Findings from Stakeholder Outreach to Inform the Mississippi Strategic Plan for Community Mental Health Services

MAY 2022

FOR:

Mississippi Department of Mental Health

REPORT BY:

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I. Introduction

A. About the Mississippi Department of Mental Health

The Mississippi Department of Mental Health's (DMH) community mental health system provides a comprehensive array of services and supports to children, youth, adults, and families. The community mental health system aims to provide accessible, person-centered, and recovery-oriented care in the least restrictive and most appropriate environment. Mississippi's mental health service delivery system is comprised of three major components: 1) state-operated programs and community service programs, 2) 14 regional community mental health centers, and 3) other nonprofit and for-profit service agencies and organizations.

B. History of Mississippi Strategic Plans for the Community Mental Health System

In 2008, DMH began to develop its first Strategic Plan, which would serve as a guiding framework for the MS community-based mental health system of care. The first strategic plan set the overarching goals for DMH and used strategic planning groups to capture the voices of community members, advocacy organizations, and DMH staff. This version of the strategic plan was a 10-year plan (FY 2010 - 2020) that included 9 goals with 3-8 objectives per goal. The first strategic plan included a SWOT (strengths, weakness, opportunities, and threats) analysis within the executive summary, DMH strategy (mission, vision, core values, and guiding principles), core competencies, future goals, and an overview of the services and supports available for clients. DMH then produced quarterly reports throughout FY 2010 – 2013 that showed progress in meeting the goals. In 2014, DMH moved to producing mid-year and end-of-year reports. DMH used strategic planning committees and advisory groups consisting of various stakeholder groups to inform the development of the plans. Based on feedback from these groups, more recent versions of the strategic plan have been streamlined to outline: 1) the overarching goals for the MS community based mental health system, 2) the desired outcomes from reaching the goal, 3) the strategies or methods to achieve the objectives, and 4) the outputs or data points needed to measure the strategy.

The DMH website[1] contains links to the current and previous versions of the DMH strategic plan. The website also contains links to PDF versions of strategic planning supplementary reports, including strategic plan reports and strategic plan highlights. Currently, there are 13 strategic plans, one strategic plan overview, 36 strategic plan reports, and 25 strategic plan highlight reports. The strategic plan provides the framework for the community-based mental health system in Mississippi; the strategic plan reports address progress made towards goals and objectives; and the strategic plan highlights contain updates to current DMH initiatives.

C. Project Purpose

The purpose of this project was to conduct stakeholder engagement research with a diverse range of different individuals, who interact with Mississippi's community mental health system, in order to provide recommendations to DMH about future versions of the community mental health services strategic plan. Participants represented 21 stakeholder groups and feedback was derived from interviews, focus groups, and surveys to understand stakeholders' thoughts on the strategic plan's format, length, general content, and ideas for future stakeholder engagement.

[1] http://www.dmh.ms.gov/what-we-believe/strategic-plan/

II. Methodology

A. Interviews and Focus Groups

Stakeholders and stakeholder categories were identified by DMH and contact information was provided to NRI. The list included 21 groups that represented DMH leadership, community partners, clinicians and therapists, regional mental health center staff and leadership, state agency partners, peer and recovery support specialists, and advisory council members (see Appendix A for the complete category list).

Both the invitation email and calendar appointment email included NRI contacted each stakeholder group separately with a tailored email that asked respondents to choose from a set of provided dates and times for participation in an interview or focus group. Prior to the email invitation, NRI identified 13 stakeholder categories that seemingly lent themselves to a focus group, such as a state agency with three identified individuals. Focus group invitees were given four dates/times and asked to choose their available times (select all that apply), with instructions that NRI would follow up with the scheduled focus group time. Focus group invitees could also choose to participate in an individual interview instead and were able to suggest times. Stakeholders who were invited as interviewees were invited to provide a date/time within a given date range or they could suggest times that were more convenient for them.

Interviews and focus groups were conducted virtually with Microsoft Teams and scheduled for 30 and 60 minutes, respectively. Both interview protocols were semi-structured, utilized the screen sharing function in Teams to show particular page(s) of the plan for discussion, and focused on three topics: the plan's layout, length, and format; overall impressions of Goal 1 and Goal 3; and current and future stakeholder engagement to collect feedback on future plans. Following respondent consent, interviews were recorded for notetaking purposes. Interviews were generally conducted by the Project Director with a Research Associate as a dedicated notetaker and lasted about 25 minutes on average. Interview notes were then reviewed, coded, and analyzed for themes and patterns in a constructed database.

An online survey was also created to gather feedback and recruit respondents for interviews. The link was included in DMH newsletters and in non-response follow up emails sent to stakeholders. A copy of the survey is in Appendix B.

B. Review of Other State Strategic Plans

In order to understand how DMH's plan compares to other states and communities, strategic plans from six other states (e.g., Alabama, Arkansas, Louisiana, Missouri, Oklahoma, and Tennessee) were reviewed to assess their general framework, length, overall format, and process for collecting input for community mental health strategic plans. These states were selected because their regional, demographic, and socioeconomic characteristics are generally similar to Mississippi. The Mississippi Department of Corrections' and Department of Health's Strategic Plans were also reviewed.

III. Findings

The findings section includes aggregated information from the focus groups, interviews, and surveys for a total of 36 response units from 39 individuals. Thirty-five interviews were completed with 37 people from 15 stakeholder groups (see Appendix A); two interviews included more than one person (a board member and a peer support specialist; a Chancery Clerk and the Deputy Clerk). Only one focus group was conducted with three people from the Department of Rehabilitation Services.

A. Plan Format and Look

i. Length of the Plan

Stakeholders were asked to comment on the current plan's length of 32 pages. Responses were equally divided on whether the plan was "about right" or "too long." There were a few response patterns by stakeholder group. Every advocacy group representative felt that the current plan was too long, particularly for consumers and families. Law enforcement (CIT officers and sheriffs) also felt that the current plan was too long for those in their field to digest. However, one law enforcement officer clarified that an optimal plan length "depends on who you are." Respondents who said the plan was an adequate length tended to be members of the DMH Board of Directors, DMH Executive Staff, or CSU and regional center directors. However, there was also not uniform agreement among these latter stakeholder groups about the plan's length, with some members reporting it was too long.

Table 1 in the *Findings from A Review of Other State Plans* section shows that the current DMH strategic plan is in line with page counts from other neighboring states (e.g., Tennessee and Arkansas). The current DMH plan is also similar in length, albeit a little shorter, than the strategic plans used by the Mississippi Department of Health and Department of Corrections.

ii. Utility and Readability of the Outline Format to Present the Plan's Content

Overall, stakeholders said that they understood and liked the outline format used to present the goals, objectives, outcomes, strategies, and outputs. These respondents tended to be the same who felt the plan was the right length, but not always. Some said that they could not think of an alternative way to present the same information and still keep it organized and streamlined. A few stakeholders also added that the plan's readability/digestibility "depends" on who is reading the plan and that while they understood it, they acknowledged that others might not. About one-third of respondents thought the outline format communicated a document that had too much information, was confusing, and/or overwhelming to digest.

A follow up question asked stakeholders if the plan was easy to understand and the majority (60%) said yes. An additional 25% said that the plan was "somewhat easy to understand" or that they could understand the parts directly related to their job. A chancery clerk stated that the current plan may be "harder for someone to read without a health background." The remaining responses were from people who said the plan was difficult to understand and was largely represented by advocacy groups or peer support stakeholder groups. Stakeholder comments include, "As a peer support specialist, I don't know what to do with the plan and how it relates to my role and daily duties. But it must because we're in there."

Respondents who were aware of previous DMH strategic plans noted improvements in the current version's organization and clarity, noting that "past plans only made sense to data nerds" and "this version is much shorter than former ones." These individuals were largely in director level positions who said they routinely referred to or used the strategic plan in their job duties or who were more familiar with the history of DMH leadership than other stakeholders.

Suggestions to improve general understanding of the plan included adding the following elements at the beginning of the document:

- Add a graphic depiction of how the three goals relate to each other; clarify that they are not hierarchal.
- Add a graphic depiction of how the three goals relate to the strategies, objectives, etc.
- Move the common acronyms list (page 30) to the beginning.
- Provide a synopsis or summary of the plan at the beginning.

iii. Overall Aesthetic and Look of the Plan

Almost all of the stakeholders liked the general look of the strategic plan, such as its font and use of pictures. However, a few respondents expressed that the plan could look more polished and professional and offered suggestions for improvement. These strategies include:

- Add more white space and decrease wordiness in the strategies sections.
- Add PDF bookmarks for easier navigation of the document.
- Include more and better pictures (they don't have to be big) that represent the population served, as well as people from diverse backgrounds and demographics.
- Review pages for pixelation (i.e., page five).

Additional white space helps draw the reader's eye to critical focal points, such as objectives or key points. Including bookmarks in PDF documents allows the user to navigate to their sections of interest more quickly, while also providing a high-level overview of the overall document.

B. Plan Content

i. Goal 1 and Objectives

Goal 1 is, "To increase access to community-based care and supports for adults and children with mental illness and/or substance use disorders through a network of service providers that are committed to a person-centered and recovery-oriented system of care." Interviewees were shown the goal and the supporting eight objectives (page 6) and were asked for the overall impressions about the objectives, to include if they align with the goal, if any objectives needed to be added or deleted, if any wording needed to be changed, if anything was unclear, and if the objectives worked together as a logical set. The majority (about two-thirds) said that the collective eight objectives were "adequate," "good," and "seem to cover everything" related to meeting Goal 1. There were no suggestions for edits and they felt the goals supported and aligned with Goal 1. This group included stakeholders from the DMH Executive Staff, DMH Board of Directors, DMH Advisory Council, Regional CMHCs, law enforcement, and an advocacy/peer group.

The remaining one-third offered suggestions or raised questions about the Goal 1 objectives; however, none of respondent felt the objectives were a mismatch, "wrong", or misaligned with Goal 1. These respondents came from advocacy and peer groups, the DMH Board of Directors, Regional CSUs, and other state departments. Most of these comments addressed DMH's ability to meet a stated objective given staffing and budget shortages. One stakeholder said, "There aren't enough providers to provide the services that we need now, so how will they do this?" Another person said, "the biggest problem in the Mississippi community mental health system is following up with patients after discharge and providing resources. Patients need resources (PACT, ICORT Team, etc.) to help reduce hospital recidivism and there's not enough."

There was some disagreement among stakeholders about the number of state inpatient beds. One stakeholder expressed that the state needs more inpatient beds, although they also recognized that Goal 1 was designed to reduce hospitalizations and support lower levels of care. A stakeholder representing CSUs voiced that Objective 1.1 does not support Goal 1, or current state objectives to decrease inpatient hospitalizations. They suggested reordering the Goal 1 objectives to follow the typical flow of treatment, so that diversion and community-based service objectives come before hospitalization and inpatient, "If the first goal is to keep people out of the hospital, you should focus on the community services, and not have the first objective address inpatient care."

One person commented that the term "wraparound" was not used correctly and should be replaced with the more accurate phrase, "supportive aftercare services." Two respondents focused on objective 1.6 and said that there is a lack of knowledge at agencies and centers about the appropriate use of peer support specialists. These people felt that without DMH providing guidance about the roles (and non-roles) of peer support specialists to the various centers, then the outcomes will not be met and retention of peer support specialists will become challenging.

Lastly, one person felt all of the goals had too many objectives and that the number of objectives should be kept to five or less. It was suggested that if more than five objectives were necessary, it might signify the need to separate a goal into different ones.

ii. Goal 3 and Objectives

Goal 3 is, "To provide quality services in safe settings and utilize information/data management to enhance decision making and service delivery." Same as the process to solicit feedback about Goal 1, interviewees were shown Goal 3 and the seven objectives (page 7) and asked to provide their thoughts about their fit. As was the case with Goal 1, the majority of respondents (about 61%) felt the objectives appropriately aligned with and reflected Goal 3, and no one said that the objectives were a mismatch or "wrong."

The remaining 30% offered suggestions or raised a concern. A respondent noted that, "data does not indicate the quality of the services," and indicated a need for the plan to discuss and collect more qualitative information beyond data metrics. One stakeholder noted a disconnect between the overall programmatic strategies and their alignment with community workforce responsibilities and roles and suggested this as an area for improvement. Another person remarked that the various facilities and mental health centers across the state, even those within the DMH system, have different resources and needs that leads to "everybody being on different pages and how does this factor into the plan?" Other specific comments for improvement were:

- More and improved clarity around roles and responsibilities related to meeting data management objectives, particularly data sharing between community partners.
- Better clarity is needed to distinguish and define DMH services, "The goals are broad enough, but there needs to be more distinction between what DMH does as a service provider, versus the standards they provide."
- Consider combining objectives 3.3 and 3.4.
- Operationalize quality and provide definitions or examples.

C. Underserved Stakeholders and Future DMH Priorities

Interviewees were asked to consider the DMH community mental health system as a whole and identify any groups, populations, or stakeholders they felt were underserved or underrepresented in the plan. The responses included:

- Advocacy groups and allies
- Children, youth, and adolescent populations
- Clinicians involved in direct client and family services
- Crisis services
- ESL consumers
- Homeless people
- ID/DD populations: children under age 5 (i.e., day programs), transitional youth ages 18-25, those with co-occurring autism and serious mental illness
- Justice-involved populations with autism and/or serious mental illness
- Law enforcement officers and agencies
- MyPACT services
- Parents and family members, to include families involved in the civil commitment process
- Racial minority groups
- Undocumented immigrants
- Uninsured consumers

Respondents were also asked about items or priorities they would like to see included in future strategic plans or continue to see addressed. A variety of answers were received and they are listed below in alphabetical order. Although clear themes did not emerge, a common thread was simply the need for "more" in the community mental health system – more resources, staff, information for consumers, and funding.

- Better acknowledgement of the lack of resources in some parts of Mississippi (i.e., Delta region).
- Consider objectives geared towards improving organizational culture, increasing clinical empathy, and/or encouraging providers to use more person-centered language.
- Engage in more partnerships with schools and law enforcement.
- Family members and caregivers should be better utilized and incorporated; develop and offer trainings for families on navigating the systems (rights, benefits, and self-advocacy).
- Improve the lack of standardization around data definitions, data reporting and data management systems across the various regions, centers, and agencies.
- Increase or designate funding for mental health courts and justice programs for people with behavioral health challenges.
- Increased focus on those that need a high level of care and often get lost or "shuffled around" in the system.
- Increase outside support options for parents/families of individuals with autism and better publicize available services.
- Manage public relations to communicate that DMH hospitals are still "safe" to go to. There is concern from some stakeholders that the DOJ lawsuit will dissuade people from getting the help they need because they fear the hospitals are bad.

- More emphasis on increasing advocacy for people seeking services; provide more clarity for consumers surrounding how and where to get help.
- More emphasis on providing care in the least restrictive environment.
- Need to better highlight and integrate EBPs and data outcomes into every goal.
- Provide better/more provisions for employees (higher pay)
- Provide more senior-focused services/programs.
- Provide a better distinction between planning and implementation objectives.
- Provide more transparency with reporting data findings.
- Solicit and incorporate more feedback from direct care staff and practitioners who work with clients into strategic planning.
- Work towards a single point of entry with medical personnel and case workers.
- Work with Medicaid for reimbursement for supportive employment programs.

D. Current and Future Stakeholder Engagement Process

Overall, there was a low level of participation in this stakeholder feedback process. In total there were 35 interviews and one focus group with staff from the Department of Rehabilitation Services. Some stakeholder groups had no representation in the interviews, despite three attempts to contact people for participation. These groups were mobile response teams, behavioral health hospital program directors, PACT teams, police officers not embedded within a crisis intervention team, county law enforcement, and housing. In addition, about 1 in 3 scheduled interviewed resulted in a "no show." One contributing factor to the low response rate was that some invitation emails were going to spam or were being filtered out by IT settings, unfortunately, this was not detected until late in the project. Once it was detected that emails were going to spam folders, the research team contacted everyone who had not responded to the original email in attempt to reschedule interviews/focus groups.

During the interviews, respondents were asked to provide feedback on the current outreach process and suggestions for contacting stakeholders in the future. Regarding the outreach process utilized for this study, respondents felt the invitation email approach was logical and appropriate. Among respondents, there were no objections or concerns raised about using email as a means to reach stakeholders. However, an unknown number of invitation emails went to spam or junk folders or were not received for some other reason. Suggestions received from two stakeholders about the invitation email process, included a desire for clearer links and confusion with the scheduling instructions (i.e., please choose from the following times, may choose all). A clearer subject line that designates that a response is requested would also be helpful.

Fourteen respondents provided an answer beyond emails and suggestions included:

- Collect feedback through electronic surveys (i.e., Survey Monkey)
- Establish a public feedback/comment period for the plan and promote it on social media
- Make the plan easier to find on the website
- Offer requests for paper copies of the plan
- Offer incentives for providing feedback
- Outsource the stakeholder feedback work to an external organization unaffiliated with DMH.

Some respondents want more transparency in the feedback process and acknowledgement when comments are submitted. An advocacy group stakeholder said, "We provide feedback every time it's been open for comment. But until this [the interview], we've never received confirmation that anything

was done with the feedback or if it was even seen. I don't know how the strategic plan is developed. Is there a committee? Can I join it?"

E. Findings from A Review of Other State Plans

The review of other plans showed that DMH's strategic plan is similar in length and format to other state departmental plans (i.e. – MS Department of Corrections and Department of Health) and behavioral health authorities in other states (i.e. – Louisiana Department of Health and Oklahoma Department of Mental Health and Substance Abuse). As shown in the table below, the lengths of the reviewed strategic plans ranged from 5 pages to 232 pages. The "expiry" date, or the number of years the plan covered, varied from 3 - 5 years. The number of goals expressed within the strategic plans ranged from 3 -16 goals.

Table 1. Strategic Plan Content Among Different States and Mississippi State Agencies

State	Years Covered	Plan Length	Number of Goals
Alabama	Varies by local health authority		
Arkansas	5 years	47	4
Louisiana	5 years	232 pages	3
Mississippi	*3 years*	*32 pages*	*3*
Missouri	5 years	5	16
Oklahoma	5 years	Online based (no page count)	5
Tennessee	3 years	40 pages	7
MS Department of Corrections	5 years	36 pages	12 (one per division)
MS Department of Health	5 years	25	10 (one to three per program)

The MS Department of Health has two statewide goals, that are supplemented by one to three individualized goals for the 7 health programs (i.e. – health services, health protection, communicable disease, tobacco control, public health emergency preparedness and response, administrative and support services, and local government and rural water systems improvements loan program and emergency loan program), for a total of 10 goals. This plan was reviewed at the suggestion of a respondent who indicated it was a good model. In 2014, a state health assessment was conducted to determine the most important needs of the Mississippians. This process collected feedback from residents, health professionals, and community partners throughout the state. A state health assessment and improvement committee (SHAIC) are involved in developing the state health improvement plan. The Assessment consisted of four parts: 1) an epidemiological-based analysis of health status assessment of demographic, social, and health indicators, 2) a thematic analysis of community and needs and strengths collected from surveys, community conversations, and focus groups, 3) a forces of change assessment (FOCA) to identify all of the forces, opportunities, and threats that can impact the public health system, and 4) a state-wide public health assessment from conversations and research from representatives government, business, academic institutions, health care providers, and a variety of community-based, non-profit, and advocacy organizations.

Similar to Mississippi, three states (Louisiana, Tennessee, and Oklahoma) have statewide strategic plans for their state mental health agency (SMHA). Other neighboring states, Alabama and Arkansas, have local mental health authorities, or local governing entities, that develop their own strategic plans and thus

were not included in the table above. These individualized, local plans operate in lieu of a statewide strategic planning tool. In Louisiana, each of the service districts also have their own strategic plan which includes a vision, mission, philosophy, and agency goals. Having unique agency goals allows the community leaders to relate to their population more closely but may decrease statewide standardization initiatives.

When comparing the strategic goals of Mississippi to these other states, Tennessee has a goal to "expand access to low-cost, high quality, and outcomes-oriented mental health" that is similar to Mississippi's first goal to "increase access to community-based care and supports for people with mental illness and/or substance use disorders." Louisiana has a strategic goal to "provide quality services" and Missouri has a goal to use "data-based decision making." Both of these goals have parallels to Mississippi's Goal 3 to, "provide quality services in safe settings and utilize information/data management to enhance decision making and service delivery."

Tennessee's plan is updated annually to reflect milestones in the achievement of Department goals and objectives. Tennessee uses an annual assessment of need for services and supports to develop its Plan. Each Spring, the seven Regional Planning and Policy Councils as well as the Statewide Planning and Policy Council's Committees (Adult, Children's, and Consumer Advisory Board) work independently to identify and prioritize two mental health and two substance abuse needs. Each identified need is supported by data supplied by the council or committee that identified the need and is submitted to the Department and compiled into a Needs Assessment summary. This summary is then shared with TN SMHA leadership to assist in the development of the Department's next three-year Strategic Plan.

In Louisiana the local mental health authorities have independence to collect stakeholder feedback. In order to develop goals, objectives, and strategies, the Northwest Louisiana Human Services District actively solicits input and feedback from community leaders, stakeholders, individuals receiving services and their families, community members via Board linkages, and employees. Tools used to gather data include employee and consumer satisfaction surveys, public forums, needs assessment via governmental and stakeholder relations, and external evaluation by grantors and the legislative audit. The Strategic Plan is also revised to reflect fiscal, managerial and programmatic changes that have occurred.

In Oklahoma, Regional Prevention Coordinators (RPC) are required to develop and submit Community Strategic Prevention Plans and receive written approval of the Plans by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) prior to service implementation. The RPCs then submit two Strategic Plans - the regional prevention plan and the Strategic Prevention Framework State Incentive Grant (SPF SIG) Community Plan. The state Strategic Plan is revised to reflect fiscal, managerial and programmatic changes and the ODMHSAS utilize several staff and stakeholder groups to review the regional Strategic Plans.

In Arkansas, leadership has developed a Strategic Prevention Plan to aid in preventing engagement in adverse behaviors, including substance use, among children and adults in Arkansas. An advisory committee consisting of approximately 30 state agencies, agents from Governor's Office, and community partners was established to guide the development process for the strategic prevention plan. During 2019-2020, a five-month-long exercise, consisting of more than 70 people from the Arkansas Department of Health and community partners to update the previous Strategic Plan and identify public health priorities. All Agency employees were invited to participate in a strategic planning survey to provide input

on what health outcomes and behaviors the agency should be prioritized. This input was then used to identify eight primary focus areas for the plan.

The Alabama Department of Mental Health has divided the state into 310 Boards, or local health authorities which include at least one county. There are several counties within the state that have more than one DD 310 Authority. The local mental health authorities have independence to collect stakeholder feedback, and the processes used in collecting input differs among health authorities. Most local health authorities solicit input and feedback from community leaders, stakeholders, individuals receiving services and their families, and employees. Tools used to gather data include employee and consumer satisfaction surveys, public forums, advocacy organizations (i.e. – NAMI), and stakeholder relations.

IV. Recommendations to Improve the Mississippi Community Mental Health System Strategic Plan

In addition to the recommendations addressed above, suggestions to improve the current strategic plan so that it performs better for a variety of stakeholders are discussed below.

A. Recommendations for the Plan's Format and Look

1. Add a point of contact (POC) in the plan, perhaps one for each Goal? Ideally this POC will be helpful, able to answer questions, or direct them to the right person. The Services/Supports Overview (page 27) may also present an opportunity to embed contact information.
2. Add the Plan's timeframe to the cover page in calendar years, "October 2022 – September 2024." Not all stakeholders will know or understand the FY abbreviation.
3. Consider adding a short description of the Goals in the Table of Contents.
    a. Goal 1: Increase access to community-based services for people with mental illness and substance use disorders
    b. Goal 2: Increase access to community-based services for people with intellectual and/or developmental disabilities
    c. Goal 3: Provide quality, data-driven services in safe settings
4. Consider moving the implementation page to the beginning, as many stakeholders wondered how the steps would be accomplished.
5. Consider the graphic design changes that were suggested by respondents (i.e., improving the quality of the photos), particularly a revision of page 5; work with a graphic designer to review and polish the overall document.
6. Delete the DMH mission statement from the bottom of page 7, it is out of place and breaks up the flow of the document.
7. Maintain the current length. Instead of focusing on reducing page numbers, stress aesthetic and information changes that can improve its overall look and information flow.
8. Move the acronym list to the front of the plan and ensure all acronyms are included.
9. Pages 31 and 32 should be combined in some way, both are not needed.
10. Think about including a list of the DMH leadership team, the Advisory Council members, Board strategic planning subcommittee members, OR other relevant plan development group. This could be presented as a stand-alone list in the Appendix, or perhaps formatted in a column or box that is part of the Chair's Letter.

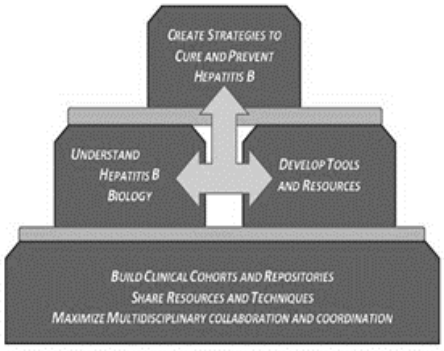
B. Recommendations for the Plan's Content

It is challenging for any entity to develop a strategic plan that can be understood by a diverse audience who represent various roles, views, and positions in the system. With that in mind, the following recommendations can improve the utility, readability, and usefulness of the plan to a greater range of stakeholders.

1. Better communicate to the readers of the plan that there are supporting reports available on the website, such as the quarterly Strategic Plan Highlights and consumer satisfaction survey reports. Some respondents were not aware of these reports or efforts.
2. Consider adding a FAQ section that is geared towards consumers, families, and community partners to provide some needed clarity. This could also be used to communicate POC information, "Who should I contact if I have a question about this plan?"
3. Explore the possibility of having a consumers/family/community partners version and a staff/clinician/DMH version of the strategic plan. Perhaps the consumer version could be an abridged version that focuses more closely on services and advocacy, versus system or agency-level strategies (i.e., developing partnerships). The abridged version would also refer readers to the full plan. As an alternative, consider short summary briefs (1-2 pages) that are Goal-specific and easier for all stakeholders to understand.
4. Include a summary at the beginning of the plan that is written in very plain language. This was suggested by several respondents, both those who did and did not understand the plan. A well-written summary (no more than a page) that describes the plan's format, discusses how/why different stakeholders can utilize it, or has tips for navigating the document could improve understanding of the plan among subgroups.
5. Include a graphic that depicts the relationship between the goals, see some examples below that can be adapted for DMH's needs. Some stakeholders thought elements of the plan (i.e., objectives) were ranked in order of priority and there were also questions about how the three goals related to each other.

   Below are three examples for depicting relationships between goals and objectives. While they might not be right for MS in their current form, there are likely elements that can be adapted to meet DMH's needs.

IMAGE 1. GOALS AND COMPONENTS GRAPHIC EXAMPLE 1



DMH could adapt the graphic on the left so that the overarching mission is at the top (i.e., improve health of Mississippians), the goals are the second tier, and the objectives, outcomes and strategies are the third tier. The ones below can be adapted with DMH's terminology.

IMAGE 2. GOALS AND COMPONENTS GRAPHIC EXAMPLE 2

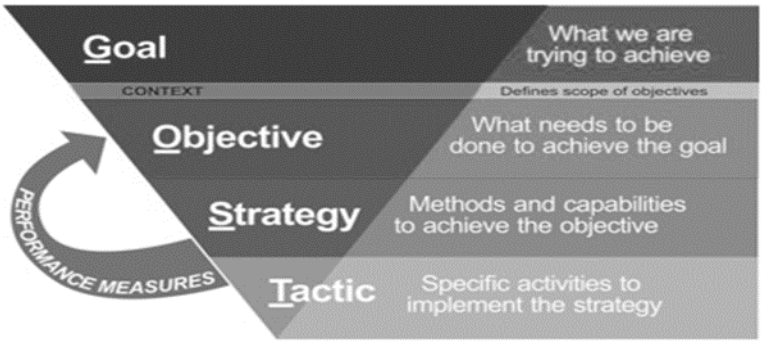


IMAGE 3. GOALS AND COMPONENTS GRAPHIC EXAMPLE 3

	WHAT	HOW
High Level	GOALS	STRATEGY
Detail Level	OBJECTIVES	TACTICS

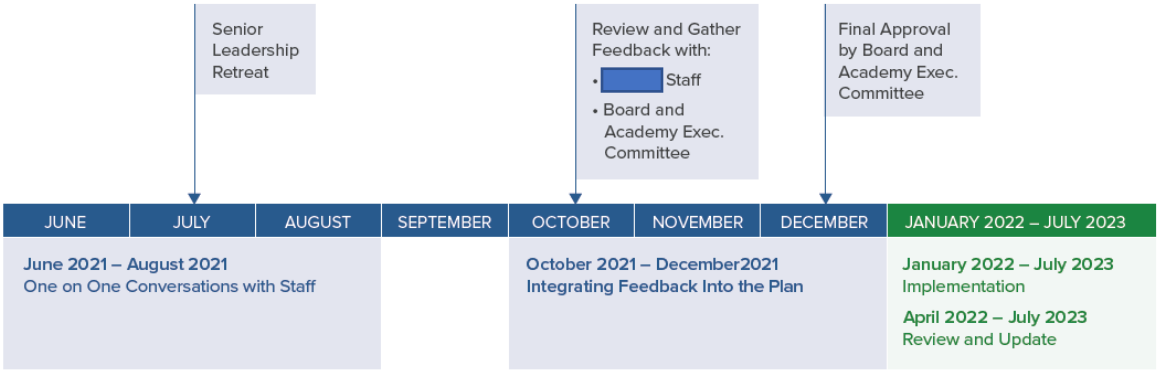
6. Provide more clarity around the specific DMH programs and efforts or consider separate objectives for the different types of programs. For example, Objective 3.5 addresses workforce retention and recruitment and a respondent questioned whether this referred to the programs that DMH funds, those they certify, or both? Other areas of the plan were also ambiguous as to which type of DMH programs were being discussed.
7. Reorder the objectives under Goal 1 from least to most restrictive care and services; consider whether an objective related to inpatient care belongs under a community-support goal.
8. Replace the term "wraparound" with the more accurate phrase, "supportive aftercare services."
9. Revamp the presentation of outputs to include a baseline number and/or a target number that can communicate the goal. Also consider adding a time period, to the extent that is feasible. For example, "Increase % of forensic beds from X number to Y number within two years," provides more information to the reader about what has already been achieved and the desired change. This approach could also address the need to designate or differentiate short-term goals and long-term goals, "*There needs to be a plan for the immediate year, and then longer-term goals. The plan should be laid out by years and have the flexibility to accelerate goals based on legislative funding and other external forces."* As implementation of this latter suggestion would require an overhaul of the current framework, it is not recommended unless DMH undertakes a full design. However, consideration should be given to an opportunity to incorporate a short-term/long-term element into the existing plan's structure, perhaps by ranking or ordering plan elements by length.
10. Strengthen the link between consumer knowledge of services and service utilization and incorporate or add this to the plan.

11. Think about the utility of including who is responsible for reporting the outputs and for what time period (i.e., monthly, quarterly). However, if this substantially expands the length or complexity of the document, it is not a priority recommendation.
12. While there were no suggestions for new objectives to add, stakeholders did communicate priority areas and/or populations they felt were underserved or underrepresented in the plan and this is discussed above. DMH is encouraged to consider how future plans can better incorporate this respondent feedback.

C. Recommendations for Future Stakeholder Engagement

1. Acknowledge when feedback and input are received. Consider adding an acknowledgements section to thank the people and agencies who provided input/feedback on the plan (separate from those who actively craft the plan). This can be done as a few lines in the front matter section, "The DMH would like to acknowledge the following stakeholders for proving feedback of the 202X Strategic Plan: name, name, etc." However, this is a lower priority than including information about the process itself.
2. Consider who the invitation email is coming from and who/what organization will get the most traction from respondents.
3. Consider an incentive in the form of an entry to win a $50 gift card to thank people for providing feedback. However, there are some ethics surrounding survey incentives (i.e., bribing people versus compensating them for their time) that DMH should weigh.
4. Develop an outreach communication plan that can be tailored to each major stakeholder groups. This might include different wording and language and different scheduling approaches (providing dates to choose from versus having the respondent provide date).
5. Do not conduct focus groups, they are difficult to schedule and hold in virtual environments. Individual interviews, less than 30 minutes in length, are ideal.
6. Explore a different interview scheduling approach where the respondents can fill out their availability (i.e., lettuce meet or doodle poll) instead of proscribing selected dates.
7. Follow-up outreach to non-respondents (i.e., people who don't respond) are a must and should be built into the timeline and communications plan. Two additional contacts past the initial invitation are recommended.
8. Identify a better location on the DMH website other than the "What We Believe" section for the Strategic Plan reports, perhaps under its own header/drop down menu on the home page. A few respondents remarked that the Plan (or information about it) was difficult to find on the website, including long time DMH employees.
9. Identify a champion(s) at the various agencies and centers who can encourage their staff and/or patients and families to provide feedback on the strategic plan.
10. Include a copy of the plan as an attachment AND as a link in all correspondence materials and the calendar invitation.
11. Increase the transparency of the stakeholder engagement process and include information about the process in the plan itself. For example, a professional membership organization's strategic plan dedicates one page to describing the process with a short, easy to understand narrative and a timeline graphic,

IMAGE 4. PROCESS TIMELINE EXAMPLE



12. Proactively work with IT to minimize emails going to spam or junk folders.
13. Short online surveys, less than 15 questions, that can be accessed through an email invitation or a social media post are likely the most efficient way to gather feedback. However, non-response follow-ups (i.e., reminder posts) will still be needed. If an interview approach is utilized, a companion survey can provide the means for scheduling via contact and availability questions, in addition to collecting some feedback about the plan.
14. Use clear subject lines that make "the ask" the focus, see the example below:

IMAGE 5. EMAIL SUBJECT LINE EXAMPLE

V. Conclusion

The overall findings from this stakeholder engagement outreach process revealed general satisfaction with the structure, content, and format of the current strategic plan across all respondents. Respondents who were familiar with previous versions were complimentary of the improvements and noted how it had changed for the better. In addition, in unprompted shares, several respondents who were familiar with past and current DMH leadership said that they were pleased with the direction the agency was headed. The incorporation of the recommendations outlined here will help improve the existing strategic plan and in turn, the community mental health system as a whole.

Appendix A. List of Stakeholder Groups Included in the Outreach and Number of Respondents who Participated in an Interview or Focus Group

Mississippi Stakeholder Group	Number of Respondents
1. DMH Board of Directors Members	4
2. DMH Executive Staff	6
3. Division of Children & Youth	0
4. Division of Adult Services	1
5. Mobile Response Teams	0
6. Behavioral Health Program Directors at state hospitals	1
7. Advocacy organizations	4
8. Community Mental Health Centers	3
9. Chancery Clerks & judges	Clerks = 2; Judge = 1
10. ICORT Teams	0
11. PACT Teams	0
12. CIT Officers	2
13. Crisis Stabilization Unit staff	3
14. Mental Health Planning and Advisory Council	3
15. Department of Rehabilitation Services	Focus group with 3 people
16. Police	0
17. Sheriffs	1
18. County law enforcement	0
19. CPSS Ambassadors	2
20. Housing	0
21. Employment and peer support specialists	1
22. Other – Academic Partner	1 (survey response, no interview)

Appendix B. Survey Sent to Mississippi Stakeholders

Mississippi Stakeholder Feedback Request Form

The Mississippi Department of Mental Health (DMH) is working with the National Association of State Mental Health Program Directors Research Institute (NRI) to gather stakeholder feedback about DMH's Strategic Plan for its community mental health system. The Strategic Plan is the guiding document that sets clear goals and objectives for the DMH community mental health system and the desired outcomes and feedback is important. As part of this effort, NRI invites you to complete this survey and indicate if you are willing to participate in an optional 30-minute follow-up interview. If you have questions about this request or would like more information, please contact Jennifer Bronson at jbronson@nri-inc.org. Thank you for your time!

1. Please provide your contact information:
    a. Name:
    b. Title:
    c. Organization you represent, if applicable:
    d. Email:
    e. Phone number:
2. To which stakeholder group(s) do you belong? Check all that apply.
    a. DMH staff
    b. Community behavioral health provider
    c. Peer support provider
    d. Individual with lived experience
    e. Family or friend of individual with lived experience
    f. Ember of the Mississippi Mental Health Planning and Advisory Council
    g. First responder (e.g., law enforcement, fire department, EMS)
    h. Mississippi courts/Justice system
    i. Member of behavioral health advocacy organization, please list:
    j. Other stakeholder group, please describe:
3. What is your overall impression of the length of the current Mississippi Strategic Plan?
    a. Too short
    b. About right
    c. Too long
4. Do you agree or disagree that the current Strategic Plan is easy to understand?
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree
5. What do you like about the current Strategic Plan?
6. What are your suggestions to improve the current Strategic Plan?
7. Are you willing to participate in a brief, 30-minute virtual interview to further discuss your thoughts?
    a. Yes
    b. No

Thank you for your time! If you indicated interest in participating in an interview, a representative from NRI will be in touch to follow up.