



Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration

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INTRODUCTION

Title XIX of the Public Health Service Act (42 U.S.C. 300x) mandates that all states establish a State Mental Health Planning Council (referred to as MHPC, council, or PC herein).¹ The council is required to review the state Mental Health Block Grant (MHBG) application and submit any recommendations it has regarding the state's plan; serve as an advocate for adults with serious mental illness, children with serious emotional disturbance (SED), and other individuals with mental illness or emotional problems; and monitor, review, and evaluate the allocation and adequacy of mental health services in their state, at least annually. The Substance Abuse and Mental Health Services Administration (SAMHSA) administers two block grants: the MHBG and the Substance Abuse Prevention and Treatment Block Grant (SABG). States are not required to establish a planning council under the SABG.

In recent years, State Mental Health Agencies (SMHAs) and State Substance Abuse Agencies (SSAs) have increasingly been merging in order to better coordinate state behavioral health services. As states align programs to promote mental health with programs and services for substance abuse prevention, treatment, and recovery, it is logical for them to coordinate and align their system planning functions as well. Recent and anticipated changes in national and state healthcare environments, as well as the new option for states to submit joint MHBG/SABG applications, have contributed to the growing trend toward creation of integrated Behavioral Health Planning Councils (BHPCs) that address both mental health and substance abuse issues.

To facilitate this transition, SAMHSA's Center for Mental Health Services (CMHS) initiated a State Technical Assistance (TA) project. Advocates for Human Potential, Inc. (AHP) manages TA to state planning councils (PCs) for this project as a subcontractor to Johnson, Bassin, and Shaw International, Inc. (JBS). The project supports delivery of both general as intensive TA to eight states per year. It also includes the development of a National Learning Community (NLC) to help councils begin, continue, and/or sustain the transition from a MHPC to a BHPC. The eight states selected in 2012-2013 were Arkansas, Colorado, Idaho, Louisiana, Kentucky, Maryland, Rhode Island, and Utah. Planning councils in those states participated in the NLC and received intensive TA, working together to identify best and promising practices for making and sustaining the transition to a BHPC.

NLC members examined their level of mental health and substance abuse integration, helped to deliver general TA to non-NLC councils upon request, participated in a series of webinars to address planning council priority issues, and employed interactive technology to provide relevant information to one another and other PCs throughout the nation.

¹ 42 USC CHAPTER 6A, SUBCHAPTER XVII, Part B, subpart I: block grants for community mental health services.

Retrieved from:

<http://uscode.house.gov/view.xhtml?req=mental+health+planning+council&f=treesort&fq=true&num=27&hl=true&edition=prelim&granuleId=USC-prelim-title42-section300x-3>



The State TA Project was charged with documenting best practices, process improvements, and challenges related to the expansion of PCs into behavioral health-oriented entities. AHP collaborated with the National Association of State Mental Health Program Directors (NASMHPD) Research Institute (NRI) to identify these best practices. Key informant interviews were conducted with representatives from each of the eight NLC states' planning councils as well as block grant planners from those states. The purpose of this manual is to suggest best practices for states at various stages of planning council integration based on those key informant interviews, reports from other PCs regarding their level of integration, and the Behavioral Health IQ Assessment (BHIQ) developed through this project and completed by each participating state (see Appendix A).

MAKING THE TRANSITION TO A BEHAVIORAL HEALTH PLANNING COUNCIL

THE HEALTH CARE ENVIRONMENT

Planning councils that may have previously focused primarily on mental health issues and concerns continue to expand their focus to encompass a wider range of behavioral health issues, including preventing and treating substance use disorders (SUDs) and providing recovery-oriented services for persons with SUDs. Increasingly, they are planning to address the service needs of individuals with mental health, substance use, and/or co-occurring mental and substance use disorders (CODs) as well as other co-morbid conditions, including physical health conditions.

Council members trying to integrate these functions while also preparing for possible shifts in the health care environment can benefit from learning more about how health care will be delivered and paid for in their state. Examining the level of council integration can help PCs set goals for their own strategic planning. Understanding how other states are responding to these same challenges can provide useful ideas, resources, and support.

State agencies are under increased pressure to develop measurable service and program goals and to use data to determine how well those goals are being met. Since planning councils are charged with reviewing the allocation and adequacy of services within the state, council chairs, state planners, and consultants providing TA said it is especially important that council members understand who in their state is eligible to receive funded behavioral health services in order to identify service gaps. Some states have already identified gaps and are pursuing innovative demonstration projects to address them that will be of great interest and could benefit service users. PCs, with their diverse stakeholder representation, can provide advice and support to state agencies attempting to meet identified needs.

Similarly, as changes in health care delivery systems are implemented, councils can expand this assessment of services to the substance abuse community. For example, they can communicate with service users about whether consumers are experiencing delays in



accessing quality services or whether there are other issues to bring to the attention of the state agency and advocates. Councils can also identify ways to encourage and support providers so they are able to offer high-quality care to people trying to access services, sometimes under difficult conditions.

It will become critically important for councils to have access to and be able to assess data and information as they strive to assess the allocation and adequacy of services within states regarding:

1. Service needs of individuals with mental health and substance use disorders, issues, and concerns;
2. Services delivered to those individuals at the program, service, and client level;
3. Service gaps that must be filled to meet the needs of those who need behavioral health care; and
4. The effectiveness and efficiency of all services, especially those funded by MHBG and SABG programs.

SAMHSA, as part of its focus on the development of a “Good and Modern Addictions and Mental Health Service System,” supports an appropriately trained and credentialed behavioral health workforce. Councils can help ensure that mental health and substance abuse providers have enough qualified mental health and substance abuse staff, as well as the training and technical support needed to upgrade their clinical and business management practices and technology. Councils may also play a more general role by helping their states monitor and promote enrollment in behavioral health services.

Most state planners, TA consultants, and council chairs involved in the NLC project said they believe that over the next few years the changing health care environment will bring significant opportunities and challenges for planning councils to help improve the behavioral health care system. Some councils are seeking opportunities not only to enhance the coordination of substance abuse and mental health treatment, but also to provide better-integrated care for people who have co-occurring behavioral health and medical conditions. They are focused on the triple aim of: (1) improving the patient experience of care (including quality and satisfaction); (2) improving the health of populations; and, (3) reducing the per capita cost of health care.²

Numerous health care resources and web sites are available to planning councils seeking to expand and strengthen their role in supporting integration of the behavioral health system. One of those sources is the SAMHSA/Health Resources and Services Administration (HRSA) Center for Integrated Health Care Solutions. The Center for Integrated Health Care Solutions offers grants, webinars, and resources to help council members, state agency representatives, and

² For more on the triple aim and behavioral health integration see: <http://www.integration.samhsa.gov/workforce/care-coordination>

providers take advantage of the opportunities to deliver better integrated care that meets the needs of the whole person.³

YOUR COUNCIL'S BEHAVIORAL HEALTH IQ

The transformation from the single focus of mental health to include other behavioral health disorders such as SUDs and CODs adds layers of complexity to service planning, monitoring, and evaluation during an already challenging time. To respond to this need, during the fall of 2012, AHP worked with states and territories to determine their level of integration of mental health and substance abuse issues and concerns into the work of the council. While some states believe that they are doing well and making progress in integrating across behavioral health, most continue to be challenged in important ways.

States fell into three categories:

1	Little or no Integration	12 States (25%)
2	Moderate Integration	23 States (48%)
3	Well Integrated	13 States (27%)

Behavioral Health IQ Assessment

The Behavioral Health IQ Assessment (BHIQ) (Appendix A) was developed by the State TA Project as a way to help councils assess how well integrated they are with respect to mental health and substance abuse issues, concerns, and expertise. It is designed to help councils develop well-informed plans as they make the transition to a BHPC capable of addressing behavioral health issues and concerns effectively. The tool can be used by all state councils, allowing them to quickly and easily assess their behavioral health-related status and functions.

Each area of the BHIQ Assessment represents an element of a council's role, structure, and function. In addition to referring to the federal law noted in each section, persons completing the form should also include state law or executive directives that apply or are uniquely relevant to each behavioral health element. Finally, as each council considers ways to strengthen and sustain its behavioral health competence, the BHIQ Assessment encourages councils to consider the actions they could take to make each element more focused on behavioral health. These actions can serve as the core of each council's behavioral health transition plan and be used as an annual planning tool. The self-administered tool is designed to help a state, territory, or jurisdiction to:

³ For more about integration with primary care, see SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) program: <http://www.integration.samhsa.gov/about-us/pbhci>

- Assess the extent to which a council has integrated mental health and substance abuse issues and concerns into its work, and
- Identify practical strategies that a council can employ to make the transition to a behavioral health planning council.

THE STATUS OF BEHAVIORAL HEALTH COUNCILS

Early in 2013, AHP asked the eight councils that were selected for the NLC to pilot test the BHIQ Assessment tool. This section summarizes responses to questions in the BHIQ and cites selected state responses. It also highlights respondents' suggestions and strategies that may support all councils as they move to maintain and strengthen their approach to behavioral health.

Council Title

 *Does the title/name of the council refer to mental health only, or behavioral health, which would be inclusive of the prevention and treatment of substance use disorders and co-occurring disorders?*

States involved in this process reported that they believed it was important to change the name of the council from “mental health” to “behavioral health” to make a public commitment to integrating with prevention, treatment and recovery of substance use disorders. Of the eight NLC states, six states include “Behavioral Health” in the name of their councils, one state is in the process of changing its name and function to include behavioral health, and one state has two separate councils with two representatives from mental health and substance abuse on each council. In addition to name changes, councils may want to review how important concepts and functions are defined. For example, SAMHSA materials include the following key definitions:



Recovery — “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”⁴

Behavioral Health — “Behavioral health refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, as well as mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases such as serious mental illnesses and substance use disorders, which are often chronic in nature but that people

⁴ Substance Use and Mental Health Services Administration, *Brief Overview of SAMHSA Recovery Definitions*. Rockville, MD: author, 2012. Retrieved from <http://dmh.mo.gov/docs/ada/TheRecoveryProcessDefinitions2005thru2012.pdf>

can and do recover from. The term is also used to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use, and related problems, treatments and services for mental and substance use disorders, and recovery support.”⁵

Council Charge, Mission Statement, and Bylaws



Is the group officially charged to work on mental health or on behavioral health issues, including substance abuse and/or co-occurring disorders?

Do your council bylaws address mental health and substance abuse?

Among NLC states, some councils have behavioral health mission statements. Others do not have separate mission statements, but rather fall under the mission statement of their affiliated state agency, which outlines the council’s purpose and charge. All of the councils with a behavioral health name and focus have changed (or are in the process of changing) their bylaws to reflect expanded membership, charge, and function.

Both Louisiana and Oregon have developed a list of guiding principles to help guide their councils. Louisiana has 10 principles focused on prevention, treatment, and recovery including this one: “Through a cooperative spirit of partnerships and collaborations, the needs of individuals, families and communities will be met by a workforce that is ethical, competent and committed to the welfare of the people it serves.” Oregon’s 16 guiding philosophies include: “We honor every voice;” “Shake up the system, not the individual;” “Ensure that what’s supported here fits the triple aim of better care, better outcomes, less cost;” and “Ensure the system does not fall exclusively into the medical model.”

The Oregon council also pledges to utilize *Culturally and Linguistically Appropriate Services in Health and Health Care* (i.e., National CLAS Standards) to ensure that their process is relevant and meaningful to a diverse set of members.⁶ CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

Some councils have included a focus on other CODs such as problem gambling, tobacco, and other behavioral health issues. Councils that have effectively integrated often assign

⁵ Substance Abuse and Mental Health Services Administration, *Leading Change: A Plan for SAMHSA’s Roles and Actions 2011-201, Executive Summary and Introduction*. HHS Publication No. (SMA) 11-4629 Summary. Rockville, MD: author, 2011. Retrieved from <http://store.samhsa.gov/shin/content//SMA11-4629/02-ExecutiveSummary.pdf>

⁶ *The National CLAS Standards* can be found at the following U.S. Department of Health and Human Services web site: <https://www.thinkculturalhealth.hhs.gov/Content/clas.asp>



subcommittees or other smaller groups that include representatives from the substance abuse field and others to rewrite mission statements with a comprehensive, behavioral health perspective. (A reference file of individual council bylaws is located in the Planning Council group resource library at www.BHTalk.org.)

Membership

Q *Does your council membership represent required and desired expertise and perspectives?*

This question asks councils to consider whether their members can provide the mental health, substance abuse, and co-occurring disorders expertise needed to adequately represent the diverse interests, perspectives, and needs of stakeholders in the behavioral health field.

Two NLC councils reported that they are working to increase the representation of substance abuse prevention/treatment providers and people in recovery from addiction.

A behavioral health approach suggests that councils should consider including consumers and individuals with lived experience of recovery from both SUDs and CODs, as well as representatives from publicly-funded substance abuse treatment programs and provider organizations that demonstrate good understanding of co-occurring issues and disorders.⁷

Results from the BHIQ Assessments and key informant interviews demonstrate that substance abuse consumers and professionals feel strongly that council representatives are needed who deal exclusively with SUDs. While SAMHSA data show that almost half of all adults with SUDs (42.8 percent or 8.9 million) have co-occurring mental illness,⁸ those in both the substance abuse and mental health communities point out that some in our systems of care have only one disorder. Including individuals to represent mental health disorders, substance abuse disorders, and co-occurring mental health and substance abuse disorders helps to guarantee a broad base of diverse perspectives.

Some councils reach out to a variety of stakeholder groups that represent various populations and constituencies when considering who to include as members. The following chart provides guidance in this regard. Council membership can be based on the unique types and levels of behavioral health interests relevant in each state. Most of the states reported that behavioral health champions – those who are passionate about the topic of integration and can gain the attention of others in the community – can be found in surprisingly unlikely places. States that were able to use champions effectively either knew who those individuals were or were able to discover them relatively quickly. The champions were then invited to join planning councils and

⁷ SAMHSA has supported the development of two measures: Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index and the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index. Retrieved from: <http://www.samhsa.gov/co-occurring/ddcat/> and <http://www.samhsa.gov/co-occurring/DDCMHT/index.html>

⁸ SAMHSA website on co-occurring disorders. Retrieved from: <http://www.samhsa.gov/co-occurring/topics/data/disorders.aspx>



use their leadership skills to benefit the council's work. As an example, the Colorado council's membership application is included in Appendix B.

MEMBERSHIP ASSESSMENT*		✓
Demographics		
Rural, suburban, and urban communities		
Various racial/ethnic/linguistic groups present in your state, including tribal communities		
Lifespan (e.g., family members of children, as well as young adults and elders)		
Those who identify as Lesbian, Gay, Bisexual, or Transgendered (LGBT)		
Consumers/advocacy organizations		
Individuals with lived experience of recovery from serious mental illness, other mental illness, or emotional problems		
Individuals with experience as a family member and/or parent of a child with serious emotional disturbance		
Individuals with lived experience of addiction and recovery from substance use disorders		
Individuals with experience as a family member and/or parent of a child/young adult with substance use disorders		
Individuals with lived experience of co-occurring disorders		
Provider representatives		
Substance abuse treatment programs (from among publicly-funded and privately-funded programs, outpatient, Intensive Outpatient Programs [IOPs], and residential treatment)		
Community-based substance abuse prevention programs and coalitions		
Mental disorder treatment programs (publicly-funded and privately-funded programs, outpatient, IOP, residential treatment)		
Provider organizations that can demonstrate a high level of capability (and therefore understanding of) co-occurring disorders. ⁹		
Providers from other behavioral health organizations as needed		
State agency representatives		
<u>Required</u> : Mental Health, Education, Vocational Rehabilitation, Criminal Justice, Housing and Social Services		
Other: Substance Abuse, Child Welfare, Medical Assistance (Medicaid/Medicare), Elder Affairs, etc.		

**This is a partial list designed to help consider possible council members.*

⁹ SAMHSA has supported the development of two measures: Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index and the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index. Retrieved from: <http://www.samhsa.gov/co-occurring/ddcat/> and <http://www.samhsa.gov/co-occurring/DDCMHT/index.html>



Staffing

Q *Is there a staff person assigned to support the council’s work on both mental health and substance abuse issues? Does that person have knowledge and/or experience in the prevention and treatment of substance abuse in addition to mental health?*

In key informant interviews and conversations with other states, council members noted that assigning sufficient state staff resources to assist the planning council in its work has been instrumental in virtually every council’s success. Council members, including leaders, frequently have full-time employment and other obligations. Being able to depend on a state employee who is responsible for maintaining council records, managing meeting logistics, navigating the state system, and serving as a general sounding board for the council’s work is crucial to its success. Sufficient, strong, and well-placed staff can connect the council to the state executive office and help guarantee that its work is acknowledged and valued. Respondents who answered this question in the pilot BHIQ Assessment said staff members assigned to support the council were supportive of integration, even though the primary professional experience of most of them was in the mental health field.

Meeting Agenda

Q *Do your council meeting agendas cover mental health, substance abuse, and co-occurring issues?*

Behavioral health councils typically include both substance abuse and mental health issues in their agendas. Councils responding to the BHIQ assessment said that when they review service, financial, and evaluation data, they strive to address both mental health and substance abuse. Several councils acknowledged that there is still room to increase the level of integration of behavioral health topics addressed at regular meetings.

Workgroups and Subcommittees

Q *Do workgroups and subcommittees address issues of mental health only or do they include substance abuse and co-occurring disorders?*

Almost all of the councils report that their subcommittees or workgroups focus both on mental health and substance abuse issues, as well as those related to as children, veterans’ affairs, criminal justice, and other areas regarded as high priority. In addition, councils report the development of subcommittees or workgroups related to process and service issues such as finance, data, strategic planning, membership, prevention programs, treatment services, recovery, advocacy and public relations, and the block grant. A number of councils use their Executive Committee to make decisions on the council’s behalf between scheduled meetings.

Block Grant Application

Q *Was the last block grant application a combined plan? Do you expect the next block grant application and plan to be combined or separate?*



Seven of the eight NLC states submitted combined block grants last year and plan to do the same going forward. The one NLC state that did not submit a joint block grant plans to submit a combined application for FY 2014-2015. States that submitted a combined block grant said that doing so helped their integration process by providing an incentive to develop a dialogue among representatives from all areas of behavioral health.

Review of Fiscal Information

Q *Does your council review fiscal information for mental health, substance abuse, and co-occurring disorders?*

Planning councils vary on their approach and ability to review fiscal information for mental health and substance abuse revenue and expenditures. Four of the NLC BHPCs review both mental health and substance abuse financial data and information. Another stated that it receives comparatively little information about funding for substance abuse. Overall, councils reported that they review some or all of the following:

- Community mental health center plans and budget allocations for mental health programs;
- Fiscal information for mental health and substance abuse programs (although councils noted that they have little input into how the monies are allocated and distributed);
- MHBG and SABG reports; and
- Fiscal information on federal block grant expenditures, as well as expenditure data on service utilization in the public mental health system.

Needs Assessment

Q *Does your council review service information for mental health, substance abuse, and co-occurring disorders?*

Councils reported that the value of a comprehensive needs assessment has increased and that they expect that trend to continue as states cope with changes in the health insurance marketplace and health delivery systems. According to SAMHSA's *Behavioral Health Treatment Needs Assessment Toolkit for States*,¹⁰ many low-income individuals with significant unmet behavioral health needs will be among the newly insured. Assessing and planning for the appropriate mix of services, developing the behavioral health workforce, and using data to improve health will ensure that their needs are met. The toolkit notes that there is a "significant

¹⁰ Substance Abuse and Mental Health Services Administration. Behavioral Health Treatment Needs Assessment Toolkit for States. HHS Publication No. SMA13-4757. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. Retrieved from <http://store.samhsa.gov/shin/content//SMA13-4757/SMA13-4757.pdf> 8/22/13.



need for quantitative tools and data on which to base mental health and substance abuse system planning.” Several planning councils are attempting to develop a better understanding of how to use these tools and data.

Councils reported that they have conducted or participated in needs assessments in various ways. For example, council members are frequently polled by council leaders and state agency staff and, as key informants, provide their thoughts and ideas on what the highest priority services are and should be. State agencies often conduct periodic or *ad hoc* needs assessments as the need arises, sometimes using data available from existing systems or developing and analyzing data for the specific purpose. As a standard part of their responsibilities, state management information system staff often provide essential information and support to councils. Existing data collection and reporting systems that can provide comprehensive and valuable data on mental health and substance abuse service needs in the U.S. can be found in the following chart.

Behavioral Health Data Sets
Treatment Episodes Data Set (TEDS)
CMHS Uniform Reporting System (URS)
Drug Abuse Warning Network (DAWN)
National Survey on Drug Use in Households (NSDUH)
Youth Risk Behavior Surveillance System (YRBS)
National Survey of Substance Abuse Treatment Services (N-SSATS)
Behavioral Risk Factor Surveillance System (BRFSS)

More information on data can be found at: <http://www.samhsa.gov/data/>

Although BHPCs review substance abuse and mental health service needs assessment information, most said they are still learning about needs assessments for the substance abuse field. One council reported that it is still new to reviewing substance abuse program and financial information. Another noted that the ability to conduct such needs assessments is “an evolution that has taken several years.” A third reviews mental health data and said it is “working diligently to encompass substance abuse data from key people within the department” along with training its council regarding substance abuse data. Finally, one council said it reviews service information related to the block grant planning and implementation reports along with reviewing information from regional updates, hospitalization updates, and Division of Behavioral Health updates.

The State TA Project will produce a brief guide to conducting a needs assessment for planning councils during the 2013-2014 project year.



Block Grant Content Knowledge

Q *How familiar are council members with the requirements of the Mental Health Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SABG)?*

Most councils report that they are familiar with requirements of the MHBG but say that they need and want a better understanding of the SABG. Several noted that although councils have historically focused on mental health, some still need periodic “refreshers” on the MHBG, especially as states implement guidance in the FY 2014-2015 Block Grant Application. Councils reported that a member’s familiarity with the grants and their requirements increases with the length of their experience as a council member.

Special Projects

Q *Does your council complete special projects that address mental health, substance abuse, and co-occurring disorders?*

Generally, councils did not report conducting joint substance abuse and mental health special projects – with the possible exception of limited program evaluations – although they expected this to change as they move further into integration. One state reported that a workgroup drafted “talking points” about the importance of integrated services for CODs, which may be a good topic for an integrated special project. Another council noted its existence as a BHPC is still too new to allow it to plan and execute such products but said it plans to engage in more integrated projects after submitting the joint block grant application.

Block Grant Review Process

Q *Describe the council’s process for reviewing block grant applications and reports.*

Councils employ various processes to review block grant applications and reports and to provide feedback related to the need for behavioral health services and programming in the state. State planners said it is important for council members to understand these because they provide detailed information about service needs and how the state is responding to them. In most states, state agency staff members draft the block grant application, then solicit feedback from stakeholders through a variety of mechanisms, including the planning council. Some councils have a subcommittee to review and provide recommendations on the block grant. Other councils have implemented a web-based planning process to help workgroups identify service priorities from the many challenges facing the state.

NLC members have requested that this area be explored in greater depth by the State TA Project so that more detailed guidance and examples can be provided to planning councils to help them fulfill their responsibilities to:

- (1) review plans required to be provided to the Council by statute and recommend modifications;



(2) serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and

(3) monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state.¹¹

State Substance Abuse Council

Q *Is there a State Substance Abuse Council or equivalent? If so, how does your council interact with that group?*

Several states have advisory councils that address the prevention of, and treatment and recovery from, substance abuse. NLC council chairs and state agency staff reported that they see state substance abuse councils as natural allies in the effort to better understand substance abuse concerns and perhaps even to integrate mental health councils, although success in those efforts has been mixed. For example, in one state there are Regional Advisory Committees (RACs) on substance abuse. In the past year, these groups have worked to merge with Regional Mental Health Boards and form a single, newly-integrated Behavioral Health Board. To date, the success of this approach varies by region. In another state the chair of the substance abuse council sits on the BHPC council, but that person does not attend meetings regularly.

In some states, a mental health council and a substance abuse council exist independently of one another, though they may relate to each other on common planning interests. NLC members indicate that efforts to bring two such separately constituted and charged groups is a developing area of activity that would benefit from greater exploration by the State TA Project. Alternatively, some states have chosen to create an entirely new council that represents both mental health and substance abuse interests at equal and balanced levels.

Strategic Planning

Q *What's the greatest challenge you face in integrating issues and concerns relating to mental health, substance abuse, and co-occurring disorders, or in maintaining and strengthening your current level of integration?*

Recurring themes include the lack of integration at all system levels, different language and funding sources, and challenges in developing a unified vision for behavioral health. Councils struggle to distinguish between areas in which it is possible to integrate substance abuse and mental health issues within the context of behavioral health and those in which the two areas

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<http://uscode.house.gov/view.xhtml?req=mental+health+planning+council&f=treesort&fq=true&num=27&hl=true&edition=prelim&granuleId=USC-prelim-title42-section300x-3>



represent real differences in population, etiology, and discipline. They also said there is a learning curve for all council members to “work outside of our funding silos.”

Council leaders completing the BHIQ Assessment raised questions they had heard from council members, stakeholder groups, and providers such as:

- Will the substance abuse community lose its ability to have input or influence on issues related to SUDs?
- Will the voice of the addictive disorders community be diminished or overshadowed by that of the mental health community?
- Will the mental health community lose its focus?
- Will the council be able to determine and implement a meaningful and effective planning and monitoring process, given that the charge has expanded to address both mental health and SUDs?

NLC states also expressed concern about how to manage integrated boards and councils that are large enough to include representatives from mental health and substance abuse, including peers and family members. Specifically, they wanted to ensure that the size is not too large to be able to focus on issues, to advocate, and to provide input into the behavioral health service delivery system. From a practical perspective, a few states wondered whether an expanded council would fit into its usual meeting room, noting that free space is hard to find in many state systems.

Councils also expressed the need for education on substance abuse disorders and addiction, as well as on the SABG. Key strategic planning challenges in integrating substance abuse and mental health/behavioral health approaches included:

- Creating a balanced, representative membership without expanding its size significantly (due to facility restraints);
- Lack of integration at all system levels; and
- Different language and funding sources.

One council reported that its challenges included:

- Developing a unified vision for behavioral health in its state;
- Determining where there is the possibility of integration within the context of behavioral health and where the two areas represent real differences in population, etiology, and discipline; and
- Determining and implementing a meaningful and effective planning and monitoring process to address the council’s expanded charge.

Assess areas that that need strengthening



What aspect(s) of your planning council role would you like to see strengthened?

Councils reported a variety of areas they would like to strengthen, mostly involving improved collaboration and integration. These include:

- Build relationships and increase collaboration with the SMHA and/or behavioral health authority;
- Build relationships and increase collaboration with the SSA and/or behavioral health authority;
- Increase legislative activities;
- Expand public advocacy and education;
- Enhance council involvement in planning, implementing, and monitoring block grant services;
- Integrate local, regional, and state planning council efforts more effectively; and
- Increase council involvement in developing and monitoring accountability measures.

BEST PRACTICES

OVERVIEW

This section of the manual highlights “best practices” meant to serve as a resource for states transitioning to a BHPC. As noted earlier in this manual, these suggestions are based on key informant interviews with the eight NLC states, as well as discussions with other states involved with the State TA Project. Because each council has different structures, opportunities, and constraints, every suggestion will not be applicable to every state. Authors believe that this section represents the “state of the art” at the present time.

GETTING STARTED AND BUILDING SUPPORT

Successful integration of a BHPC requires more than changing a name; the experience of the NLC councils and other planning councils suggests it will take time to implement fully. States that were interviewed advised that councils attempting a transition be persistent in their efforts and expect that the transition will be ongoing, at least until an integrated approach to behavioral



healthcare is the national standard. For instance, Rhode Island formally integrated its BHPC in 2002 and is still experiencing challenges to full integration, largely due to separate federal funding streams and mandates. Although the process evolves over time, taking certain steps can encourage and facilitate successful integration.

Identify a Champion(s)

An advocate for an integrated BHPC can facilitate dialogue, answer questions that may arise about the transition, and articulate the importance of making the transition to a behavioral health focus. Champions can be drawn from and/or interact with the state legislature, state agencies, advocacy organizations, service providers, and other interested parties about the progress and benefits associated with integration. The role of champion may default to the state's behavioral health commissioner, planning council chair, or block grant planner.

Dedicating a position to this effort may be valuable. In some states, a dedicated employee is located in the Office of Consumer Affairs in order to ensure the neutrality of the position and to gain respect from consumers and family members. While he or she may assist in building trust with consumers and family members, the individual in the champion's role need not necessarily be a consumer or family member. A savvy consumer or family member, behavioral health professional, or planner might all perform this function. Several NLC states commented that consumers and family members may be more likely to trust an integration champion if the position is relatively autonomous and has easy access to influential positions within the state, such as the Commissioner/Director of Behavioral Health, Substance Abuse Authority, Governor's staff, and so on.

NLC members recommend that the state behavioral health authority and planning council work together to identify a person who has the interest, ability, and time available to dedicate efforts to the planning council and the integration effort. Council chairs interviewed – who were themselves often the behavioral health integration champion – said that keys to a champion's success include the interest, ability, and availability to focus on the task. NLC states say that in their experience, support from the state's department/division of mental health and substance abuse (or department/division of behavioral health, etc.) is important to bolster the champion's efforts. The support of state behavioral health leaders is seen as playing an important role in moving integration forward, in that it sends an important message to planning council members that integration efforts are valued. Supportive state agency leaders can also provide the PC with needed administrative support as the council makes this transition. An abbreviated position description developed by Kentucky is included in Appendix B.

Obtain Support from the State Legislature

Some state statutes mandate the membership composition of planning councils, above and beyond federal requirements. In such states, legislative support is crucial for effective integration to occur. NLC members suggested the most effective way to influence the legislature



is to demonstrate how an integrated council and an integrated approach to behavioral healthcare will result in cost savings and more effective care in the state. Key informants also mentioned that it is critical to emphasize that the integration process will be inclusive and that no populations or stakeholders will be overlooked.

Obtaining legislative support may involve inviting legislators to attend planning council meetings or regional board meetings. Their participation provides an opportunity to better understand the needs of constituents as well as the benefits of integration. It also gives council members the chance to ask questions and better understand the needs and goals of the state.

Louisiana has multiple regional boards that meet monthly and report to the planning council. One of the regions has consistent participation from their local state legislator. During these lunchtime meetings members of the regional board are able to direct questions to the representative about his/her past voting record and plans for future votes. The legislator has an opportunity to ask questions of council members to learn more about their efforts together and obtain information to take back to colleagues in the legislature. The representative's presence at these meetings acknowledges the importance of the regional board's efforts and empowers members to be proactive. A similar approach could be used for state-level planning council meetings. Building relationships with other stakeholder groups is also vital for gaining support from the state legislature, as these groups can join in advocacy initiatives related to integration efforts.

Build Relationships

Healthy relationships are essential to gain respect from and influence over the state's public behavioral health system. States transitioning to a BHPC can make it a priority to engage state agency directors, representatives from behavioral health advocacy organizations, and representatives of the state substance abuse council (if one exists). Key informants from several state planning councils found it helpful to reach out to other states to learn from their peers' experiences.

Most importantly, planning councils should seek support from the directors of the SMHA and the SSA, or the director of behavioral health for states with integrated agencies. Key informants from every state said the involvement of these directors is critical to provide guidance and leadership to integration efforts. If possible, the directors should attend and participate in planning council meetings. For instance, Maryland's mental health commissioner and Rhode Island's behavioral health director report on mental health and substance abuse activities at every planning council meeting. The involvement of this executive and/or senior staff members – an approach adopted in many states – provides an additional incentive to strong participation from planning council members and is a tangible demonstration of the agency's support.

NLC members recommend that planning councils actively develop relationships with other state agencies, many of which also have a stake in the delivery of public behavioral health services. State planning councils can have "seats" that are dedicated to representatives from the state



Medicaid agency, education, criminal justice, vocational rehabilitation, and health services, among others. Key “sister” state agency representatives who aren’t council members may attend planning council meetings and report on activities in their departments that are of interest to planning councils. In Rhode Island, for example, both the Medicaid authority and the Child Welfare/Children’s Behavioral Health authority make regular reports to the behavioral health planning council. However, it can be challenging to ensure that the participation of these agencies remains consistent and strong.

Planning councils can successfully engage representatives from other agencies by demonstrating how their budgets and resources are negatively impacted by a failure to address behavioral health needs. For example, Arkansas successfully engaged their Medicaid agency by demonstrating how much it cost the state not to support certain behavioral health services. Because of their relationship with the Medicaid agency, the planning council successfully advocated for Medicaid to pay for substance abuse services for pregnant women, youth, and special populations. In addition to these services, the planning council is also working with Medicaid to develop a [Home and Community-Based Services 1915\(i\) Plan](#) to fund behavioral health homes that will provide intensive outpatient substance abuse treatment. This collaboration allowed Arkansas not only to expand services, but also to demonstrate to consumers and family members how their efforts actually influence the system.

Planning councils in states that have a substance abuse council said it is imperative to engage that group in the process. If possible, a member of the mental health planning council or the designated BHPC champion can request an invitation to attend a substance abuse council meeting. At the council meeting, the BHPC representative can present their goals and vision for an integrated council. Key informants suggested that during their presentation, they were advised to make their intentions as transparent as possible and encourage active participation in future planning council meetings by members of the substance abuse council. State planning councils with vacant positions can advertise them and encourage substance abuse council members and other substance abuse experts to apply. Key informants emphasized that transparent communication is critical to gain support for the success of integration efforts.

States can also be proactive in collaborating with other states that have successfully integrated planning councils. NLC representatives indicated that the most helpful resource during their integration efforts was learning about the experiences of other states. States may consider setting up a monthly conference call or listserv to discuss ideas, challenges, and opportunities for integration. Key informants suggested that participants for these discussions may be the state planner, another administrator championing integration, or the BHPC chair.

INTEGRATING AND INCREASING UNDERSTANDING

Councils noted how important it is for their members to be well educated about the differences in planning, overseeing, and administering the two block grants. That knowledge allows them to



take the steps needed to bridge the cultural divide between the mental health and substance abuse fields by recognizing differences, acknowledging and affirming mutual strengths, and finding common ground in improving care.

Improve Support for Integration

The needs of individuals with behavioral health disorders and the importance of addressing them are increasingly well understood. A focus on open-mindedness, flexibility, and the desire to form new, well-integrated relationships can assist in shedding discrimination and bias, removing it as an obstacle to mental health and substance abuse communities working together respectfully and collaborating on common goals.

Planning councils can develop educational materials and dedicate meeting time to identify and address common misconceptions about mental illness, addiction, and co-occurring disorders. NLC members suggested that councils promote recovery and trauma-informed care as systemic goals applicable to both mental health and substance abuse treatment services.

Understand Differences in Cultures

Interviewees suggested that successful council integration begins by recognizing the differences in mental health and substance abuse cultures.

For example, individuals receiving mental health services are often referred to as “consumers,” while recipients of substance abuse services are more likely to be referred to as “clients.” Many other differences in language exist. Several states have begun to develop a glossary of terms that can be used to inform planning council members about nuances in language between the two fields. Councils can collaborate with stakeholders from the mental health and substance abuse communities to identify terms for consideration. Once an extensive list is identified, these terms can be compiled into a glossary and distributed at new member orientation and other trainings, as appropriate. These terms can be used during planning council meetings and considered when developing council documents, including bylaws, mission, vision, and membership applications.

Planning councils that have educated their members on differences in language and terminology reported that their members feel more comfortable and able to engage in a meaningful dialogue. An Oregon council member recently suggested providing each member with a piece of paper that says “Acronym Alert” that can be held up during meetings as a gentle way to increase awareness. A list of acronyms developed by the Kentucky council is included in Appendix B.

NLC members suggest assigning each council member a mentor from a different field (e.g., a mental health advocate with a substance abuse advocate). These “teams” could sit next to each other during planning council meetings so that whenever a question or confusion arises, they

can be addressed immediately. Mentors in some NLC states also provide guidance and information outside of planning council meetings.

An important step toward integration is to learn about members' understanding of mental health and substance abuse prevention, treatment, and recovery methods—i.e., their service cultures. For example, SAMHSA developed two toolkits that enable practitioners to assess their knowledge and capability around providing co-occurring services to persons with a mental illness (i.e., Dual Diagnosis Capability in Mental Health Treatment [DDCMHT]) and those with SUDs (i.e., Dual Diagnosis Capability in Addiction Treatment [DDCAT]). These two useful tools measure aptitude around program structure, program milieu, assessment, treatment, continuity of care, staffing, and training.^{12,13} Although the tools are commonly used to assess providers' level of aptitude, BHPCs could consider administering the assessments to their members. This will enable BHPCs to identify their current level of understanding and identify areas they need to learn more about in order to more efficiently educate members on current practices.

The graphic below is based on a SAMHSA illustration which describes the mental health and substance abuse capacity of service agencies. It has been revised to illustrate the continuum of behavioral health planning council integration. Movement toward integration can come from both directions, with members from both the substance abuse/addictions and mental health communities moving toward one another to create a cohesive and integrated vision for behavioral health.



STRUCTURE, MEMBERSHIP, AND DEFINING COUNCIL PROCESSES

The way in which a BHPC organizes itself and operates contributes to its success. Key informants suggest that carefully analyzing and planning for membership composition can help foster collaboration and respect among members. Evaluating the council through a classic

¹² SAMHSA (2013). *The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit*. Retrieved from <http://www.samhsa.gov/co-occurring/ddcat/>.

¹³ SAMHSA (2013). *The Dual Diagnosis Capability in Mental Health Treatment (DDMHT) Toolkit*. Retrieved from <http://www.samhsa.gov/co-occurring/DDCMHT/index.html>.



“SWOT” Analysis (Strength, Weakness, Opportunity, and Threat)¹⁴ can provide strategic direction and allow councils to take advantage of opportunities that may arise in the health care environment. Key informants also suggested that thoughtful planning around meeting logistics encourages participation from all stakeholder groups. These ideas are discussed in detail below.

Structure and Membership Composition

Colorado and Oregon’s BHPCs each appointed co-chairs to lead their integrated planning councils. In Colorado, one co-chair is a professional with mental health expertise; the other co-chair is a professional from the substance abuse community. In Oregon, one co-chair represents the professional perspective, while the other represents the consumer, family member, or advocate perspective. These NLC members noted that appointing two chairs with different perspectives reassured council members and other stakeholders that diverse perspectives receive equal consideration. Such an arrangement also allows for sharing the burden of work and leadership and provides a broader network of contacts.

All key informants mentioned the importance of planning council members representing stakeholders from both mental health and substance abuse fields. Several noted that is important to have members representing mental health, co-occurring disorders, and those with addictive disorders and their family members. Balanced membership representation is critical to ensuring that substance abuse prevention and treatment representatives feel welcomed, supported, and influential in decision-making.

Council members from several states remarked on the challenges involved in identifying persons with a history of substance abuse diagnoses to participate in planning councils, perhaps due to the culture of anonymity related to substance abuse treatment and recovery. Working with advocates from SUDs prevention, treatment, and recovery organizations remains the best strategy to find people in recovery or family members who can be engaged in and passionate about the work of a planning council.

Meeting Logistics Can Encourage Participation

States indicated that participation and attendance at planning council meetings can be challenging, for many reasons. The following strategies and tactics are used by NLC and other states to improve attendance and participation at planning council meetings:

- Provide a stipend for travel, hotels, child care, and meals, if possible.
- Encourage participation of consumers and family members by hosting meetings during times that are considerate of working families’ schedules. Meetings held

¹⁴ The Community Toolbox offers detailed information about how organizations can conduct a SWOT Analysis. http://ctb.ku.edu/en/tablecontents/sub_section_main_1049.aspx



during a weekday in the afternoon are less likely to be well attended than those held in the evening or on a weekend.

- *For example:* To encourage participation from state employee representatives and family members, Arkansas alternates council meetings between Thursdays and Saturdays. Attendance records reflect that federally mandated employees and a few family members/consumers attend on Thursdays, while the overwhelming population represented on Saturdays is consumers and family members. Voting and SWOT analyses take place on Saturdays to encourage consumer participation and engagement in the process.
- Allow members to bring their children to the meetings. Not only does this encourage participation by members who cannot afford child care, but it also allows the youth population to be represented and to have a voice at the table.
 - *For example:* In 2006, Arkansas experienced a decline of participation by family members, including the caretaking grandparents of children with a mental illness or substance abuse diagnosis. The planning council began encouraging the grandparents to bring their grandchildren to the meetings rather than not come at all. As a result, children and adolescents began actively participating in the meetings and lending their voices and experiences to the planning council. In Arkansas, many young adults have stayed on the council until they leave for college.
- Since access to transportation is a commonly cited barrier to consistent attendance at planning council meetings, BHPCs have identified where members live to encourage and support carpooling to meetings. Not only does this help people attend meetings, it also builds relationships among members, resulting in a more efficient council.
 - *For example:* Staff from Rhode Island's behavioral health authority provide rides to consumers and family members who could otherwise not attend meetings.
- Use teleconferencing as a way to include those who may be too far to come for regular meetings.

Meeting Evaluations and SWOT Analyses Support Quality Improvement

Many successfully integrated BHPCs have developed and implemented an evaluation process to receive feedback from members on the quality and effectiveness of their planning council meetings. One council requests that members rank how well each agenda topic was covered using a Likert scale. It also asks stakeholders to identify which topics were the most and least useful and invites them to provide suggested subjects to address in future meetings.



SWOT analyses can help planning councils better understand how history has influenced their current operating dynamic and to identify potential challenges and opportunities to success. Several councils conduct annual SWOT analyses to identify council strengths, weaknesses, opportunities, and threats. The majority of states that conduct SWOT analyses do so during planning council meetings through a simple but structured process. To the extent possible, all members should be strongly encouraged to participate in the SWOT analysis to ensure that all perspectives are represented.

Councils can also use interactive strategies to engage members in setting priorities. For example, Kentucky conducts a brainstorming session, at the end of which each council member uses three green paper dots to vote for their top three priorities identified during brainstorming. Members may identify three different priorities or use all three of their three votes on a single priority that is especially important to them. The three priorities receiving the most votes become the planning council's priorities for the coming year.

Engaging Members beyond the Walls of the Planning Council Meetings

Many online collaboration tools allow people located in different places to collaborate easily. Colorado's planning council uses a web-based system for simultaneous group collaboration, sharing all agendas, notes, and documents that are relevant to planning council efforts. By engaging members outside of planning council meetings, Colorado reported that the council is better able to focus its meetings on the areas and tasks that benefit most from face-to-face communication. For example, the state council conducts a SWOT analyses on line, voting on priority areas. Once the top three areas are identified, members then use an online communication tool to focus conversations on block grant planning. Colorado has seen improvements in efficiency and participation by using this system. The Colorado BHPC can be contacted directly for further information about their experience with the online system.¹⁵

Developing the BHPC's Mission, Vision, and Bylaws

Most NLC states are in the process of developing mission and vision statements and bylaws and made the following recommendations to facilitate the process for other states:

- **Bylaws:** The very act of creating bylaws or other group process documents supports membership development.
 - Several councils use a generic template to save time (such as the one provided in the National Association of Mental Health Planning and Advisory Councils (NAMHPAC) *Promising Practices Manual*).¹⁶ Key informants noted that BHPCs can customize the template to ensure

¹⁵ Contact James Carr at: (303) 884-1260

¹⁶ The manual can be retrieved from: <http://www.namhpac.org/PDFs/PPhandbook.pdf>



language in the bylaws is sensitive to, and inclusive of, the substance abuse prevention and treatment community.

- One successful strategy reported is for an executive committee or a bylaws committee to develop the bylaws/processes and allow the full planning council to vote on it. A bylaws committee can then meet periodically to determine whether the by-laws are current or if revisions are needed.
- The Resource Library at www.BHTalk.org contains an extensive collection of state planning council by-laws that are available to all BHTalk Planning Council group members. To join the Planning Council Group at BHTalk:
 - 1) Go to www.BHTalk.org and register to gain access to the site;
 - 2) Request membership in the Planning Council Group by clicking on the “[View all Groups](#)” link at the bottom of the **Latest Groups** box on the left;
 - 3) Enter the user name and password chosen at registration; and
 - 4) Request membership in the planning council group by clicking on the link in the message displayed. Speedy approval provides immediate access to the Planning Council Resource Library and other BHTalk services.
- **Mission and Vision:** Members of planning councils said they believed it was important that BHPCs have mission and vision statements. As with SWOT analyses, it is critical that all stakeholders be represented in the process of developing these guidance documents. A number of states were successful in revising the MHPC’s original mission and vision statements to incorporate language that is more inclusive of the substance abuse and behavioral health community as a whole.

Governance

In 2013-2014, NLC Council membership size ranged from 17 to 50 members as follows:

- Idaho: 17
- Rhode Island: 26
- Utah: 29
- Kentucky: 35
- Louisiana: 40
- Colorado and Maryland: 47
- Arkansas: 50



Key informants reported that the work of a large group can be challenging to manage and focus during brief planning council meetings. To provide order to these meetings, Kentucky relies on Robert's Rules of Order and has a parliamentarian present at each meeting to ensure that time is efficiently used and agenda goals are achieved. A copy of The Basics of Robert's Rules of Order can be found on BHTalk in the Planning Council Group Resource Library file on "Council Purpose, Policies and Procedures."

OREGON: WHEN INCREMENTAL CHANGE IS NOT ENOUGH, GO BIG

Former MHPCs may move toward BHPC integration with relatively small changes such as adding a few new members to represent the substance use disorder community, revising bylaws over time, or changing the council's name. Oregon's council took the position that incremental change would not work for them. Instead, the Oregon council was completely dismantled and reconvened into what they believe is a more powerful and well-integrated planning body.¹⁷

The decision to integrate the council came late in 2011 when leaders in the Oregon Addictions and Mental Health Division (AMH) received SAMHSA guidance on the possibility of submitting a combined block grant application. At the same time, they recognized that changes in the health care environment would alter the council's operating environment. According to Marisha Johnson, Oregon's Adult Planner, the council initially added representatives with experience with co-occurring disorders and changed its name. Ms. Johnson explained that "the mental health people felt that COD covered it, but it didn't. The alcohol and drug perspective was still missing." Adding people to the existing council also brought out issues of turf ownership.

The turf issues and the lack of engagement from the SUDs prevention and treatment community resulted in the council floundering and struggling to fill seats, problems with attendance, and an overall lack of active engagement, according to Matt Holland, council co-chair. Ms. Johnson observed, "We got stuck in this cycle...we couldn't get people on the council, so we couldn't get work done. We couldn't get work done because we didn't have the right people, and people didn't want to be on it, because we didn't get anything done." Ms. Johnson and Mr. Holland noted that the executive leadership team in the Oregon Addiction and Mental Health Services department wanted to see the council become more effective and more meaningful and so gave the go-ahead to dismantle it. Mr. Holland and Ms. Johnson report that the structure and buy-in is much better, attendance is no longer a problem, and "so many people are interested in joining the council that they are turning people away."

Oregon leaders note several key steps that they believe supported the success of the new Addictions and Mental Health Planning and Advisory Committee (AMHPAC). First, they made a commitment to develop a truly integrated council that would not only include SUDs, but also

¹⁷ More information about the OR planning council can be found at <http://www.oregon.gov/oha/amh/Pages/amhpac.aspx>



problem gambling. Next, they developed a strategy for the various categories of representatives they wanted to be on the council and made a decision to expand the size of the council. They created a new membership application, conducted a thorough and flexible recruitment campaign, developed a two-day training program for new members, and created a new member handbook.

Minimizing resistance to the transition

Mr. Holland noted that “sunsetting” the former council was facilitated by a ceremony developed by Ms. Johnson, which honored members’ past contributions and allowed everyone to say goodbye. Most members who had a very strong interest in working on the newly integrated council remained involved, although membership reapplication was required. Ms. Johnson noted that former council members who had expressed frustration with the previous council experience “really had to trust that it wasn’t going to be the same.”

Membership

The council committed to find provider and consumer representatives from both mental health and SUDs, as well as those who could represent these issues across the lifespan, various ethnic/racial and geographic groups, and those who identify as Lesbian, Gay, Bisexual, Transgendered and Questioning (LGBTQ), as well as other types of diversity, such as those who self-identified as formerly experiencing homelessness. As a result, the Oregon council increased from 30 to 43 members. Fifty-eight percent of council members are family members, consumers, and advocates. In addition, the new council has service providers and state agencies, including a representative of the state’s Coordinated Care Organizations and (for the first time) a tribal representative.

To transform the membership of their council, key council members and state agency staff conducted a massive e-mail and networking campaign. The new membership application – issued in November 2012 – made it clear that this was a large time commitment. AMH staff selected members in December, conducted a two-day orientation in January 2013, and held their first meeting shortly afterward. Marisha Johnson notes the timing of their restructuring with planning for state health reform helped generate great interest in council membership.

Organizational Process

The full council meets from 9:00 a.m. to 12:00 p.m. every other month; subcommittees meet for two to three hours once a month. The executive committee meets every month with e-mail and phone communications in between. The council provides call-in options for members who live at a distance but notes that this can be a difficult solution, in terms of acoustics. They are currently exploring video conferencing options. The member handbook has basic information, including a copy of the PC roster, SAMHSA guidance on the block grant application, background information on planning councils, and a 10-page list of acronyms.

Council Structure

The AMHPAC bylaws call for two co-chairs. One represents a service provider while the other is a consumer/family member/advocate. Mr. Holland said that this approach helps divide



responsibility and ensures that families and consumers and provider perspectives are represented in leading the council.

One condition of membership on the council is that members have to participate on at least one subcommittee because much work is accomplished through subcommittees. In addition to the Executive Committee, the council developed subcommittees based on the Institute of Medicine's (IOM's) spectrum of interventions: Behavioral Health Promotion and Prevention, Treatment, Recovery Support Services, and Olmstead/Housing. The Executive Committee doubles as a Metrics and Data subcommittee. A private consultant serves as a neutral convener and works with each subcommittee to define its work plan. Each subcommittee is also supported by an AMH employee.

State Resource Allocation

AMH officials reviewed the effectiveness of a number of agency advisory councils and identified redundancy within councils. The new AMHPAC replaced at least one committee but has not reduced the administrative or staffing load, since these have increased under the new structure. In addition to taking meeting minutes, state agency administrative assistants arrange for meetings, provide phone access, and send e-mails and agendas, among other tasks.

AMH created an internal group within the agency to support staff members who work on consumer advisory councils. Staff involved with these groups meet once a month and focus on how they can be more collaborative, avoid duplication, and support one another. They created this in-house support group because, Ms. Johnson comments, "it's a lot of work to support an advisory council and often it is an add-on to other work."

Moving from "Listen Only" to Action-Oriented Mode

Oregon asks its council to take action. "We learned a lesson about using an advisory group to just listen to presentations. It doesn't work," Ms. Johnson notes. Now, she said, "we give them something to do. We report back about what action we have taken."

According to Mr. Holland, now that AMH has a new and more effective council, state agency staff members are using the council as an ongoing "focus group," whereas in the past they spent a great deal of time bringing various groups of stakeholders together. For example, state agencies often try to find consumer, family members, and providers to score grants or contracts to ensure community input into decision-making. Ms. Johnson noted that the council and its subcommittee members have participated in funding application reviews for the Mental Health Block Grant and new investments. She said: "Before we would be scrambling to get consumers and providers to participate – now we have an active group to call on."



“We learned a lesson about using an advisory group to just listen to presentations. It doesn’t work. We give them something to do. We report back about what action we have taken. We are carrying that forward.”

— Marisha Johnson, OR

The Oregon BHPC and department representatives note that one reason the new council integration works is because the state has a joint behavioral health department that includes both addictions and mental health. Although they acknowledge that there is still a great deal of work to do on integration in the department itself and in state services, Mr. Holland and Ms. Johnson said they believe the combined department created a supportive environment for a collaborative and integrated council.

Both Mr. Holland and Ms. Johnson believe that the careful recruitment, selection, training, and other processes help the behavioral health community and state department see the Addictions and Mental Health Planning and Advisory Committee in a new light, which makes people want to be involved. Ms. Johnson notes, “It’s a powerful group; they really will have an impact.”

TECHNICAL ASSISTANCE TO MOVE TO BEHAVIORAL HEALTH

This section provides information regarding the technical assistance needs of planning councils as they transition to, strengthen and sustain a behavioral health orientation, including:

- A description of the types of TA offered through the State TA Project;
- Products developed and delivered through TA;
- The challenges inherent in providing TA to planning councils as they transition from mental health to behavioral health, and the strategies recommended by planning councils; and
- TA needs of planning councils that relate to council process and structure at each level of behavioral health integration.



TA PROVIDED BY STATE TA PROJECT

The following TA has been made available on topics related to planning council efforts to begin, continue, and/or sustain the transition to a BHPC.

Individual state general technical assistance

Project TA staff review specific requests and needs and provide resource information in real time. Planning councils are also referred to additional sources of information and assistance.

Multi-state consultation

TA is arranged that connects state and territorial councils facing similar issues and concerns through multi-state videoconferences and teleconferences. Peers share experiences and help one another consider innovative problem resolution and program improvements. Project staff members facilitate discussions and call on additional experts as needed.

Webinars on cutting-edge topics

Specialized, state-specific webinars are delivered as real-time opportunities to help councils accomplish their work. Topics encompass broad considerations in understanding council membership, roles, and functions, as well as issues related to the process of transitioning to a behavioral health council.

BHTALK

The *BHTalk.org* online forum offers planning councils the opportunity to reach out to colleagues and access diverse reference and resource materials that are maintained and regularly updated on the site.

Manual of best and promising practices

TA staff collect and assess information on best and promising practices that councils identify as useful in their work. These are included in a regularly updated manual that is posted on the *BHTalk.org* site.

Intensive TA

Intensive TA is delivered to state planning councils individually and through membership in the National Learning Community. Members must be committed to integrating, strengthening, and expanding their behavioral health planning council; express a clear TA need that is supported by a proposed TA Plan; and be willing to mentor and support their colleagues in other councils throughout the country. NLC members receive on-site assistance and other TA from expert consultants. They participate in monthly teleconference sessions to build mutual support and assistance and acquire important education and skills through periodic special topic webinars. Each state completed the BHIQ Assessment to use as the basis for its planning activities.



TA PRODUCTS AND SERVICES

Expert consultation has been provided to state planning councils to support their efforts to integrate mental health, substance abuse, and co-occurring disorders into their work. TA has identified strategies to broaden and diversify membership, manage large meetings of diverse constituents, and plan strategically to set and achieve council priorities in a changing health care environment.

The State TA Project has developed the Behavioral Health IQ assessment instrument to help councils in their integration planning and a Best Practices Manual for State Planning Councils to communicate effective state council activities. The project also collects and disseminates numerous resources that span the full spectrum of issues and concerns that arise for planning councils, including: by-laws; committee structure, membership and operations; health care legislation impacting planning council work; developing strong partnerships with state departments; and evaluation and outcome measures.

CHALLENGES IN PROVIDING TA TO COUNCILS

Key questions and challenges for councils that emerged through the TA process include:

- Deciding whether to expand the existing mental health planning council or sunset that group and create an entirely new behavioral health planning council.
- Identifying effective strategies to balance strong voices and diverse perspectives in the council's work so that the group's priorities can be accomplished.
- Creating council-specific solutions that are responsive to unique state environments.
- Completing and monitoring block grant applications and reports. TA can be structured to optimally support this high-priority task by being offered relative to block grant deadlines and extended over the longest possible period of time.
- Maintaining continuity despite turnover among state agency staff and council personnel. Both state agencies and councils are challenged to maintain the knowledge and relationships needed to conduct council operations and achieve planning council goals in an efficient and effective manner.
- Responding to the impact of the changing health care environment on behavioral health systems. Councils see both challenges and opportunities as they monitor these changes through block grant applications and reports, choose their action priorities, and contribute their knowledge and expertise to building effective systems of care.



TA RECOMMENDATIONS

The State TA Project has monitored PC activities throughout the year, responding as quickly as possible to expressed and emerging TA needs. The following chart lists TA Topics and TA Process recommendations that have been identified by planning councils.

MAKING THE TRANSITION TO, STRENGTHENING AND SUSTAINING A BEHAVIORAL HEALTH PLANNING COUNCIL TA PRIORITIES – FY 2012-2013	
TA TOPIC RECOMMENDATIONS	TA PROCESS RECOMMENDATIONS
Council Membership, Recruitment, and Representation <ul style="list-style-type: none"> • SAPT <u>and</u> COD provider representatives • Collaboration with SA councils • Consumers and family members • Dealing with turnover and maintaining focus • New member orientation • Expanding people skills (e.g., dealing with resistance) • Engaging young people • Outreach to GLBTQ communities 	<ol style="list-style-type: none"> 1. Create diverse and multiple opportunities for dialogue and information exchange at every opportunity. 2. Build strong PAC foundations by offering basic information and education early in the TA process and follow with more extensive and in-depth consultation. 3. Extend TA over as long a period as possible to support PAC change. 4. Use technological platforms that support interaction: polls, shared screens, multiple document editing, etc. 5. Expand on-site TA capacity. 6. Focus on strengths-based system change.
Council Infrastructure and Operations <ul style="list-style-type: none"> • Bylaws and budgets • Committees/subcommittee role and function • Agenda setting and meeting management • Assessing PC effectiveness • Influencing state decision-makers • Managing the “culture shift” to behavioral health 	
Advocacy and Outreach <ul style="list-style-type: none"> • Direct action organizing • Developing agency, legislative, media partnerships • Strategies to advocate with behavioral health authorities 	
Using Data for Decision-Making <ul style="list-style-type: none"> • Understanding MH and SA data and information • Needs assessment • Outcome measurement 	
Topic Education <ul style="list-style-type: none"> • Understanding the BG application • Role of peers • Recovery-oriented systems • Prevention and promotion • Cultural competence • Integrating MH and SA systems • Legislative process • Health reform 	



CONCLUSION

This manual presents current and emerging best practices in successfully making the transition from a Mental Health Planning Council to a Behavioral Health Planning Council. These recommendations were taken from guidance provided by the states in the NLC who received intensive TA, along with other states that requested TA or shared their experience or materials with AHP. This document will be periodically supplemented by additional materials that are developed or identified that represent good practice in moving to, maintaining, and strengthening the behavioral health integration of state planning councils.

Expanding a council's vision to focus on behavioral health can be complicated and challenging, but the experience of the councils highlighted in this document demonstrates how much can be accomplished with thoughtful planning, open communication, and focused implementation of top priorities.



APPENDICES LIST

- **Appendix A:** Behavioral Health IQ (BHIQ) Assessment
- **Appendix B:** State Council Resource Materials
- **Appendix C:** Acronyms Used in the Manual



**APPENDIX A:
BHIQ SELF-ASSESSMENT
FOR PLANNING COUNCILS**



SAMHSA Center for Mental Health Services

TA for State Planning Councils

Assessing Your Behavioral Health IQ: The Road to Planning Council Integration

As national and state health reform evolves, state planning councils are challenged to adjust their structure, operations and work in ways that allow them to more comprehensively address mental health and substance abuse (i.e., “behavioral health”) issues and concerns. This self-administered instrument can help a State, Territory or Jurisdiction to:

1. assess the extent to which a State Planning Council (PC) has integrated mental health and substance abuse issues and concerns into its work; and,
2. identify practical strategies that a PC can employ to make the transition to, strengthen and sustain itself as a Behavioral Health Planning Council.

Instructions: Each element represents an area of Council role, structure and function and includes three sections:

- Federal law or guidance related to that element, when available and applicable. The link to access federal law regarding planning councils is noted here.
- State law and/or executive guidance that relates or applies to the behavioral health element. This may be as a result of legislative or executive action related either to mental health, substance abuse, or both.
- Activities a state council might consider in order to expand its behavioral health capacity. These actions can become the basis of your Council’s behavioral health “Strategic Plan” or “Transition to BH Plan.”

Notes: (1) The instrument and process can be used as often as desired;
(2) Revised versions of the instrument and process will be disseminated on BHTalk.org as they are developed.
(3) Please review SAMHSA’s guidance included in the FY 2014-2015 Block Grant Application Instructions as you consider “What a behavioral health approach suggests that you do next” for each element. The application can be located at samhsa.gov.

If you have questions, suggestions or recommendations about this self-assessment guide, please contact BEmerly@ahpnet.com).



State: _____ Person Completing Form: _____ Date: _____

Contact Information: _____

COUNCIL ROLE, STRUCTURE & FUNCTION	DESCRIPTION/QUESTION	RESPONSE
COUNCIL NAME	Does the name of the council refer to mental health only, to substance abuse only or to behavioral health, incorporating both mental health and substance abuse?	
Federal law or guidance	http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm	
State law or executive guidance		
What a behavioral health approach suggests that you do next (e.g., rename to State Behavioral Health PC).		
COUNCIL CHARGE	<p>Is (Are) the group(s) officially charged to work on mental health, on substance abuse or on behavioral health issues, including mental health, substance abuse and/or co-occurring disorders?</p> <p>Who gave the Council its charge?</p> <p>___ Governor ___ Legislature ___ State MH Executive ___ Other</p>	
Federal law or guidance	http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm	
State law or executive guidance		
What a behavioral health approach suggests that you do next		
MISSION STATEMENT	Does the Council's Mission Statement address mental health, substance abuse or both?	
Federal law or guidance	http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm	
State law or executive guidance		
What a behavioral health approach suggests that you do next		

COUNCIL ROLE, STRUCTURE & FUNCTION	DESCRIPTION/QUESTION	RESPONSE
BY-LAWS	Do your Council's By-laws address mental health and substance abuse?	
	Federal law or guidance http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm	
	State law or executive guidance	
	What a behavioral health approach suggests that you do next (e.g., review and revise by-laws to be behavioral health focused)	
MEMBERSHIP	Does your Council membership represent required & desired expertise and perspectives? (e.g. members who can provide mental health and substance abuse expertise and perspective, in addition to co-occurring perspective, as well as other diversity such as rural/urban, Tribal, racial/ethnic/linguistic, life span, LGBT, and other diverse communities.)	
	Federal law or guidance http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm	
	State law or executive guidance	
	What a behavioral health approach suggests that you do next	
STAFFING	Is (Are) there a staff person(s) assigned to support the Council's work on both mental health and substance abuse issues? Does that person (they) have knowledge/experience in mental health and substance abuse prevention, treatment and recovery services?	
	Federal law or guidance http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm	
	State law or executive guidance	
	What a behavioral health approach suggests that you do next	

COUNCIL ROLE, STRUCTURE & FUNCTION	DESCRIPTION/QUESTION	RESPONSE
MEETING AGENDA	Do your Council meeting agendas cover mental health, substance abuse and co-occurring issues?	
Federal law or guidance http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm		
State law or executive guidance		
What a behavioral health approach suggests that you do next		
WORK GROUPS & SUBCOMMITTEES	Do workgroups and subcommittees address issues of mental health only, substance abuse only or do they include mental health, substance abuse and co-occurring disorders?	
Federal law or guidance http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm		
State law or executive guidance		
What a behavioral health approach suggests that you do next		
BLOCK GRANT APPLICATION	Was the last block grant application a combined plan? Do you expect the next block grant application and plan to be combined or separate?	
Federal law or guidance http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm		
State law or executive guidance		
What a behavioral health approach suggests that you do next		
FISCAL INFORMATION	Does your Council review fiscal information for mental health, substance abuse and co-occurring disorders?	
Federal law or guidance http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm		
State law or executive guidance		



What a behavioral health approach suggests that you do next		
NEEDS ASSESSMENT	Does your Council review service information for mental health, substance abuse and co-occurring disorders?	
Federal law or guidance http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm		
State law or executive guidance		
What a behavioral health approach suggests that you do next		
BG CONTENT KNOWLEDGE	On a scale of 1 to 5 (5 being very familiar), how familiar are Council members with Mental Health Block Grant requirements? On a scale of 1 to 5, how familiar are Council members with Substance Abuse Prevention and Treatment Block Grant requirements?	
Federal law or guidance http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm		
State law or executive guidance		
What a behavioral health approach suggests that you do next		
SPECIAL PROJECTS	Does your Council complete special projects that address mental health, substance abuse and co-occurring disorders?	
Federal law or guidance http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm		
State law or executive guidance		
What a behavioral health approach suggests that you do next		
BLOCK GRANT REVIEW PROCESS	Describe the Council's review of the Mental Health Block Grant Application AND Block Grant Report. Describe the Council's review of the Substance Abuse Prevention and Treatment Block Grant Application and Block Grant Report.	
Federal law or guidance http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm		



subchapXVII-partB-subparti-sec300x-3.htm		
State law or executive guidance		
What a behavioral health approach suggests that you do next		
STATE SUBSTANCE ABUSE COUNCIL	<p>Is there a State Substance Abuse Council or equivalent? If so, how do the Mental Health and Substance Abuse Councils interact?</p>	
Federal law or guidance http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap6A-subchapXVII-partB-subparti-sec300x-3.htm		
State law or executive guidance		
What a behavioral health approach suggests that you do next		
Strategic Planning	<p>What are the greatest challenges you face in integrating issues and concerns relating to mental health, substance abuse and co-occurring disorders, or in maintaining and strengthening your current level of integration?</p>	
	<p>What aspect(s) of your Planning Council role would you like to see strengthened? (check all that apply)</p> <p><input type="checkbox"/> relationship/collaboration with state mental health/behavioral health authority (SMHA)</p> <p><input type="checkbox"/> relationship/collaboration with single state agency for substance abuse (SSA)</p> <p><input type="checkbox"/> legislative activities</p> <p><input type="checkbox"/> public advocacy and education</p> <p><input type="checkbox"/> involvement in planning, implementing and monitoring Block Grant services</p> <p><input type="checkbox"/> knowledge of issues and trends (e.g., outcome measures, Affordable Care Act)</p> <p><input type="checkbox"/> Other (please describe)</p>	

This form revised 1/28/14





**APPENDIX B:
STATE COUNCIL
RESOURCE MATERIALS**



**Colorado Behavioral Health Planning and Advisory Council
Prospective Board Member Information Sheet**

Name				Date of Birth	
Home Address					
City		State		Zip Code	
Telephone			E-mail		
Agency Name					
Agency Address					
City		State		Zip Code	
Telephone			E-mail		
Ethnicity	African American	<input type="checkbox"/>	Hispanic	<input type="checkbox"/>	
	Asian	<input type="checkbox"/>	Native American	<input type="checkbox"/>	
	Caucasian	<input type="checkbox"/>	Other		

For electronic submission: You may click and type in each white space, to select a check box, right click on box, drop down menu will appear click on "properties" on "default value" item click the "checked" circle, then click "ok"

Core Principles for BHPAC Membership (Goal for representation on BHPAC)
<ul style="list-style-type: none"> ▪ 51% of Membership will be Consumer/Client, Family Member, and Advocacy Organization ▪ Equal Representation of Substance Abuse and Mental Health ▪ Balanced Representation or Prevention, Treatment, and Recovery ▪ Balanced Representation of Gender, Race, Ethnicity, and Age ▪ Balanced Representation Across Urban, Suburban, Rural, and Frontier Communities ▪ Balanced Representation Across Children, Adolescents, Transitional Youth, Adults, and Older Adults

Why are you interested in serving on the Colorado Behavioral Health Planning and Advisory Council (BHPAC)?

Identify skills, strengths and interests that you would bring to the BHPAC

The BHPAC is eager to recruit a diverse membership. Explain how you might contribute to that goal.



List your involvement with behavioral health issues, groups and/or organizations, including your experience, training and past/present involvement with underrepresented communities and groups.

Identify any current work regularly performed for pay as, or for, a provider of behavioral health services please indicate the organization, the position you hold, and whether the position is half time or less.

Please check first column one category that you intend to primarily represent on the BHPAC (You can only apply for one category in this column)
Second column check all other categories you also represent (as many that apply to you in this column)

For Consumer/Family/Advocacy (51% or more of the BHPAC Membership)		
	Primary (Select one that you will primarily represent)	Secondary (Select all that you can also represent)
Consumer/Client/Person in Recovery Mental Health		
Youth	<input type="checkbox"/>	<input type="checkbox"/>
Adult	<input type="checkbox"/>	<input type="checkbox"/>
Older Adult	<input type="checkbox"/>	<input type="checkbox"/>
Consumer/Client/Person in Recovery Substance Abuse		
Youth	<input type="checkbox"/>	<input type="checkbox"/>
Adult	<input type="checkbox"/>	<input type="checkbox"/>
Older Adult	<input type="checkbox"/>	<input type="checkbox"/>
Family Member of an Adult/Older Adult Mental Health	<input type="checkbox"/>	<input type="checkbox"/>
Family Member of a Child/Adolescent/Transition Youth Mental Health	<input type="checkbox"/>	<input type="checkbox"/>
Family Member of an Adult/Older Adult Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Family Member of a Child/Adolescent/Transition Youth Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Advocacy	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Advocacy	<input type="checkbox"/>	<input type="checkbox"/>
Disabilities Advocacy	<input type="checkbox"/>	<input type="checkbox"/>
Veterans Advocacy	<input type="checkbox"/>	<input type="checkbox"/>
Community Prevention Coalition/Advocacy	<input type="checkbox"/>	<input type="checkbox"/>
Legal Advocacy	<input type="checkbox"/>	<input type="checkbox"/>
Youth Advocacy	<input type="checkbox"/>	<input type="checkbox"/>
Other Explain	<input type="checkbox"/>	<input type="checkbox"/>



For Provider Agency and State Agency (49% or less of the BHPAC Membership)		
	Primary (Select one that you will primarily represent)	Secondary (Select all that you can also represent)
Mental Health Treatment Provider (including Managed Care ACO, BHO)	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Treatment Provider (including Managed Care MSO)	<input type="checkbox"/>	<input type="checkbox"/>
Hospital	<input type="checkbox"/>	<input type="checkbox"/>
Private Practice Provider Mental Health	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Recovery Provider	<input type="checkbox"/>	<input type="checkbox"/>
Consumer Provider - Employed over 50% of time by provider organization	<input type="checkbox"/>	<input type="checkbox"/>
Crisis Center (27-65/Detoxification)	<input type="checkbox"/>	<input type="checkbox"/>
Federally Qualified Health Center/Clinic	<input type="checkbox"/>	<input type="checkbox"/>
Prevention Provider	<input type="checkbox"/>	<input type="checkbox"/>
Residential Treatment Provider Mental Health	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Alternative Care Provider	<input type="checkbox"/>	<input type="checkbox"/>
Homeless Service Provider	<input type="checkbox"/>	<input type="checkbox"/>
Faith Based Provider	<input type="checkbox"/>	<input type="checkbox"/>
LGBTQ Provider	<input type="checkbox"/>	<input type="checkbox"/>
Nursing Home/Assisted Living Provider	<input type="checkbox"/>	<input type="checkbox"/>
Other Explain	<input type="checkbox"/>	<input type="checkbox"/>
Community		
Family Resource Center	<input type="checkbox"/>	<input type="checkbox"/>
Legal/Court	<input type="checkbox"/>	<input type="checkbox"/>
Suicide Prevention	<input type="checkbox"/>	<input type="checkbox"/>
Centers for Independent Living	<input type="checkbox"/>	<input type="checkbox"/>
Community/Neighborhood Organizations	<input type="checkbox"/>	<input type="checkbox"/>
Sheriff/Police	<input type="checkbox"/>	<input type="checkbox"/>
Jail	<input type="checkbox"/>	<input type="checkbox"/>
Other Explain	<input type="checkbox"/>	<input type="checkbox"/>
State Agency/Employee		
Behavioral Health	<input type="checkbox"/>	<input type="checkbox"/>
Social Services Child Welfare	<input type="checkbox"/>	<input type="checkbox"/>
Youth Corrections	<input type="checkbox"/>	<input type="checkbox"/>
Adult Protective Services	<input type="checkbox"/>	<input type="checkbox"/>
Public Health	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>
Education	<input type="checkbox"/>	<input type="checkbox"/>
Veteran/Military Affairs	<input type="checkbox"/>	<input type="checkbox"/>
Criminal Justice Probation	<input type="checkbox"/>	<input type="checkbox"/>
Prison	<input type="checkbox"/>	<input type="checkbox"/>
Housing	<input type="checkbox"/>	<input type="checkbox"/>



Will you commit to attend monthly meeting?
Will you commit to join a Sub-Committee?

Do you affirm that you understand that submitting an application does not guarantee being selected for a seat on Council? Selection to Council positions will be recommended by an Advisory Group and appointment is made by the State Behavioral Health Commissioner. I further understand that terms on council will be rotating and there will be an equal representation by persons, families, providers and advocates of individuals with mental health, substance use disorders.

- I agree with the above statement
- I disagree with the above statement

Please sign:

RETURN TO: BHPAC, Division of Behavioral Health, 3824 West Princeton Circle, Denver, CO 80236, Attention: Gloria Avitia or FAX to 303.866.7481.



Kentucky Behavioral Health Planning and Advisory Council

Membership Application Information

Overview:

The Kentucky Behavioral Health Planning and Advisory Council is seeking applications of individuals to serve as voting members of the Council. The Council represents and makes recommendations regarding issues and services for persons with or at risk of substance abuse, substance use disorders, mental health disorders and co-occurring mental health and substance use disorders.

The 35-member Council is made up of representatives from state agencies, providers, individuals in recovery from mental health and/or substance use disorders, family members of individuals in recovery, parents and guardians of a child with behavioral health challenges and one young adult in recovery. The individuals in recovery, parents and family members make up the majority of the membership. New members will be given an orientation and may be linked with a mentor to provide greater understanding of Council activities.

Mission: The Council is the active voice promoting awareness of and access to effective, affordable, recovery-oriented and resiliency-based services in all communities.

Vision: All children, adolescents, and adults in the Commonwealth have the right to excellent, recovery-oriented behavioral health services that are affordable, consumer driven, value their individuality, assists them to achieve their fullest potential, and enables them to live and thrive in their community.

Eligibility Criteria:

Applicants must be a representative of one of the following groups:

1. An Individual in Recovery (from mental health and/or substance use disorders)*
2. A Young Adult in Recovery (from mental health and/or substance use disorders) - age 18-25 years only
3. A Parent/Guardian of a Child with Behavioral Health Challenges (serious emotional disturbance (SED)**, substance use disorder, or co-occurring SED and substance use disorder)
4. A Family Member of an Individual in Recovery (from mental health and/or substance use disorders)

*Recovery is an on-going, non-linear process that may include relapse.

**Definition of a Child or Adolescent with Serious Emotional Disturbance (SED)

Children with "serious emotional disturbance" are persons: (1) from birth up to age 18; (2) who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R; (3) that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities. The definition goes on to indicate that "these disorders include any mental disorder (including those of biological etiology) listed in DSM-III-R or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-III-R 'V' codes, substance use, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious emotional disturbance....". Functional impairment is defined



as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in their environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition....". (Federal Register: May 20, 1993, Vol. 58, No. 96, pg. 29422-29425.)

A full-time employee of a state agency is only eligible to serve on the Council as a representative of his/her respective agency. A full-time employee of a provider of mental health services (e.g., community mental health center, IMPACT Plus provider, school, advocacy organization, etc.) is **not** eligible to serve on this Council.

The Membership Committee solicits widely for potential members of the Council. Membership applications are distributed to contacts at the community mental health centers, advocacy organizations, and state agencies. The Committee reviews all completed applications and makes a recommendation to the Council. Per the Council's Bylaws, members of the Council shall be appointed, upon the Council's recommendation, by the Commissioner of the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). If an application is not selected for a current Council seat, it will be retained for one year from date of application. The Membership Committee reserves the right to contact applicants for additional information.

Things to Know:

As an appointed member of the Council, your name and representation will be posted to the DBHDID webpage. Your contact information (telephone number, mailing address, and email address) will only be included on the Council roster and the Unified Mental Health and Substance Abuse Prevention and Treatment Block Grant application and reporting.

Per federal mandate and the Council Bylaws, the Scope of Duties Include:

- A. To serve as advocates for adults and children with behavioral health disorders and their families.
- B. To report directly to the Commissioner of the Department for Behavioral Health, Developmental and Intellectual Disabilities.
- C. To review the Unified Mental Health and Substance Abuse Prevention and Treatment Block Grant application which serves as Kentucky's plan for community-based behavioral health services for adults and children. The plan is provided to the Council pursuant to Public Law 102-321, Section 1915 (a) and the Council is required to submit any recommendations for modification to the plan. Subsequently, the Council is required to review the annual Implementation Report for the prior year and submit any comments desired.
- D. To monitor, review, and evaluate, not less than once a year, the allocation and adequacy of behavioral health services within the Commonwealth.
- E. To serve a minimum of a two-year term and attend at least four meetings per year in Frankfort, Kentucky. Expenses are reimbursed and a modest stipend is provided for the individual's time.

For more information about the Kentucky Behavioral Health Planning and Advisory Council, visit its website at <http://dbhdid.ky.gov/dbh/kbhpac-about.aspx>.



Kentucky Behavioral Health Planning and Advisory Council

Membership Application

A completed membership application must be submitted via email, fax or mail (email is preferred). Any interested applicant may also be asked to briefly meet with the KBHPAC Membership Committee.

Please type or print clearly.

Name of Applicant

Email

Address

Telephone Number(s)

CMHC Region

Date Submitted

Per federal mandate, full-time employees of a state agency or provider of mental health services are not eligible to serve as an appointed member of this Council.

- I affirm that I am not a full-time employee of a state agency.
- I affirm that I am not a full-time employee of a provider of mental health or substance use services (e.g., community mental health center, IMPACT Plus provider, school, advocacy organization, etc.).

Representative Group (please check one):

- Individual in Recovery (from mental health and/or substance use disorders)**
"I am willing to be identified as an individual in recovery from mental health and/or substance use disorders."
- Young Adult in Recovery (age 18-25 years only)**
"I am willing to be identified as a young adult in recovery from mental health and/or substance use disorders."
- Family Member of an Adult in Recovery (from mental health and/or substance use disorders)**
"I am willing to be identified as a family member of an individual in recovery from mental health and/or substance use disorders."
- Parent/Guardian of a Child with Behavioral Health Challenges**
"I am willing to be identified as a parent/guardian of a child with behavioral health challenges."

Please state the age of your child: _____

- Please state why you would like to become a member of the Kentucky Behavioral Health Planning and Advisory Council.



- Please provide a description of the condition or situation that qualifies you as a representative of one of the above representative groups (e.g., diagnosis). Please include information about services you or your family member has received from the publicly-funded behavioral health system, such as a comprehensive care center.
- What are your specific interests and concerns regarding Kentucky’s publicly-funded behavioral health system?
- Please identify skills, knowledge and strengths that you would bring to the Kentucky Behavioral Health Planning and Advisory Council.

The Kentucky Behavioral Health Planning and Advisory Council has an ongoing commitment to advancing diversity within its membership. We acknowledge that diversity includes any aspect of an individual that makes him or her unique. Our Council values and actively promotes diverse and inclusive participation by its officers, members, and staff. We recognize that diversity is vital to all elements of our mission. At your option, you may state how you would contribute to the diversity of the Council.

Please list three character references (other than a relative or a current member of the Kentucky Behavioral Health Planning and Advisory Council).

1. Name: _____ Phone and/or Email: _____
 - Relationship to Applicant: _____
2. Name: _____ Phone and/or Email: _____
 - Relationship to Applicant: _____
3. Name: _____ Phone and/or Email: _____
 - Relationship to Applicant: _____

I am available to briefly meet (if needed) with the Membership Committee of the Council. I understand that I will not be reimbursed for my travel expenses on this day.

Council members are expected to treat other members, officers, and staff with respect and dignity at all times. Any threatening or offensive behavior may be cause for dismissal from the Council, at the discretion of the Council and Department staff. Each member shall use good judgment to keep confidential all sensitive information pertaining to Council members and applicants, both during and after serving on the Council.

Thank you for your interest in becoming a member of the Kentucky Behavioral Health Planning and Advisory Council. You will be contacted regarding the outcome of your application.



By my signature, I confirm that the above information is accurate and reflects my interest and commitment to serve on the Kentucky Behavioral Health Planning and Advisory Council.

Signature: _____ Date:

A completed membership application must be submitted via email, fax or mail to Mark Hertweck.

Mark Hertweck
Mark.Hertweck@ky.gov

DBHDID/Division of Behavioral Health
100 Fair Oaks Lane, 4E-D, Frankfort, Kentucky 40601
Telephone (502) 564-4456 ext. 4449 or Fax (502) 564-9010

Revised 3-4-2013



Job Title : 7583 PROGRAM COORDINATOR
Title Code : 9615
Minimum Requirement - Primary Education : Graduate of a college or university with bachelor's degree.
Minimum Requirement - Primary Experience : Must have three years of professional experience in management or administration.
Education Substitution : A master's degree will substitute for one year of the required experience.
Experience Substitution : Administrative or business experience will substitute for the required education on a year-for-year basis.
Special Requirements : None
Agency : 53 - Cabinet for Health and Family Serv.
Department/Division/Branch/Address Department for Behavioral Health Developmental and Intellectual Disabilities/Location: Franklin.
Agency Contact :
of Vacancies : 1
Position Type : Full-time Merit (18A)
Work Schedule : 1st Shift
Vacancy Type : Promotional - Open Only To State Merit Employees
Work Week : 37.5 hr/wk
Pay Grade : 13 (Salary Range: \$32,042.40 - \$42,656.40 yearly)
Special Entrance Rate : No
Description of Job Duties This position provides administrative program coordination for behavioral health programs that includes: monitoring and providing contract oversight for 14 regional mental health centers, monitor and assure accurate and up to date information is on the website. Collect, coordinate and analyze data generating programmatic data. Prefer a candidate with strong organization background, administrative skills and knowledge of behavioral health programs and contract monitoring.
Selection Method : Qualifying: All candidates who apply and meet the minimum requirements are eligible for placement on the register for hiring consideration.
Group : GENERAL ADMINISTRATION
Characteristics of the Class : Coordinates all inter- or intra-unit administrative functions of a specific program(s) on a statewide basis; and performs other duties as required.
Typical Working Conditions and Unique Physical Requirements : Work is primarily performed in an office setting. Minimal travel may be required.
Additional Requirements : Applicants and employees in this classification may be required to submit to a drug screening test and background check.
Post Date : 06/14/2011
Post Ending Date : 06/23/2011

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Acronym List for Kentucky Behavioral Health Planning and Advisory Council Orientation

A&FM	Division of Administrative and Financial Management, part of the Department for Behavioral Health, Developmental and Intellectual Disabilities.
ADHD	Attention Deficit Hyperactivity Disorder
AOC	Administrative Office of the Courts
ARH	Appalachian Regional Hospital
ARNP	Advanced Registered Nurse Practitioner
BPCH	Bluegrass Personal Care Home-1 of 3 statewide specialized personal care homes serving adults with psychiatric issues.
BRFSS	Behavioral Risk Factor Surveillance System-Ongoing, nationwide surveillance system supported by the Centers for Disease Control and Prevention.
CDC	Centers for Disease Control and Prevention
CCRC	Caney Creek Rehabilitation Complex-1 of 3 statewide specialized personal care homes serving adults with psychiatric issues.
CCSHCN	Commission for Children with Special Health Care Needs
CDAR	University of Kentucky Center for Drug and Alcohol Research
CDW	Court Designated Worker
CEU	Continuing Education Unit
CHFS	Cabinet for Health and Family Services
Children's Directors	Directors of the children's mental health programs at the CMHCs
CMHC	Community Mental Health Center
CMHS	Center for Mental Health Services (within SAMHSA)
CMS	Center for Medicaid and Medicare Services
CRR	Center for Rehab and Recovery- 1 of 3 statewide specialized personal care homes serving adults with psychiatric issues.
CSH	Central State Hospital (State operated psychiatric hospital)
CSP Directors	Community Support Program Directors (oversee the Therapeutic Rehabilitation Programs and other programs).
CSU	Crisis Stabilization Unit
DBHDID	Department for Behavioral Health, Developmental and Intellectual Disabilities
DCBS	Department for Community Based Services Kentucky's adult and child protection agency.
DD	Developmentally Disabled (or Delayed)
DHHS	US Department for Health and Human Services
DJJ	Department of Juvenile Justice
DMR	Division of Mental Retardation
DOC	Department of Corrections



DOE	Department of Education
DOJ	Department of Justice
DMS	Department of Medicaid Services
DPH	Department for Public Health
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Revision
EBD	Emotional-Behavioral Disability (Education designation for children)
EBP	Evidence Based Practice
ECMH	Early Childhood Mental Health
EPSDT	Early Periodic Screening, Diagnosis & Treatment (Medicaid)
ESH	Eastern State Hospital
Executive Directors	Executive Directors of the CMHC's
FAS, FASD	Fetal Alcohol Syndrome; Fetal Alcohol Spectrum Disorders
FFY	Federal Fiscal Year (October 1-September 30)
FRYSC	Family Resource and Youth Service Center (pronounced Frisky)
FY	Fiscal Year (usually refers to state fiscal year, July 1-June 30)
HANDS	The Health Access Nurturing Development Services (HANDS) program is a voluntary home visitation program for new and expectant parents.
HB 144	Kentucky Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities
HB 843	Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnosis
HIPAA	Health Insurance Portability and Accountability Act of 1996
IDEA	Individuals with Disabilities Education Act
IEP	Individual Education Program
IMPACT	Targeted case management for children with severe emotional disabilities. Provider network limited to CMHCs and open to children regardless of ability to pay
IMPACT Plus	A behavioral health program for Medicaid-eligible children. IMPACT Plus was developed to increase the variety and availability of community-based service options and to decrease the need for inpatient care. Provider network is broader than the CMHCs.
IPOP	University of Kentucky, College of Pharmacy, Institute for Pharmaceutical Outcomes and Policy
KAR	Kentucky Administrative Regulations
KARP	Kentucky Association of Regional MHMR Programs (CMHCs trade org)
KCHIP	Kentucky Children's Health Insurance Program
KCPC	Kentucky Correctional Psychiatric Center
KERA	Kentucky Education Reform Act
KBHPAC	Kentucky Behavioral Health Planning and Advisory Council
KPFC	Kentucky Partnership for Families and Children
KRS	Kentucky Revised Statutes
KYCAN	Kentucky Consumer Advocates Network



KYSEED	System to Enhance Early Development (state's 3rd SOC grant)
LCSW	Licensed Clinical Social Worker
LD	Learning Disabled
LIAC	Local Interagency Council (IMPACT Program)
LRC	Local Research Committee
LRCs	Local Resource Coordinators (IMPACT Program)
MHA	Mental Health Association
MHSA	KY Division of Mental Health and Substance Abuse
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MR	Mental Retardation
MRDD	Mental Retardation/Developmental Disability
MSW	Master's Degree in Social Work
NAMHPAC	National Association of Mental Health Planning & Advisory Councils
NAMI	National Alliance for Mental Illness
NCLB	No Child Left Behind
NIMH	National Institute of Mental Health
NMHA	National Mental Health Association
NOM/NOMs	National Outcome Measures
OFL	Opportunities for Family Leadership
OIG	Office of Inspector General
OT	Occupational Therapy
OVR	Office of Vocational Rehabilitation
PAR	People Advocating Recovery
PCH	Personal Care Home
Ph.D.	A Doctoral Degree
PDD	Pervasive Developmental Disorder
P & A	Protection and Advocacy
P & B	Plan and Budget
P & P	Protection and Permanency (Child Welfare and Adult Protection)
PRTF	Psychiatric Residential Treatment Facility
PT	Physical Therapy
PTSD	Post-Traumatic Stress Disorder
QPR	Question, Persuade, and Refer-a suicide prevention curriculum
RFP	Request for Proposals
RIAC	Regional Interagency Council (IMPACT Program)
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration (within DHHS)
SCL	Supports for Community Living
SED	Severe Emotional Disturbance
SEED	System to Enhance Early Development (state's 3rd SOC grant)
SFY	State Fiscal Year (July 1-June 30)



SIAC	State Interagency Council
SMI	Severe Mental Illness
SPCH	Specialized Personal Care Home
SPMI	Serious and Persistent Mental Illness
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSN	Social Security Number
TA	Technical Assistance
TCM	Targeted Case Management
TFC	Therapeutic Foster Care
TOT	Training of Trainers
WSH	Western State Hospital



APPENDIX C:
ACRONYMS USED IN THE MANUAL



Acronyms Used in the Manual

ACO – Accountable Care Organization

AHP – Advocates for Human Potential, Inc. (contractor)

AMH - Addiction and Mental Health

AMHPAC - Addictions and Mental Health Planning and Advisory Committee (Oregon)

BG – Block Grant

BHIQ - Behavioral Health IQ Assessment

BHPCs - Behavioral Health Planning Councils

CLAS Standards - *Culturally and Linguistically Appropriate Services in Health and Health Care*

CMHS - SAMHSA’s Center for Mental Health Services

CODs - co-occurring mental and substance use disorders

DBHDID - Department for Behavioral Health, Developmental and Intellectual Disabilities

DDCAT - Dual Diagnosis Capability in Addiction Treatment

DDCMHT - Dual Diagnosis Capability in Mental Health Treatment

HRSA - SAMHSA/Health Resources and Services Administration

IOM - Institute of Medicine

LGBTQ - Lesbian, Gay, Bisexual, Transgendered and Questioning

MH – Mental Health

MHBG - Mental Health Block Grant

MHPC - Mental Health Planning Council

MSO – Management Service Organization

NAMHPAC - National Association of Mental Health Planning and Advisory Councils

NASMHPD - National Association of State Mental Health Program Directors

NLC - National Learning Community



NRI - National Association of State Mental Health Program Directors Research Institute

PAC – Planning and Advisory Council

PC – Planning Council

PBHCI – Primary and Behavioral Health Care Integration

SABG - Substance Abuse Prevention and Treatment Block Grant

SAMHSA - Substance Abuse and Mental Health Services Administration

SAPT – Substance Abuse Prevention and Treatment

SED - serious emotional disturbance

SMHAs - State Mental Health Agencies

SMI – serious mental illness

SSAs - State Substance Abuse Agencies

SUDs - substance use disorders

SWOT Analysis - Strength, Weakness, Opportunity, and Threat

TA - Technical Assistance