the external environment.

PEER could not find evidence in any of the four state plans that DMH has conducted any of the types of internal or external analysis mentioned in Appendix C. If DMH were to conduct such analysis, the DMH would be able to

identify strategic issues the department faces and could then choose the issues most vital to its success and develop strategies to best meet the mission, vision, goals, and objectives of the department.

PEER did find that the Department of Mental Health does receive demographic mental health data from both federal (SAMHSA and the U.S. Census Bureau) and state sources (Department of Human Services), along with briefs on legal issues. However, while the department does gather demographic data from national and state sources, there is no evidence of the department's analysis of such data and how it affects strategic actions, such as the potential cost differences among service options, allocation of resources toward new facilities, or decreasing /closing of current facilities.

There is also no evidence of the Department of Mental Health's analyzing the competitor's market, both within the state or nationally, to allow it to compete for limited state and federal funds. Such an analysis would require that the department analyze the role of other mental health providers within the state such as community mental health centers, for-profits, and not-for-profits as to how they impact, potentially harm, or potentially benefit the Department of Mental Health's efforts to provide services.

The act of gathering demographic, economic, legal, political, and technological information pertaining to mental health is not an environmental analysis. For such an analysis to occur, data would need to be refined by analyzing potential short-term and long-term effects of environmental changes on the department itself. The resulting analysis should then be incorporated into planning.

The department's planning documents do not contain evidence that the department has identified the core competencies needed to maximize the department's effectiveness.

Core competencies are the organizational components that are vital to achieving an organization's mission. For example, core competencies for a mental health agency could be its patient tracking system, its management information system, its infrastructure, or its system for allowing consumer input and outside advising.

Defining core competencies can provide the following benefits to an organization:

- a disciplined approach to identifying those activities that the organization must undertake to

best provide services to its current and prospective clients;

- a process for evaluation and prioritization of the collective "know-how" of the organization; and,

- a process for identifying values and prioritizing the activities of the organization in a way that lends itself to making strategic decisions on the use of organization resources or the need for new or additional resources.

The DMH does not define its core competencies for the agency as a whole and none of the four state plans define the core competencies for their respective bureaus. By determining its core competencies, the DMH would be able to define what skills, processes, and systems make the department successful. As a result, the DMH would be able to plan to maximize its effectiveness.

Although all four of the state plans contain goals and objectives (or "targets"), these are for the individual bureaus or specialty areas represented by the four plans. However, the department has not developed overarching goals and objectives to guide the agency as a whole.

The purpose of establishing strategic goals is to provide a clear, "well-marked" pathway for achieving the aim or purpose of the strategic plan.

PEER found that although the individual state plans contain goals and objectives, DMH does not have stated agency-wide goals tied to a comprehensive strategic planning process. The individual state plans' goals focus on the bureau level and, if a time frame is given, are only for the upcoming fiscal year. The goals also lack defined, objective measurements that the bureau is supposed to achieve. For example, all goals stated in the Bureau of Mental Retardation's state plan have objectives covering only FY 2008 and not beyond. The Bureau of Mental Retardation's first goal for its FY 2008 state plan is to:

> *...promote awareness about available services/ supports for persons with mental retardation/ developmental disabilities and autism.*

However, the plan does not include any standard or level of measurability for success for this goal. Instead, the evaluation method is to document that public awareness activities were held and to disseminate information when requested. In this case, the evaluation standard should be defined, measurable criteria to document the *success* of the public awareness activities in promoting awareness

about DMH services for persons with mental retardation and autism, not documentation of whether the awareness activities were held.

Goal ambiguity in public organizations makes performance expectations difficult to specify. Vague performance expectations have several consequences. First, success cannot be easily recognized, often making it difficult to identify and reward key contributors. Second, failure is not easily detected and corrected in a timely manner. Third, failure to have clear goals impedes the learning process among departmental leaders after elections and political appointments, thus possibly delaying their efforts at goal refinement or redirection. As a result, organizations' plans and projects may be interrupted or slowed, resulting in a state of inertia. These interruptions may lead to cautiousness, inflexibility, and low rates of innovation.

The department's short-term operational goals could be implemented to the degree possible within available annual funding, while a strategic plan with long-term goals would enable the department to convey its multi-year funding needs to the Legislature.

The Department of Mental Health justifies its practice of planning only for the short term by stating that it must operate within the limitations of a public agency, one being an annual appropriation that makes long-term planning difficult. However, the annual appropriation process does not preclude the department from developing both short-term and long-term goals. The department's short-term operational goals could be implemented to the degree possible within available annual funding, while a strategic plan with long-term goals would enable the department to convey its multi-year funding needs to the Legislature.

Finally, PEER notes that the bureaus and specialty areas of the department list numerous goals (many without measurable objectives) in the four state plans. These should be distilled into six to ten strategic goals for the department as a whole in order for agency's managers to be able to focus on and prioritize these goals. An excessive number of goals to be monitored at the board level could cause it to become overwhelmed with the details of data collection and performance and lose perspective.

Because the department has not developed an agency-wide strategic plan, it has never developed strategies for the agency as a whole, but instead has piecemealed strategies from the four individual state plans.

Strategies backed by clearly defined action plans are the means by which an agency achieves its goals and objectives and, to a greater extent, the agency's mission and vision of success. Such strategies incorporate all the information a department learns through analysis that will

enable it to maximize its core competencies, its internal strengths, and its external opportunities and to minimize its internal weaknesses and external threats.

As a result of the department's failure to develop an agency-wide strategic plan, the department has never fully developed strategies for the agency as a whole. Instead, agency strategies are piecemealed by way of the four individual state plans. The most recent state plans for alcohol and drug abuse and Alzheimer's disease/dementia briefly list a strategy for each objective, but they are not complete because they do not include resource allocation decisions or specific actions for implementation. The most recent state plans for community services and mental retardation/developmental disabilities include goals and objectives, but do not include defined strategies for achieving the goals and objectives. Because it does not clearly define strategies and how resources are allocated, the department cannot develop a prioritized action plan that best meets the agency's needs.

Because it does not clearly define strategies and how resources are allocated, the department cannot develop a prioritized action plan that best meets the agency's needs.

Also, one of the major purposes of strategic planning is to maximize the use of limited resources through best use. Each goal the DMH seeks to achieve has resource costs, including money and people. Because of limited resources, not every hope, dream, and goal is feasible because they cannot all be funded. As a result, the development of strategies with defined action/task plans, including allocated resources, would allow the department to develop plans that maximize the department's and the state's use of limited resources, while clearly defining future goals that cannot be achieved with current resources.

Also, strategies must interface with other strategies across the agency (and to a greater extent, across state government), not just within an individual bureau. Any misallocated or misdirected strategy costs the state valuable resources because the resources could be better utilized within the agency or elsewhere within the state.

Strategic issues vary in importance, cost, and as to what level they need to be addressed by an organization. According to John M. Bryson, Ph.D., a professor and Associate Dean for Research and Centers at the University of Minnesota, in *Strategic Planning for Public and Nonprofit Organizations,* three kinds of strategic issues exist:

> · *Those for which no organizational action is required at present, but which must be continuously monitored.*

- *Those that are coming up on the horizon and are likely to require some action in the future and perhaps some now (can be handled as part of the organization's regular strategic planning cycle).*

- *Those that require an immediate response and therefore cannot be handled in a more routine way.*

By planning only for the upcoming year, the Department of Mental Health restricts its ability to manage the first two types of strategic issues because they do not require immediate attention. Yet these types of strategic issues must be monitored and included in the overall planning process to ensure the long-range success of the department and its programs.

Although the department provides budget-specific performance measures that anticipate service levels for estimated funding, the measures are not indicators of performance progressing toward strategic goals. In addition, the department does not establish overall agency-wide performance indicators and although the department does list performance indicators in all four of the state plans, DMH does not quantify the indicators to be used in future evaluation.

Performance indicators with defined targets are meant to serve as a guideline to measure the success of agency strategies. Thus one of the major stumbling blocks to measuring an organization's strengths and weaknesses is the lack of performance indicators and performance analysis capable of detecting and presenting problems both for the organization and its stakeholders. As noted in *Strategic Planning for Public and Nonprofit Organizations*, without performance criteria and information, it is difficult for an organization to evaluate the relative effectiveness of alternative strategies, resource allocations, organizational designs and distribution of power.

The Department of Mental Health does not establish overall agency-wide performance indicators, due in large part to the fact that it has not established an agency-wide strategic plan with defined goals and strategies.

Although the Department of Mental Health provides performance measurement information in its annual budget request submissions, the Department of Mental Health does not establish overall agency-wide performance indicators, due in large part to the fact that it has not established an agency-wide strategic plan with defined goals and strategies. The department does list performance indicators in all four of its state plans. However, DMH does not quantify the performance indicators in the plans and, as a result, the targets are left undefined.

In addition, in some cases, the objectives listed in the plans are not truly objectives. As part of an objective, one state plan included the following:

> *Continue the State Plan development process, which includes reviewing the philosophy, mission, purpose, values, and vision for services and supports to individuals with mental retardation/development disabilities; updating the information on each component of the service array; and formulating annual goals and objectives.*

The evaluation of this particular objective was the development of the FY 2008 state plan. Although a review of the philosophy, mission, purpose, values, and vision for services annually is a worthy component of annual reviews, the development of a state plan is not a proper performance indicator of the review.

The purpose of performance indicators is to gauge progress toward achieving desired levels of performance for the agency in terms of its goals and objectives. However, since the department's plans do not define target levels for performance indicators to be successful, the performance indicators have little use. Without defined performance indicators, the DMH is not able to determine accurately whether the department is fully achieving its goals and objectives and maximizing its available resources.

The Board's Role is Chiefly Reactive

Advisory councils and the department's administrators, who assume the major portion of responsibility for developing state plans, drive the current DMH planning process. The board is not integrated early into decisionmaking and mainly reacts to the proposed plans.

As described on page 37 of this report, the substantive work of developing goals and objectives for the four state plans is performed by the advisory councils and the department's administrative staff without significant prior input from the Board of Mental Health.

While the board has final approval of the state mental health plans, there is little evidence that the board exercises more than a passive role in the process of plan development.

PEER reviewed minutes from twenty-three separate board meetings over three years and focused specifically on the most recent year. According to PEER's review of these minutes, the board primarily takes a reactive position in relation to strategic issues facing the Department of Mental Health. For example, minutes indicate that the board receives strategically important information when it is placed on an agenda without producing a documented opinion or explicit direction that the department should

take. The flow of such information originates from advisory councils and management and ultimately reaches the board, but is not in an iterative loop, meaning there is no documented forum for an exchange of ideas between the board and the other entities.

Presently, the heart of policy development seems to occur at the advisory and administrative level and the board simply gives or withholds approval upon receipt of the information. While the board has final approval of the state mental health plans, there is little evidence that the board exercises more than a passive role in the process of plan development. While the information required for strategic planning must come from throughout the organization, the development of strategic goals and objectives should come from the Board of Mental Health and the agency's Executive Director.

No Common Data Collection Method

The department does not have a common data collection method for its facilities and programs by which to collect, compile, and analyze data to be used in decisionmaking.

DMH does not have a common data collection strategy in that there are no clear indicators of what data needs to be collected across all the agencies in order to develop needed strategic goals for the agency as a whole. An absence of indicators partially stems from a lack of clarity of what the performance measures actually intend to measure in the state plans.

This is not to say that the bureaus and division do not collect data. For example, the Bureau of Alcohol and Drug Abuse collects the following types of data:

- demographic data describing the need group;

- criminal data on the need group;

- addictions requiring service strategies;

- work history and status of the need group; and,

- recovery status of those undergoing treatment.

This data is collected both at intake and during discharge/transfer of patients. This data, which is recorded on a Treatment Episode Data Set form, fulfills a federal requirement for integrating a minimum amount of alcohol data across the states, and is compiled outside of the bureau and sent to the federal government. However, according to officials from the Bureau of Alcohol and Drug

Abuse, *no other information* (aside from facility utilization rates) is collected by the bureau.

In a separate example, the Division of Alzheimer's Disease and Other Dementia records the following data:

- utilization rates (total enrolled/maximum or licensed capacity per day/average daily attendance/capacity ratio);

- referral data (number of assessments/number of discharges);

- participant data (number of care plans during month/primary diagnosis);

- professional staff data (number of vacancies/number of part-time employees/total number of volunteers);

- logistical data (number of participants brought by caregivers/number picked up per facility);

- demographic data (age, sex, diagnosis, length of stay, frequency of visit, reason for leaving, volunteers frequency/source); and,

- program goals/objectives and performance measures (*Note*: while goals were realistic and achievable, performance measures were underdeveloped or irrelevant, similar to the state plans).

Although the DMH is collecting data, it is either being used only for federal purposes or for operational planning only.

The Division of Alzheimer's Disease uses this information in-house (no other bureau within the department uses it) to determine how to shift resources between facilities.

Both examples show that, though data is being collected, it is either being used only for federal purposes or for operational planning only. Understanding agency performance and asset management requires the proper collection and compilation of data in order to foster efficient and effective service.

Effects of the Lack of Strategic Planning for the Delivery of Mental Health Services

The lack of strategic planning for the delivery of mental health services has hampered the Department of Mental Health's ability to manage change within the mental health environment, while placing a ceiling on its ability to plan for the future.

As noted previously, PEER believes that the Department of Mental Health's current planning process emphasizes operational planning. The result is a heavy emphasis on the maintenance and improvement of existing programs and facilities, with little effort devoted to the development of information and processes of future-focused strategic value to the board.

While the current mental health planning process may ensure that the department will reach the community it intends to serve in the ways that have been established and are traditional, it does not question the composition or mode of service for possible needed change.

Based on PEER's analysis of the department's current state planning effort, strategic planning does not appear to be at the core of the board's management strategy, nor could it be without key changes in orientation and available information. According to PEER's analysis of three years of the board's minutes, there is little evidence that the planning process properly focuses the board on data needed to identify and prioritize critical issues and policy challenges. While the current process may ensure that the department will reach the community it intends to serve in the ways that have been established and are traditional, it does not question the composition or mode of service for possible needed change.

PEER identified at least three results of DMH's emphasis on operational planning rather than strategic planning:

- the department's continued emphasis on a more expensive service delivery model (institution-based versus community-based care);

- underutilization of the Home and Community Based Services - MR/DD Waiver Program as a funding source; and,

- allocation of resources to operating facilities that could lie outside the department's mission.

Continued Emphasis on Expensive Institution-Based Service Delivery

Despite national trends and a Supreme Court decision to the contrary, the Department of Mental Health has continued to focus state resources on institution-based services.

Mississippi might have unique mental health needs that would require it to continue to place such a heavy emphasis on institutional services. However, it is possible that Mississippi's mental health needs mirror nationwide

needs and that Mississippi's current delivery system is not the result of careful planning but is the result of believing it should be done "the way things have always been done." Without a comprehensive strategic planning process, the Board of Mental Health does not have adequate information to determine the best method of service delivery to meet Mississippi's mental health needs nor does the board know whether a delivery system with heavy institutional services is the most efficient manner to deliver mental health services to the citizens of the state.

Without a comprehensive strategic planning process, the Board of Mental Health does not have adequate information to determine the best method of service delivery to meet Mississippi's mental health needs nor does the board know whether a delivery system with heavy institutional services is the most efficient manner to deliver services.

PEER does not suggest that mental health institutions or institution-based services should be dismantled in sole deference to an as yet undefined community-based service model. Any policy changes made should be made rationally, based on a comprehensive planning process that carefully balances the competing interests inherent in a service shift of such magnitude.

If a comprehensive strategic analysis of Mississippi's mental health needs and opportunities indicates that community-based services should be significantly increased, it would require an initial infusion of funds. The source of those funds would not likely be new federal or local dollars, though both would be desirable, but a rational reallocation of the state's current financial commitment to mental health, including the reallocation of matching dollars for existing federal programs. Should this occur and community-based programs become a more viable treatment alternative, residents of institutions could then be moved to these programs and resources freed for development of additional community services.

The department's focus on institution-based care represents a much more expensive service delivery model than does community-based care.

Evaluation of clients' individual needs could result in appropriate transitioning of some clients from institution-based service delivery to community-based service delivery.

Generally, institution-based services cost more per client than community-based services. For example, according to the SSDD 2008, the FY 2006 cost of an MR/DD client in a state-operated institution in Mississippi was approximately $117,000 annually, but only $7,850 annually for an MR/DD client in a supported living or personal assistance program.

PEER acknowledges that a supported living or personal assistance program is not appropriate for every MR/DD client. Some MR/DD clients require care beyond that available in a non-institutional setting. However, MR/DD clients diagnosed with mild or moderate conditions can frequently function in a non-institutional setting. According to DMH staff, during 2007 over 500 individuals diagnosed as mild or moderate were housed in DMH

MR/DD institutions. An evaluation of clients' individual needs could result in appropriate transitioning of some clients from institution-based service delivery to community-based service delivery. This could provide the opportunity for closure of some institutions (or of some units within institutions) and thus free a portion of the department's resources to be used for other mental health needs.

Underutilization of the Home and Community Based Services – MR/DD Waiver Program

The lack of strategic planning has led to the department's underutilization of the HCBS Waiver program as a funding source.

In 1981, Congress authorized the Home and Community Based Services (HCBS) – MR/DD Waiver Program as an alternative to the Intermediate Care Facilities/ Mental Retardation (ICF/MR) program. The HCBS Waiver provides federal reimbursement for community services such as habilitation training, respite care, supported employment, supported living, and various professional therapies. Since 1981, states have increasingly provided more community services under the HCBS Waiver program. In 2001, the HCBS Waiver program became the primary Medicaid program underwriting long-term MR/DD care in the states. In FY 2006, federal-state spending under the HCBS Waiver program constituted 50% or more of total MR/DD long-term spending in twenty-seven states.

The HCBS Waiver program offers opportunities for significant savings in providing care to individuals in a community setting rather than in an ICF/MR setting. On a per capita basis, in FY 2006 Mississippi ranked 51st behind all other states and the District of Columbia in utilization of the HCBS Waiver program.

The HCBS Waiver program offers opportunities for significant savings in providing care to individuals in a community setting rather than in an ICF/MR setting. According to the SSDD 2008 report, in FY 2006, the average annual cost in Mississippi for a person in an ICF/MR setting with fifteen or fewer persons was approximately $71,000 and during that same period, Mississippi's average annual cost for a person in the HCBS Waiver program was approximately $19,000. Mississippi's HCBS Waiver program did not begin until 1995, over ten years after the federal program started. According to the SSDD 2008, in FY 2006, Mississippi had 1,835 participants in its HCBS Waiver program with expenditures of $35 million, which represents a decline of 11% in the number of waiver participants since FY 2004. On a per capita basis, Mississippi ranked 51st behind all other states and the District of Columbia in utilization of the HCBS Waiver program.

DMH officials indicated that the primary reason for not implementing the program earlier was that the HCBS Waiver program represented an expansion of services to eligible individuals and the expected difficulty in finding additional matching funds for the HCBS Waiver program,

which is a Medicaid program. In Mississippi, one dollar of state funds must be used to match approximately every three dollars of Medicaid funds.

Rather than seeing the HCBS Waiver program as an expansion of services, strategic planning would facilitate the exploration of alternatives, such as using the HCBS Waiver program to move individuals from an ICF/MR facility to a less costly setting and using the savings to meet the matching fund requirement. Also, the savings generated by moving individuals to less costly service structures would possibly allow the DMH to expand services to other individuals qualifying for HCBS Waiver services.

Operation of Nursing Homes that Could be Outside the Department's Mission

While providing nursing home care for the department's elderly clients could be considered part of DMH's responsibility, the department's operation of two nursing homes open to anyone in the state (including those without mental health issues) could be outside the department's mission.

DMH operates two long-term nursing care facilities, the Jaquith Nursing Home at Mississippi State Hospital and the R. P. White Nursing Home at East Mississippi State Hospital.

The Jaquith Nursing Home has 479 beds and is the largest nursing home in Mississippi. According to the Jaquith Nursing Home's website, this facility is not a "psychiatric" nursing home, but accepts anyone in need of long-term care.   During FY 2007, the Jaquith Nursing Home provided 155,481 client days of care for an average of 426 clients daily. FY 2007 direct costs for Jaquith, including Medicaid match payments, were $21.8 million, which equals $140 per client day, or $51,100 per client annually.

Strategic planning would allow the DMH to determine whether these nursing homes are a necessary part of the department's service delivery mode.

The R. P. White Nursing home operates 240 beds and also accepts anyone in need of long-term care. During FY 2007, the R. P. White Nursing Home provided 71,062 client days of care for an average of 195 clients daily. FY 2007 direct costs for the White home, including Medicaid match payments, were $12.3 million, which equals $173 per client day, or $63,145 per client annually. During 2006, the White home moved into a new facility.

An argument could be made for the need for providing long-term care for elderly institutional clients and operating the nursing homes in such a manner that qualifies for Medicaid reimbursement. However, questions arise regarding whether the $34 million in direct costs,

including Medicaid match payments, is the most efficient method of providing long-term care to the institutional clients in need of such care and whether the department should be providing long-term care for *anyone* in need of such care.

This seems to evidence the possibility that the board currently has no identifiable process for deciding whether current or proposed programs and services fall within its mission, allowing the department to be pushed in directions that fragment its mission and increase competition for critical resources. Strategic planning would allow the DMH to determine whether these nursing homes are indeed a necessary part of the department's service delivery mode.

Recommendations

The Legislature's commitment to the mental health needs of the citizens of Mississippi is evident by the financial support the Department of Mental Health has historically received. The commitment of the board members, DMH officials and staff, CMHC officials and staff, and advisory council members to providing mental health services to the citizens of Mississippi has been evident throughout this review.

PEER believes that through strategic planning the resources of the state and the knowledge and commitment of mental health officials and staff could be enhanced to better serve the mental health needs of the state's citizens. To this end, PEER offers the following recommendations.

1. The Board of Mental Health should implement a strategic planning process to address the current and future mental health needs of the state. The strategic planning process should incorporate clear missions and goals for the state's mental health system and contain clear performance measures to evaluate the effectiveness of the strategic plan in meeting the mental health needs of the citizens of the state.

2. The Board of Mental Health should conduct a self-assessment, taking into consideration performing:

    ▪ an evaluation of the management information currently received by the board and how such management information could be improved to facilitate the board's planning and oversight capacities; and,

    ▪ a review of the current board requirements under MISS. CODE ANN. § 41-4-7 (1972) for the purpose of identifying current duties that hinder the board's ability to address broader departmental issues (such as strategic planning) and those that could be satisfactorily handled by the Department of Mental Health's administrative staff. The board should submit proposed revisions to the law to the appropriate committees for consideration during the 2009 legislative session.

3. The Legislature should amend MISS. CODE ANN. Section 41-4-3 (1972) to establish a nonvoting advisory position on the Board of Mental Health for a designee of the Mississippi Association of Community Mental Health Centers.

4. The Board of Mental Health should consider developing a patient tracking and management information system, in conjunction with the fifteen regional community mental health centers, to track patients within the state mental health system and to yield usable performance information for managing the Department of Mental Health and for providing mental health services throughout the state.

5. In order to ensure clear observation and measurement of progress toward the agency's and individual bureaus' goals, the Board of Mental Health should develop a comprehensive set of program-specific quantitative performance measures and goals as part of its strategic planning effort. As a model, the board should consider the National Outcome Measures required by the Substance Abuse and Mental Health Services Administration as a part of its grant accountability process.

6. The Board of Mental Health should develop a well-defined agency-wide mission statement that provides guidance for the agency in its decisionmaking process. Further, the Board of Mental Health should develop a complete vision statement that provides a realistic benchmark for the agency's long-term success.

Following is an example of what a well-defined mission statement for the department might be:

Our mission as the state's lead agency in charge of regulating and providing mental health services to the people of Mississippi is five-fold:

- *To provide a comprehensive system of care to people affected by mental illness, mental retardation / developmental disabilities, alcohol and drug abuse, and Alzheimer's Disease and other dementia in both community and institutional settings;*

- *To regulate mental health services within the state of Mississippi;*

- *To educate the people of Mississippi about mental health issues within the state and to reduce the stigma associated with mental health issues;*

- *To continually explore new means in which to better improve the lives of those affected by mental health issues; and,*

- *To maximize the benefit of the taxpayer's dollars by meeting the state's mental health needs in the most efficient and effective means possible.*

Following is an example of what a well-defined vision statement for the department might be:

> *The Mississippi Department of Mental Health will provide its clients the opportunity for a better tomorrow by providing the highest quality of life possible via a community-based system of care, where feasible. Our system will be a person-centered environment that is built on the strengths of individuals and their families while meeting their needs for special services and supports.*

Appendix A: Summary of Requirements of the Mississippi Access to Care (MAC) Plan

Overview of the MAC Plan

As noted in this report, in 1999 the United States Supreme Court held in *Olmstead v. L. C.* that the unnecessary segregation of individuals with disabilities in institutions could constitute discrimination based on disability. The court ruled that the Americans with Disabilities Act may require states to provide community-based services for people with disabilities who would otherwise be entitled to institutional services when:

- the state's treatment professionals reasonably determine that such placement is appropriate;

- the affected person does not oppose such treatment; and,

- the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving services.

In June 2000, the Governor appointed the Division of Medicaid as the lead agency to develop, in coordination with the departments of Mental Health, Health, Education, Human Services, and Rehabilitation Services, a comprehensive, effective plan for addressing the issues related to the *Olmstead* decision. The Mississippi Legislature passed House Bill 929 in the 2001 Regular Session, which mandated the development of a comprehensive state plan to provide services to people with disabilities in the most integrated setting appropriate.

The *Mississippi Access to Care Plan* (MAC Plan) was submitted to the Mississippi Legislature in 2001. Since then, one of the two MAC Plan-required implementation reports has been filed in compliance with the MAC Plan. As noted in this report, implementation of the MAC Plan was scheduled to begin in FY 2003, but implementation of the MAC Plan is only partially into Year 1.

Critical Success Factors

The MAC Plan creators, led by the Division of Medicaid with help from individual focus groups, identified seven critical success factors deemed essential to optimum plan

implementation and included a list of these factors in the MAC Plan:

1. *Developing and implementing a tracking system*—This must be correlated to quality assurance and enhancement activities, data collection, aggregation and interpretation as related to the overall MAC plan performance and outcomes. Such a tracking system will enhance strategic planning across and among various state agencies.

2. *Sustaining collaborative partnerships*--The plan's success will ultimately rest on the substantial involvement of all stakeholders in continuous review, revision, and updating throughout its implementation.

3. *Sustaining legislative support and advocacy*--To implement the MAC plan, additional financial resources will be needed from the Legislature. Its understanding and support will be critical to achieving the desired results.

4. *Achieving quality management*--A quality management system must address major focus areas of the state plan and interface with existing quality management instruments now in use. Key system components must track state plan elements, goals, action steps, timelines, and accountability for assigned responsibilities. Monitoring should be developed to reflect person-centered consumer outcomes, evaluation, and alteration of supports to ensure the quality of individualized services.

5. *Creating a person-centered service delivery system*--A person-centered service delivery system values direct action over process and individualized dignity over external controls. An individual's achievement of personal goals demands sustained, continual shaping of supports and provision of flexible services to bring about the most integrated setting.

6. *Attaining independence and inclusion*--Attaining independence and inclusion rests in the combined partnership of all stakeholders who are, and remain committed to, a consumer's defined personal development goal.

7. *Meeting challenges in a rural state*--Our state's rural demographics work in direct opposition

to desired service improvements for citizens with disabilities. Successful implementation of a community-based service delivery system that affords individuals with opportunities in the most appropriate setting must neutralize demographically based constraints.

System Modifications

To address the issues brought forth through the MAC planning process, the MAC Plan creators identified certain comprehensive and coordinated needs. The MAC Plan creators identified the following systemic needs, crossing over state agencies, providers, and advocacy organizations, as being critical to creating a service delivery system that allows individuals with disabilities to live and work in the most integrated setting of their choice:

- *Information/Data Development*--Lack of a comprehensive, unduplicated data collection system has been recognized as one of the primary barriers to serving individuals with all disabilities in the most integrated setting of their choice. Without knowing who needs/wants community-based services, the availability of services/supports, or the providers of such services and supports, it is difficult to ensure that all people with disabilities will have the opportunity to transition into the most integrated environment. Therefore, one primary means of achieving the MAC goals is the development and maintenance of comprehensive, reliable data.

- *Communication and Education*--A system that is designed to broadly publicize and increase awareness of community-based services/supports, to specifically identify those individuals not currently being served that need/want services/supports in the most integrated setting, and to facilitate user-friendly, timely access to information is crucial to achieving the desired results identified by the MAC Plan.

- *Training*--The MAC goals are primarily about enhancing access and expanding capacity for services/supports. Ongoing training of public and private providers and advocacy groups, as well as state agency

employees, is critical to compliance with the "spirit" of the MAC goals.

- *Individual Assessment*--An evaluation/assessment procedure working in concert with a single point of entry referral system will be key to identifying, assisting and developing comprehensive care plans based upon services in the least restrictive environment that are both desired and appropriate for the individual with disabilities.

- *Transition from Institutions*--Preventing premature or inappropriate out-of-home placement and facilitating the earliest possible re-entry into the community when appropriate is the overall goal. Individuals with disabilities who are currently residing in institutions and could receive services in a more integrated setting have the right to be advised of the community-based alternatives available.

Primary Support Services

According to its creators, the fundamental goal of the MAC Plan is to enhance access to services, provide more options for individuals with disabilities, and increase the capacity of community-based services and supports. Listed below are the supports and services MAC Plan creators identified as most needed and/or with the greatest opportunity for positive impact.

- *Transportation*--The majority of individuals with disabilities reported transportation needs as the most important support lacking in their lives, particularly in rural areas of the state. They reported the need for transportation to medical and social services as well as the need for transportation for meeting their primary needs and to recreational activities to increase the quality of life. The need for wheelchair-accessible transportation should be considered. Both mass transit and personal mobility options should be addressed.

- *Community-Based Housing*--Appropriate housing options are necessary for people with disabilities to remain in the community. However, persons with disabilities have a difficult time locating and accessing safe, affordable, ADA-compliant housing

and the supports needed to remain in the environment of their choice. This is due to the scarcity of community supports such as attendant care, transitional care, skills training, and case management. Another difficulty is financing. People with disabilities have difficult time saving money for down payments, closing costs, repairs, and maintenance. Training in such things as maintenance and home living skills, socialization skills, and self-help skills is needed to assist the consumer with maintaining or increasing self-sufficiency in community-based housing. Before additional segregated facilities are built, those individuals currently living in facilities should be evaluated to determine whether they could live in the community with proper supports.

- *Home and Community Based Services – MR/DD Waiver Program*—This program allows the state increased flexibility in the types of services that can be provided to those individuals who are Medicaid-eligible. All waivers must be approved by the federal Centers for Medicare and Medicaid Services (CMS) and are limited to target populations and number of "slots" approved by CMS in the waiver applications and renewals.

Other Support Services

The MAC Plan creators wrote:

> *In order for individuals with disabilities to be able to live in the most integrated setting possible and to keep individuals with disabilities from feeling they have to choose an institutional setting, there must be a system of services in the community that will support them.*

The following is a non-exhaustive listing of the services the MAC Plan creators envisioned to help support individuals in the community setting when designing the MAC Plan:

- *Employment and Vocational Services*--There is a need for more programs designed to provide training that will enable individuals to function more independently and become as self-sufficient as possible.

- *Prevention and Early Intervention Services*—These are services designed to intervene as early as

possible in a person's life with the intent of preventing and/or abating identified problems.

- *Diagnosis and Evaluation*--In order for individuals suspected of having a serious and persistent mental illness or a serious emotional disturbance to receive appropriate services, there must first be an assessment and evaluation conducted.

- *Day Treatment*--Day treatment is a non-residential therapeutic program for children in need of more intensive treatment services in the community. It is typically provided in schools by CMHC staff.

- *Outpatient Therapy*--Outpatient therapy services are non-residential, community-based mental health services to individuals with serious emotional or mental disorders that allow the consumer to remain in the family home while receiving treatment.

- *Medication Evaluation/Monitoring*--Medication evaluation and monitoring are provided by a physician or nurse practitioner to assess the need for psychotropic medication, prescribe medication, and provide regular monitoring of the medications prescribed for effect and safety.

- *Therapeutic Nursing Service*--Nurses provide community-based therapeutic health intervention services as part of an individualized treatment plan.

- *Respite Services*--Respite services are planned temporary services that provide family members and/or primary caretakers a break from the stress of caring for a child with serious emotional disturbances.

- *Therapeutic Foster Care*--The model employs trained therapeutic foster parents with only one child with a serious emotional disturbance (SED) placed in each home to provide the child with the intensive special attention needed to adapt to a new home environment.

- *Therapeutic Group Homes*--The primary function is to provide individualized services to youth who are in need of intensive therapeutic treatment in a structured home environment through an array of community-based intervention services.

- *Making A Plan (MAP) Teams*--MAP teams employ a comprehensive (holistic) approach in developing a

family-centered multi-disciplinary plan for youth with SED and a high risk or history of hospitalization.

• *Psychosocial Rehabilitation/Day Support Programs*-- A day program with an emphasis on enabling individuals with serious mental illness to function in society as independently as possible, psychosocial rehabilitation includes the addition of a rehabilitation component to treatment models.

• *Case Management*--A system designed to facilitate access to services for individuals who meet the criteria of serious mental illness or mental retardation/developmental disabilities and who reside in the community.

• *Medication Purchase*--A program designed to support the purchase of psychotropic medication for indigent individuals with mental illness.

• *Family Education and Support*--Provides positive support for families whose members have long-term disabilities and helps establish linkages with services.

• *Crisis Centers*--These centers provide more immediate access to crisis services for short-term emergency mental health treatment and can serve to divert placement in a state mental health facility.

• *Intensive Residential Treatment*--A time-limited program designed to serve individuals who are having a severe mental health episode that, if not addressed, would likely result in the need for in-patient care. Follow-up outreach and aftercare services are provided as an adjunct.

• *Services to Vulnerable Adults*--The Department of Human Services is responsible for providing services for vulnerable adults, including adult protective services, homemaker services, sitter services, shelters, and personal care homes.

SOURCE: PEER analysis of *Mississippi Access to Care (MAC) Plan.*

Appendix B: Summary of Content of the Most Recent State Mental Health Plans

The Bureau of Mental Retardation's *State Plan for Services and Supports for Individuals with Mental Retardation/ Developmental Disabilities* contains the following:

- the plan's purpose and the bureau's mission, vision, and values;

- data on population being served, including current or previous year's data;

- a listing of the types of fiscal resources the bureau receives to fund its operations;

- a description of the current services offered, including the locations where each service is offered and the number of people currently being served (if applicable); and,

- goals with one-year objectives and a method of evaluation for each objective.

The Department of Mental Health's FY 2007 *Mississippi State Plan for Community Mental Health Services* includes the following:

- a description of the state service system, including general state population description, organizational structure of the Department of Mental Health, its administrative role in administering mental health services, listing of achievements for needs highlighted in the previous year's plan, a description of new developments/issues affecting mental health service in the state, any legislative changes, and a description of CMHCs and state-operated facilities;

- a listing of the agency's strengths and weaknesses for both the children's mental health system and adults' mental health system, an analysis of unmet needs/gaps in the current system, and priorities and plans for the upcoming year to address unmet needs;

- performance goals and action plans to improve the service system, including five separate criteria with status, goals, targets, and action plans for both the children's and adults' mental health system; and,

- projected expenditures for both children and adults by service along with projected CMHS block grant allocations to providers, including CMHCs.

The *Mississippi Department of Mental Health State Plan for Alzheimer's Disease and Other Dementia* contains the following:

- the plan's purpose, along with the philosophy of the Department of Mental Health;

- the organizational structure of the Department of Mental Health, including each section's responsibilities;

- a listing of facilities in either the opening, construction, or planning phases;

- demographics for the state, with a specific focus on the population age sixty-five or older, current Alzheimer's disease population in Mississippi, and a description and symptoms of dementia;

- an overview of Mississippi's public mental health service system, with a specific focus on dementia and the Division of Alzheimer's Disease and Other Dementia, including service locations;

- a brief description of DMH's Ideal System Model;

- a brief description of the division's three funding sources; and,

- goals with underlying objectives, each objective listing the strategy, indicator, and funding source.

The *Alcohol and Drug Abuse State Plan* includes the following:

- the plan's purpose, along with the philosophy of the Department of Mental Health;

- the organizational structure of the Department of Mental Health, including each section's responsibilities;

- an overview of Mississippi's public mental health service system, including alcohol and drug abuse treatment locations and CMHC locations;

- a description of alcohol and drug abuse prevention and treatment services, including a description of the service system; the role of state-operated facilities, the CMHCs, and nonprofits; process for

funding community-based services; sources of funding; projected expenditures for the upcoming year; and a description of the population currently served;

- a brief description of DMH's Ideal System Model;

- a description of each of the current components of the prevention and treatment services system; and,

- goals with underlying objectives, each objective listing the strategy, indicator, and funding source.

SOURCE: PEER analysis of the plans.

Appendix C: A Handbook on Strategic Planning

Strategic planning's purpose is to not only define who the agency is, but to also provide a road map guiding the agency toward its planned future. The goal of strategic planning is to integrate all aspects of the agency's activities into a mutually supportive system.

Strategic planning is important because it defines who the agency is, where the agency currently is, what the agency has to work with, where the agency is going, and how the agency is going to get where it plans on going, both in the short-term and the long-term.

Using the Department of Mental Health as an example, strategic planning could have a major impact on:

- the Department of Mental Health's ability to provide a comprehensive, financially feasible patient care system;

- the Legislature's ability to have a defined, visible avenue in which to effectively allocate resources to the Department of Mental Health's mission, goals, objectives, and strategies; and,

- the ability to provide oversight for the Department of Mental Health based on identifiable and defined critical success measures.

What are Strategic Management and Strategic Planning?

Strategic management is applied by leaders to align an organization's direction with that organization's aims. Strategic planning, the major tool of strategic management, is where a firm develops long-term goals for itself and then develops an action plan designed to achieve those goals.

What is Strategic Management?

Strategic management is the ongoing process of ensuring a competitively superior fit between the organization and its ever-changing environment.   Strategic management of public organizations often poses the "what" and "how" questions to managers. The "what" question concerns content. What does a strategy look like and how can organizational leaders use it to effect change in their organizations? The "how" question concerns the process. How can organizational leaders create a strategy that can then be used by their organizations?   Leaders use

strategic management to align an organization's direction with the organization's aims. This alignment takes place when needed changes in clients or customers, services, procedures, policies, and the like are devised and put into practice.

What is a Strategic Plan?

A strategic plan is a document that lays out an organization's vision, mission statement, critical success factors, core competencies, values, goals, strategies and actions for objectives (i. e., a means by which to achieve the organization's mission, vision, and goals), prioritized implementation schedule, and reliable measures in which to determine the success of the organization in achieving its goals.

However, to be able to develop a strategic plan, an organization must first determine who it is and what its purpose is. For example, the Department of Mental Health was created to provide the Mississippi public with mental health services, to educate the Mississippi public about mental health issues within the state, and to regulate mental health services within Mississippi. The Department of Mental Health is the lead state agency in charge of managing the public need, education, and regulation of mental health services in the state of Mississippi.

Why is Strategic Planning Important?

Why is strategic planning important? In *Management*, Robert Kreitner quotes then-Exxon Company U.S.A. Compensation Manager Douglas Gehrman on the following eight reasons for planning:

- increases chances of success by focusing on results, not activities;
- forces analytical thinking and evaluation of alternatives, thus improving decisions;
- establishes a framework for decisionmaking consistent with top management's objectives;
- orients people to action instead of reaction;
- modifies style from day-to-day managing to future-focused managing;
- helps avoid crisis management and provides decisionmaking flexibility;
- provides a basic for measuring organizational and individual performance; and,

- increases employee involvement and improves communication.

For a strategic plan to be successful, the plan must cover the entire organization; the plan must have a time frame in which to measure success and progress; and the plan must have a defined mission and vision in which to establish the agency's purpose and standards for success.

A United, Consolidated Strategic Plan

The goal of strategic planning is to integrate all aspects of the agency's activities into a mutually supportive system. As a result, agencies should develop a single agency-wide strategic plan.

Since the state of Mississippi has no explicit guidelines for strategic planning efforts within the state, PEER reviewed multiple tools for developing a strategic planning manual. For overarching guidelines and best practices recommendations and analytical tools, PEER turned to the federal level's Office of Management and Budget (OMB) under the U. S. Executive Office of the President.

According to the Office of Management and Budget, "a strategic plan must cover the major functions and operations of the agency [it was created for]." The OMB also states that agencies "should submit a single agency-wide plan," although OMB does state that "an agency with widely disparate functions [is able] to prepare several strategic plans for its major components or programs."

Time Frame for Strategic Plans

Strategic planning over a specified period provides a road map for the agency's financial and building decisions, both short-term and long-term.

According to the Office Of Management and Budget, "a strategic plan [should] cover a minimum of six years," but could be for a longer period, especially if it contains a project completion goal that is ten years into the future.

The Foundation for Community Association Research cites John B. Cox's "Professional Practices in Association Management" in recommending that strategic plans cover "a three- to five-year period." The foundation also recommends that "strategic plans be a living document that has a one-year drop off and a new year added so that [the strategic plan] always covers the same time period."

This also would allow for goals that have been achieved to be removed from the plan, current goals to be updated as to their success or future growth, and new goals to be added. Subsequent changes in creation of objectives and action plans should follow adjustments or additions of goals.

Mission and Vision

For an organization to be successful, it must know who it is and what its purpose is. An organization must also lay out an image of success in which to define and plan for its future.

To be able to develop a strategic plan, an organization must first determine who it is, what its purpose is, and where it wants to be in the future. Informally, answers to these questions combine to form the organization's mission and vision statements. Formally speaking, an organization's mission statement defines its social justification for existence and defines where the agency is going. An organization's vision statement then provides a shared mental image describing what the organization should look like once it has successfully implemented its strategies and achieved its potential. However, in order to develop strategies, an organization must fully understand the following:

- Who are they as an organization?

- What does the organization do?

- How does the organization currently do things?

- How does the organization stand within its external environment?

- What are the organization's internal strengths and weaknesses?

- What opportunities are available for the organization to pursue?

- What threats are there for the organization to minimize/avoid?

- What are the organization's options for moving forward?

To answer these questions, the organization must develop research to gather information about the above questions so that the organization can develop strategies to achieve its mission and vision based on the factors affecting the organization.

The research and analysis stage is the backbone of strategic planning. By completing the research and analysis stage, the organization will fully understand its internal workings, along with the external environmental factors that affect the organization. Armed with such information, the organization will be able to develop strategies capable of achieving the organization's mission and vision.

For an organization to develop a successful comprehensive strategic plan, it is vital that the organization learn about what it is and the factors affecting the organization. Most organizations are great at some things, average in other areas of the organization, and less than average in other parts of the organization. Through research and analysis, the organization will be able to define both the internal and external factors affecting the organization, as well as the organization's strengths and weaknesses. Nine types of analysis often used in strategic planning are:

- stakeholder analysis;

- environmental analysis (external and internal);

- market analysis;

- product analysis;

- service delivery structure analysis;

- organization systems and process analysis;

- human resource/management analysis;

- corporate governance analysis; and,

- financial/feasibility/cost benefit analysis.

Stakeholder Analysis

According to Bryson, an organization should complete at least the first few steps of a stakeholder analysis before developing a mission statement. A stakeholder is defined as "any person, group, or organization that can place a claim on an organization's attention, resources, or output or is affected by that output." According to Bryson, "attention to stakeholder concerns is crucial" because "the key to success for public and non-profit organizations is the satisfaction of key stakeholders."

The first few steps in a stakeholder analysis require the strategic planning team to identify who the organization's

stakeholders are, what their criteria are for judging the organization's performance (i.e., what is their stake in the organization or its output), and how well the organization performs according to those criteria from the stakeholder point of view. Once completed, a stakeholder analysis should "clarify whether the organization needs to have different missions and perhaps different strategies for different stakeholders and whether it should seek to have its mandates changed."

Environmental Analysis

An organization should conduct an environmental analysis (scan and assessment) in order to consider conditions and trends in both the external and internal environments of the organization that may impact the future success of the organization. The results of the environmental analysis are then assessed to identify the opportunities and threats presented by factors in the external environment and the strengths and challenges presented by factors in the organization's internal environment. The assessment of an organization's strengths, weaknesses (challenges), opportunities, and threats is called a SWOT analysis.

External Environmental Analysis

Monitoring an organization's external environment should identify all opportunities for and threats against the organization from outside the control of the organization. Opportunities and threats tend to pertain to the future rather than the present and can be discovered by monitoring a variety of demographic, political, economic, social, technological, educational, environmental, and physical environmental forces and trends. Attention to opportunities and threats, along with a stakeholder analysis, can be used to identify an organization's critical success factors. "Success factors are the things an organization must do or the criteria it must meet in order to be successful in relating to its external environment."

Internal Environmental Analysis

Monitoring an organization's internal environment should identify all strengths and weaknesses inside the control of the organization. Strengths and weaknesses focus on the present organization and can be discovered by monitoring an organization's resources (inputs), present strategy (process), and performance (outputs).

Market Analysis

The goal of a market analysis is to determine the attractiveness of a market and to understand its evolving opportunities and threats as they relate to the strengths and weaknesses of the firm. David A. Aaker (professor emeritus at the University of California at Berkeley's Haas School of Business) outlined the following dimensions of a market analysis:

- market size (current and future);
- market growth rate;
- market profitability;
- industry cost structure;
- distribution channels;
- market trends; and,
- key success factors.

Although the listed dimensions are primarily associated with business, these could also be applied in a governmental setting. In the case of the Department of Mental Health, the following types of questions could be incorporated into a market analysis: What is the mental health market in the state of Mississippi? Are there varying degrees of need within these market types? Are there other organizations that provide mental health services within the organization and how do their respective markets correlate in relation to providing services? What are the demographics of the market?

Product Analysis

The purpose of a product analysis is to identify an organization's product's key strengths and weaknesses as they relate to market opportunities and threats defined during the environmental analysis section of the strategic plan. A product analysis would then provide for developing strategies to address each of the organization's product's strengths and weaknesses by building on product strengths and correcting/minimizing product weaknesses. Budgetary and fiscal constraints must be factored in.

Product analysis and planning should be considered across the following stages:

- current situation;
- key product and market issues;

- key strategies; and,
- performance measures and targets.

For the Department of Mental Health, products come in the form of the services the department offers, ranging from case management, group therapy, day treatment, institutional care, and crisis facilities for patients who have a mental illness, are mentally retarded, battle substance abuse, and/or have some form of dementia. New services could become available, but the department should determine the benefits, costs, and environmental impact for each level of service to determine what should be offered and why, in accordance with the mission, strategic objectives, feasibility, and financial impact.

Service Delivery Structure Analysis

The purpose of the service delivery structure analysis segment of the strategic plan is to develop a plan for delivery of agency services. The service delivery structure analysis should provide a background to current activities and then identify and develop key strategies to address the strengths, weaknesses, and gaps in the agency's service capacities. Budgetary and fiscal constraints must be factored in. Key issues such as location, facility size, and staffing requirements are typically identified following an evaluation of key production and delivery performance drivers.

For the Department of Mental Health, the service delivery structure analysis should result in a designed continuum of care developed based on the department's market, services offered, location to be offered, mission, and strategic objectives.

Organization Systems and Process Analysis

The purpose of the organization systems and process analysis of the strategic plan is to develop strategies to address the key issues (strengths, weaknesses, and gaps) within the organization's systems and processes that drive organizational performance. Performance reviews to improve internal organization systems and processes typically include an assessment of the following areas: quality management, risk management, regulatory compliance, information management and security, financial management, employee performance and morale, stakeholder relationships, board and management performance, future planning and ongoing innovation, performance improvement across the organization (including performance indicators and targets), and

management of the environmental and social impacts of the organization's operations.

One of the major stumbling blocks to measuring an organization's strengths and weaknesses is the lack of performance indicators and performance analysis capable of detecting and presenting problems both for the organization and its wide variety of stakeholders. "An absence of performance information may also create--or harden--major organizational conflicts" because "without performance criteria and information, there is no way to evaluate the relative effectiveness of alternative strategies, resource allocations, organizational designs, and distribution of power."

Human Resource/Management Analysis

Since the service delivery structure analysis segment of strategic planning should provide new service delivery projections and targets for the agency, current organizational structures and human resource capabilities may require improvement to meet increasing agency demands.   The organizational and management analysis segment should include an analysis of the current situation and growth projections for the agency to identify key organizational and human resource issues that must be addressed if these growth projections are to be realized. Strategies with key performance measures and targets to address these key organizational and human resource issues should be developed. Areas to be addressed, both the current situation and the future, typically include:

- organizational chart;

- management team and their resumés;

- staffing requirements;

- job descriptions and work design for management and staff;

- performance standards, measurements, and feedback;

- management and staff training and development;

- recruitment and induction;

- encouraging innovation across the agency;

- providing leadership and building morale;

- occupational health and safety;

- industrial relations;

- wages; and,

- other relevant human resource issues.

Corporate Governance Analysis

Areas of corporate governance typically include agency structures, agency constitution, board of directors (size and composition), duties and responsibilities of the board, board performance, board advisors, and shareholder agreements.

Financial/Feasibility/Cost Benefit Analysis

The first purpose of the financial analysis segment of the strategic plan is to develop a set of financials for the duration of the plan based on the strategies and plans formulated in previous sections, calculated costs, and revenue projected. These financials should include cash flows, balance sheets, investment requirements, and key financial performance indicators and related performance targets.

Every organization, including the Department of Mental Health, has numerous strategies it wants to pursue, but not all of them are feasible and/or cost-effective considering we all operate in an environment with limited resources. As a result, before strategies should be pursued, an organization should conduct a feasibility analysis and a cost-benefit analysis for each proposed strategy/plan. A feasibility study is "an inquiry to determine what can be achieved given certain specified resources and constraints." A cost-benefit analysis is a "branch of operations research that aids in evaluating the implications of alternative courses of action" (e. g., strategy, location choices, equipment choices, product choices). A cost-benefit analysis not only allows an organization to determine cost and projected benefit (both economic and social), but also to be able to assign priority to different strategic objectives based on the cost-benefit analysis combined with a short-term and long-term needs assessment.

The second purpose of the financial analysis segment of the strategic plan is to address the application of investment/grant funds by linking all prior planning and, at minimum, address the following:

- What will be the total investment requirement across the duration of this plan--when and how much?

- Which investors will be involved; how much will they provide and when will they provide it?

- How will the funds be used at each round of investment?
- What will the capital structure and ownership be after each round of investment?

Other Elements of a Strategic Plan

Other elements of a strategic plan include organizational values, core competencies, goals and objectives, strategies with defined action/task plans, and critical success factors/performance indicators.

Organizational Values (Culture)

As noted in this report, organizational values define the culture of each organization. These values are an organization's essential, lasting values that should not be compromised or short-changed for expediency, financial reasons, or for other values that have been identified as important, but would not be considered "essential" to providing service and client care.

Critical Success Factors

Critical success factors are the factors/conditions that must exist in order for an organization to achieve its goals. Critical success indicators (operational objectives) are measures, or gauges, of progress toward achieving desired levels of performance in terms of critical success factors.

Core Competencies

Core competencies are the organizational skills that are vital in achieving an organization's mission. Core competencies are a set of unique internal skills, processes, and systems that provide competitive advantage in the market. Three important criteria an organization could use in trying to identify core competencies are:

- Does the activity provide unique or valued potential access to the market?
- Does the activity add value to the real or perceived perspective of customer benefits?
- Is it difficult for competition to imitate the activity?

Goals and Objectives

The purpose of establishing strategic goals is to provide a clear and well-marked pathway for achieving the aim (purpose) of the strategic plan. To establish clear, concise, action-oriented goals, the goals should be specific, measurable, action-oriented, affordable, achievable, and time-bound. To ensure the strategic plan has a sharp focus, the number of key goals should be limited.

After each goal has been clearly formulated, a set of supporting objectives and strategies should be developed. Objectives define the best pathway for achieving each goal. Objectives should also meet the criteria listed above (e. g., specific, measurable).

Strategies with Defined Action/Task Plans

Strategies define the pathway for achieving each objective. According to Bryson, a strategy is defined "as a pattern of purposes, policies, programs, actions, decisions, or resource allocations that define what an organization is, what it does, and why it does it. Strategies can vary by level, by function, and by time frame."

Bryson notes that an effective strategy must meet the following criteria. First, a strategy must be technically workable, politically acceptable to key stakeholders, and fit the organization's philosophy and core values. Second, a strategy should be ethical, moral, and legal, and it should further the organizational pursuit of the common good. A strategy must address the strategic issue it was supposed to address. Strategies, as well, should meet the standards for goals and objectives listed above (e. g., specific, measurable).

The action /task plan then allocates people and resources to completing the tasks required for each strategy to be successful. Action plans should address the following questions: "what work is to be completed (actions steps), who is responsible for getting the work completed, how will the work be completed (operational details if necessary), when will the work be completed, what resources are needed, and how will success be measured." Also, vital budget and resource considerations should be integrated into the overall strategic plan to ensure all planned actions are feasible.

Strategies with defined action/task plans are the outlined means to which an agency plans to achieve its goals and objectives and to a greater extent, the agency's mission and vision of success. Strategies with defined action/task

plans incorporate all the information a department learns about its agency through its different levels of analysis to be able to maximize the department's core competencies, internal strengths, and external opportunities and minimize the department's internal weakness and external threats.

Performance Indicators

Performance indicators with defined targets are meant to serve as a guideline to measure the success of agency strategies. Thus one of the major stumbling blocks to measuring an organization's strengths and weaknesses is the lack of performance indicators and performance analysis capable of detecting and presenting problems both for the organization and its stakeholders. As noted in *Strategic Planning for Public and Nonprofit Organizations*, without performance criteria and information, it is difficult for an organization to evaluate the relative effectiveness of alternative strategies, resource allocations, organizational designs and distribution of power.

Checklist for an Effective Strategic Plan

The following checklist could be helpful in ensuring a useful strategic plan:

- Does the organization's strategic plan have a defined set of priorities that allows for the strategic plan to be adjusted according to changing needs and resources?

- Does the organization's strategic plan include goals that are not only achievable but also measurable and time-sensitive?

- Is the organization's strategic plan flexible and responsive enough to be able to adapt to unforeseen detours such as unexpected crisis, new opportunities, or changes in available resources?

- Does the organization's strategic plan focus on the most important things the agency is trying to accomplish by being simple and concise, yet thorough?

- Is everything in the organization's strategic plan not only capable of being accomplished but also needed to be accomplished?

- Does the organization's strategic plan outline a clear process to reach the agency's intended

goals, and does not just contain goals with no means to achieve them?

- Does the organization's strategic plan stay in the present by being reviewed and updated yearly, but still covers a longer time frame?

- Does the organization's strategic plan have a short-term, mid-range, and long-term outlook with corresponding goals for each?

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Edwin C. LeGrand III - Executive Director

June 4, 2008

Dr. Max Arinder, Executive Director
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Dear Dr. Arinder:

The members of the Board of Mental Health and administrative staff are in receipt of the draft of the report compiled by your staff entitled "Planning for the Delivery of Mental Health Services in Mississippi: A Policy Analysis." We would like to commend David Pray, Matthew Holmes and Brian Dickerson for the professionalism and courtesy they exhibited throughout the review.

We appreciate the recommendations made by your staff. We feel they support the decision made in early 2007 by the Board of Mental Health and our Executive Director, Ed Legrand, to reorganize the administrative structure of the Department, to begin a process of changes in the Board's method of governance, and to refocus the Department's service/support delivery system from one that is predominantly institution-based to one that will rely more heavily on a community model. Toward this end, the following measures have already been instituted:

1. The Bylaws have been amended to reflect the relationship of the Board to its Executive Director as described by the Agency's enabling legislation.
2. The Board has implemented a Board committee structure that allows its members a more in depth review of the business and services/supports of the Department. The following committees are now very active: the Property Committee, the Finance Committee, the Clinical Services Committee, and the Strategic Planning Committee.
3. The Board and Mr. Legrand are experimenting with revised Board meeting processes including the development of the meeting agenda, in order to refocus our priorities.
4. Mr. Legrand has reorganized the central administrative structure of the Department to reflect renewed focus on all service areas mandated by the enabling legislation and to reinforce our determination to create a strong, expanded community-based system.

We appreciate the recommendations made by your staff supporting the need for more Board involvement in the departmental strategic planning process. Earlier this year, the members of the

Board established the Strategic Planning Committee. This committee is chaired by me as the current board chairperson and includes Board members Mr. George Harrison and Mr. Johnny Perkins as well as three department staff consultants. As one of its first actions, the Subcommittee sent written requests to all Board members, Facility Directors, Bureau Directors, Community Mental Health Center Directors, advocacy groups, the four planning councils, and Dr. Gray Norquist, Chairman of the Department of Psychiatry and Human Behavior at University of Mississippi Medical Center requesting their "vision" of what DMH services should look like in the year 2020. This information was due back to the Committee at the end of May. We will use the information in developing the kind of strategic plan you describe in your report.

The Board has had much discussion regarding the nature of the future DMH service/support delivery system and desires to develop a mission statement that reflects the current trends in mental health service provision. As part of the strategic planning process, the Board is currently in the process of developing a mission statement and five-year and ten-year goals and objectives for DMH services. We will then devise a comprehensive set of program-specific quantitative performance measures to assess the effectiveness and efficacy of departmental services and supports.

We are pleased that most of the recommendations in your report are directly in concert with the vision of the Board of Mental Health and our Executive Director of a future moving away from additional institutional care to expanded community based services. During the last legislative session, our Executive Director and staff had as one of their primary goals to secure funding for Medicaid Match for the Community Mental Health Centers. Our staff was successful in procuring a $10,000,000 deficit appropriation to assure that all 15 regional CMHCs will stay in business. Our Executive Director has shown his commitment to partnering with the CMHCs to provide mental health services through the creation of the new Bureau of Community Mental Health Services as a part of his restructuring of the agency administrative function. In addition, the members of the newly formed Association of Community Mental Health Centers are in regular dialogue with our staff about plans for future services.

We must point out that you mentioned Central Mississippi Residential Facility and the Juvenile Rehabilitation Facility in your report as examples that DMH was continuing to expand the institutional model. These facilities as well the Specialized Treatment Facility and many of the ten bed ICF/MR programs were initiated by the legislature and not requested by the DMH. Ed LeGrand has frequently stated publicly that future service expansion by DMH will not be "brick and mortar." As part of the DMH legislative agenda, Ed LeGrand requested a "lump sum" appropriation to give facilities more flexibility and more accountability for the management of their resources. He requested additional funds for the HCBW program for MR/DD as you recommended in your report. He also intended that CMHCs could operate one or more of the crisis centers, if their budgets would allow, to free up DMH resources. These changes are in keeping with our interest in moving away from institutional care to community services. These requests were not approved during this legislative session, but will continue to be requested.

The DMH has embarked on formal "succession planning" or "accelerated leadership development." DMH has also developed a "Knowledge Transfer" program, a comprehensive, DMH-relevant "how to" in the areas of fiscal management, human resource management,

physical plant management, regulatory standards and an overview of DMH administrative functions. Both programs are cutting edge in strategic planning for human resources.

Under the direction of Ed LeGrand and the staff of Mississippi State Hospital, Mississippi State Hospital is already in process of "rightsizing" via closing some long-term psychiatric patient buildings through attrition. The intent is to move the long-term services into the community setting as funding allows. The seven crisis centers located in communities across the state will no longer operate under a "hospital model" but will function under a behavioral health/crisis stabilization model designed to prevent unnecessary involuntary admissions to our Department's four psychiatric hospitals.
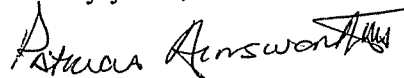
The Board and administrative staff of DMH are very much aware of the Olmstead Decision and the Mississippi Access to Care plan, having actively participated in developing recommendations for the plan. As you state in several places in your report, resources have not been made available to fund the MAC plan. We will continue to ask the legislature for funding for expansion of the HCBW and for development of community living programs.

The Board concurs with your recommendation that an enhanced, system-wide patient tracking and management information program is desirable. The Department has been stymied in the past by the anticipated complexity and expense of such a system but has contracted with the Mississippi Department of Information Technology Services to begin the process.

In addition, the Board believes that a system-wide Fiscal Management System is needed to effectively and efficiently manage the resources provided the Department by the Legislature. Such a system must of necessity be part of a larger state government system and this is presently under study by the Mississippi Department of Finance and Administration.

In conclusion, the Board of Mental Health and administrative staff are committed to improving and changing the direction of mental health services for Mississippi's citizens. We will develop an effective strategic planning process that will guide the Department's future services and supports. Your report supports the direction in which we intend to go as a Board and as an agency. Citations from your report will be helpful to our staff in developing the budget request to be presented to the Legislative Budget Committee this fall. We would like to extend an invitation to you and your staff to visit the programs operated by the Department of Mental Health. Again, please thank your staff for the courtesy extended during this review process.

Sincerely yours,

Patricia Ainsworth, M.D., Chair
Board of Mental Health

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